

budget and cut the only program that benefits them by somewhere close to a million dollars.

Mr. Speaker, I ask my colleagues to support me in this effort. I thank all the Members of the fire and EMS caucus, over 340 of them in the House and the Senate, for paying attention.

Now I say, Mr. Speaker, it is time to respond. I would ask our colleagues to join in this response together.

PATIENTS' BILL OF RIGHTS

The SPEAKER pro tempore (Mr. SHERWOOD). Under the Speaker's announced policy of January 6, 1999, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, I have spoken over the last couple of weeks during our special orders in the evening a number of times on various health care issues because I do believe that this new session of Congress that began a few weeks ago must focus attention and try to pass legislation that would address three major health care concerns. First and in many ways most important because it has moved the furthest and has the best chance I think of getting passed before the Congress adjourns this coming fall is HMO reform, the need to pass the Patients' Bill of Rights which is the House version of HMO reform that passed this fall that is now in conference with the Senate.

The conferees have been appointed, and we understand that the conference is scheduled to meet at some time towards the end of this month, but I cannot stress enough how important it is to move quickly on the Patients' Bill of Rights. I am going to devote my time this evening to that.

I did want to also mention the two other major health care initiatives that were outlined by the President in his State of the Union address and which are at the top of the Democrats' agenda and the second issue after the Patients' Bill of Rights, after the HMO reform, is the need for a prescription drug package, benefit package, under the auspices of the Medicare program.

Any one of us, any Member of Congress, any of my colleagues, either Democrat or Republican, knows that when they go back home, if they have a town meeting or they stay in their office and they hear from their constituents they will hear over and over again about the problems with seniors who do not have access to prescription drugs, either because Medicare does not provide it as a basic benefit or because they cannot find an HMO or pay privately for a medigap policy or some other kind of insurance that will cover prescription drugs. They do not find either the insurance policy affordable or they do not have enough money to pay for the prescriptions on a daily or

weekly basis that they need, and I should mention that tomorrow night during special orders we intend to take up that issue.

The third issue, of course, is access to health insurance for the uninsured. The bottom line is that we now have about 45 million Americans that have no health insurance, and the numbers continue to grow. The President again outlined in his State of the Union address, and as one of the priorities of the Democratic agenda, the fact that we now have articulated a way to try to cover a significant number of those uninsured Americans, first by expanding the CHIPS, the kids' health care initiative, second by enrolling patients of those children who are eligible for the CHIPS, for the kids' care initiative and, third and just as important, addressing the problems of the near elderly, those between 55 and 65 who are not now eligible for Medicare because they are not old enough but who perhaps can buy into Medicare or could buy into Medicare with a little bit of help either through a tax credit or some kind of subsidy from the Federal Government.

I do not think there is any question that all three of these health care initiatives need to be addressed and can be addressed in a bipartisan way in this Congress if we sit down and put our minds to it. So far, the Republicans have not moved on any of these initiatives, any of the three; and I want to concentrate tonight on the Patients' Bill of Rights because I think that has the best chance of getting passed and getting to the President's desk.

I have been basically critical of the Republican leadership in the House because they dragged their feet so long on true HMO reform, and the Patients' Bill of Rights was a piece of legislation that was put together by Democrats but with the help of some Republicans, the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Iowa (Mr. GANSKE). These were physicians and health care professionals who worked with the Democrats, a small group of Republicans, in trying to put together the Patients' Bill of Rights.

We had a very hard time getting a hearing, getting anything out of committee, getting it brought up on the floor. The Republican leadership put up all kinds of roadblocks and alternatives, but finally we were able to pass the Patients' Bill of Rights in the House of Representatives.

I would like to outline a little bit of the good points of the Patients' Bill of Rights and why we insist, as Democrats, that this be the bill that finally goes to the President. I say that by way of contrast because on the Senate side, the other body, I should say, the other body has passed a bill that is now in conference with the House version; but the version passed in the other body is far inferior and does not really constitute true HMO reform.

Before I get to the contrast, let me, Mr. Speaker, talk about what is in the House bill in the Patients' Bill of Rights and why it is so important for the average American that this legislation pass pretty much intact.

I think a lot of people are aware of the abuses and excesses within the HMO system. What happens frequently, when I talk to my constituents, is they complain to me about the fact that they need a certain procedure, a certain operation, or they need to stay in the hospital a certain number of days or they need certain kinds of medical equipment and the insurance company says, no, we will not pay for it. We do not think it is necessary.

The problem is that too often that is the case. Something, whether it is an operation or procedure or some kind of service or equipment, that your physician feels is necessary, medically necessary, the insurance company says is not. Well, we know traditionally that the doctors who were sworn to the Hippocratic oath and went to school to learn what is good for you should be, with you, should be making the decisions about what kind of medical care you need. That is why they went to school. That is why they became doctors. They are now hamstrung. They do not have the ability to decide what kind of medical care you get because if the insurance company will not pay for it and you cannot afford it, you are simply out.

So what we really need to do, and I think the two most basic aspects of the Patients' Bill of Rights that are really crucial is, one, the decision about what is medically necessary needs to be taken from the insurance company, from the HMO, and given to the physician and you, the patient, and that decision about what is medically necessary then is once again made by the physician and the patient, not by the insurance company.

The second thing is that if you are denied care, if you are told that this is not medically necessary by the insurance company, then you should have some way to redress that grievance, either by some sort of external review that is not influenced and decided or determined by the insurance company, or ultimately be able to go to court and sue the HMO for your rights or for any damages that are inflicted upon you because you were not able to have the medical procedure that you and your physician deem medically necessary.

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Well, unfortunately, that is not the case right now. Right now, many times the insurance company has an internal appeal procedure but they control the procedure, and they simply say we made the right decision and that individual cannot sue. Because under Federal law, in many, many cases, an employee that works for an employer who

is self-insured, which most of the larger ones are, then under Federal law, what we call ERISA, there is a Federal preemption that says an individual cannot bring suit against the HMO, against the insurance company.

Well, the Patient's Bill of Rights reverses all that. Basically it says the decision about what is medically necessary is made by the physician and the patient, not by the insurance company. And in order to enforce that definition about who decides what is medically necessary, there is both an internal review and an external appeal that is devoid of the influence of the insurance company because it is a panel that does not have the insurance company on it. And then, failing that, you have the right to go to sue and for the court to make a determination that that particular operation or procedure should be granted; or, alternatively, if the procedure or operation was denied and someone has suffered, that damages can be obtained from the HMO because they denied what was legally entitled.

Those are the basic tenets of the Patient's Bill of Rights. There are a lot more specific items, which I would like, Mr. Speaker, to basically outline, if I could, for a few minutes this evening. And I am only going to cover the ones that I hear the most about in terms of abuses that come to me from my constituents.

One is with regard to emergency services. In the Patient's Bill of Rights, individuals are assured that if they have an emergency the services will be covered by their insurance plan. The bill says that individuals must have access to emergency care without prior authorization in any situation that a prudent layperson would regard as an emergency.

Now, that sounds a little bureaucratic, but basically it is saying that the insurance company cannot say, if an individual has an emergency and they think it is a legitimate health emergency, that they have to go to a particular hospital which may be much further away than the closest one, or that they have to call the insurance company and get a prior approval before they go to the emergency room.

Some people say how can that be? How can they issue a call for approval if they are having a heart attack? Unfortunately, in many cases, that is the case. And in many cases they will not pay if a patient goes to the emergency room that is a few blocks away, because they say that individual should have gone to one that was 30 miles away. Well, this Patient's Bill of Rights, this bill, says that is not the case.

If the average person would think, for example, that they are having a heart attack, they can go to the nearest emergency room and they do not have to call for prior approval, because

it is a true emergency and there is no time for it.

The second major area in terms of access to care under the Patient's Bill of Rights is specialty care. Patients with special conditions must have access to providers who have the requisite expertise to treat their problem. The bill allows for referrals, for enrollees to go out of the plan's network for specialty care at no extra cost if there is no appropriate provider in the network for covered services.

So what it says is, if the HMO does not have a particular person who can handle that specialty care, and I will give an example, the HMO may have a number of pediatricians but they do not have a pediatrician who specializes in heart problems or one who specializes in kidney problems or whatever, then that individual would be able to go outside the plan's network and get a doctor who has that particular ability and there would be no extra charge to them.

In addition, for individuals who are seriously ill or require continued care by a specialist, plans must have a process for selecting a specialist as a gatekeeper for their condition to access necessary specialty care without impediments. This is a situation where the HMO says an individual can go to a cardiologist, but every time they go, or maybe every other time, they have to get another referral from the primary care physician. Well, if this is a chronic illness where that individual needs the cardiologist on a regular basis, the cardiologist should be the person the patient sees regularly without having to go to their primary care physician for approval every time.

That is very important for a lot of people. Because what happens is the primary care physician becomes the gatekeeper. And if he is under pressure, he or she is under pressure not to allow too many visits to the specialist, then that patient may not have access even though they have a chronic illness to the cardiologist, for example, on a regular basis.

The Patient's Bill of Rights provides direct access to OB-GYN care and services for women. It ensures that the specialties of children are met, including access to pediatric specialists and the ability for children to have a pediatrician as their primary care provider. I could go on and list a number of other things that are provided and guaranteed as patient protections under the Patient's Bill of Rights, but I think I have covered enough of some of the major areas that people complain to me about where abuses exist.

I do want to talk a little bit about information, though, because many people complain to me and say that their HMO, when they sign up, does not provide adequate disclosure of what benefits are provided and what is essentially in the insurance plan. That is a

major problem because many times seniors sign up for HMOs and they do not necessarily know what they are getting into. They do not know the limits of it.

We have in the Patient's Bill of Rights protections with regard to health plan information that says informed decisions about health care options can only be made by consumers who have access to information about their health plans and, therefore, we require managed care plans to provide important information so that consumers understand their health plan's policies, procedures, benefits, and other requirements.

Now, that is a kind of a general broad statement, but I will give an example. In my home State of New Jersey, Mr. Speaker, there have been a number of situations over the last 6 months where HMOs have decided to drop seniors in a given area or for a given reason, and a lot of the seniors do not understand that that can happen. So that is the type of information that they certainly should have.

I talked about the external appeals process; that individuals would have access to an external independent body with the capability and authority to resolve disputes for cases involving medical judgment. If a plan refuses to comply with the external reviewer's determination, the patient may go to Federal Court to enforce a decision about what is medically necessary. We have already discussed that.

There are also a number of protections with regard to the doctor-patient relationship. Many of my constituents are surprised to learn that we have gag rulings with a lot of the HMOs today. In other words, if the HMO, or the insurer, figures that a particular operation or procedure is not going to be paid for, is not going to be covered, they will simply tell the physician that the physician cannot talk about that procedure because it is not covered.

Well, it is bad enough if the doctor tells his patient that they need a particular operation and then the patient finds out the insurance company will not cover it. But imagine that the doctor cannot tell his or her patient about an operation, even though he or she feels that that patient needs it, because the HMO contract says he cannot talk about it if it is not covered. Well, that is in fact a reality for many Americans today with some of the HMOs. That is totally wrong. It violates every notion of freedom of information and free speech. I suppose it is questionable whether it is even constitutional.

But we, in the Patient's Bill of Rights, specifically say that we prohibit plans from gagging doctors and from retaliating against physicians who advocate on behalf of their patients. We also prevent plans from providing inappropriate incentives to providers, to physicians, to limit medically necessary services. So, in other

words, there cannot be any financial incentive, which is often the case to a physician if he cuts back on services or does not provide for a number of services and keeps costs down for the HMO, for the insurance company, in that way.

There are a lot of other protections in the Patient's Bill of Rights, and I do not want to go through every one of them, but, Mr. Speaker, I do want to make the point that this is a very strong bill. And this problem is a problem, the abuses within HMOs, that Americans and all our constituents face. These abuses need some very strong medicine to make sure that they do not occur any more on a regular basis. That is why the Patient's Bill of Rights is a strong bill, and that is why Democrats, myself and other Democrats, keep insisting that it be the bill that comes back to the House from the Senate and goes to the President's desk. Because if we do not have good patient protections and strong patient protections then we will not accomplish anything in terms of this debate on the HMO reform.

Now, I wanted to, if I could, just make some comparisons with the version of HMO reform that came from the other body, from the Senate, and is now in conference with the House Patient's Bill of Rights that I just described. The point I want to make here is that if the conferees, when they meet, were to accede to a version that is more like the Senate bill as opposed to the House Patient's Bill of Rights, we would have accomplished nothing, in my opinion, on this issue, and no reform that is meaningful would take place in this session of Congress.

I will give some examples of how the Senate Republican bill differs from the House Patient's Bill of Rights. The Senate bill leaves more than 100 million Americans uncovered, because most substantive provisions or protections in the bill apply only to individuals enrolled in private employment-based self-funded plans.

Now, this is what I talked about before where most of the larger employers, and even some smaller employers but certainly most of the larger employers, they have their own insurance fund. They are self-insured. Well, about 100 million Americans, the majority of Americans, do not fall into that category. What the Republican bill says is that the bill applies only to individuals who are enrolled in those self-funded plans. So most Americans would not even be covered by the patient protections because they are not in those self-insured plans that the Senate bill covers.

Just an idea. There was a study done by Health Affairs, which is a publication, that found that only 2 percent of employers offer HMOs that would be covered by the standards in the Senate bill and only 9 percent of employees are

in such HMOs. Self-funded coverage is typically offered only by large companies. Of the 161 million privately insured Americans, only 48 million are enrolled in such plans. Of those 48 million only a small number, at most 10 percent, are in HMOs.

So that is an interesting statistic. Because what it says is that of all the Americans out there who are covered by health insurance, only 48 million are in these self-insured plans that are covered by the Senate bill. But even of those 48 million, about 10 percent are in HMOs because most of the people who are in those plans are not in HMOs. They are probably in some kind of traditional insurance policy on a pay-as-you-go basis as opposed to an HMO.

The Senate bill does not allow designation of an OB-GYN, or obstetrician gynecologist, as a primary care physician. With regard to the specialty care that we talked about, it provides no ability to go outside the HMO network at no extra cost if the HMO's network is inadequate. So what I said before, about the House version of the Patient's Bill of Rights, it says that an individual can get a specialist outside the network at no extra cost if they do not provide it in the network. We do not have that language in the Senate bill.

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It allows the HMO to write contracts rendering the protection meaningless, e.g., specialty care is covered only when authorized by a gatekeeper. There are all kinds of gimmicks, if you will, in the Senate bill that basically make it difficult to really apply any of the patient protections in a significant way.

I just wanted to mention a couple more things, just by way of contrast. With regard to continuity of care for patients, in other words, when a doctor is dropped from a network or an employer changes insurance plan, in the Senate bill it leaves out protection for all Americans who are not terminally ill, pregnant, or hospitalized. It provides only 90 days of continued care for terminally ill or hospitalized patients, forcing them to change doctors or hospitals even if they live longer or have not been discharged from the facility.

Most important, though, and I think this really gets to the heart of the debate, in the Senate bill, and this goes back to what I said before, Mr. Speaker, the key really to this HMO reform is who is going to define what is medically necessary and how are they going to enforce their rights if they have been denied care that they and their physician think is medically necessary.

Well, in the Senate bill, in the Senate Republican bill, the HMO continues to define what is medically necessary. No matter how narrow or unfair to patients the HMO's definition is, their

definition controls in any coverage decision, including decisions by the independent third-party reviewer.

So what that says is that, if my physician and I feel that I need a particular operation and the HMO denies it, even if I go to an outside reviewer, they are only reviewing the HMO's definition of what is medically necessary; they cannot go beyond that definition. So if the HMO defines what is medically necessary in a way that would preclude that particular operation procedure, it does not matter whether they go to an outside panel or if they go to court, or whatever, because the bottom line is the HMO is going to decide what is medically necessary.

I could go on and on and talk about so many other things in the Senate bill. It does not ensure doctors can talk about the HMO's financial incentives or its processes. It does not prohibit the gag clauses that I talked about before. In terms of information that is provided to patients when they sign up for their HMO, it is very limited in the Senate version.

And so, again, the point that I am trying to make is that we can hear my colleagues on the other side of the aisle talk all they want about how they want to pass good HMO reform, but the only way that is going to happen is if this conference comes up with a bill that is very much like the House passed Patients' Bill of Rights. Without that, if the bill comes out similar to the Senate version, in effect, the Congress would have failed in its responsibility to enact true HMO reform.

The one other thing that I wanted to mention in the context of the Patients' Bill of Rights and HMO reform, the Republican leadership in the House, when they passed the Patients' Bill of Rights, attached to it a number of provisions which I call poison pills. These are provisions that really have nothing to do with patient protections but which the Republican leadership claim also address some of the access problems for the uninsured.

We do not have a consensus in the House or in the Senate at this point on how to deal with the problem of the uninsured. Obviously, as I mentioned before, the Democrats and myself feel very strongly that what is needed is a major effort through legislation both monetary as well as a change in policy that would allow children, the parents of children who are not covered, and the near elderly, at a minimum those groups, to be insured.

The President has talked about, as I mentioned before, a major new initiative that expands the kids' health insurance to sign up more kids, to sign up the parents of those kids that were uninsured and to make it possible for people who are 55 or 65 to buy into Medicare or to even have a subsidy or a tax credit so they could afford to do so.

What the Republicans have done with the Patients' Bill of Rights, they have attached provisions which they claim are going to address the problems of the uninsured but do not effectively do so. They have attached provisions that would expand MSA, medical savings accounts.

Medical savings accounts are a device whereby, under Medicare, for example, rather than buy an HMO or traditional fee-for-service policy, they could buy a policy whereby they get a lump sum; and if they do not use a certain amount of their care over the course of the year, that money is paid back to them in a check that they can use to go on a vacation or to buy a car, whatever they want to do.

Basically what it does is to create a situation where they are kind of gambling with their health, if you will. They assume that they will not have certain expenses; and they, basically, establish a threshold, if you will, for the level of care that if they do not meet they pay out of pocket up to that certain threshold. And it has not worked.

I mean, basically, very few Americans have signed up for medical savings accounts. And the whole idea is, essentially, something that very few seniors or anybody is responding to. But the Republican leadership says, oh, this is a great idea. This is a great way of expanding health insurance. Well, I do not see how it accomplishes that at all.

They also have HealthMarts and they have other devices that supposedly are going to make it possible for more people to have health insurance but, in fact, do not accomplish that at all.

What I see happening here, without getting into the details of it, is, rather than addressing the Patients' Bill of Rights and trying to come to a consensus on the HMO reform that the majority of the people in the majority of this Congress have supported, they now are trying to muck up this whole issue by talking about these access issues for which there is no consensus and which will simply delay any action on the Patients' Bill of Rights and on HMO reform in this Congress.

And so, what I have said to my colleagues, and I will say again, Mr. Speaker, is let us pass a good Patients' Bill of Rights; let us deal with the HMO reform issue, which is now ripe, which overwhelmingly the people and the Members of Congress have voted for in this House and support; let us go with the House version; let us send this to the President, because he says that he will sign it; and let us make this the first priority to show that that Congress can accomplish something that is important to the American people on a bipartisan basis.

I know that I, as a Democrat, and my colleagues on the Democratic side, including those of us who are conferees, will continue to insist on that, insist

that the conference meets, that we come up with a strong Patients' Bill of Rights similar to the House version, and that we get it to the President so that we can have a great accomplishment and a great victory for the American people. And we will be back here many times in the evening demanding that that happen. Because the Republicans are in the majority and they control the process, and it is up to them to make sure that this happens, with bipartisan support from the Democrats.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. DEFazio (at the request of Mr. GEPHARDT) for today and the balance of the week on account of illness.

Mr. STUPAK (at the request of Mr. GEPHARDT) for today on account of medical reasons.

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

Ms. CARSON (at the request of Mr. GEPHARDT) for today on account of official business.

Mr. BAIRD (at the request of Mr. GEPHARDT) for today on account of an unavoidable family matter.

Mrs. CAPPS (at the request of Mr. GEPHARDT) for today on account of a death in the family.

Mr. SCHAFFER (at the request of Mr. ARMEY) for today on account of official business.

Mr. SAXTON (at the request of Mr. ARMEY) for today on account of illness in the family.

Mr. CALLAHAN (at the request of Mr. ARMEY) for today and the balance of the week on account of a death in the family.

Mr. KASICH (at the request of Mr. ARMEY) for today 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 Ms. JACKSON-LEE of Texas) to revise and extend their remarks and include extraneous material:)

Mr. BISHOP, for 5 minutes, today.

Mr. BARCIA, for 5 minutes, today.

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

Mr. GUTKNECHT, for 5 minutes, today.

Mr. WOLF, for 5 minutes, today.

Mr. WELLER, for 5 minutes, February 16.

Mr. HUTCHINSON, for 5 minutes, today.

Ms. ROS-LEHTINEN, for 5 minutes, today.

Mrs. MORELLA, for 5 minutes, February 15.

Mr. HANSEN, for 5 minutes, February 15.

Mr. MCINNIS, for 5 minutes, February 15.

ENROLLED BILLS SIGNED

Mr. THOMAS, from the Committee on House Administration, reported that that committee had examined and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 764. An act to reduce the incidence of child abuse and neglect, and for other purposes.

H.R. 1451. An act to establish the Abraham Lincoln Bicentennial Commission.

SENATE ENROLLED BILL SIGNED

The SPEAKER announced his signature to an enrolled bill of the Senate of the following title:

S. 632. An act to provide assistance for poison prevention and to stabilize the funding of regional poison control centers.

ADJOURNMENT

Mr. PALLONE. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 8 o'clock and 38 minutes p.m.), under its previous order, the House adjourned until Tuesday, February 15, 2000, at 9:30 a.m., for morning hour debates.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

6150. A letter from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting the Department's final rule—Horses From Qatar; Change in Disease Status [Docket No. 97-131-3] received January 3, 2000, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

6151. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Mepiquat Chloride; Pesticide Tolerance [FRL-6485-4] received January 3, 2000, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

6152. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Maneb; Extension of Tolerance for Emergency Exemptions [OPP-300954; FRL-6394-9] (RIN: 2070-AB78) received January 5, 2000, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

6153. A communication from the President of the United States, transmitting the request and availability of appropriations for the Department of Health and Human Services' Low Income Energy Assistance Program; (H. Doc. No. 106-196); to the Committee on Appropriations and ordered to be printed.