

I guess if I lived in other parts of the country, I would have a hard time believing as well that that is how we can treat our children. I think I said it to the gentleman from North Carolina once I heard that Reverend Jackson had taken a number of children from inner-city schools in Chicago and brought them out to the suburbs and showed them what it was like in those suburban schools. What I thought was more important, he took those children from the suburbs and brought them back to the city to show those children what the city schools are like and what they were not afforded in those schools.

I think the same can be done in my district. We are lacking so much in terms of proper environments to, as the gentleman said before, caring, instilling that in children.

Getting back into buildings, we really have to address that issue. I do not want to wait to address that issue before we start addressing this issue as well. But sometimes it can be difficult to imagine how can we do this, how can we teach all these issues, respect and caring and honesty and justice and fairness and citizenship, when children are being taught in makeshift classrooms and hallways. There is no gym anymore because it has been put into cubicles so children can have a seat in a classroom.

What we are facing in my district is that, by the year 2007, if we do not do more, we are going to be between 20,000 and 60,000 seats shy in Queens County alone. Queens County is going to be between 20,000 and 60,000 seats shy. It is a major, major crisis. So it is sometimes hard for me to imagine how we can do it.

We have great teachers in New York City. We really do, fantastic and dedicated people. But it is hard to imagine how can they do it. They have to.

We need to do this, and we cannot wait for the other to get done first. We have got to address both. But it is an awesome task and awesome responsibility. But I do hope, despite our problems in New York, that this bill does become more.

Mr. ETHERIDGE. Mr. Speaker, I think it comes back to the issue that the gentleman from New York raised earlier. We have to do it whether it is done at the Federal, State, local, however, jointly get the job done.

In my district, well in North Carolina as a State, over the next 10 years, we are projected to be the fifth fastest growing State in the Nation in school population. We cannot build schools fast enough. Yet, I went by a school, visited a school earlier this morning where my children used to go. It is a fairly new school by school standards. They had trailers all over the place. All the inside interior of the building, like the gentleman from New York was saying, the lounge was now a classroom. It

was never built for a classroom. It was a small area where one was tutoring students. That is not acceptable. That is not acceptable. They are doing it, but it is not acceptable.

One can talk about these principles, and one can teach them, and teachers can reinforce them. But children also understand that somewhere along the line somebody is not being quite honest with them when they say they do not have the resources when they see other nice new buildings going up or they think they are not really caring whether other things are happening when they could provide those resources. Children do not know what they need. They only know what they get.

Mr. CROWLEY. Mr. Speaker, just going back to the list of the gentleman from North Carolina again, it is a lack of responsibility, a lack of caring, a lack of being honest, a lack of justice and fairness, a lack of respect.

A word that is not up there but I think is encompassed in all of that I think is dignity. There is no dignity here if we are not teaching these points we are talking about here. But more importantly, if we are not demonstrating it on a daily basis in school construction and modernization, giving them the tools and making sure the teachers are prepared are really all a part of that. But right now, if we do not provide these, we are guilty of not showing the true dignity of the student and the individual and the human being.

Mr. ETHERIDGE. Mr. Speaker, I thank the gentleman from New York (Mr. CROWLEY) for sharing with me his time this afternoon and sharing with my colleagues and the people the critical needs of, not only character education, but this whole issue of education that he cares so much about and has worked so hard on here, and I thank him for it.

As we work together with our colleagues to make sure that, not only is character education integrated and a part of our curriculum in the future, but all of these issues of education continue to be at the top of our agenda. Because if we are going to have the kind of future we want to have in the 21st century, and America continues to be strong and a Nation that leads the world, we will do it through one thing. We will do it through education and providing those opportunities to our children and all the children of this country, no matter where they may live, no matter what their economic background might happen to be.

□ 2130

HMO LEGISLATION

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

Mr. GANSKE. Mr. Speaker, I rise tonight to clarify points about HMO legislation before Congress for my colleagues, particularly members of the conference committee, and to specifically address two memoranda that have been recently released by the Heritage Foundation and one by the Blue Cross/Blue Shield Association.

Mr. Speaker, I refer to the Heritage Foundation Background N1350, The Patients' Bill of Rights, Prescription for Massive Federal Health Regulation, by John Hoff; to Heritage Foundation Executive Memorandum 658, Why the Texas HMO Liability Law is Not a Proven Model for Congress; and to a letter by Mary Nell Leonard, Senior Vice President of Blue Cross/Blue Shield, with accompanying memo, A Regulatory Quagmire, Questions and Answers about the Bipartisan Consensus Managed Care Improvement Act of 1999.

Mr. Speaker, these memos are primarily a rehash of previous arguments that have been made frequently on the floor. We had several days of full debate on the Bipartisan Consensus Managed Care Improvement Act, and we debated all of these issues. However, these repackaged arguments deserve comment, I think, precisely because they are so specious.

Let me start with the Backgrounder. It makes three main charges: that the House bill would encourage costly litigation, expose employers to risk of litigation over benefits, and would impose powerful new Federal regulations on private health plans.

The organization of this paper is clever in that there is a mixture of accuracy and distortions in discussing the House bill. But it primarily tries to scare conservative legislatures with the bogeyman of massive Federal regulation. The summary of this paper bemoans the establishment of an intrusive new Federal bureaucracy with new rules on utilization review, internal and external review, grievance processes, drug formularies, clinical trials, patient information, and doctors' incentive arrangements, among others.

This paper makes it seem as if these rules are proposed just for the fun of it, as if these new regulations would be there just for their own sake. Well, Mr. Speaker, the gentleman from Georgia (Mr. NORWOOD), the gentleman from South Carolina (Mr. GRAHAM), the gentleman from Georgia (Mr. BARR), myself, and many other conservatives do not propose regulations just for the hell of it. The paper leaves unmentioned the reasons for these rules for HMOs, reasons why 80 percent of the American public wants Congress to fix this problem and fix it now.

Let me give my colleagues some real-life examples of why new rules are necessary for HMOs. This little boy lost his hands and his feet because an HMO decided he could travel 60 miles to an

emergency room instead of going to the nearest emergency room. This woman lost her life because an HMO gagged her doctors. This woman's HMO would not pay her hospital bills because, when she fell off a cliff and went to the emergency room, she had not phoned for prior authorization.

Mr. Speaker, if regulation is bad simply because it is regulation, then we can just pack up the Federal and State governments, and we can all go home. Of course, we would soon have monopolies controlling everything; water we could not drink and buildings that fall down in earthquakes.

Mr. Speaker, a year ago we talked an awful lot on this floor about the rule of law. Well, without patient protection legislation, we will sure continue to have lawless HMOs. If there are no Federal standards in health care, then who does ensure quality and solvency? Who fights against fraud in the insurance industry?

Well, the State should do it, some say. Okay. Then let us repeal ERISA, the Employee Retirement Income Security Act, which preempts State oversight of employer health plans. Let us turn it back to the States. Oh no, would say the group health plans. We do not want State oversight. But then again, we do not want Federal oversight either. To be quite frank, the HMOs say, we do not want any oversight. So just leave ERISA alone, we will police ourselves, thank you.

Well, Mr. Speaker, maybe we ought to ask that little boy who lost his hands and feet, or the family that lost its mother how well self-imposed standards in the HMO industry work.

I could give a reasoned rebuttal to every page of this Backgrounder, but we do not have time tonight to go over this sentence by sentence. So let me just give my colleagues a few examples.

On page 4 this paper says the House's bill's external appeals board is "biased" because, and this is from the Backgrounder, "neither the entity nor its members can have what is considered to be a conflict of interest or have familial, financial, or professional relationships with the insurer, the health plan, the plan sponsor, the doctor who provided the treatment involved, the institution at which the care is provided, or with the manufacturer or medical supplier involved in the coverage decision." That is in the Backgrounder.

This Backgrounder says the board is "biased" because it does not have a specific statutory language prohibition against one of those peer reviewers having a familial relationship with the patient but does prohibit a relationship with the HMO. Well, Mr. Speaker, that is just plain wrong. The bill that passed on this floor with 275 votes specifically says, "A clinical peer or other entity meets the independence require-

ment of this paragraph if the peer or entity does not have a familial, financial, or professional relationship with any related party." Mr. Speaker, what could be clearer than that?

Or how about the discussion on the "medical necessity quandary" on page 5 of this Backgrounder? Now, I have spoken many times on this floor about the Employee Retirement Income Security Act and medical necessity. Indeed, the Heritage Backgrounder tries to use some of my own arguments.

Under current Federal law, HMOs can define as medically necessary or unnecessary anything they want. One HMO, for example, has defined medically necessary as "the cheapest, least expensive care." That HMO could deny surgical correction of this boy's cleft palate because it would be cheaper to just provide a plastic upper denture. Of course, his speech would not be very good, but it sure does meet that plan's definition of medical necessity. After all, that would be cheap.

The bipartisan House bill corrects that travesty by giving the external appeals board the final say in determining medical necessity, as long as the treatment is not explicitly excluded from coverage in the contract. The review panel can consider many things in its decision, even the plan's own guidelines, but is not "bound" by those planned guidelines.

So the author in this Backgrounder rightly states that outcomes data can provide valuable guidance but cannot match the characteristics of individual patients, thus echoing arguments that I have made on this floor many times. Amazingly, he then, the author of this paper, then criticizes the House bill's external appeals provision exactly because it recognizes that reality and states that the appeals board can consider outcome studies but is not bound by them.

But in the very next paragraph in this paper, we get to what the HMOs really do not like about that provision in the Bipartisan Consensus Managed Care Improvement Act that passed this House, and that is that doctors, not HMO bureaucrats, would be making those medical decisions. As this paper states it, "The legislation would punt these crucial questions to the subjective consideration of external reviewers." Mr. Speaker, note the pejorative words punt and subjective. Where in this paper is the criticism of the "subjective consideration" of HMOs looking at their bottom line?

The author goes on to say, "The bill will turn the determination of what is covered over to government-controlled external reviewers who are directed to make their decision regardless of what the private health plan and its enrollees agree upon." Once again negative adjectives, like government-controlled, show the writer's prejudice. For heaven's sake, we have already established

that the House bill reviewers are independent, not government-controlled. What the HMOs really do not like is that the peer reviewers in the bill that passed this House are not HMO controlled.

Furthermore, as I already stated, the external panel cannot overrule specifically excluded benefits. But that is rarely where the dispute is. It usually involves denial of care for treatment that fit well within standards of care.

To show my colleagues how abusive the HMO industry can be on this issue of medical necessity, listen to testimony that a former HMO medical reviewer gave before my congressional committee in which she admitted that she had made medical decisions for HMOs that had killed people. She said, "I wish to begin by making a public confession." Mr. Speaker, this is a former HMO medical reviewer. She said, "In the spring of 1987, as a medical reviewer, I caused the death of a man. Since that day, I have lived with this act and many others eating into my heart and soul. The primary ethical norm is to do no harm. I did worse; I did death. Instead of using a clumsy bloody weapon, I used the 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 this moment. When moral qualms arose, I was to remember 'I am not denying care, I am only denying payment.'"

This former HMO medical reviewer then listed the many ways that managed health care plans deny care to patients, but she emphasized one particular point: the right of HMOs to decide what care is medically necessary. She said, "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.

□ 2145

"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 is rarely available for prior review by the physicians or members of the plan."

Well, Mr. Speaker, I have a complete discussion of this critical issue in this Dear Colleague. I will be sending this Dear Colleague to every Member of the House and the Senate. I especially hope that the conferees, at least, will take the time to read this because this is one of the two or three most important issues before the conference.

The next several pages of this Heritage paper describes some of the House bill's provisions, again, without providing a context of the problems with HMOs that make these provisions important. The author even criticizes the

prohibition on gag rules that some HMOs have tried to impose on doctors.

For heaven's sake, Mr. Speaker, over 300 Members of the House signed on to a bill that would ban HMOs from trying to keep doctors from telling patients the whole story about their treatment options.

Apparently, the Heritage Foundation also does not like the fact that Congress has already prohibited Medicare HMOs from paying doctors to limit care. This is on page 9 of this Backgrounder.

The Norwood-Dingell-Ganske HMO reform bill uses the same language that the vast majority of Members of this House and the Senate voted on for Medicare to prohibit HMOs from paying doctors to limit care.

I am a physician, and I want to tell my colleagues that there should not be a conflict of interest in doctors providing needed care to their patients. Yet some HMOs pay a doctor more if he or she withholds referrals or treatment.

Congress has already overwhelmingly said that this practice is ethically wrong. So, as an aside, and I hope somebody from the Supreme Court, some clerk, is listening to this special order, I think the Supreme Court should consider that Congress has already legislated on this behavior of HMOs as it considers the Hurdrick case that is currently on its docket.

Well, this paper even calls the bipartisan bill an attack on fee-for-service coverage. Wrong again. In fact, the House bill recognizes the difference between HMOs and fee-for-service plans and exempts those fee-for-service plans from requirements that are pertinent to HMOs.

The House bill would, however, require PPOs and point-of-service plans to follow fair utilization reviews, a fair internal and external appeals process, and require that enrollees be given adequate information about the plan. ERISA plans do not currently have to do that. And 275 bipartisan supporters of the House bill do think that every plan covering everyone in this country, regardless of the type, should follow those minimum requirements.

Now, the Blue Cross paper, "a regulatory quagmire," tries to make some similar points on regulation. So my comment will apply to both. I would note that Blue Cross owns HMOs, so caveat emptor.

Well, how would the House bill work? As in the Health Insurance Portability and Accountability Act, the provisions of the House bill form a Federal policy floor. States are encouraged to bring their laws into compliance. If a State fails to enforce the law, then the Federal Government would. Same way under the Health Insurance Portability Act. And under the Health Insurance Portability Act, all States except four have already complied.

Now, on the patient protection issue, most States have already enacted some of the provisions of the House HMO reform bill into State law. For example, 50 States have enacted internal review, 50 States have enacted access to information, 46 States gag prohibition, 41 States emergency care provisions, 32 States external review, 34 States direct access to OB-GYNs, 24 States continuity-of-care provisions.

Mr. Speaker, it will not be hard for those States to comply. But the important point to note is that no matter how good a State's patient protections law are, these State laws generally do not apply to ERISA plans. And that is exactly why we need Federal legislation to protect the people who receive their insurance from their employer.

Now, the HMO industry complains that the Norwood-Dingell-Ganske bill would result in dual regulation and be confusing to consumers. But we have dual regulation today. We already have complex dual regulation that differs from jurisdiction to jurisdiction.

The Bipartisan Consensus Managed Care Improvement Act will actually simplify things for consumers. What is clear today is that the consumer in an ERISA health plan, an employer health plan, has basically nowhere to go to turn for help. But if our bipartisan House bill would become law, the vast majority of consumers would be able to go to their State insurance commissioners for questions about their rights because all States would have a minimum standard.

Furthermore, I would point out that it can be hardly valid to criticize the House bill for Federal-State conflicts. We have had a Federal-State system of regulation of commerce for 200-plus years.

Yes, if the Norwood-Dingell-Ganske bill becomes law, there will be questions of Federal-State jurisdiction to work out, as there is in any bill. And I would say, what is new?

Now, as an example of delay of implementation, the Blue Cross memo, the one that says "quagmire of regulation," points out that the Health Insurance Portability Act still has not been fully implemented on the privacy regulations. Well, I should point out that Congress had something to do with that, since Congress did not meet its own deadline on legislation for privacy. But I sure do not see any groundswell calling for repeal of the Health Insurance Portability Act. In fact, Mr. Speaker, I have had many constituents thank me for their health insurance portability.

In any congressional bill, there has to be the right balance between prescription and flexibility. The House bill provides a reasonable balance. But on page 6, again of this Heritage Backgrounder, the legislative language of our bill, the House bill, is criticized for being too loose. But then, Mr.

Speaker, on page 11, the same bill is criticized for being too rigid. There is just no pleasing those opponents of HMO reform.

Let us discuss the liability issue a bit. The HMO community is clearly getting nervous that Governor Bush says he supports the Texas Health Care Liability Act of 1997. So Heritage came out with a memo entitled "Why the Texas HMO Liability Law is not a Proven Model for Congress."

However, if you actually read the memo, you will be struck with how similar the House bill is to the Texas law, which Governor Bush says is working just fine, thank you. No avalanche of lawsuits. No extraordinary increase in premiums. No Diaspora of HMOs from Texas.

Now, the Heritage memo notes that, on September 1, 1997, the Texas legislature passed the Texas Health Care Liability Act, according to Heritage, by a "sizable majority." Sizable majority indeed. The bill passed the Texas Senate unanimously. It passed the Texas House 120-21. It was veto proof.

Well, what did the Texas bill do? According to this Heritage paper, it "created a new cause of action against three entities in the event of a failure to exercise ordinary care. These entities are: a health insurance carrier, a health maintenance organization, or other managed care entity."

Mr. Speaker, in plain language, the Texas liability bill allowed patients to sue HMOs for negligence, just plain language.

So what has happened in Texas since the bill was passed? Well, in September 1998, Federal judge Vanessa Gilmore refused to void the Texas right to sue. On October 18, 1999, the first case was filed "Plocica v. NYLCare."

The HMO wanted the case moved to Federal court, but the Federal court remanded it back to State court. But it is interesting to know a little bit about this case because it makes the case for having a strong enforcement provision in a bill that Congress would pass.

Mr. Plocica was suicidal in a hospital in Texas. His treating doctor thought he should stay in the hospital, needed more psychiatric care. His HMO, NYLCare, said, no, we are sending you home. Under State law, NYLCare should have taken their treatment denial to what Governor Bush calls the "IRO Panel," the Independent Review Organization Panel. But NYLCare ignored State law, so Mr. Plocica went home. That night he drank half a gallon of antifreeze, and he died a horrible death. His family has sued NYLCare for breaking Texas law.

It should be noted that, under current Federal ERISA law, NYLCare would be liable for only the cost of care denied, in this case I guess the cost of a day or two in the hospital. That is hardly justice to a family that has just

lost its father and hardly a disincentive to an HMO from not following the law.

There have been only a few cases filed under Texas law. Heritage says it is too early for this to be accurate. I would point out that Texas has a 2-year statute of limitations on these cases.

What you see is what you have got. If the cases are not filed by now, they never will be. The Texas law exempts employers from liabilities stating "this chapter does not create any liability on the part of an employer or employer group, purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees."

Mr. Speaker, the Norwood-Dingell-Ganske bill is written differently, for the following reason: Unlike State-regulated plans, ERISA, the Employee Retirement Income Security Act, provides liability preemption for self-insured plans, some of which are self-administered or actually are HMOs owned by the company.

Now, I am referring here to section 302(a) of the Bipartisan Consensus Managed Care Reform Improvement Act of 1999. This section creates a limited exception to ERISA's general "preemption" of State laws that relate to employee benefit plans. This exception only applies to State law causes of action against any person based on personal injury or wrongful death resulting from providing or arranging for insurance, administrative services or medical services by such person to or for a group health plan.

So that is kind of complicated language. Let me see if I can explain this a little simpler. This language does not, let me repeat, "does not" disturb ERISA preemption of State law actions against a plan sponsor except, "except" for the exercise of discretion by an employer on an employee's treatment that has resulted in a personal injury to that patient.

□ 2200

Other decisions by plan sponsors, including setting up a uniform benefit plan, is not, let me repeat, is not affected by section 302(a) of the Norwood-Dingell-Ganske bill. Opponents to our legislation claim that the bipartisan bill would subject employers to a flood of lawsuits in State courts over all benefit decisions and suggest that employers would be forced to abandon health insurance benefits.

Mr. Speaker, according to a memorandum done by one of the leading ERISA labor law firms in Washington, Gardner, Carton and Douglas, this memorandum, which I will be happy to share with any of my colleagues, this is simply not correct. I will be happy to provide this brief to anyone who desires a copy.

The gentleman from Georgia (Mr. NORWOOD) and I and the gentleman

from Michigan (Mr. DINGELL) have always wanted to protect innocent employers from liability. The vast majority of businesses, certainly small businesses, simply contract with an HMO to provide health coverage for their employees. They do not get involved with the HMO's decisions.

So we wrote protections for businesses into our bill, the bill that passed this House. Those provisions are discussed in this brief, which makes four main points in a well-documented and scholarly review.

First, lawsuits would not be against employers. Under current ERISA law, suits seeking State law remedies for injury or death of group health plan participants are already allowed in some jurisdictions. Those cases show us that suits are normally brought against the HMO, not against the employers. Why? Because employers are generally not involved in treatment decisions, the type of decisions that lead to an employee's injury or death. Ordinary benefits decisions, such as setting up a benefit plan, are not affected by our bill.

Second, employer exposure would be limited. If an employer exercises discretion in making a benefit claim decision under its group health plan and that decision results in injury or death, then the section in our bill makes an exception to the ERISA preemption and would allow an employee to sue in State court, but to recover a patient must first prove that the sponsor exercised discretion which resulted in the injury or death and then must prove all elements of a State law cause of action based on the employer's conduct in making the decision on that particular claim. The injured patient must have a viable State law cause of action because section 302(a) in our bill only creates an exception to the preemption and does not create a new cause of action.

Three, the statute's plain meaning limits employer liability. According to a thorough review of the law in this brief, the brief by Gardner, Carton and Douglas from September 27, 1999, the liability provisions in this House bill that protect employers would be interpreted under the Supreme Court's well established, quote, plain meaning, unquote, analysis. Such an analysis supports the bill's clear intention to continue to prevent any liability suits against employers that do not exercise discretion that results in injury or death. Specific language in our bill states that other types of discretionary employer language would not be affected and would not be subject to State tort law claims.

The Heritage interpretations in this backgrounder simply ignore the quote, plain meaning, unquote, language of the Supreme Court.

Number 4, employer health plans would not be destroyed. The limited

legal exposure of employers in the House bill will not cause them to abandon health insurance for their employees. The experience of nonERISA group health plans supports this. A recent study by Kaiser Family Foundation compared ERISA health plans to nonERISA employer health plans, such as CalPERS or the State of Colorado. That study showed that the incidents of lawsuits and costs against nonERISA health plans, where an employee can sue the health plan, is very low, in the range of 0.3 to 1.4 cases per 100,000 enrollees per year at a cost of 3 to 13 cents per month per employee.

Mr. Speaker, am I going to be told that an employer is going to drop his health care coverage for an employee for the difference in cost of 3 to 13 cents per month per employee? I think that a lot of employers would soon have no employees if that were the case.

Furthermore, employees would not need to abandon control, control, over a group health plan to remain protected under our bill, the bill that passed the House. Having HMOs or other third parties make claims decisions as in the case for the vast majority of small businesses, but then monitoring the third party would preserve your employer control. If they are not doing a good job, you do not sign them up next year.

An alternative for some self-insured third party administrators would be to insure their exposure. If third party administrators truly are not making medical decisions like they all claim, then their risk will be small and their premiums will be very low.

Mr. Speaker, in addition, the House bipartisan bill delineates in section 514(e)(2)(B) several employer activities which specifically will not constitute an exercise of discretionary authority, such as decisions to include or exclude any specific benefit from the plan; decisions to provide extra contractual benefits outside the plan; decisions not to consider the provision of a benefit while an internal or external review of a claim is being conducted.

Contrary to our opponents' claims, these carve-outs further insulate employers from State law actions, but I think a bit of legislative history is interesting here.

Mr. Speaker, first business groups complained that without these provisions they would not be able to advocate for an employee not being treated fairly by their HMO. So the gentleman from Georgia (Mr. NORWOOD) and I put those exceptions into the bill. Then those same business groups complained that the exceptions were in the bill. You just cannot please some people.

Now let us talk about the punitive damages protections in the House bill. This is another case in point of how you just cannot please some people. This provision was suggested to me, as

a matter of fairness, by members of the industry. They said if we are going to be bound by the external review board's decision and if we follow the board's decision, then we should not be liable for punitive damages, quote/unquote.

Know what? I agreed, and this provision in my original bill was incorporated into the Norwood-Dingell-Ganske bill. Maybe Heritage does not think that this provision is significant, but that is not what I have heard from the industry. Remember, this punitive damages relief would apply to all health plans under our bill, not just to group health plans.

While the Heritage paper closes by saying that the bipartisan House bill would result in, quote, a staggering amount of red tape for American doctors and patients, unquote, well, Mr. Speaker over 300 patient and professional organizations have endorsed the bipartisan House bill. Spare them your crocodile tears, please.

The Heritage paper also quotes Professor Alain Enthoven, a health policy analyst, from his paper, "Managed Care: What Went Wrong? Can It Be Fixed?"

Mr. Speaker, the Bipartisan Consensus Managed Care Improvement Act will go a long way to fixing the problem that Dr. Paul Ellwood, the father of managed care, expounded on at a Harvard conference last year. In speaking of the takeover of health care by managed care, Dr. Ellwood said, quote, "Market forces will never work to improve health care quality, nor will voluntary efforts by doctors and health plans. It does not make any difference how powerful you are or how much you know, patients can get atrocious care and can do very little about it."

Remember, this is the originator of the concept of managed care. He goes on to say, "I have increasingly felt that we have to shift the power to the patients. I am mad," he said, "in part because I have learned that terrible care can happen to anyone."

Mr. Speaker, the Norwood-Dingell-Ganske bipartisan House bill which passed this House with 275 bipartisan votes would shift that power to the patient. I sincerely hope that the conference committee gets the message.

CYBER TERRORISM, A REAL THREAT TO SOCIETY

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentleman from New Jersey (Mr. ANDREWS) is recognized for half the remaining time until midnight, approximately 50 minutes, as the designee of the minority leader.

Mr. ANDREWS. Mr. Speaker, I want to begin by expressing my appreciation to the Chair at this very late hour and to the members of the staff who are so diligently working here with us and for us at this very late hour as well.

We are gathered tonight at a time of unprecedented peace and power for our country. Because of the enormous dedication and sacrifice of Americans who have served in our armed forces throughout history, around the world in the past and at present, our country is stronger and more secure than it has ever been, and that is a blessing for which we are truly thankful.

Certainly that thanks is directed at those who wear the uniform of our country tonight around the world and those who have so nobly worn it in the past. It is truly a gift and a legacy that we enjoy tonight.

Our relative strength in the world does not mean that we live in a purely safe world, a world without risk. We must endeavor not to repeat the mistakes of history, where very often at times when we felt most safe we were most vulnerable.

There are clearly three areas of major threats to our country's security as we gather tonight. The first is the threat of an emerging competing global superpower in the People's Republic of China. The second is the continued virulent presence of regional negative hostile dictatorial forces such as Saddam Hussein in the Persian Gulf, President Milosevic in the former Yugoslavia. Those two threats, the threat of China and the threat of those regional dictators, are very severe threats indeed. I trust that in the coming weeks and months we will consider as a Congress, along with the executive branch and the military, ways to confront those threats.

This evening I want to spend, Mr. Speaker, some time talking about a threat that is not so easily detected, is not so obvious, but a threat that I believe is truly lethal and deadly, a threat that is unlike any threat that we have faced in the history of our republic, and that is the silent but deadly threat of cyber terrorism, the quiet but lethal assault on our country's systems and people, which I believe will be one of the major issues in the new century, the new millennium, in the defense of our country.

Unlike the growth of a large superpower army, unlike the proliferation of arms from a hostile nation state, we cannot readily or easily see the development of the cyber threat. I pray that we may never feel it and tonight I would like to talk about how we can prepare for it.

I would like to begin by talking about what has already happened to make it clear that our subject tonight is not an imaginary one. It is all too real. Listen to George Tenet, the director of the Central Intelligence Agency, speaking a few months ago. He said, and I am quoting, "An adversary capable of implanting the right virus or accessing the right terminal can cause massive damage to the United States of America," the right virus or the right terminal.

□ 2215

In 1998, two youngsters in California, directed by a hacker in the Middle East who was later described as the Analyzer, launched attacks which disrupted our troop movements in the Persian Gulf. These two young hackers, based in California and directed by the Analyzer in the Middle East, disrupted troop deployments to the Persian Gulf in February of 1998 from California, launched attacks against the Pentagon systems, the National Security Agency and a nuclear weapons research lab.

The deployment disruptions, that is, the disruptions in the deployment of our troops around the world and the Persian Gulf, from a computer terminal in California, were described by Deputy Secretary of Defense John Hamre, a real leader in this field, as "the most organized and systematic attack" on U.S. defense systems ever detected. In fact, they were so expertly conducted that President Clinton was warned in the early phases that Iraq was most probably the electronic attacker.

Two teenagers steered and directed by a master hacker halfway around the world, launching what our number one defender has called the most organized and systematic attack on sophisticated defense computer systems, so sophisticated that in the early hours of the attack the President of the United States was told by his most wise and knowledgeable advisers that Iraq was the electronic attacker. It was not Iraq, it was two U.S. citizens directed by a hacker in the Middle East.

On March 10, 1997, another teenager, this one based in Massachusetts, invaded a computer system run by the Bell Atlantic company in Massachusetts, knocked out telephone communications, among them telecommunications, telephone service, for the Worcester, Massachusetts air traffic control system at that airport in western Massachusetts. The tower was knocked out for 6 hours.

Let me read from a report from the Boston Globe of March 19, 1998. "The computer breach knocked out phone and radio transmission to the control tower at the Worcester airport for 6 hours, forcing controllers to rely on one cellular phone and battery powered radios to direct planes."

One teenager hacking into a computer system of a major regional telephone company, knocking out for 6 hours the telecommunications capacity of an entire area, and including an airport. And as people flew through the skies above Worcester, Massachusetts, the air traffic controllers relied on one cell phone and battery powered radios to direct the planes.

Joseph Hogan, who manages the control tower at Worcester and 26 other airports for the Federal Aviation Administration, said this: "We relied on