

now, millions of seniors depend on it. Policy makers have an obligation to try to make Plus Choice work. If we cannot make the Plus Choice program work, then we have an obligation to get rid of it.

I am offering legislation today to try to make Plus Choice work. Under the Plus Choice Reliability Act, private health plans would sign a contract to provide continuous service within a service area for 3 years. Health plans would agree not to terminate this coverage within the service area and would be required not to reduce their benefit package during that time period.

Health plans would receive payments for enrollees equivalent to what Medicare would have spent had the enrollees stayed in-fee-for service, no more, no less.

If we pay private health plans what it would cost fee-for-service to cover these individuals, and if private plans still cannot cover them and provide stable benefits or guarantee continuous coverage, as the fee-for-service program does, then it would be fiscally irresponsible and a breach of the public interest to permit these plans to stay in Medicare. It is as simple as that.

I hope my colleagues will join me in promoting a Medicare Plus Choice option that actually provides continuity and stability, attributes that should be a given under our Medicare program.

#### STATUS OF HMO REFORM

The SPEAKER pro tempore (Mr. SHIMKUS). 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 am going to talk a little bit about the status of HMO reform before the House and the Senate. I have to admit that I am a little bit disappointed, because I thought that this afternoon or this morning, we would have been debating a bill called H.R. 1304, which is the Quality Health Care Coalition Act. This is the bill of the gentleman from California (Mr. CAMPBELL).

The gentleman from California (Mr. CAMPBELL) has worked on that bill for 3 years. In essence, that bill would allow health professionals to group together to advocate for patient consumer rights without forming a union in negotiating contract provisions with HMOs.

This is pretty important because, in the last 5 or 6 years, there have been over 275 mergers of health plans around the country, leaving us, in this country, with about five or six large HMOs. In many parts of the country, these HMOs, a single HMO may control 50 percent or more of the people who have health care in that area. It is curious that a lot of these, several of these

large HMOs do not go into other areas in order to compete with another large HMO.

So what that means, then, is that, if an HMO, for instance, gives a health care provider, a nurse or a pharmacist or a physician, a contract that has a provision in it that is, for instance, a gag rule, a gag clause, where it says one cannot tell a patient all of their treatment options unless one first gets an okay from us.

So, in other words, in my prior life before being a congressman, as a physician, if I had a woman come to me with a lump in her breast, I examined her, talked to her, I would have to say, excuse me, leave the room, get on the phone, tell the HMO I have got this woman here with a breast lump, and ask them if it is okay if I tell this woman all three of her treatment options. I mean, that is an egregious infringement on the right of a patient to know all of the information that he or she needs in order to make a decision.

Yet, there are contract provisions that HMOs have put in physician contracts to that extent. There are other contract provisions that HMOs put into employee contracts where it says that HMO's can define medical care as the cheapest, least expensive care "as determined by the HMO."

What would be the problem with that? Let me give my colleagues an example. As a constructive surgeon, I have taken care of a lot of children born with cleft lips and palates. The correct treatment for a kid born with a cleft palate is a surgical repair to close that huge hole in the roof of their mouth so that food does not come out their nose, so they can learn to speak correctly.

But under that HMO's contract provisions where they can define medical necessity as the cheapest, least expensive care, they could say, no, we are not going to authorize routine surgical repair, we are just going to authorize a piece of plastic to shove up into that hole, something called a plastic obturator. It would be like an upper denture.

Now, will the child learn to speak very well with that? No. But it meets that plan's own contractual language of being the cheapest, least expensive care.

Now, let us say that I, as a physician, taking care of children, whose treatment is denied, like this one, decide to get together with other reconstructive surgeons, and we start talking about how this one HMO is routinely denying medically necessary care. We say to each other, I do not think I can renew my contract with that company. Under current U.S. anti-trust law, we could be prosecuted and fined, if not thrown in jail, for being concerned about our patients' concerns.

That was the bill that was supposed to be on the floor. It was a bill that did

not, it was not about physicians forming unions, in fact, it would have the opposite effect. It was not a bill about price fixing. It has nothing to do with price fixing. It is a good bill. It had 220 bipartisan cosponsors. We only need 218 votes to pass the House. One would think this would come to the floor.

The gentleman from California (Mr. CAMPBELL) had worked on this for 3 years. Last year, he got a commitment from the Speaker of the House to bring it to the floor last year. Then he got a commitment from the Speaker to bring it onto the floor in January. Then yesterday, before the entire Republican Conference, the Speaker said, yes, this is coming to the floor today.

But a curious thing happened last night. The Committee on Rules was meeting about midnight, they were debating this bill that we should have debated today. All of a sudden, they just tabled the bill indefinitely. So it did not come to the floor today.

I find this very curious because, as everyone in Washington knows, the Committee on Rules functions as the right arm of the Speaker. The Committee on Rules follows the Speaker's will. Some people have said the Committee on Rules is a rubber stamp for the Speaker. In the 5 years I have been in Congress, I cannot remember the Committee on Rules doing an action in committee that has been contrary to the Speaker's will.

Now, yesterday, the Speaker said we were going to have this bill on the floor. He had given his promise to the gentleman from California (Mr. CAMPBELL). Then at midnight, the Committee on Rules tables the measure. Very curious.

Is this the first time the Committee on Rules has disregarded the Speaker's promise? We do not know. It is either that the Committee on Rules, which should function at the Speaker's discretion, did not, that they did not follow their own Speaker's prescription, in which case, the Speaker ought to have a long talk with those Members for not following out his instructions.

Or the other alternative is that they received word from the Speaker, pull the bill. If that is the case, then there is a disparity between what the Speaker promised the gentleman from California (Mr. CAMPBELL) yesterday morning and what happened at midnight.

Most curious. Very unusual. Something in 5 years I have never seen happen here in Congress.

So we are left with the situation that, today, we did not get to debate on a bill that is a free market bill to try to correct HMO abuses.

Last year, last October, when we passed the Bipartisan Consensus Managed Care Reform Act, the Norwood-Dingell-Ganske bill that I helped write, passed this floor with 275 votes, with only 151 against it, last year we heard a lot of people say, I think that we

ought to move to HMO reform in a more free market way. We ought to make sure that there is equal playing field so that these types of patient abuses can be addressed in the realm of the free market, in equal negotiations.

Well, we are seeing a situation where we have, in some cases, almost monopolies by large HMOs, squishing any type of concerted action by providers to stick up for their patients. This bill of the gentleman from California (Mr. CAMPBELL) would have gone a long way toward correcting that. Yet, for all those people on both sides of the aisle who voted against the Bipartisan Consensus Managed Care Act, saying I would rather see a free market approach, they do not get a chance today to vote, to correct those types of HMO abuses.

Now, it is no secret that the insurance industry has been lobbying very vigorously on this issue. It is no secret that, last night, the insurance industry dumped millions of dollars into fundraisers here in Washington. It would be most curious if there is any connection between the Committee on Rules' action and political contributions. I would certainly hope that is not the case.

Why do we need HMO reform? Well, last week, in the Los Angeles Times, I saw this article on a case. The California State Department of Corporations said that it discovered systemic health care delivery problems at a California HMO, and they levied a \$1 million fine against that HMO for delaying the urgently needed care of a 74-year-old woman who died.

So we gave the California Department of Corporations a phone call. They sent us their memo on this case. I am going to share this with my colleagues today, because as I am speaking, at this very moment here in the Capitol, the conferees to that HMO reform bill are meeting. They have been meeting for months and months and months, and virtually nothing has happened. I think they need to listen to a case like this, because it is pretty incredible. This is happening every day around the country.

"In January, 1996," and I am going to pretty much just read from this brief by the California Department of Corporations, "Margaret Utterback, 74 years old, and" an HMO "patient for 50 years, was still living in her home. She took reasonably good care of herself and she was in generally good health up to the day that she" complained to her HMO of "back pain that radiated to the right side of her abdomen."

It is important to note that she had been a smoker and that she had high blood pressure. That is from her HMO records.

Now, as a physician, let me lay a little groundwork for this. There is a condition called an aortic abdominal aneurysm. This is a balloon-like enlarge-

ment of the large blood vessel in one's abdomen, the aorta. It develops more frequently in people who have been smokers, who have atherosclerosis, and who have high blood pressure. If that balloon-like dilation of the aorta breaks, the patient usually dies. They bleed to death in a short time. It takes many years to develop.

Generally a patient that is systematic with an aortic abdominal aneurysm is an older person who complains of abdominal and back pain. That aortic aneurysm impinges on the lumbar vertebrae, and that is responsible for the back pain.

□ 1630

If it is caught in time, surgery can fix it. The balloon-like dilatation can be bypassed. Just think of taking a balloon and blowing it up. As we blow and blow, the bigger it gets, and all of a sudden it gets easier to blow it up. That is because the walls of that balloon are getting weaker and weaker. Then all of a sudden it gets so easy that it just breaks. That is what can happen with this type of dilatation, this aortic aneurysm.

On January 26, 1996, Mrs. Utterback woke up with pain in her back. It radiated towards her abdomen on the right side. She had been experiencing back pain since the day before. She thought the pain might be due to some hard work, but the pain progressed that morning. She also experienced abdominal pain she attributed to something she had eaten.

At about 8:15 in the morning, she called her daughter, Barbara Winnie, and she asked her to come over because she had some really sharp pain. When her daughter got there, at about 9:30, she found her mom in bed, still in her pajamas. Mrs. Utterback reported to her daughter that she had tried reaching her primary care doctor at the HMO when the clinic opened at 8:30. She was put on hold so long that she had to hang up.

The phone number that she used to secure an appointment came from her address book. Between 9:45 and 10 a.m. she tried to call this HMO again. Her daughter overheard this conversation and was also informed of the details. Mrs. Winnie essentially recalls this as follows: Mrs. Utterback explained her symptoms; that she was having pain on the right side of her back that was going around to her abdomen and she asked if she could get an appointment to see her doctor. She was told by the person who answered the phone that there were no appointments available.

Mrs. Utterback explained her symptoms again. She asked if she could be put through to her doctor or the clinic so that she could talk to somebody there. But the person at the HMO, at the other end of the phone, said she could not do that. After that, the person said something to the effect that,

If you think you need to be seen, call back at 3 p.m. and you will get an urgent care appointment for the evening. Mrs. Utterback was told that the urgent care clinic was the procedure to be used when there were no same-day appointments available to her doctor.

Now, I want to point out something. This person she talked to did not suggest that if she was having really severe pain she needed to go to the emergency room.

After hanging up, Mrs. Utterback and Mrs. Winnie, her daughter, discussed the conversation. Mrs. Utterback decided to call back again. She described her symptoms again to the new person who answered the phone, i.e., that right side back pain was radiating to her abdomen. After being transferred a couple of times, she was finally put into contact with somebody who Mrs. Utterback thought was kind and willing to listen. That particular woman offered to send an e-mail message to her doctor about her wanting to be seen that day.

So Mrs. Utterback thought that once the e-mail was sent, she was supposed to wait for her doctor to get back to her. That is what she understood from the conversation. Her daughter recalls that this conversation occurred at approximately 10:15, which is consistent with the time that the e-mail was actually sent, which was 10:18.

Mrs. Utterback was not given an appointment during that conversation. While waiting to hear back from the doctor's office, Mrs. Utterback reclined almost the whole time, but she did get up around 12 noon to have some soup. After not hearing back for nearly 2 hours, Mrs. Utterback and her daughter said they agreed that they would surely hear from her doctor either during lunch or after the lunch hour. However, when 1:45 p.m. came around, Mrs. Utterback and her daughter agreed that enough was enough, and they tried to call back to find out what, if anything, her doctor had decided to do.

Mrs. Utterback called again. She explained to the person who answered the phone this time the steps she had taken up to this point in order and wanted to be seen by Dr. Perry. She again explained that she had right back pain radiating to her abdomen, which was getting more painful. She reiterated her efforts to see her doctor and reiterated her symptoms, as she was transferred several times. She also explained that she was frustrated. She wanted a same-day appointment, and she had been waiting to hear from her doctor since 10 o'clock, and it was now the middle of the afternoon.

After speaking to several different people, it appeared to her daughter that Mrs. Utterback, her mother, had finally reached somebody sympathetic based on the tone of Mrs. Utterback's voice. Apparently this person offered to transfer Mrs. Utterback to patient assistance. However, when that transfer

occurred, Mrs. Utterback reached a voice mail recording. So she hung up.

She immediately phoned back the phone bank, and after explaining her symptoms and all of her attempts to get assistance again, she finally, after several attempts, reached a person who was able to get her scheduled for an appointment at 4:15. However, she had to insist on being seen that day because the medical assistant at first told Mrs. Utterback that her doctor declined to give her an appointment that day but, instead, would write her a prescription for narcotic pain medicine.

Finally, upon Mrs. Utterback's insistence, the medical assistant agreed to give her an appointment late in the day. Well, Mrs. Utterback is not feeling very good. The pain is getting worse. She and her daughter decide to go immediately to the clinic to try to get in to see her doctor earlier, if possible. This is corroborated by an HMO employee, the medical assistant who booked the appointment at the doctor's station, who recalls that the daughter told her that they were leaving right away to try to get worked in sooner in the day.

Until arriving at the clinic, Mrs. Utterback never spoke to a registered nurse or an advice nurse, nor was she instructed to go to the emergency room by that HMO.

Mrs. Utterback left about 2 p.m. and checked in no later than 2:45 at the HMO clinic. Despite requesting three separate times to be seen sooner because her pain was getting worse, staff at the HMO refused. While waiting, Mrs. Utterback's pain increased to the point where her discomfort was visually observable. She squirmed in her chair. She held on to her side. At times she was in plain view of the reception desk and the open hallway where the medical assistants would come to call patients. But it was not until 4:30 that her physician examined her.

At one point, the medical assistant who was filling in for the doctor's patients that day was informed of Mrs. Utterback's desire to be put in a room. Two Kaiser receptionists testified that this assistant came to the front, glanced through the chart, looked into the waiting room where Mrs. Utterback was sitting, and stated, "Doesn't look that sick to me, tossed the chart back and walked away. She did not stop, did not even bother to go out and talk to this woman."

Well, once examined by her physician, what did he diagnose? He immediately diagnosed that she had not just an aortic aneurysm but a dissecting aortic aneurysm, one that was rupturing. Now, that is a life-threatening condition. It requires complete adherence to a stringent test of protocols in order to save the patient's life. IVs need to be put in, the patient needs to be given pain medicine, that pain medicine will help reduce the patient's

blood pressure. If their blood pressure is too high, the medicine reduces the blood pressure. Because the higher the blood pressure is the more pressure every beat of the heart places on that enlarging balloon that is in that patient's abdomen.

That patient is a medical emergency. That patient needs to be transported immediately to an emergency room, stabilized, and into the operating room in order to save that patient's life. But instead of calling 911 or arranging for advanced life support, and this is amazing, Mrs. Utterback and her daughter were initially asked to drive themselves to the emergency room. Imagine that. As a physician who has taken care of patients with this problem, to suggest that this patient should hop into the car and drive themselves there and possibly collapse enroute is just, it is just beyond me. It is just beyond me.

The seriousness of Mrs. Utterback's diagnosis and condition were not even communicated to the Hayward Fire Department or to the ambulance personnel. Chief Michael Jay of the Hayward Fire Department, who had been dispatched to the scene, was not informed this patient had a dissecting aortic aneurysm. Instead, he was informed by the clinic that "the patient needed a transport, and the patient was complaining of lower back pain." Chief Jay stated, "a diagnosis of a dissecting aortic aneurysm indicates a sense of urgency that would necessarily need to be communicated to the medical facility for the emergency personnel on scene," including himself, and it was never done.

That lack of urgency was confirmed in the ambulance report, where it states, "doctor nowhere to be found, nurse had very little patient information, patient transferred for 'question mark' for evaluation."

Mrs. Utterback did not arrive in the emergency room until 5:30. Remember, this saga started at about 8:15 in the morning. She did not get there until an hour after the diagnosis was made. Unfortunately for Mrs. Utterback, her aneurysm ruptured completely minutes after she got in the emergency room. She was taken to the operating room and given 24 units of blood, but by then it was too late and the next day she died.

The California Department of Corporations looked at this case and they found systemic lack of safety all the way through the day that this patient was treated. There should have been protocols in place. Certainly if a patient cannot be gotten into see her physician promptly, when she is having severe pain, she ought to be told to go to the emergency room. Do not pass go, just go to the emergency room, do not collect \$200.

It is these kinds of problems that we are hearing about HMOs. In fact, right at this moment one of my colleagues is

holding a press conference over in the Longworth Building where he has 24,000 HMO complaints of abuse stacked up and piled up that have been gathered just in the last few months. 24,000. And, believe me, that is a small number, because most of the problems do not get reported.

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And so, what have we been doing here in Congress? Well, after we passed a strong patient protection bill here in the House with 275 votes back in October, the Speaker did not even name the conferees for a long time; and then the Republican conferees that were named from the House side, all except one, had not even voted for the bill.

The two Republican authors of the bill, the gentleman from Georgia (Mr. NORWOOD) and myself, were not even named to the conference committee. The Senate had passed a bill, which, charitably, could be argued an HMO protection bill, not a patient protection bill. It is so weak, it is worse than weak. And we have had months now where the conference committee has gotten virtually nothing done. And, furthermore, there has been no legislative language put out on even the non-controversial items. And every day goes by and somebody like Mrs. Utterback is being injured or loses their life.

I could give my colleagues many, many other examples of this. If my colleagues would just take this one defect, cleft lip and cleft palate, in the last few years more than 50 percent of the surgeons who take care of this condition have had HMOs deny surgical repair related to cleft lip and cleft palate.

I mean, this is a birth defect. This is not a cosmetic procedure. This is something to make somebody normal so they can speak right so they can walk through the grocery store and not be an object of contempt.

For goodness sakes, why is it taking so long for us to address this problem? I guess you could only say, it is part of the systemic problem that exists here in Washington. There are very powerful special interests that oppose a real patient protection piece of legislation. That is the HMO industry, that is the insurance industry, and some of the big businesses.

It is very interesting, though, that if you look at the polls that are done of, say, small businesses, even small business employers, by about a three to five margin think that Congress ought to pass patient protection legislation. These are the employers.

What is the hang-up? Well, the hang-up in conference is on several things. One is the scope of the bill, who should the bill cover.

Well, we in the House voted overwhelmingly that these patient protections should cover all Americans, not

just a few like are covered in the Senate bill. Every American ought to have access to patient protection so they are not abused by their HMO. That is one of the issues.

Another issue has to do with who determines medical necessity. Well, in the House-passed version, we passed a bill that said, you know, if there is a dispute you can go to an internal review, then an external review, an independent panel, and the panel can make a decision free of conflict of interest with the HMO and that that decision would be binding on the HMO, they would have to follow it. And if they did not follow that recommendation on a denial of care, then they could be subject to a fine. And if a patient was injured because of their not taking the advice of that panel, then they could be subject to liability.

Nothing like that in the Senate version, nothing has been dealt with on that issue in conference.

Now, some people are starting to think, well, maybe we ought to include some provisions from a substitute that was debated on this House floor and lost in regards to the liability. And that was the Goss-Coburn-Shadegg managed care liability provision. It is full of flaws and loopholes. I sincerely hope that the conference committee would correct these loopholes and flaws if they are looking at this. But more importantly, they just ought to adopt the provisions that were in the bill that passed the House.

But let me just read a couple of them. The Goss-Coburn-Shadegg HMO liability provision creates a Federal cause of action. Now, that is something we did not do. We simply said, if there is an injury, it goes back to be handled in the State, like all other insurance disputes do.

The Goss-Coburn-Shadegg says other related claims could be brought in State court but not at the same time. That would create a procedural nightmare. Patients would be forced to bring actions in both State and Federal related to the same wrong, wasting judicial resources and posing an undue burden on them.

The provision is unclear as to whether patients would be shut off from bringing related causes of action between various courts. The provision is vague whether a Federal court would have supplemental jurisdiction of State law claims, thereby taking a patient's State law claims away from a State jury.

That is one example. Here is another problem with it. There was a provision in that Goss-Coburn-Shadegg liability bill that required a certification of injury by an external review panel that could deny a patient's Seventh Amendment constitutional rights. A defendant HMO could apply to a second external review panel under the Goss-Coburn-Shadegg bill not involved in

the external review decision to determine issues of substantial harm and proximate cause. These are traditional jury issues.

If the external review panel, which could be completely devoid of any legal expertise, determined that either substantial harm has not occurred or that the HMO did not proximately cause the injury, then the patient's action would be dismissed unless the patient could overcome such a finding by clear and convincing evidence.

Further, if a patient fails that burden, he or she is responsible for the HMO's attorney's fees. The use of an external appeal entity to establish causation or harm is unconstitutional. A patient's Seventh Amendment right to a trial by jury cannot be superseded, and external review panels cannot make decisions about injury and causation, which are reserved for our judicial system.

There are many other problems with that substitute. But one of them is this, and that is that the Goss-Coburn-Shadegg bill would force a patient to exhaust internal and external review. To bring an action, a patient would have to exhaust current ERISA administrative remedies and all internal and external review processes, get this, even when he or she has already suffered an injury or even die due to the HMO's negligence.

Let us go back to Mrs. Utterback. Mrs. Utterback started her problem at 8:15 in the morning when she phoned, goes through the day, how many times did she phone the HMO to try to get some resolution, did not get any help, was not treated properly, finally ended up dying, being taken to surgery about 9 and dying the next day.

You know what? She would have no legal recourse under the Goss-Coburn-Shadegg liability provision because, well, you know what, she had not gone through internal or external review. It is just unfortunate for Mrs. Utterback, I guess, that she died before she could bring it to review. But that does not mean that that HMO should not be liable.

That is why the California Department of Corporations fined that HMO \$1 million because of their negligent actions.

We need to fix this problem. We need to address this. That is why we should have had a debate today on the Campbell Quality Health Care Coalition Act, which is one way to approach the problem; and that is why the conference committee on HMO reform really ought to get something done and soon.

If they cannot move to some real substantive decisions and agreements, then we need to start looking at other ways to move this legislation. This is just too important for us for this to languish.

There are millions of decisions being made every day on people's health care

that are being interpreted to the disadvantage of patients because of an HMO's ability to determine "medical necessity."

I hope it does not happen to a member of your family or to a loved one of yours or to you. Unfortunately, it could. All our constituents should be phoning and writing their congressman and they should say, please, enough is enough. Do not let this go anymore. Come to a resolution. Work with the President. Get a strong Patients' Bill of Rights passed this year, or we will hold you responsible at the voting booth.

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#### ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SHIMKUS). Members will be reminded that their remarks in debate should be directed to the chair and not to the gallery or the listening audience.

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#### POLICE BADGE PROTECTION ACT OF 1999

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

Mr. HORN. Mr. Speaker, I rise today to call attention to this morning's headlines in the National Press about the use of counterfeit badges in and undercover investigation conducted by the General Accounting Office at the request of our colleague the gentleman from Florida (Mr. MCCOLLUM).

The General Accounting Office is the arm of investigation on both financial matters and programmatic matters on behalf of the Congress. They are part of our legislative branch. Agents from the GAO's Office of Special Investigations used fake badges purchased over the Internet to get through security at two airports and 19 Government offices, including the Central Intelligence Agency, the Department of Justice, the Federal Bureau of Investigation, the State Department, and the Department of Defense.

The relative ease with which the General Accounting Office agents penetrated security shows the vulnerability not only of these Government offices but of the public.

The American public recognizes the authority of the badge. They know they can count on those men and women in law enforcement.

The American public needs law enforcement when they are in times of trouble and they are in need of help. However, misuse of the badge reduces public trust in law enforcement and endangers the public.

Although there are State statutes against impersonating law enforcement officers, the threat of counterfeit badges reaches across State lines. Criminals can purchase fraudulent