that got in a fight at their school. For the first time, I heard a term, ''third-year freshman''. I thought, third-year freshman? What is a third-year freshman?

I asked my sister Kathleen, she is a school counselor, what is a third-year freshman? Oh, that is somebody who has been in high school three years and does not have any high school credits. What? In the old days, look, if one did not want to try in school, if one were not going to make an effort at it, get out. We have got a lot of students in our schools that want to make an effort at it. We have got a lot of students in our schools that want to succeed.

Our society has become so politically correct in education that discipline has almost all but been taken away from our teachers. How can we expect teachers and instructors that will deliver the kind of product that will continue to make this country a superpower if we do not give them the tools they need? One of those tools happens to be discipline, to make our students accept responsibility for their actions and to have consequences for the actions that they take. That is where we are going to increase production out of our schools.

I have been very excited lately because, frankly, in the State of Colorado, in my opinion, we have ended up with a darn good Governor, and he has been very aggressive on education reform. It is very interesting. He came out and said we are going to grade schools.

What was interesting about the criticism, a number of people from schools, school administrators, and people dealing with the schools came out and said, ''Governor, how could you possibly use grades, grade schools?'' It is pretty interesting. I always thought, ''Wait a minute, schools. That is what you do. You use grades to grade students. Why should we not use grades to see whether your school is doing what it ought to be doing?''

We have got a Governor in Colorado who stood up to some pretty tough opposition from people in my opinion who do not want to change the status quo and people in my opinion that I would question whether the focus is on the student or on the well-being of some bureaucrats that have opposed this plan.

But this plan was signed into law. This is a good plan. Who is the winner? The winner are the students. When students win, who else wins? The teacher wins. The teachers. I will tell my colleagues, most teachers I know are very proud. Most teachers dedicate a lifetime to a career of seeing success in their students.

My sister, for example, or my aunt, Jewel Geiger, down there in Walsenburg, Colorado, they take great pride, not in the money they make, they do not make much money as teachers, they take great pride when years after they have sent a student on their way, the student comes back and has a remarkable pattern of success because they were taught responsibility at the lower levels of school.

I will tell my colleagues I am excited about education. I have got to tell my colleagues I had a group of students in today. We had some students from Ouray, Colorado. We had some students from Steamboat Springs, Colorado. I had some 4–H students, one from Grand Junction, Delta. So I had several communities in my district represented today, and not all at once. So I had three or four meetings with these students. Canyon City students.

I asked the students, I said, let us open it up for questions. I am telling my colleagues, they have experienced it, my gosh, these questions were solid, well-thought-out questions. Their thoughts on policy were well thought out.

We have got a great bunch of young people coming up behind us. This next generation is going to have multitudes of more opportunities than any generation that has ever preceded them. This generation has more possibilities, more capabilities than any other generation that preceded them. But this generation could be handicapped by being too politically correct in our schools, by being too politically correct to say to our students they have individual responsibility. They have certain behavior that they have to recognize. There are consequences for misbehavior.

If we can give this generation with so much hope and so much promise, if we can set aside the politically correct stuff and just react from our gut and let our local people work on their school boards, I will tell my colleagues this, there is nothing that will stop this next generation. They will lead our country to continue to be the greatest country the world has ever known.

We can be safe knowing that, when we turn our country over to this next generation, that we are turning it over to a better management team, to a management team that will make our results look somewhat slow.

But we have got to give these young people the tools. It is as good for them as it is for our society to teach individual responsibility.

Mr. Speaker, let me wrap up, then, by my conclusion. Number one, I want to caution my colleagues, I am not trying to use this floor for a partisan attack, but we do have in this country, we do have a balance of powers. I spoke tonight about the Republican program, the tax reduction on capital gains, the tax reduction for the homeowners in this country, the tax reduction on the marriage penalty, our pursuit to eliminate the death tax and our elimination of the earnings limit on seniors. We have hit every category out there that I can think of. I am proud of that as a Republican. I think that we should go out, and when we talk to our constituents, we should remember these programs, because what we have done is give incentive to the capitalistic system.

Now, everybody out there, regardless of their economic category, wants success. Government only impedes success with taxes that are unfair or punitive or have no sense on their face. We have recognized that, and the Republicans have taken the lead to do something about it.

I thank my conservative colleagues on the Democratic side who have joined us. I also thank all of my colleagues who, when the real vote came up there, when it came time to face the music, we had all ''yes'' votes to eliminate for the seniors that earnings limitation.

This country is a great country. But we must resolve to be fair to our taxpayers. We must resolve to deliver the best educational product that we can to our next generation, our young people. We must resolve to keep the foundations, the pillars in our foundations strong, those of a strong military, of a strong education system, of a strong health care system, and of a strong military.

HMO REFORM

The SPEAKER pro tempore (Mr. VITTER). Under a previous order of the House, the gentleman from Iowa (Mr. GANSKE) is recognized for 60 minutes.

Mr. GANSKE. Mr. Speaker, tonight we will talk about two aspects of health care that are important. The first will be about the conference committee that is going on in regards to the HMO reform bill that passed both the House and the Senate. For our colleagues and constituents, it should be noted that the bipartisan Managed Care Reform Act of 1999, the Norwood-Dingell-Ganske bill passed the House back in October 275 to 151. The Senate bill had passed sometime before that.

So the Speaker of the House and the Majority Leader in the Senate, as well as the minority leaders in both bodies, appointed Members of Congress to meet together to iron out the differences between the bill that passed the House and the bill that passed the Senate. Once that is done, then the unified bill is brought back, both to the House and to the Senate for a vote. If it would pass in both Houses, then it would be sent to the President for signature and become law.

Now, the conference committee has been meeting for some time. I am told that they are currently working on internal and external appeals. Even though I helped write the bill, I unfortunately was not named to the conference, and I cannot be more specific than that. I would note that, of all the Republicans from the House that were named to the conference, only one actually voted for the bill that passed the House with such a large margin.

But I want to talk about one particular aspect of the Managed Care Reform bill that is crucial to getting it right, and that is on the issue of whether the HMO at the end of the day can

define as ''medically necessary'' anything that they want to. Now, my colleagues may say, well, how can that be? The answer, Mr. Speaker, is that, under a 27-year-old law that Congress passed, Federal legislation, an employer plan can define as ''medically necessary'' anything they want to, regardless of whether it meets medical standards of care.

Now, way back in 1996, a year or so after we started debate on HMO reform, so it has already been 4 years, a woman who was a medical reviewer at an HMO gave testimony before my committee, the Committee on Commerce. I think it is important to go back through her testimony, even though I have read this testimony on the floor several times in the past, because it is so crucial to whether we are going to get a bill that is worth the paper that it is written on.

This medical reviewer said, ''I wish to begin'', this is her testimony before the Committee on Commerce, ''I wish to begin by making a public confession. In the spring of 1987, I caused the death of a man. Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred. I was rewarded for that. It brought me an improved reputation in my job and contributed to my advancement afterwards. Not only did I demonstrate that I could do what was expected of me, I was the good company employee. I saved half a million dollars.''

She continued, ''Since that day, I have lived with this act and many others eating into my heart and soul.''

□ 2145

For me, a professional is charged with the care or healing of his fellow human beings. The primary ethical norm is do no harm. I did worse, ''I caused death.'', said this HMO reviewer.

She went on to say, ''Instead of using a clumsy bloody weapon, I used the simplest cleanest 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 any moral qualms arose, I was to remember, 'I am not denying care, I am only denying payment.' ''

She then listed the many ways managed care plans deny care to patients, but she emphasized one particular issue, the right to decide what care is medically necessary.

She went on to say, ''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. 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.''

She went on, ''We have enough experience from history to demonstrate the consequences of secretive, unregulated systems that go awry.'' And the thought of the Holocaust came to my mind at that point.

She finished by saying, ''One can only wonder how much pain, suffering, and death will we have before we have the courage to change our course. Personally, I have decided even one death is too much for me.''

Well, Mr. Speaker, what we are talking about here is the ability of an employer health plan to define as medically necessary anything they want to or to exclude anything they want to.

Let me give my colleagues an example. Before coming to Congress, I was a reconstructive surgeon. I still go overseas and do these types of operations. Here was one of my patients. This was a little baby born with a complete cleft lip and cleft palate.

Now, the standard of care for this birth defect is surgical correction of the lip and of the roof of the mouth. But, Mr. Speaker, there are some HMOs out there that are defining as medically necessary ''the cheapest, least expensive care as defined by us, the HMO.''

Now, some of my colleagues may say, what is wrong with the cheapest, least expensive care? Here is an example. Let us take this little baby with this hole in the roof of his mouth. He cannot speak normally. He will never learn to speak normally if that is not corrected. Food goes up his nose and comes out his nose. He cannot eat right. But under that HMO's ridiculous definition of medical necessity, the HMO could justify not treating this child with surgery to fix the roof of his mouth but by merely requiring or authorizing the construction of a little piece of plastic, like an upper denture; something to sort of plug the hole. That is wrong. Where is the quality?

The parents of that little baby would have no recourse with their health plan, because a 27-year-old Federal law, the Employee Retirement Income Security Act, says that an employer health plan can define that medical care in any way they want to.

And so what has been the result? Well, more than 50 percent of the reconstructive surgeons in this country who have had children with this type of birth defect, and who requested to perform operations to correct this, have been denied as not medically necessary by HMOs.

Here is a little baby that was born with a lack of fusion of the bones between the eyes, so that the eyes are very widely spaced, as my colleagues can see. Much more widely than normal. I have treated some children with this defect where the eyes are almost on the sides of their head, almost like a fish.

Now, there is a surgical operation, it is an intensive operation, it is a big operation, to fix that. It involves making an incision across the top of the head, peeling the soft tissues off the bones, taking some of the bones of the face out and the skull out, remolding them and putting them back together, and then bringing all the tissues back up so that the gap between the eyes is narrowed.

This is a birth defect. That is not a cosmetic operation. A cosmetic operation is where we have a normal process, like aging, where there are droopy eyelids or droopy skin of the face and we make it, or we try to make it better than normal. A reconstructive procedure like this is where we are trying to get that person back to normal so that they do not look so abnormal that they feel like they cannot even go out in public.

A few weeks ago we had a press conference here in Washington in which some families and some children with these types of birth defects came to town. Stacy Keach, a famous actor, was the emcee. He did this because he was born with a cleft lip and a cleft palate and he has a real feeling in his heart for children born with this type of deformity and for the problems that they are experiencing with HMOs in denying their treatment as not medically necessary.

So I am going to take the opportunity tonight to read to my colleagues some of the statements by the mothers and fathers of some of the children that were born with these types of defects.

This little girl's name is Breanna Fox. Here she is before her operation. This is after the operation. This shows that Breanna's skull bones came together, grew together prematurely, and resulted in a significant deformity of her forehead, her eyes, and her skull. These are the words from her mother and the problems that they had with an HMO in trying to get this birth defect fixed. This is Breanna's mother's words.

''Our daughter Breanna was born July 30, 1998. We knew she would be arriving into this world with a craniofacial deformity, as this had been detected during a prenatal sonogram in my 8th month of pregnancy. As predicted, Breanna was born with a misshapen head and was diagnosed with craniosynostosis, that is where the bones of the skull fuse together, and a severe plagiocephaly, that is the description for the type of facial anomaly that she has.

''Before we left the hospital, we learned that a baby's skull is really a collection of many smaller bones adjacent to one another at sites known as sutures. As the brain grows, the sutures allow for expansion of the skull. When brain growth is complete, the sutures gradually become fused. In Breanna's case, two of the sutures had already fused. Her growing brain was forced to grow away from the fused sutures, resulting in an abnormally-shaped face and skull. Fortunately, surgery could correct her condition.

''Because the first year of life is when the most rapid brain growth takes place, surgery should be performed in early infancy. Delayed surgery could lead to brain damage or worsen the facial deformity requiring more complex and risky surgery later on. Our pediatrician, neonatologist and obstetrician all recommended the same skilled surgeon. We were comforted by the wealth of information we had obtained and the knowledge that this surgeon had been successfully treating children with craniofacial deformities for almost 30 years.

''Then the insurance nightmare began. When we left the hospital to take Breanna home, we planned to see this doctor as soon as possible. Our HMO told us that a craniofacial surgeon was not available in the physician network. We assumed that because Breanna's condition required a team of craniofacial specialists she would be allowed to go out of network to a qualified surgeon. We confidently sent our HMO a form requesting an out-of-network referral. Boy, was our assumption wrong. We had no idea that the next 3½ months would turn into a constant battle with our HMO.

''We were ready to do whatever was necessary to ensure our daughter's health. Our initial referral request was turned down. The insurance company found a surgeon in-network that performed cranial vault reconstruction 'every now and then.' We were advised to 'stay in-network.' To appease our HMO, we made an appointment with the network physician. We were not satisfied with the surgeon's experience and qualifications. It was his opinion that only one, not two, of Breanna's skull sutures were fused, and had not bothered to look at her CT Scan results.'' The mother said, ''We shudder to think what could have happened.''

Mom continued. ''We requested a reconsideration of the denial for an out-of-network referral. After numerous calls, the HMO authorized one visit to Dr. Salyer. The authorization letter stated 'service approved', not services. We knew the battle was on.

''At age 7 weeks our surgeon finally examined Breanna. My husband and I were impressed with his qualifications and experience. We were shown before and after photos of other children with craniofacial deformities. We were assured Breanna would be fine. What a sense of relief. We knew we were in the right place.

''So we sent the HMO a request for a follow-up visit to this doctor. One additional visit was approved. One. The HMO asked, 'We have an in-network provider. Why can't Breanna stay in-network?' Breanna's complex case requires experienced specialists that are not available in-network, we explained.

''During the second appointment, a January 18 surgery date was set. It was critical that surgery be completed on schedule to prevent brain damage. Our doctor explained the role of a multidisciplinary team, including an assisting neurosurgeon and a geneticist. The mandatory referral request forms were sent to the HMO, along with all the required medical documentation. Our HMO questioned the medical necessity of each and every appointment and x-ray.

''At this point, the sixth precertification manager,'' sixth, ''to follow Breanna's case continued the company line and pressured us to go in-network. We again explained that our little girl's complex case required an experienced team of specialists who were not on staff at the in-network hospital. We were told that we were not following protocol and we should have known what we were getting into when we signed up for an HMO.

''Breanna's future quality of life and health was on the line. We simply could not sit back and risk delaying the surgery or the possibility of pending brain damage. Two weeks prior to the appointment with the multidisciplinary team of specialists, we filed a complaint with the Texas Department of Insurance.

''Authorization for the CT Scan and specialist visit had still not arrived 2 days before the scheduled appointments. After numerous calls to the HMO, I was advised that because the primary care physician had not forwarded the necessary documentation, a medical necessity decision could not be made on the geneticist and neurosurgeon's visits.''

This mother was furious. Why? Because this mother works for Breanna's primary care physician, and she had witnessed the office insurance manager sending the requested documentation on many occasions.

She continued. ''I had been in communication with the HMO by phone or fax at least twice a week for the entire month of November. I faxed all the requested documentation again for the fifth time. I received approval for the CT Scan and the surgeon and the geneticist visit 1 day before the preop appointments. The HMO reported no record of a request to see the neurosurgeon and again accused the primary care physician of not supplying the necessary information.''

Remember, this is her boss. ''I faxed the requested documentation for the sixth time. After repeated phone calls and complaints, I received the last preop appointment authorization approval at 4:45 p.m.

□ 2200

The Texas Department of Insurance's investigation of our HMO must have helped Breanna's case. Suddenly, the intimidation and the obstruction ceased.

This mother continued. I am sure many of you have children and can remember a time when they were ill. Remember the pain you felt as a parent when you wanted so badly for them to feel better, how much you wanted to take away their pain. Now, imagine a child with a severe craniofacial deformity, and magnify that pain and misery 10 times.

Our hope today is that insurance companies will no longer be allowed to intimidate the families whose children suffer from birth defects or deformities. Families should never have to encounter the same obstacles we experienced. Please do not allow insurance companies to dictate who can or cannot treat these children. Many children with craniofacial deformities require the expertise of surgeons and other skilled medical professionals.

Remember this is a child's face, and all children must be allowed a chance at a normal life. And she finished her testimony.

I would say to my colleagues, this mother worked in a doctor's office, she knew how to negotiate the system. She knew that they had sent from the primary care doctor's office the information six times. What was that HMO doing? They were doing what they do all the time, they were delaying. They were denying. They were obstructing, because, you know, they figured that if they do that often enough, a lot of people will not know how to navigate the system, and they will just give up.

In this case, fortunately, for this little girl, her mother was an insider. She worked in a doctor's office and she knew how to navigate the system. But I ask my colleagues, how many of our constituents would have been able to have done what this mother did to get her daughter the kind of care that she needed?

Another mother testified, her little daughter Brenna was born August 25, 1987. This is her picture before surgery. You will note her craniofacial deformity. She has protrusive eyeballs. The middle face is forward. She has basically no jaw. Her eyes are widely set. This is her mother's testimony. We knew at the time of her birth that Brenna had a congential birth defect, but it was not until 2½ years that she was diagnosed with Hajdu-Cheney syndrome.

Brenna has the abnormal facial features characteristic of this syndrome. Her eyes are set too far apart, with overgrowth of the eye sockets causing the eyeballs to protrude unprotected. Like any preteen girl, this is in the mother's words, as Brenna has grown older, she has become more and more aware and concerned with her appearance. But, unlike her peers who endure the usual adolescent bad hair days, Brenna suffers from the knowledge that she truly does look different.

As you may have expected, Brenna has been teased by her peers. She is hurt by these remarks. It is not something that someone just gets used to; however, despite the emotional pain, she has hope. Through consultation with a reconstructive surgeon, we learned that reconstructive surgery is available to reconstruct her face to a semblance of normality. However, because of this severity of her deformity, she will need a series of operations.

The first surgery was scheduled, a minor procedure, to see how well she would tolerate surgery. The remaining procedures would be more intensive, involving reconstruction of the bones around her eyes.

With high hopes, we sent the preauthorization forms to our HMO. Two days before Brenna's surgery, we received a letter from Cigna HealthCare denying the first procedure. Brenna's surgery was categorized as ''cosmetic'' and, therefore, not a covered defect. See, we are back here again to the definition of medical necessity.

When Brenna was informed of the insurance company's denial, she became distraught. She was worried that she could not have the surgery and also worried about the financial burden it would place on her family. We simply cannot understand how the insurance company could possibly consider her surgery ''cosmetic.''

Simple every day activities, like a trip to the mall or grocery store are not enjoyable for Brenna. People stare at her. The looks come from other children, as well as adults. I have seen people go out of their way to get a better look. Brenna rarely says anything about it, but I watch her shift her position, this is her mother telling the story, usually trying to get behind me to avoid the stares.

She may suddenly claim to have a headache and want to go home. At times like this, her mother continued, my fierce protective instincts kick in, and I shield Brenna as much as possible. However, this is part of Brenna's life every single day. I am not with her every moment. She is remarkably brave, but she is a child.

Will she limit her participation in education and social activities fearing that she looks like a funny-looking kid? Without the medically necessary care she needs, of course, I worry about the lifelong impact that this may have on her.

Her mother finished by saying, Brenna's craniofacial surgery will not be performed on a normal face to remove wrinkles or to make her face appear more youthful. Her reconstructive surgery will be performed on a face with congential abnormalities with the goal of constructing her face to appear more normal. These are not cosmetic procedures.

She finished by saying, no family should have to wonder if their child will receive medically necessary care. No family should be forced to take on a financial burden for medically necessary care the insurance companies refuse to pay for.

Insurance companies should be required to cover reconstructive surgical procedures for those children with congential or developmental abnormalities.

I would add this, a famous surgeon from the Midwest a long time ago, one of the founders of the Mayo Clinic, Will Mayo had this to say, it is the divine right of man to look human. When somebody is born with their eyes on each side of their head, they do not look human.

This little girl has functional reasons why she needs surgery. Her eyeballs, as you can see, are very protuberant. When she grows older, that will get worse. It may even affect her vision, but it certainly leaves her eyes in an unprotected position because they are not surrounded as eyes normally are by a bony socket. She is at increased risk for trauma to her eyes.

I would say this, even if that were not the case, it is an arbitrary definition by her insurance company to deny her the coverage of this.

Let me talk about a few other types of medical necessity denials that HMOs have done. This woman with her family was denied a type of treatment for breast cancer by her HMO. She was featured on a cover story in Time magazine a few years ago. Her doctors and consultants recommended the treatment, but the HMO said it wasn't ''medically necessary.'' And they denied it, and this woman died.

Mr. Speaker, I recently received a letter from an emergency room doctor in Iowa who had sent this letter to the medical director of an HMO in my home State. Let me read this letter to you. Dear Dr. so and so, Dear Dr. medical doctor, this letter is in response to the ''educational'' letter I received from your HMO regarding the admission of, let us call him Smith, Mr. Smith presented with a hypertensive urgency to the emergency room, and after two doses of IV Trandate, his continued hypertensive urgency required hospital admission.

He previously had a documented myocardial infarct and stent treatment in September 1999. He had been observed in the emergency room for persisting extreme elevation of his blood pressure, and he was admitted to the intensive care unit, because we cannot monitor patients in our emergency room by our hospital regulations in Marshalltown. His blood pressure became well controlled that night.

He was discharged the following day. The patient's risk factors and extreme blood pressure elevation necessitated ICU admission for monitoring, and I had no recourse but to admit the patient.

He had got an educational letter from the patient's HMO questioning why would that patient have to go spend a night in the hospital. He went on and continued, routine harassment by HMO organizations for cases like this demonstrates why physicians and patients will push Congress for legislative relief.

I have to spend time responding to questions about a very appropriated mission when my time would be much better spent taking care of patients, especially when I was obligated by hospital regulations that the patient be admitted. Your HMO continues to place roadblocks and unnecessary obstacles in front of both patients and physicians for obtaining routine care.

I will continue to fight inappropriate letters and hassles by HMOs, including yours, and I will do everything I can to try to see that the Federal regulations are changed, and HMOs have to be responsive both to their patients and the physicians taking care of those patients.

Let me give you another example, Mr. Speaker, of the emergency care problems that could be taken care of if we could deal with the emergency care provisions in the Bipartisan Consensus Managed Care Reform Act that passed this floor, but also if we could take care of the problems as it relates to HMOs, employer health plans' ability to define as medically necessary anything they want to.

This is a well-known case of a young woman who fell off a 40-foot cliff, 50 miles, 60 miles west of Washington, D.C. When she was out hiking with her boyfriend, she fell off a cliff. She was lying at the bottom of the cliff with a fractured skull, broken arm, broken pelvis, semicomatose. Her boyfriend managed to get a helicopter in there.

This is her picture as they are bundling her up to take her to the emergency room. They took her to the emergency room. They stabilized her. They put her in the hospital. She got IV morphine for the pain and was treated. Needless to say, she was out of touch with the world for several weeks.

Her insurance company refused to pay the bill. Why, you ask. Well, because she did not phone ahead for prior authorization. Mr. Speaker, I just have to ask you, what was this young lady supposed to do? Was she supposed to have a crystal ball and know she was going to fall off this 40-foot cliff and before that happened phone ahead and get prior authorization from her HMO?

Then the HMO backed down a little bit and said, well, you know, once you were in the hospital, you should have phoned and let us know, we are still not going to pay your bill. She pointed out that she had been on IV morphine for a considerable period of time, and the thought just did not cross her mind that she had to phone her HMO.

This young lady was fortunate, because the type of health plan she had enabled her to go to her State insurance commissioner, a State ombudsman, and get help, and the HMO ended up paying the bill.

☐ 2215

But the problem, Mr. Speaker, is that most people in this country receive their health insurance through their employer, and those employer plans are shielded from state insurance oversight. So they have nowhere to turn when an HMO would arbitrarily say, you know, ''It does not fit our definition of medically necessary. We are just not going to pay for this.''

Let me give you another example of a real live tragedy caused by an HMO's decision, which under current Federal

law they can defend as ''medically necessary.'' This was a little boy a few years ago, you see him here tugging at his sister's sleeve, who one night had a temperature of about 104 degrees. It is about 3 in the morning. His mother and dad look at him and they know he is sick and he needs to go to the emergency room, so they do what they are supposed to do, they phone their HMO. They dial that 1–800 number, and they get some clerk 1,000 miles away, and they explain that little Jimmy here has a really high temperature and looks sick and he needs to go to the emergency room.

That clerk makes a medical decision, over the phone, never having seen the child, and that decision is well, we will authorize a visit, but only to our hospital which is 60, 70 miles away. If you go, by the way, to another hospital as an emergency without our authorization, you will pay for that visit.

So mom and dad bundle up little Jimmy and they start their trek about 3:30 in the morning. It is stormy and rainy out. They live south of Atlanta, Georgia. The hospital that they have been authorized is clear on the north side, so they have to drive through Atlanta. Less than halfway there they past three hospitals with fine emergency rooms that they could have stopped at, but they did not have an authorization from that HMO.

Not being medical professionals, they push on. Unfortunately, en route, before they get to the authorized hospital, little Jimmy has a cardiac arrest. Picture yourself as the dad driving frantically trying to find the hospital, the mother trying to keep this little baby alive. They go squealing into an emergency room entrance, mother leaps out carrying Jimmy, screaming ''help me, help me, help save my baby,'' and a nurse comes out, starts resuscitation. They get the IVs in, and they get little Jimmy back to life.

Unfortunately, they are not able to save all of little Jimmy. At least as a contributing factor, his arrest en route, when he could have gone to a nearer hospital, Jimmy ends up with gangrene in both hands and both feet. No blood supply, both hands and both feet are dead. So the doctors have to amputate both hands and both feet. Here is a picture of Jimmy after his HMO treatment.

Now, if this happens to you and your baby and your insurance is in an ERISA self-insured plan, an employer plan, your recourse, the responsibility of that health plan under Federal law, is simply to provide the cost of treatment, in this case the cost of Jimmy's amputations.

Is that fair? Is that justice? Knowing that you, the health plan, are not legally liable for anything other than the cost of care denied, are you likely to skimp on definitions of medical necessity?

Well, it sure happens, my friends. It sure happens, and it needs to be fixed, and the only way it can be fixed is for Congress to fix it.

Jimmy today is able to pull on his leg stumps, his leg prosthesis, with his arm stumps, and he is able to hold a pen with his arm stumps. He does have bilateral arm prosthesis hooks, but he needs help to get them on. And he is a good little guy, and because of particular circumstances with his insurance, he was able to receive some compensation. But most people who would have gotten their insurance through their employers would not be able to recover anything other than the cost of care denied.

So, my friends, as the conference is meeting, we need to adopt the provisions on external appeals that were in the bipartisan Consensus Managed Care Reform Act, the Norwood-Dingell-Ganske Act, that passed the floor of the House, and that basically said that if there is a disagreement between the patient or his parents and the company on a denial of care, that you can take that through an internal appeals, but then take it to an independent appeals board consisting of doctors that have no relationship to the HMO, and that that group of physicians is able to determine what is medically necessary, as long as it does not involve a specific exclusion of coverage in the plan, i.e., a plan might say our plan does not cover liver transplants. But as long as there is not a specific exclusion of coverage, then the independent panel ought to be able to make that determination, and these are the crucial words that need to be in the legislative language that comes out of the conference, that independent panel should ''not be bound by the plan's guidelines.''

They can take the plan's guidelines under advisement, they can consider the patient's history, they can consider NIH Consensus Statement, they can consider the medical literature, all sorts of things, but they should not be bound by the plan's own guidelines.

That is what is in the Senate bill. That is why the Senate bill is not worth the paper that it is written on, because it is a circular bill. It does not do anything. At the end of the day, it does not address the problem that you have to address if you are going to do HMO reform, and that is you have to break the Federal law that says that an employer health plan can define as medically necessary anything they want to, or can deny it, according to their own guidelines.

TOBACCO

Well, Mr. Speaker, I want to talk just a few minutes about probably the number one public health problem in the country today, and that is tobacco. Each year more than 400,000 people in this country die of disease related to tobacco. Mr. Speaker, that is more people than die in a single year combined from AIDS, automobile accidents, homicides, suicides, burns, certainly medical errors. You can add all those things together, and it is still less than the number of people that are dying each year from tobacco-related diseases.

Each day in this country, each day, 3,000 children, 3,000 adolescents, start smoking, and 1,000 of those kids will die of a disease related to smoking.

As a surgeon, I have had to take care of people who have cancers of their mouth, that have required resection of most of their mandibles. In response to that, many states have done settlements, including my own State of Iowa, so we are now seeing billboards like this one, which is in Des Moines. This was put up by the Attorney General of Iowa, Iowa Department of Public Health, Centers for Disease Control. It shows two Marlboro-type cowboys. ''Bob, I have got emphysema.'' There is another one in Des Moines that says ''Bob, I have lost my lung.''

These will help, but we need to do more, because we know that the tobacco companies have in the past and are continuing to target and market kids. We know from internal tobacco company documents that they know that nicotine is one of the most addictive drugs we know of. It is more addictive, or at least as addictive, as morphine and cocaine, and they know that, the tobacco companies know, that the earlier they can get kids addicted, the harder it is to quit. That is why this cartoon shows big tobacco lighting up a ''kids'' cigarette with a ''victims'' cigarette, a chain smoker.

And it is not just that the tobacco companies have marketed and targeted cigarettes towards kids. Did you know, for instance, Mr. Speaker, that a survey was done not too long ago that showed that 80 percent of five-year-old children could associate cigarettes with Joe Camel?

Tobacco companies are also marketing and targeting kids, especially high school boys, for smokeless tobacco, chewing tobacco. There are over 1 million high school boys today who regularly use chewing tobacco.

I point out, Mr. Speaker, that we have not had tobacco spittoons in this House chamber for a long, long time.

What is the consequence of chewing tobacco? Well, as a surgeon I can tell you firsthand what the consequences are. It is like this surgical specimen. This shows the teeth of the anterior lower jaw, part of the tongue, the lymph nodes underneath the jaw. This is a surgical resection for a cancer caused by chewing tobacco. And what have the tobacco companies done? Well, they have made that chewing tobacco taste good. They have tested the flavors to see which flavors would be enticing to kids, and that is how they get them hooked on that tobacco product.

Just in Iowa alone, 37 percent of high school students smoke. Each year in Iowa, each year in Iowa, and we only have about 2.8 million people in my home state, each year 12,000 kids under the age of 18 become new smokers. Each year in Iowa more than 3 million packages of cigarettes are illegally sold to kids.

The number of people who die each year in Iowa from smoking is almost 5,000. The number of Iowa kids alive today who will die from smoking is 53,000.

It annually costs Iowa $610 million to take care of diseases directly related to tobacco use. The Iowa government Medicaid payments directly related to tobacco use are $70 million.

Mr. Speaker, I could go on with a whole bunch of statistics, but the reason that we are talking about this is that 3 weeks ago the Supreme Court by a 5 to 4 decision said Congress must authorize the Food and Drug Administration to regulate tobacco.

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I can read from Sandra Day O'Connor's closing statement. The Supreme Court said that because there are implications for other regulatory agencies. But that did not mean that they did not think that Congress should do that, and they certainly did not think or give any indications that there would be anything unconstitutional with Congress giving the FDA that authority.

Here is what Sandra Day O'Connor said:

''By no means do we question the seriousness of the problem that the FDA has sought to address. The agency has amply demonstrated that tobacco use, particularly among children and adolescents, poses perhaps the single most significant threat to public health in the United States.'' Justice O'Connor is practically begging Congress to grant the FDA authority to regulate tobacco.

So last week I introduced, along with the gentleman from Michigan (Mr. DINGELL), a bill that would do that. The bill simply says that the FDA has authority to regulate tobacco; that the 1996 FDA regulations would be law.

Let me point out, Mr. Speaker, that this is not a tax bill. There would be no increases in the price of cigarettes with this bill. This is not a liability bill. This does not confer any legal immunity to tobacco companies.

This is not a prohibition bill. I have in this bill a provision that says that the FDA does not need to ban this substance. All of the health groups agree that we cannot just cold turkey all of the addicted smokers out there. After all, this is a very strong addiction.

The bill has nothing to do with the tobacco settlement.

This bill simply recognizes the facts: Tobacco and nicotine are addicting. Tobacco kills over 400,000 people in this country each year. Tobacco companies have and are targeting children to make them addicted to smoking. The FDA should have congressional authority to regulate this drug and, as they put it, the ''delivery devices.'' That is in the tobacco companies' words, those cigarettes are drug delivery devices.

Mr. Speaker, I just want to call on my colleagues to cosponsor this legislation. This is H.R. 4207. As I said, I introduced this with the gentleman from Michigan (Mr. DINGELL). Here are some of the people who are currently already cosponsors:

The gentleman from Iowa (Mr. LEACH), the gentleman from California (Mr. WAXMAN), the gentleman from California (Mr. COX), the gentleman from Iowa (Mr. BOSWELL), the gentleman from Utah (Mr. HANSEN), the gentleman from Arkansas (Mr. SNYDER), the gentleman from Maryland (Mr. GILCHREST), the gentlewoman from New York (Mrs. MALONEY), the gentlewoman from Maryland (Mrs. MORELLA), the gentleman from Virginia (Mr. MORAN), the gentlewoman from New Jersey (Mrs. ROUKEMA), the gentleman from Washington (Mr. MCDERMOTT), another physician, just like the gentleman from Arkansas (Mr. SNYDER), the gentleman from California (Mr. HORN), the gentleman from Texas (Mr. BRADY), the gentleman from Arizona (Mr. SALMON), the gentleman from New York (Mr. GILMAN), the gentleman from California (Mr. MCKEON), the gentlewoman from Colorado (Ms. DEGETTE), the gentlewoman from California (Mrs. BONO), the gentleman from Oregon (Mr. BLUMENAUER), the gentleman from Florida (Mr. WELDON), the gentleman from Massachusetts (Mr. MARKEY), the gentleman from Illinois (Mr. PORTER), Mr. BARRETT, the gentleman from California (Mr. BILBRAY), the gentleman from Massachusetts (Mr. OLVER), the gentleman from California (Mr. CUNNINGHAM), the gentleman from Nebraska (Mr. BEREUTER), the gentlemen from California, Mr. GALLEGLY and Mr. HUNTER, the gentlewoman from New York (Ms. SLAUGHTER), the gentleman from California (Mr. CAMPBELL), the gentleman from New Jersey (Mr. SMITH), and the gentleman from New York (Mr. WEINER).

These are just cosponsors. Many others are looking at this bill. This is a very, very important issue that Congress should address. We need cosponsors for this. It will not be easy to get an FDA tobacco authority bill to the floor. But the more people that we have sign up for this, the better the chances are that we will have to address the number one public health problem in the country today, and especially for children.

Once again, I call on my colleagues from both sides of the aisle to join in a bipartisan effort to do the right thing. As I said, this is not a tax bill. This is not a liability bill. This bill would allow the FDA to regulate tobacco, especially as it is marketed and targeted to children, and it would allow the 1996 regulations to go into effect.

These are the regulations that the FDA put out that said, tobacco companies cannot market kids. They cannot put billboards up by schools, they cannot put tobacco enticement ads into children's magazines. Vending machines, cigarette vending machines, need to be in adults-only places so kids cannot just go and get cigarettes, and that kids should be carded to make sure they are the proper age before they can receive cigarettes. Those are reasonable regulations.

Also, we ought to have full disclosure on the contents of tobacco products as well, not proprietary trade secrets.

THE PROBLEM OF ILLEGAL NARCOTICS

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

Mr. MICA. Mr. Speaker, I am pleased to come to the floor again tonight to talk about the subject I usually attempt to address on Tuesday night before the House when we have these Special Orders to call to attention to the House of Representatives, my colleagues, Mr. Speaker, and the American people, one of the most serious social problems we are facing as a Nation. That is the problem of illegal narcotics, their disastrous impact on the United States, our economy, on families across this Nation, the tremendous toll it takes on our judicial system, and the loss of lives.

In fact, in the last recorded year, 1998, some 15,973 Americans lost their lives as a direct result of illegal narcotics. If we take in all of the other figures that are not reported, our national drug czar, the director of our Office of National Drug Control Policy, Barry McCaffrey, has testified before our Subcommittee on Criminal Justice, Drug Policy, and Human Resources that the toll exceeds some 50,000 each year in the United States.

That is truly a devastating number when we consider that we have incarcerated nearly 2 million Americans, and that some 70 percent of them are there because of drug-related offenses or committing crimes, in most cases two and three felonies on their record, under the influence of illegal narcotics and substance abuse, and we know that something is seriously wrong and something needs our attention, not only as a Congress but as a people who care about people and should care about their fate.

Unfortunately, the toll continues to mount, the tremendous impact illegal narcotics have had again on our Nation. Tonight I wanted to cite just some of the most recent statistics we have, and how some of the people who are most at risk in our national population are some of the highest victims as far as percentage, again in this terrible conflict with illegal narcotics.

According to the 1998 National Household Survey on Drug Abuse, drug use increased from 5.8 percent in 1993 to 8.2 percent in 1998 among young African-Americans; again, the victims of illegal narcotics and drug use, in particular the minority population, and in this case not quite doubling but a dramatic increase for African-Americans.

Also, according to this 1998 survey on drug abuse, drug use increased from 4.4