

some of the tax overpayment to working American families.

So after the Patients' Bill of Rights, we do have the vote scheduled on Friday on the lockbox for Social Security, and then we are looking at other appropriations bills that we could go to Friday or early next week or the intelligence authorization bill. We will confer with leadership on both sides before that announcement is made.

With that, I thank my colleagues, and I yield the floor so that Senator GRAMS can make his statement.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, leadership time is reserved.

MORNING BUSINESS

The PRESIDING OFFICER. Under the previous order, there will now be a period for the transaction of morning business not to extend beyond the hour of 10 a.m. with Senators permitted to speak therein for not to exceed 5 minutes each. Under the previous order, the Senator from Minnesota, Mr. GRAMS, is recognized to speak for up to 15 minutes.

The Senator from Minnesota.

Mr. REID. Mr. President, parliamentary inquiry.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. It is my further understanding that under the unanimous consent agreement of last night the Senator from Wisconsin is to be recognized for 10 minutes and the Senator from Rhode Island is to be recognized for 5 minutes. Is that true?

The PRESIDING OFFICER. The Senator is correct.

Mr. REED addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. REED. Further parliamentary inquiry. Would that carry us past the 10 o'clock hour?

The PRESIDING OFFICER. The Senator then would go past the 10 o'clock hour.

Mr. REED. I thank the Chair.

The PRESIDING OFFICER. The Senator from Minnesota.

PATIENTS' BILL OF RIGHTS

Mr. GRAMS. Mr. President, I rise today to talk a little bit about the health care bill we are debating in this Chamber.

Our colleagues on the other side of the aisle have day after day asserted that their Patients' Bill of Rights legislation is better than the Patients' Bill of Rights Plus legislation, of which I am a proud cosponsor.

If we are to believe that raising the cost of every insured individual's premiums by 6.1 percent and increasing the number of uninsured by roughly 1.8 million people is what is good for

America, then, yes, this could be called a better bill. I, however, don't think those statistics suggest it's a better bill. Most Americans who know that this legislation increases costs and increases the number of uninsured do not think it is a better bill at all.

I firmly believe that the Patients' Bill of Rights Plus, S. 300, is a much more productive solution to problems facing Americans in the health care market today.

Mr. President, eight to ten percent of Minnesotans are uninsured today. Now, we in Minnesota enjoy a lower uninsured rate than the national average and we have historically had one of the lowest uninsured populations in the country.

However, if S. 6 is adopted into law, I could expect to see about 36,000 more Minnesotans become uninsured. Nationally, about 15 percent of our population today is without insurance. They may be uninsured for a number of reasons, but I bet the biggest obstacle for most people is access, and access is determined by costs. They simply cannot afford the costs of insurance.

These uninsured Americans would be left even further behind if we adopt the Kennedy-Daschle health care bill. Our colleagues make no effort whatsoever to address the problems of the uninsured. I do not think this is good policy, I do not think it is good for the Nation, and it certainly is not good for those already uninsured or those who will be forced to drop health care insurance because of increased costs.

Thankfully, we have an alternative, and it is called the Health Care Access and Equity Act of 1999, or S. 1274. I was pleased to introduce this legislation along with my colleagues Chairman ROTH and also Senator ABRAHAM of Michigan. When we introduced this bill on June 24, we did so with the support of 15 of our colleagues.

The Health Care Access and Equity Act does several things to increase access to health insurance, but one of the most important components is the full deductibility of health insurance costs for those without access to health insurance coverage through their employer. The Health Care Access and Equity Act of 1999 presents us with the opportunity to create the most comprehensive tax deductible coverage system in our Nation's history. It achieves this by eliminating one of the most discriminatory portions of the Tax Code: the disparate treatment between an employer purchasing a health plan as opposed to an individual purchasing health insurance on their own.

When employers purchase a health care plan for their employees, he or she can fully deduct the cost of providing that insurance, effectively lowering the actual cost of providing that coverage. However, when an employee purchases an individual policy on their own, they must do so with after-tax dollars and cannot fully deduct the cost of that plan. They do not have the ability or the advantage offered to em-

ployers to reduce the actual costs of their policy by deducting the premiums from their taxes every year. Therefore, health insurance is too costly and, for many, they usually wind up without health coverage. The Health Care Access and Equity Act will end this discrimination within the Tax Code and make health care available for many more Americans.

Let's make the same tax incentives for purchasing health insurance now available to employers apply to everybody. Let's level the playing field, and we will have taken the next logical step in the evolution of our health care system.

I believe Congress should be doing what it can to lower the cost of health insurance, making it more affordable—not by proposing legislation that will raise the costs and will make health insurance more and more difficult to afford.

I have a chart with me that shows the impact my legislation would have for my constituents. As you can see, it would reduce health insurance costs by anywhere from \$796 to \$1,384 for a family of four living in Mankato, MN, and also \$887 to about \$1,542 for a family of four living in St. Paul, or the Twin Cities. This is because they could deduct their premiums on their taxes, and this is what they would save off their tax bills which they could use then to pay for health insurance policies, thus making health care more affordable.

These are very significant costs which could make health insurance coverage available for many more people in my State, as well as across the country, who are currently in the individual health insurance market, and that is more than my colleagues on the other side of the aisle can say about their bill.

It seems most proposals before the Senate are just out there forcing some Federal definition of quality health plans onto the consumers and then sticks them with the bill, the increased cost for those mandates. It is not good policy, it does nothing for those who are uninsured, and it will not help those who will be forced to drop their health insurance because they can no longer afford the increase in those health care premiums.

Even without the increased costs associated with the so-called Patients' Bill of Rights legislation, employers are already anticipating premium increases of between 7 to 10 percent over and above the costs that would be forced to go up under the plan by Senator KENNEDY. Add on to that the costs of the Patients' Bill of Rights and you get higher numbers across the board, you get higher premiums, higher uninsured and higher frustration because any raise in pay that a middle-class worker might expect will now go toward even higher health care premium costs.

It is estimated that benefit mandates comprise over 20 percent of the price of health plan premiums already in the

State of Minnesota, and if you add on top of that the 5- to 6-percent tax on health plans and we are getting close to one-third of that premium being attributed to taxes or mandates.

You might say: Employers can cover the premium increases. Some may, but some may not. Regardless, the money employers use to cover higher health insurance premiums could be used to increase the employee's salary. By increasing the employers' costs, Congress will force employees to forego a pay increase. My colleagues across the aisle may believe this is a good direction for the country to go in, but I do not, and I know that most Minnesotans do not agree.

If all this were not bad enough, 57 percent of small businesses say they will stop providing health insurance for their employees if they are exposed to the Kennedy-Daschle bill's liability provisions. This is not just a threat. Most small businesses are not able to absorb higher operating expenses without cutting back or eliminating some costs, and that could mean as well some jobs that would be lost.

Let's talk about the liability issue a little bit.

Under Senator KENNEDY's legislation, employees will be able to sue their employers for something the employer is not obligated to provide. That sounds a little strange to me, so I have to say it again. People will be able to sue their employer if they are unhappy with something their employer is not in any way obligated to provide.

Proponents of increasing costs through liability will say: We have carved out employers from the liability provisions so only insurers, HMOs, and third-party plan administrators would be liable. This may be true in theory, but what they will not tell you is that there is already no way to separate the two under recent guidance from the Department of Labor. The guidance clarifies that employers have a fiduciary obligation to monitor plan quality. This responsibility renders so-called carve-outs ineffective because there is no way employers can completely absolve themselves of benefit decisions under their health plan which is required under the Democrats' illusory carve-outs.

As I have mentioned before, the Kennedy-Daschle approach will increase costs, and even if employers could meet the guidelines for that liability exemption, the costs are still passed on to the employers and, of course, those costs are then passed on to their employees. Essentially, the Kennedy-Daschle liability provision does not guarantee quality health care. What it does guarantee is increased health premium costs for every American.

What fork in the road is this country taking when a notion such as this is given any serious discussion? Isn't it apparent to supporters of the Kennedy bill that if companies are exposed to this type of liability they would just drop insurance coverage for their employees?

I have never believed we need more litigation in this country, and this is certainly not an exception. We all want patients to have protection as much as anyone else. Yet how do we ensure patients are receiving the health care they need in a timely fashion?

I believe a strong, independent, quick, and easily accessible appeals process for those who have been denied health care services they and their physicians believe is necessary is what is needed and appropriate means to resolve coverage disputes. Again, as an original cosponsor of the Patients' Bill of Rights Plus legislation, I support an idea for this strong, independent, external appeals process to ensure people receive the health care they need and to make sure they get it when they need it.

Perhaps the best part of the appeals process is the fact that the external appeal is binding on the health plan but not binding on the person who is appealing. What does that exactly mean?

It means if you were denied care you and your physician believe is necessary, go through the appeals process and the appeals board agrees with you, the health plan then is legally bound to pay for that care. However, if you are unsatisfied with the outcome of the appeals process, you can then sue the health plan under current law, which allows the collection of attorney's fees, the cost benefit, court costs, injunctive relief, and other equitable relief.

No one can sue their way to good health, but we can give them the tools they need to get the care they need when they need it, and the Patients' Bill of Rights Plus gives consumers those tools.

The Kennedy-Daschle bill also includes a provision which, on the surface, also sounds very reasonable. It allows physicians and patients to determine what is medically necessary. Who could be against that? But what they do not tell you is creating such a standard could, under some circumstances, work against the patient's best interest. I will give an example of how this could happen.

Under Senator KENNEDY's bill, health plans would be required to cover the costs of whatever setting or duration of care a physician decides is "medically necessary." The bill goes on to define medical necessity as whatever is consistent with generally accepted principles of professional medical practice.

This effectively prohibits health plans from intervening in situations when it is clearly in the patient's best interest. For instance, the Centers for Disease Control figures indicate that approximately 349,000 unnecessary caesarean sections were performed in 1991.

While decisions regarding these individual procedures were based on generally accepted principles, a large number of women were needlessly subjected to major surgery and risk of infection.

Another shortcoming of the generally accepted principles of medical practice is the variance in treatments

from region to region. Let's take a look at what the Dartmouth Atlas of Health Care 1998 says about treatments for breast cancer;

Once diagnosed, surgery is universally recommended for the treatment of breast cancer. There are two principle surgical approaches: breast sparing surgery (lumpectomy, which is followed by radiation therapy) and mastectomy (complete removal of the breast). Randomized clinical trials have shown that these two approaches have nearly identical rates of cancer cure. . . . Despite scientific evidence that the survival rate is the same for breast sparing surgery and for mastectomy, and in spite of wide consensus that patient preferences should determine which treatment is chosen, the wide variations in surgical rates suggest that physician, rather than patient, preferences are the deciding factor on most cases.

That's what the Dartmouth Atlas of Health Care 1998 has to say about the choice between lumpectomies and mastectomies. Let me tell you about a related incident which actually happened in my state of Minnesota.

Several years ago, one of the major health plans in Minnesota received a telephone call from a Minnesota physician seeking authorization to perform an outpatient mastectomy on a woman suffering from breast cancer. This physician wanted to admit a woman to a same-day surgical center, remove her breast and then send her home later that day.

The health plan's medical director had never heard of an outpatient mastectomy being done before. In answer to questioning by the health plan, the physician admitted he had done the procedure only one time before. When asked why he wanted to do this procedure on an outpatient basis, he told the plan it was at the request of the patient. The plan's representative told the physician to wait and make no plans to do the procedure outpatient.

The health plan then went to the patient and asked why she would want to procedure done as an outpatient. She told the plan's representative that the physician told her the plan was ordering him to do the procedure on an outpatient basis. "You know how insurance companies are," she said he told her.

When the plan told her they hadn't ordered the physician to do the procedure outpatient, she began to cry. She did not want the procedure done outpatient.

The health plan called the physician back and told him that due to the lack of medical necessity, they were denying his request for authorization to do the mastectomy on an outpatient basis. The patient had the mastectomy as an inpatient, and because of complications, she ended up staying in the hospital for several days.

Mr. President, this woman was a single-mother of three who would have been totally incapable of caring for herself, much less her three children, if the physician had done the procedure outpatient as he originally requested.

This example demonstrates how health plans can and do contribute to

quality in our health care system. Are there problems in some areas? Have mistakes been made? Yes. But, let's think about the consequences of what we do here today. Will the Kennedy bill really make health care better? More quality oriented? I don't think it will.

New breakthroughs in pharmaceuticals and medical devices are unveiled almost daily. Many of these breakthroughs come from Minnesota companies and research facilities. These breakthroughs represent opportunities for individuals to live longer, healthier, more productive lives. I believe it would be difficult for physicians, or anyone, to be able to keep up with all the latest technology and treatments by themselves. Yet, that's what we're forcing them to do if the medical necessity provision included in the Kennedy bill passes as written. Further, if plans are required to pay for whatever procedure, treatment, drug or device providers offer, we could be putting patient's health, and perhaps their lives, at stake.

To show the inconsistency of President Clinton and Senator KENNEDY display by insisting the medical necessity provision be part of the Patients' Bill of Rights, they directly contradict a report issued in February by the Office of Inspector General of the Department of Health and Human Services. The report found that the majority of all Medicare fee-for-service fraud cases is a lack of medical necessity. You may recall Secretary Shalala holding a press conference in response to this report calling on America's seniors to be more vigilant when receiving health care services to assure that fraud is not being committed.

If the administration is urging consumers and health plans to take action in order to reduce fraud in the Medicare program, why is it proposing to bar health plans from using the very same tools to prevent fraud in their programs?

While I'm thinking about Medicare and the Patients' Bill of Rights, it was President Clinton who insisted, under the threat of a veto, a provision be included in the Balanced Budget Act which denies seniors one of the most basic patient's rights—the ability to use their own money to pay for the health care services they believe are necessary. Our Democratic colleagues agreed with the President and have stalled reconsideration of this egregious violation of a basic right. I am hopeful we can get to that patient's right later this year.

The problems our health care system faces are not just the result of managed care. If it were, Minnesota, where 90 percent of health care consumers are in managed care organizations, would not have the longest life expectancy in the United States. The Twin Cities of Minneapolis and St. Paul would not have the lowest health care costs of the top 20 metropolitan areas in the United States, and we wouldn't have an uninsured rate half the national average.

Minnesota has found a way to live and thrive with managed care. It's not without problem, but for the vast majority of Minnesotans, it works well. With all due respect to my colleague from Massachusetts, Minnesotans don't want his definition of a quality health plan and we don't want him to tell us what protections we need or don't need.

During my first term in Congress, President Clinton introduced the Health Security Act, which is now commonly referred to as "Clinton Care." I was opposed to the President's legislation because it was nothing short of a government take-over of the best health care system in the world. I remain opposed to this type of legislation because it is too prescriptive, too centralized and limits health care choices.

Over the past two years, we've seen bill after bill introduced which propose, in the name of quality health care, to allow federal bureaucrats, Congress and lawyers to practice medicine without a license. Benefit mandates are thrown around Congress as if there were no consequences. I've heard it referred to as legislating by body part.

We are told by those on the other side of the aisle, "we need to have benefit mandates so Americans can receive quality health care," and "let's preempt the states because they don't know what they're doing." I disagree, and the very individuals who regulate HMOs and every other type of health plan for the respective states—the insurance commissioners—also strongly disagree. In fact, State insurance commissioners have already spoken to Congress on this issue. The National Association of Insurance Commissioners wrote this to Chairman JEFFORDS in March of this year.

It is our belief that states should and will continue the efforts to develop creative, flexible, market-sensitive protections for health consumers in fully insured plans, and Congress should focus attention on those consumers who have no protections in self-funded ERISA plans.

The letter goes on to explain very precisely their view of pending legislation:

The states have already adopted statutory and regulatory protections for consumers in fully insured plans and have tailored these protections to fit the needs of their states' consumers and health care marketplaces. In addition, many states are supplementing their existing protections during the current legislative session based upon particular circumstances within their own states. We do not want states to be preempted by Congressional or administrative actions.

There has been a lot of smoke blown around here about how many health-based organizations have endorsed this bill or that bill, but when it comes to regulating health insurance policies, I believe we need to put more stock in the option of those who are currently responsible for regulating health insurance—our state insurance commissioners. They know best what the people in their states need—they know

best how to achieve their goals, and Congress should know better than to question their ability or willingness to meet those challenges.

As we get deeper and deeper into the details of the Kennedy-Daschle bill, I am reminded of something Minority Leader DASCHLE said in the opening hours of this debate. He claimed that the reason insurance companies call them HMOs "is that H-M-O stands for their patient philosophy: Having Minimal Options." Mr. President, I suggest that it is the Kennedy-Daschle bill that would take away options and our colleagues should be willing to admit it.

We have seen our colleagues' true motives when they backed President Clinton's Health Security Act, when they backed President Clinton taking away a senior's right to use their own earnings to pay for medical services without the government and now we see it with the Kennedy-Daschle Patients' Bill of Rights. Consumer's options are becoming minimal and we have government to thank for that.

To suggest that our bill—the only one expanding options for the American people by eliminating restrictions on medical savings accounts, allowing the self-employed to fully deduct the cost of purchasing health insurance, and permitting the carryover of unused funds in flexible spending accounts—limits Americans choices, ignores the contents of our bill and ignores the reality of the Kennedy-Daschle bill.

Another issue I would like to talk about is something I have taken great interest in over the past three years—emergency medical services. This is perhaps one area in our debate which Republicans and Democrats have agreed is important enough to ensure access for Americans in need of immediate care. Every proposal in Congress contains some form of the prudent layperson standard for emergency services. That is with good reason.

The Federal Government has some precedence in dealing with access to emergency care through a law enacted in the 1980s called EMTALA, or The Emergency Medical Treatment and Active Labor Act. This act requires hospitals to treat everyone and anyone who enters their emergency department regardless of ability to pay as a precondition to participation in the Medicare program.

All the proposals before Congress with the prudent layperson standard include some reference to EMTALA. Where I have concern is the lack of any mention of ambulance services in any Patients' Bill of Rights legislation. While there has been some mention of ambulance services being included as part of the ancillary services clause under EMTALA, this simply will not work.

I will remind my colleagues that EMTALA only affects what happens once an individual arrives at a hospital's emergency room door. It covers none of the pre-hospital care people receive from courageous EMS personnel

all over the Nation whose sole function is to get the sickest among us to the emergency room quickly, efficiently and safely so emergency physicians can tend to our condition.

Contrary to what most people think, EMS personnel do not make diagnoses. They do not make decisions about whether a patient should or should not be transported to an emergency room based on their medical condition. Ambulance personnel respond to calls initiated in any number of ways, arrive at the location, assess the patient's condition, stabilize them and ready them for transportation to a facility with the personnel trained to make a diagnosis.

The reason I wanted to bring this to everyone's attention is because I believe many of us have not taken the time to fully understand the function ambulance services performs in the health care delivery system. We cannot afford to continue ignoring the important role EMS plays in health care.

For the past 3 years, I have introduced legislation which would address some of the problems ambulance services faces every day. My most recent iteration is S. 911, the Emergency Medical Services Efficiency Act. I invite any and all of my colleagues to join me as a cosponsor of this important legislation. I am hopeful we can include several of its provisions in the Patients' Bill of Rights legislation before us today.

For every 1 percent increase in premiums, there are an additional two to four thousand uninsured in Minnesota. Whether it's a family of four in Ada, Minnesota or a single mother of two in Zumbrota, I don't want to be responsible for any Minnesotan losing their health insurance coverage. I believe if I were to vote for the Kennedy-Daschle bill, I would be doing just that—ensuring that 36,000 Minnesotans will be forced to drop their coverage because they can no longer afford it.

That is something I, along with 97 of my colleagues in the Senate, voted not to do in a sense-of-the-Senate resolution last year. I urge my colleagues to honor the promise they made in that vote and defeat the government-centered, one-size-fits-all vision of health care illustrated by the Kennedy-Daschle Patients' Bill of Rights. Patients will get a bill all right—one taken out of their paychecks every month.

I urge my colleagues to say yes to creating choices, yes to protecting consumers who aren't currently protected, yes to being mindful of costs, and yes to increasing the number of insured—they can do all that with one vote for the Patients' Bill of Rights Plus.

The PRESIDING OFFICER. Under the previous order, the Senator from Rhode Island is recognized to speak for up to 5 minutes.

Mr. REED. Thank you, Mr. President.

PATIENTS' BILL OF RIGHTS

Mr. REED. Mr. President, I will discuss several issues that are central to the debate we are having on managed care in the Patients' Bill of Rights.

First, I was very disappointed that the Senate rejected Senator KENNEDY's amendment which would have extended the protections of the Patients' Bill of Rights to all privately insured Americans. Those in favor of much more limited coverage, very much restricted coverage, argue that the cost in the Democratic alternative would cause many Americans to lose their health insurance through increased premiums. They argue, as we have heard time and time again, that premiums would rise and that employers would drop coverage.

When you actually talk to many employers, particularly those in small businesses who are represented by the American Small Business Alliance, for example, they tell quite a different story. They talk about a situation in which they have already seen premiums rise, but they get very little for what they pay for.

For example, Mr. Brian McCarthy, President of McCarthy Flowers and Cabs, from Scranton, PA, had this to say. His words:

Workers who spend time out sick or are consumed in battles with their health plan wreak havoc on the bottom line. That lost productivity costs my business a lot more than the modest premium increases that may result from this legislation.

He went on to add:

The Patients' Bill of Rights is about giving people the care they need and deserve, and it clearly gives small businesses a better deal for their health care dollar.

That is not the voice of a Senator, but of a small businessperson who has seen the effects of managed care on his own bottom line.

Another small business owner, Mr. Tom Reed, who owns Lake Motors in Eagle Lake, TX, said:

My premiums go up now and I get nothing, or sometimes even less coverage. The Patients' Bill of Rights at least will give me something tangible, bringing me better value for the health care money I spend.

Those are the words of businesspeople who are struggling with the issues. They are in favor of this legislation because they want to get what they have been paying a lot for, and that is quality health care. They will only get that with the Democratic Patients' Bill of Rights.

There have been studies that have supported these anecdotal comments. The Kaiser-Harvard Program on Health Policy surveyed small business executives from the small business sector, and they found that 88 percent support independent appeals such as those that are in the Democratic alternative; 75 percent support the right to see a specialist without prior approval; 61 percent favor giving people the right to sue their health plan; and fewer than 1 percent suggested that they might drop coverage if rates increased.

These are small business executives. This is compelling and persuasive evidence that, in order to be responsive to the needs of small businesses throughout the country, it is imperative that we pass the Democratic alternative.

There is another aspect of this legislation which deserves discussion, and that is the fact that health care plans, HMOs, are immune from liability because of what is apparently a loophole in the ERISA law.

A physician can be sued for malpractice, a physician can be sued for making misjudgments, but an insurance company, often working through nonphysicians, administrators, and reviewers, are immune from such suits.

This aspect of accountability is critical to making sure that we have rights that are enforceable and that actually produce tangible results throughout the country.

In another survey, the Kaiser Family Foundation found that 73 percent of those surveyed believe that patients should be able to hold their managed care plans accountable through the courts.

This is not to suggest that anyone is encouraging a mass exodus to the courthouse. In fact, there is quite a bit of experience that suggests this probably will not happen.

In Texas, in May of 1997, bipartisan legislation was passed making it the first State where managed care organizations can be sued for medical malpractice. Like the Democratic plan, the Texas liability law is closely tied to tough, independent external review processes. In fact, you cannot take advantage of the right to sue until you have been through this independent review process.

Despite all the warnings about a flurry of lawsuits—the same thing we are hearing today—this has not been the experience in Texas. Neither has the State experienced increased premiums. What has happened is that both sides now are claiming success. HMOs are saying: Look, this is working. And consumers are saying: This is helping us out. In fact, according to Texas State Senator David Sibley—

The PRESIDING OFFICER. The time has expired.

Mr. REED. I ask unanimous consent for an additional minute.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REED. I thank the Chair.

According to one of the sponsors, Texas State Senator David Sibley, who is Republican, in his words, stated:

[T]he Texas experience has been very positive. . . . Both sides are claiming victory: the HMOs are saying "see how well it works; people aren't filing many reviews." The consumer groups are saying that HMOs are being more responsive and are looking more carefully at the needs of patients before they deny claims.

Mr. REID. Will the Senator yield?

Mr. REED. Yes.

Mr. REID. Is the Senator aware that George W. Bush, Governor of the State