The assistant legislative clerk proceeded to call the roll.

Mr. EDWARDS. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

PATIENT PROTECTION LEGISLATION

Mr. EDWARDS. Madam President, for too long the law has been on the side of HMO's and big insurance companies. It is time we give power back to patients and families and doctors. Nearly every one of us has had some sort of bad experience with an HMO or an insurance company, either personally or through a family member or a friend. Sometimes the problems are frustrating, sometimes the problem is just red tape and bureaucracy, sometimes it is simply impersonal treatment.

Sometimes the problems are much more serious than that. Sometimes the problems are dangerous: when an HMO, for example, refuses to authorize a visit to a specialist or the nearest emergency room, or denies treatment that is desperately needed by a patient, or refuses to be held accountable for any of the decisions it makes. Americans have the right to expect that decisions about their health care and their family's health care will only be made by the patient, in consultation with physicians and family members, and that physicians will be able to help them make those decisions on the basis of the patient's best medical interests. Those decisions should not be made by HMOs and insurance companies concerned only about the bottom line.

That is why we need a Patients' Bill of Rights. That is why last week I joined Senator JOHN MCCAIN, along with a bipartisan group of Members of the House and the Senate, to introduce a bill that builds on the progress that has already been made in this Congress to pass a Patients' Bill of Rights.

The Bipartisan Patient Protection Act provides comprehensive patient protection for all Americans. It will, No. 1, guarantee access to specialists for all people who have private insurance, so that women, for example, can go directly to an OB/GYN or a child can go directly to a pediatrician for care. No. 2, it strengthens the right to go to an emergency room, to the ER, immediately after an emergency arises, without first having to be concerned about calling some 1–800 number and asking permission from an insurance company or an HMO.

When a family is involved in a medical emergency, the last thing they need to be worried about is calling the insurance company. They need to be able to do what is best for their family and go immediately to the emergency room that is closest to them. Our bill provides for that.

We also eliminate the gag rule. What we need to do is give doctors the ability to speak freely with their patients about the treatment options that ought to be considered by the patient. What we have done is prohibit clauses between insurance companies and doctors—the so-called ''gag rule''—that restrict doctors from talking to their patients about the various treatment options, and instead only allow doctors to talk about the cheapest treatment options. We prohibit that practice and prohibit gag rules.

Scope. Our bill covers every single American who has private insurance through an HMO or an insurance company. Some of my colleagues have argued, during the course of the debate about a real Patients' Bill of Rights, for a more limited approach. I do not agree. I believe every single American who has health insurance or receives coverage through an HMO deserves, and is entitled to, exactly the same rights. The same basic rights and freedoms that we provide for some people ought to be available for every single American who has HMO or health insurance coverage.

Make no mistake, in States like Texas where strong protections already exist under State law, the State's own efforts in this area should be respected. Under our bill, if the State law is comparable or more protective of patients than those we enact here in the Congress, State law will remain in effect.

In most cases, HMOs and other health care providers respect the decisions that are made by patients and doctors. This is usually not a problem. The people get the treatment they are entitled to, the treatment their doctor recommends, and they get better. But if the patient or the doctor believes that the quality of their health care may be at risk because of what the HMO is doing, because of some bureaucrats sitting behind a desk somewhere who decides that they know better what care or treatment the patient should receive, that they know better than the doctor or specialist who is taking care of the patient, then we need to provide some way for the patient to appeal that decision.

What we have done here is provide an alternative recourse whenever the HMO or insurance company decides that coverage for treatment should be denied. Under existing law, the HMO's decision is final. If the HMO, no matter what its reasoning for the decision is, decides that this care, this treatment—for example, that a sick child should not be able to go directly to a pediatric oncologist—the patient, the family, the child can do nothing. The HMO holds all the power. The law is completely on the side of the HMO and the insurance company, and patients are left totally defenseless.

What we are doing today, through this legislation, is putting accountability back into the system so that, like all other Americans, HMO's are held accountable for what they do.

As a first resort, patients are guaranteed both an internal and an external appeals process. If they go to an HMO and the HMO says that they won't pay for a particular treatment or a particular doctor, patients have a place to go to appeal. All patients will have a right to appeal treatment denials to an external review authority with outside medical experts, which is critical. The independence of the appeals process is crucial. We have provided for extensive protections to ensure that the independence is in fact there. Once the appeal is made and the independent board decides that coverage should have been provided, the decision is final and binding on the HMO or the insurance company.

As a matter of last resort—and I emphasize last resort—if the HMO has denied coverage, and the appeals process fails, the patients should have the ability to go to court.

I want to emphasize that the ability to go to court is a matter of absolute last resort. For example, in States such as Texas that have enacted legislation—about 3 years ago, Texas enacted legislation providing patients the right to go to court—experience has proven that actual litigation virtually never happens. It does not happen for a very practical reason: because, first of all, the HMO has to deny coverage; second, there is an internal review and appeal process; and third, there is an external appeal process to an independent body. So it is a very rare circumstance where anybody feels the need to go to court. In States such as Texas that have enacted patient protection legislation, there have been very few lawsuits filed.

What the Bipartisan Patient Protection Act does is ensure that medical judgment cases go to State court. The basic reasoning here is that if the HMO or the insurance company is making a medical judgment, if they make the decision that they are going to insert their judgment in the place of the physician or the health care provider, then normally those are cases that are decided in State court, under State law, using State standards. Our belief is that the HMO, if they are going to exercise medical judgment, if they are going to substitute their own judgment for the judgment of the doctor involved, ought to be subject to the same standards to which doctors are subject. If a case were brought against a doctor for exercising his or her medical judgment, that case would go to State court.

What we have provided here is simple: when the HMO steps in and inserts itself into the process of exercising medical judgment, their case goes to State court just as a medical negligence case would go to State court. We should not preempt State law. State law has traditionally controlled these kinds of cases. Under our bill, the law that the Governor at the time—now President Bush—enacted in Texas, the HMO protection law would be respected, as would HMO patient protection laws that exist all over the country. So essentially what we are doing

in our legislation is deferring almost entirely to the oversight of medical judgment that has traditionally been regulated by State law.

I point out that the Judicial Conference of the United States has spoken on this issue. The Chief Justice of the United States, Chief Justice Rehnquist, is the presiding officer of the Judicial Conference of the United States.

The Judicial Conference, through its executive committee, adopted the following position on February 10, 2000:

The Judicial Conference urges Congress to provide that in any managed care legislation agreed upon—

This is the legislation we are talking about today—

that State courts be the primary forum for the resolution of personal injury claims arising from the denial of health care benefits.

The Judicial Conference of the United States, a nonpartisan, nonpolitical body headed by the Chief Justice, decided that cases involving medical judgment should go to State court. These types of cases have been traditionally resolved in State court.

Federal courts, of course, are courts of limited jurisdiction. And these are not cases that should go to Federal court. Our bill does exactly what the Judicial Conference, headed by our Chief Justice, has recommended. It sends these cases to the place where they have traditionally been decided.

Contract cases, based solely on what the terms of the contract are—for example, if there were a provision requiring that insurance coverage be in place for 60 days before payment can be made for any particular treatment—if there were a dispute about whether 60 days had actually passed, or whether the coverage or the contract applies, that would be an interpretation of the contract and would go to Federal court. In those limited cases where there is a dispute about the actual language of the contract, those cases go to Federal court.

There are limitations contained in our bill about any recovery in Federal court. The basic structure here is simple: medical judgment cases, where the HMO is inserting its judgment for that of the health care provider, go to State court. Cases that have always traditionally been decided in State court go to State court, just as our Chief Justice in the Judicial Conference is recommending. The only cases that go to Federal court, a court of limited jurisdiction, are cases involving pure interpretation of the contract—cases that have historically been decided in Federal court under ERISA. So they essentially maintain the same bifurcation that the U.S. Supreme Court suggested.

We have included a balanced approach and imposed some limitations. Under our bill, there are no class actions. Appeals have to be exhausted, except for the very rare circumstance where the patient can show an immediate and irreparable harm. In all other cases, internal and external appeals have to be exhausted before a patient can go to court.

Third, the vast majority of cases go to State court and are therefore subject to whatever State court limitations apply. For example, the limitations that exist under State law in Texas would apply to cases that go to State court in Texas.

We are attempting to balance interests and create really meaningful and enforceable rights for the patient, giving the patient the ability to enforce those rights through an appeals process, and then, as a matter of absolute last resort—and as history has proven, it happens very rarely—giving them the right to take the HMO to state court, where these kinds of cases are traditionally decided.

We have debated this issue over and over on the floor of the Senate. Many Members of the Senate have been involved. Congressmen NORWOOD and DINGELL have led the effort on the House side in the debate. It is time for us to get past simply talking about this issue and debating the various parties' positions. Senator MCCAIN and I, along with others in support of this bill, are making an effort to resolve our differences and get this legislation enacted. It is time, finally, that we enact legislation that puts law on the side of the patients, on the side of families, and on the side of doctors, and not on the side of big HMOs and insurance companies.

I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. VOINOVICH. Madam President, I ask unanimous consent to speak for up to 5 minutes.

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

FEBRUARY AS AMERICAN HEART MONTH

Mr. VOINOVICH. Madam President, I rise today to highlight February as American Heart Month, a designation that has stood since 1963 when Congress first recognized the need to focus national attention on cardiac health. I think it is particularly appropriate since it is Valentine's Day.

The theme of this year's Heart Month is one that resonates deeply with me: ''Be Prepared for Cardiac Emergencies.'' This theme is especially meaningful because on January 20, the day of the Presidential Inauguration, the Voinovich family almost lost one of its beloved members to sudden cardiac arrest.

Indeed, as the country welcomed the arrival of a new administration, I, like many of my colleagues, was looking forward to sharing this joyous occasion with family and friends. Tragically, our celebration was suddenly upended when Patricia Voinovich, my brother Vic's wife, was struck by sudden cardiac arrest. As she entered the Ohio Inaugural Ball, she crumpled to the ground without a pulse or respiration.

Sudden cardiac arrest—as the name imples—happens abruptly and without warning. It occurs when the heart's pumping chambers suddenly stop contracting effectively and as a result, the heart cannot pump blood.

Although it has received much less attention than heart attacks, sudden cardiac arrest is a major cause of death in the United States.

This usually fatal event causes brain damage or death within minutes if treatment is not received immediately, and is estimated to cause more than 220,000 deaths in the United States annually.

That is more than three lives every 7 minutes—more than 600 deaths a day. These deaths are largely attributed to the lack of preparedness and immediate accessible medical attention in the short window between the heart ceasing to pump and death.

Just as in most sudden cardiac arrests, with Pat there was no warning or indicating that she would be susceptible to such a sudden physical trauma. She was in good health. As a matter of fact, she had just been to the doctor and had a check up.

Even after the incident, doctors commented that her heart was undamaged and healthy. After she became stabilized, my family and I listened to the doctors at the George Washington University Hospital who informed us just how lucky Pat, Vic, and the rest of the family had been. I was told that when individuals are struck with sudden cardiac arrest, only a minuscule number, 5 percent, survive.

Fortunately, Pat had been blessed to be in a place where there was what the American Heart Association calls a strong chain of survival in place.

As a matter of fact, one of the doctors from George Washington University Hospital had been assigned to the convention center for the specific purpose of responding to an incident such as the one that occurred to my sister-in-law.

It was only 2 or 3 months before the inaugural ball that this equipment had been put in place at the convention center in anticipation that something like this could happen. I think all convention centers throughout the United States should have that equipment on board. I think all of us here in the Senate should feel very fortunate that because of Dr. FRIST, that kind of equipment is available to the floor of the Senate and the House and the corridors of the Capitol.

The chain of survival, developed by the American Heart Association, is a four-step process to saves lives from cardiovascular emergencies. The process includes early access to emergency medical services, early CPR, early defibrillation and early access to advanced cardiovascular care. Its goal is to minimize the time from the onset of symptoms to treatment.

Although I did not know it at the time, all of these factors were present that night at the Ohio Inaugural Ball.