

of peace and prosperity around the world.

HIV/AIDS alone will reduce the gross domestic product of South Africa by \$22 billion, or 17 percent, over the next decade. That is why I believe debt relief must also be part of any conversation about a broader global HIV/AIDS strategy.

While most African countries spend less than \$10 per capita on health care, they spend up to five times that amount in debt service to foreign creditors. In fact, the burdens of debt repayment have come into direct conflict with public health efforts in some instances. For example, structural adjustment programs have sometimes required governments to charge user fees for visits to medical clinics, a practice that stands in the way of effective prevention and treatment programs. As discussions of global HIV/AIDS prevention proceeds, consideration should be given to the role of international debt relief in the overall plan to combat HIV/AIDS.

I have written to the U.N. General Assembly President Harri Holkeri to express my support for his efforts and to urge inclusion of debt relief strategies in any effort that comes out of the general assembly.

I also urge our own Government to look more closely at what we can do. In the last administration, we forgave a lot of our bilateral debt for the poorest of the nations, but we should look at expanding beyond the circle of the poorest of the poor to the next poorest of the poor, and we should also look at our multilateral debt.

I am hoping I will find support on both sides of the aisle for a sense-of-the-Senate resolution I will be submitting to express the policy view that debt relief can and should be an important tool.

I have visited African countries. I have visited Asian countries. I have visited HIV/AIDS programs. I have been in places where 12-year-old girls who were sold into prostitution by their families have come home to die in northern Thailand.

I have been in programs in Uganda which have done probably the best job I know of in Africa certainly to spread the message about how to prevent HIV/AIDS. I have listened to the songs that were taken out into villages to tell villagers about this new disease that nobody really knows where it came from or how it arrived, but to warn people about its deadly consequences.

I was fortunate and privileged last year to participate in the United Nations discussion about AIDS, and I sat with AIDS orphans: A young boy from Uganda whose father and then mother died of AIDS, leaving him responsible for his younger brothers and sisters; a young boy from Harlem whose mother died of AIDS; a young boy from Thailand who was also orphaned by this terrible disease.

In some parts of Africa now, one will only find children, and most of them

are orphans. The rate of infection ranges from 15 to 35 percent, and I am deeply concerned we are still in some parts of the world in a state of denial about HIV/AIDS.

Certainly, both India and China face tremendous challenges to educate their population about this disease and to avoid practices that might spread it. It is commonplace in some parts of China for very poor villagers to sell their blood to make a little money. In so doing, they are subjecting themselves to the possible transmission of this terrible disease.

In other parts of Africa and Asia, even the best intentions to immunize children against measles or other communicable diseases lead to tragedy because the sterilization is not up to par and needles are reused, leading to the infection of people with HIV/AIDS.

I have long maintained there is a deep, profound connection between the economic health of a nation and the physical health of that nation's people. That is why we have to act now to address the HIV/AIDS pandemic.

There is so much the United States can and should do. We have the finest health care system in the world. We are the richest nation that has ever existed in the history of the world. We not only should care about people in other parts of the world because of this disease, but we should act in our own self-interest because there will be many parts of the world where it will be difficult, potentially even dangerous, to travel if the entire social structure and economy collapses because of the strain of HIV/AIDS, where tourists and business people from America will be told they should not go to do business. Suppose they are in an accident or suffer injury and might need medical care and that medical care might not be deliverable because the health care system has collapsed under the weight of HIV/AIDS.

I look forward to working with my colleagues in the Senate and in our United States delegation to the United Nations General Assembly special session on these and other desperately needed proposals to halt and reverse the social and economic damage caused by HIV/AIDS and the direct and immediate threat this pandemic poses to America and Americans. I urge my colleagues and I urge our Government and the United Nations to look deeply into the concept of forgiving debt in return for nations doing what we know works to prevent, treat, and eventually find a vaccine for this terrible disease.

I yield the floor.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

RECESS

The PRESIDING OFFICER. Under the previous order, the Senate will now

stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:52 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer [Mrs. CLINTON].

Mr. REID. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

BIPARTISAN PATIENTS PROTECTION ACT—Continued

Mr. REID. Madam President, I ask unanimous consent that there be 45 minutes for debate with respect to the McCain amendment No. 812, which is pending, with the time equally divided and controlled in the usual form with no second-degree amendments in order thereto; that upon the use or yielding back of time the amendment be temporarily laid aside, and Senator GREGG or his designee be recognized to offer the next amendment as under a previous order.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Who yields time?

Mr. REID. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. REID. Madam President, I ask unanimous consent that the time during the quorum call be equally divided.

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

Mr. REID. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. KENNEDY. I yield myself 7 minutes.

The PRESIDING OFFICER. The Senator is recognized.

Mr. KENNEDY. Madam President, the cornerstone of an effective patient protection program is the right to timely, fair and independent review of disputed medical decisions. This amendment reaffirms a critical element of that right—the right to an independent appeal process that is not stacked against patients by giving the HMO the right to select the judge and jury.

This is a critical difference between our approach to that issue and the approach of the alternative legislation before the Senate. Under their bill, the HMO gets to select the so-called independent appeals organization. Under our bill, neither the HMO nor the patient selects the appeals organization. Instead, it must be selected by a neutral and fair appeals process. This amendment puts the Senate on record as supporting that fair and impartial appeal process.

The approach of allowing one party to a dispute—in this case the HMO—to select the judge and jury to a dispute is so inherently unfair that it has been rejected out of hand by virtually every expert who has considered the issue. It flies in the face of every principle and precedent founded on fair play.

We don't allow it in our civil court procedures. We don't allow it in our criminal procedures. Doesn't a child with cancer whose HMO has overruled her doctor deserve at least the same basic fairness we provide for rapists and murderers?

The unfair approach of allowing one party to the dispute is not only alien to our court system, it is prohibited under the Federal Arbitration Act. It is unacceptable under the standards of the American Arbitration Association. It is rejected by the standards of the American Bar Association. Of the 39 States that have created independent review organizations, 33 do not allow it; neither should the Senate.

Do we understand, in the 39 States that have created independent review organizations, 33 do not allow the HMO to select and pay the independent reviewer; and neither should the Senate.

Under the fair external review approach we have in Medicare and in most States, the reviewer decides the plan is right about half the time and decides the patient is right about half the time. In the financial services industry, the industry gets to select the reviewer in disputes, and the industry wins 99.6 percent of the time. No wonder HMOs want that system: it makes a mockery of the whole idea of independent review. A vote for this amendment is a vote against making this bill a mockery of everything that a true Patients' Bill of Rights should stand for.

And how ironic it is that the sponsors of the competing proposal are vociferous supporters of the President's principle that we should preserve good State laws. But under this amendment, the 39 State external appeals systems currently in place would be wiped out. Do we understand? There is one provision in the two major pieces of legislation before us; that is, the McCain-Edwards bill and the Breaux-Frist bill. In the Breaux-Frist bill, their appeals provision effectively preempts all of those 39 States. They have to follow what is in their legislation. As I pointed out, that is the process by which the HMO selects the independent reviewer. They would be null and void, even

where they provide greater consumer protections than the Federal standard. In all of these instances, the consumer has greater protection than even under the underlying proposal of the McCain-Edwards bill.

We have heard a lot of tragic examples of HMO abuse during the course of this debate and through the extensive discussions in the press over the last 5 years. We heard of children denied life-saving cancer treatment by their HMO. It is wrong to let that same HMO choose the judge and jury that could decide whether those children live or die. And our amendment says it is wrong.

We have heard of women with terminal breast and cervical cancer denied the opportunity to participate in clinical trials that could save or extend their life. It is wrong to give that same HMO that overruled the treating physician and denied the care the right to choose the judge and jury that could decide whether that woman has a real chance to live to see her children grow up or is guaranteed to be dead within 3 months.

We have heard of a young man whose HMO decided that it was cost-effective to amputate his injured hand instead of providing the surgery that could restore normal functioning. It is wrong to give the HMO that made that heartless decision the right to choose the judge and jury that could decide whether that young man goes through life with one hand or two.

We have heard of a policeman with a broken hip, whose HMO decided it was better to give him a wheelchair than to pay for the operation that would have restored his normal functioning. It is wrong to give the HMO that put its profits so far ahead of that patient's interests the right to choose the judge and jury that will decide whether that man ever walks again.

Last week, in discussing the issue of access to specialty care, I mentioned what had happened to Carley Christie, a 9-year-old little girl who was diagnosed with Wilms Tumor, a rare and aggressive form of kidney cancer. Her family was frightened when they received the diagnosis, but they were relieved to learn that a facility close to their home in Woodside, CA, was world-renowned for its expertise and success in treating this type of cancer—the Lucile Packard Children's Hospital at Stanford University.

The Christie family's relief turned to shock when their HMO told them it would not cover Carley's treatment by the children's hospital. Instead, they insisted that the treatment be provided by a doctor in their network—an adult urologist with no experience in treating this rare and dangerous childhood cancer. The Christies managed to scrape together the \$50,000 they needed to pay for the operation themselves—and today Carley is a cancer-free, healthy and happy teenager. If the Christies had been less tenacious or had been unable to come up with the

\$50,000, there is a good chance that Carley would be dead today.

Under our opponents' plan, the HMO that passed a possible death sentence on little Carley Christie would have the right to choose the judge and jury to determine whether that possible death sentence should be upheld. No family should have to go through what the Christie's did.

The PRESIDING OFFICER. The Senator has used 7 minutes.

Mr. KENNEDY. I yield myself 5 more minutes, Madam President.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. No HMO should behave as the Carley's did. And that HMO should certainly not have the right to choose the external review organization to decide whether Carley should get the care she needed.

Another case that I find particularly shocking is that of Melissa Yazman, right here in Washington. In May, 1997, Melissa Yazman was a second year law student at American University, going to school full-time, living in suburban Virginia, working part-time for an attorney in D.C., and taking care of her two kids while her husband traveled with his job.

In the past 4 years, much has changed for Melissa. Her dreams of law school and a career in the working world are gone, and her new career is focused on healing and living every day to enjoy the time she has with her husband and her two sons—Ben who is 11, and Josh who is 8.

In the spring, in 1997, at the age of 36, she was diagnosed with stage IV pancreatic cancer at the age of 36. Pancreatic cancer is a fairly rare cancer, and, for the majority of patients like Melissa, diagnosis is not possible until the cancer is in an advanced stage.

Melissa was told that she had 3 to 6 months to live. There are no curative treatments for pancreatic cancer. For most pancreatic cancer patients clinical trials are their only hope.

Melissa was referred to a clinical trial at Georgetown University. Her insurer refused to cover the treatment. Melissa and her husband were forced to go through lengthy and time consuming negotiations with the insurer—negotiations that took her husband away from their children for 2 to 3 hours a day—negotiations that ultimately ended in failure. She and her husband ended up paying for these costs themselves because they ran out of time waiting for a decision from her insurer.

Because she and her husband had enough money in their savings account, they were able to pay for her routine costs—costs that her insurer should have covered and would cover for a patient not enrolled in a life-saving clinical trial.

Because of the therapy she received in a clinical trial, Melissa has been able to have 4 extra years with her family and with her young boys. Without the clinical trial, she would have

had 3-6 months. Every patient with incurable cancer hopes for enrollment in a clinical trial that can save or extend their life. No patient should have their hopes dashed because their insurer simply says no. And no patient like Melissa should have their right to a fair, impartial appeal voided because the HMO that said "no" gets to choose the organization that will decide the case.

For cancer patients, for women, for children—indeed, for every patient whose HMO denies critically needed care—the right to a speedy, fair, impartial appeal should be a fundamental right. This amendment will put the Senate on record as saying that this appeal should truly be fair and impartial, that it will not load the dice and stack the deck against patients. Every Senator knows that this amendment represents simple justice, and I urge every Senator to vote for what they know to be right.

Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

RECORDING OF VOTE

Ms. STABENOW. Madam President, I want to indicate that on rollcall vote No. 197, I was present and voted "no." The official record has me listed as absent. Therefore, I ask unanimous consent that the official record be corrected to accurately reflect my vote. This will in no way change the outcome of the vote.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. REID. Madam President, I ask unanimous consent that the order for the quorum call be rescinded. How much time is on both sides?

The PRESIDING OFFICER. There is no time remaining on the proponents' side, and there are 14 minutes 44 seconds on the opponents' side.

Mr. REID. I see nobody here of the opponents. If they require more time, I will be happy to give them whatever time I may use here. I ask unanimous consent that I be allowed to speak, and if the opponents of this sense-of-the-Senate amendment desire more time, they can have whatever time I use.

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

Mr. REID. Did the Senator from New Hampshire hear the request?

Mr. GREGG. No.

Mr. REID. We have no more time left. You have 14 minutes. I said I would like to speak. If you want more time, whatever time I use, you can

have that in addition to the 14 minutes.

Mr. GREGG. I am not aware of any speakers. We are waiting for people to return from the White House before we get really started.

Mr. REID. I want to direct a question to the Senator from Massachusetts. I say to my friend from Massachusetts, we heard a lot of talk about how this legislation has an adverse effect upon the business community. Has the Senator heard those comments?

Mr. KENNEDY. Yes, I certainly have.

Mr. REID. I received an e-mail from Michael Marcum of Reno, NV. Here is what he said. I would like the Senator to comment on this communication I received from one of my constituents:

DEAR SENATOR REID, as a small business owner, and as a citizen I urge you to support the upcoming bill commonly known as the "Patients' Bill of Rights." I also would like to state that I support your and Senator McCain's version of the bill. If the HMO's can afford to spend millions on lobbyists and advertisements then they can afford to do their job correctly, preventing the lawsuits in the first place . . .

I am willing to pay to know that what I am purchasing from my HMO will be delivered, not withheld until someone is dead then approved post mortem (AKA a day late and a dollar short). While a believer in the market and freedom, I feel that we need a better national approach to health care. As the richest nation in the world, as the only real super-power, why do so many Americans get third world levels of health care, even when they have insurance.

Thank you for your time—Michael Marcum (Reno, NV).

Will the Senator acknowledge that Michael Marcum is one of the hundreds of thousands of small business people who do not have the money to run these fancy ads; that their only way of communicating with you and me is through e-mails and communicating through the standard means, not through these multimillion-dollar advertising campaigns? In short, will the Senator acknowledge there are a lot of Michael Marcums, small business people, in America who support this legislation?

Mr. KENNEDY. I thank the Senator for bringing two matters to the attention of the membership. One is the example the Senator referred to, and the other point is the fact we have heard so much during the course of the debate that if these protections are put in place, it is going to mean millions of insured individuals as a result of this legislation will become uninsured.

Yet it is apparent, as the Senator has pointed out, that the HMOs have millions of dollars to spend on these advertisements—millions of dollars that ought to be spent on either lowering premiums or giving patients the protections they need. Evidently, it is an open wallet for the HMOs because they have been on the national airways and have been distorting and misrepresenting the legislation, as the Senator has just pointed out, distorting what its impact would be on average families in this country.

I am wondering if the Senator is familiar with the Texas Medical Association letter we just received. It confirms that the Texas law mirrors the letter and spirit of the McCain-Edwards-Kennedy bill. This is from the Texas Medical Association. They point out that the Texas Medical Association and President Bush agree that any entity making medical decisions should be held accountable for those decisions. This is not only the position of the Texas Medical Association but is exactly what President Bush called for in a Patients' Bill of Rights.

We resolved that issue earlier today. The Texas Medical Association believes it is consistent with the intent of the Texas law to hold any entity, whether employer or insurer, accountable if they make a medical decision that harms a patient or results in death. We upheld that today.

The Texas law was never designed to exempt from accountability businesses that made harmful medical decisions. It was suggested earlier, the Senator remembers, that it would be, rather, a clarification that the liability provisions did not apply to small- and medium-sized businesses that purchased traditional insurance.

That is interesting to hear because we heard a great deal earlier about where the Texas Medical Association was. This is a clarification.

The Senator is pointing out we spent a good deal of time trying to catch up with the distortions and misrepresentations, but as the Senator from Nevada knows, what this is really about is doctors and nurses making decisions on health care for their patients and not having them overridden by the HMOs or by employers who put themselves in the place of HMOs.

That is what this legislation is about: letting our doctors and nurses practice their best in medicine. We have so many well-trained medical professionals. They are highly motivated, highly committed, and highly dedicated. What is happening in too many places, as the Senator has pointed out in this debate, too many times those medical decisions are being overrun and overturned by the HMOs, and that is plain wrong. That is what this battle is about. I thank the Senator for his comment.

Mr. REID. I say to my friend from Massachusetts, yes, I am familiar with the letter from the President of the Texas State Medical Association. I believe that is his title.

Mr. KENNEDY. That is correct.

Mr. REID. I heard Senator MCCAIN read the letter word for word. I was so impressed because what has happened the last few years is that doctors, who in the past have been totally non-political, have been driven into the political field because they are losing their practices, they are losing their ability to practice medicine, their ability to take care of patients they were trained to take care of. They have come into the political field and have

joined together with the American Medical Association—all the different specialists and subspecialists—they have joined together saying: We as physicians of America need some help. If you want us to be the people who take care of your sick children, your sick wife, husband, mother, father, neighbor, then we need to have the ability to treat patients and give them the medicine they need.

The Senator from Massachusetts read part of this letter. Senator MCCAIN read the full text of the letter earlier today. It confirms this legislation is not being driven by a small group of fanatics but, rather, by the entire medical community. When I say “medical community,” it is more than just doctors. It includes nurses. It includes all the people who help render care to patients.

I say to my friend from Massachusetts, I commend him, Senator MCCAIN, and Senator EDWARDS for their diligence in doing something the American people need. We all have had the experience of having sick people in our families and seeing if care can be rendered. We know how important a physician is. When a loved one of mine is sick, I want the doctor to have unfettered discretion to do whatever that doctor, he or she, believes is best for my loved one. That is what this Patients’ Bill of Rights is all about. When a doctor takes care of a patient, let the doctor take care of the patient.

Mr. KENNEDY. I thank the Senator. He has summarized the purpose of this legislation. As the Senator knows now, we are ensuring there will be remedies for those patients if the HMO is going to make a judgment and overturn that medical decision with internal and external appeals.

Now the matter before the Senate is to make sure that appeal is truly independent and not controlled by the HMO, not paid for by the HMO. As I mentioned earlier in my presentation, 33 States at the present time do not permit the HMOs to make the determination and select the independent reviewer. That is our position. That is in the McCain amendment. We do not want to have an appeals provision that is rigged in favor of the HMO that may be making the wrong decision with regard to the patient’s health in the first place and then be able to select the judge and jury to get it to reaffirm an earlier decision which is clearly not in the interest of the patient.

Mr. REID. I say to my friend from Massachusetts, the manager of this bill, before I came to Congress, I was a judge in the Nevada State Athletic Commission for prize fights. As the Senator knows, Nevada is the prize fight capital of the world. One thing they would not let the fighters do is pick the judges. They thought it would be best if some independent body selected the judges to determine who was going to sit in judgment of those two fighters.

It is the same thing we have here. We simply do not want the participants

picking who is going to make the decision. That should be made by an unbiased group of people who have nothing to gain or lose by the decision they make.

This is very simple. This sense-of-the-Senate resolution says that if there are going to be people making a decision, they should be unbiased; they should be people who have nothing in the outcome of the case. Is that fair?

Mr. KENNEDY. I agree. Senator, as you may know, the language in the alternative legislation not only permits the HMO to select the reviewer and to pay that, but also it preempts all the other States that have set up their own independent review, and 33 of the 39 that have set up their reviews have chosen a different way from this process, a truly independent review. They would effectively be usurped or wiped off the books.

We hear a great deal about State rights and not all wisdom is in Washington. This is a clear preemption of all of the existing State appeals provisions. It is done in a way that permits the HMO to be the judge and jury. That is why the McCain amendment—which says there will be an independent selection of review, and we will not preempt the States—makes a good deal of sense.

Mr. REID. If I could refer a question to the Senator from New Hampshire, our time under the agreement is just about out. Are you arriving at a point where you might offer the other amendment?

Mr. GREGG. I hoped we would be. Some of the Senators involved in that amendment are at the White House, so we are waiting for them to return. When they return, we will be ready to proceed.

Mr. REID. I have been told they probably won’t return until about 3:30.

Mr. GREGG. I suggest we divide the time between now and 3:30 between the two sides equally.

Mr. KENNEDY. I don’t know at this time of other amendments on this side. We are making good progress dealing with this legislation. We are eager to address these other matters. There are continued conversations on some of the issues. We certainly welcome ideas that can protect the patients. Looking at this realistically, we have several Members who want to address the Senate and have spoken to me several times that they would like to make comments about the legislation. We can use the time productively, but we indicate we are ready to deal with amendments and we look forward to receiving them. We want to continue business.

We thank the Senator from New Hampshire for his cooperation. I will notify my colleagues who might want to speak.

Mr. REID. We have no objection to the request of the Senator from New Hampshire.

Mr. GREGG. I ask that the time between now and 3:30 be equally divided between myself and Senator KENNEDY,

and any quorum calls be divided between each side.

The PRESIDING OFFICER (Mr. CARPER). Without objection, it is so ordered.

Mr. REID. Mr. President, I have been reading into the RECORD names of organizations that support this legislation. I will read some of the names into the RECORD. If someone from either side desires to speak, I will cease.

I have been through the A’s, B’s and C’s of organizations supporting this legislation, hundreds of names. I begin with the D’s:

Daniel, Inc.; Denver Children’s Home; DePelchin Children’s Center in TX; Developmental Disabilities; Digestive Disease National Coalition; Dystonia Medical Research Foundation; Easter Seals; Edgar County Children’s Home; El Pueblo Boys’ and Girls’ Ranch; Elon Homes for Children in Elon, College, NC; Epilepsy Foundation; Ettie Lee Youth and Family Services; Excelsior Youth Center in WA; Eye Bank Association of America; Facing Our Risk of Cancer Empowered; Families First, Inc.; Families USA; Family & Children’s Center Counsel; Family & Children’s Center in WI; Family & Counseling Service of Allentown, PA; Family Advocacy Services of Baltimore; Family and Child Services of Washington; Family and Children’s Service in VA; Family and Children Services of San Jose; Family and Children’s Services in Tulsa, OK; Family and Children’s Agency Inc.; Family and Children’s Association of Mineola, NY; Family and Children’s Center of Mishawaka; Family and Children’s Counseling of Louisville, KY; Family and Children’s Counseling of Indianapolis; Family and Children’s Service of Minneapolis, MN; Family and Children’s Service in TN; Family and Children’s Service of Harrisburg, PA; Family and Children’s Service of Niagara Falls, NY; Family and Children’s Services in Elizabeth, NJ; Family and Children’s Services of Central, NJ; Family and Children’s Services of Chattanooga, Inc. in TN; Family and Children’s Services of Fort Wayne; Family and Children’s Services of Indiana; Family and Community Service of Delaware County, PA; Family and Social Service Federation of Hackensack, NJ; Family and Youth Counseling Agency of Lake Charles, LA; Family Centers, Inc.; Family Connections in Orange, NJ; Family Counseling & Shelter Service in Monroe, MI; Family Counseling Agency; Family Counseling and Children’s and Children’s Services; Family Counseling Center of Central Georgia, Inc.; Family Counseling Center of Sarasota; Family Counseling of Greater New Haven; Family Counseling Service in Texas; Family Counseling Service of Greater Miami; Family Counseling Service of Lexington; Family Counseling Service of Northern Nevada; Family Counseling Service, Inc.; Family Guidance Center in Hickory, NC; Family Guidance Center of Alabama; Family Resources, Inc.; Family Service Agency of Arizona; Family Service Agency of Arkansas; Family Service Agency of Central Coast; Family Service Agency of Clark and Champaign counties in OH; Family Service Agency of Davie in CA; Family Service Agency of Genesee, MI; Family Service Agency of Monterey in CA; Family Service Agency of San Bernardino in CA; Family Service Agency of San Mateo in CA; Family Service Agency of Santa Barbara in CA; Family Service Agency of Santa Cruz in CA; Family Service Agency of Youngstown, OH; Family Service and Children’s Alliance of Jackson, MI; Family Service Association Greater Boston; Family Service Association in Egg Harbor, NJ; Family Service Association of Beloit, WA; Family Service Association of Bucks County in

PA; Family Service Association of Central Indiana; Family Service Association of Dayton, OH; Family Service Association of Greater Tampa; Family Service Association of Howard County, Inc. IN; Family Service Association of New Jersey; Family Service Association of San Antonio, TX; Family Service Association of Wabash Valley, IN; Family Service Association of Wyoming Valley in PA; Family Service Aurora, WI; Family Service Center in SC; Family Service Center in TX; Family Service Center of Port Arthur, TX; Family Service Centers of Pinell; Family Service Council of California; Family Service Council of Ohio; Family Service in Lancaster, PA; Family Service in Lincoln, NE; Family Service in Omaha, NE; Family Service in WI; Family Service Inc. in St. Paul, MN; Family Service of Burlington County in Mount Holly, NJ; Family Service of Central Connecticut; Family Service of Chester County in PA; Family Service of El Paso, TX; Family Service of Gaston County in Gastonia, NC; Family Service of Greater Baton Rouge; Family Service of Greater Boston; Family Service of Greater New Orleans; Family Service of Lackawanna County, in PA; Family Service of Morris County in Morristown, NJ; Family Service of Norfolk County; Family Service of Northwest, OH; Family Service of Racine, WI; Family Service of Roanoke Valley in VA; Family Service of the Cincinnati, OH; Family Service of Piedmont in High Point, NC; Family Service of Waukesha County, WI; Family Service of Westchester, NY; Family Service of York in PA; Family Service Spokane in WA; Family Service, Inc. in SD; Family Service, Inc. in TX; Family Service, Inc. of Detroit, MI; Family Service, Inc. of Lawrence, MA; Family Services Association, Inc. in Elkton, MD; Family Services Center; Family Services in Canton, OH; Family Services of Cedar Rapids; Family Service of Central Massachusetts; Family Service of Davidson County in Lexington, NC; Family Service of Delaware Council; Family Service of Elkhart County; Family Service of King County in WA; Family Service of Montgomery County, PA; Family Service of Northeast Wisconsin; Family Service of Northwestern in Erie, PA; Family Service of Southeast Texas; Family Service of Summit County in Akron, OH; Family Service of the Lower Cape Fear in NC; Family Service of the Mid-South in TN; Family Service of Tidewater, Inc. in VA; Family Service of Western PA; Family Services Woodfield; Family Services, Inc. in SC; Family Services, Inc. of Layfette; Family Services, Inc. of Winston-Salem, NC; Family Solutions of Cuyahoga Falls, OH; Family Support Services in TX; Family Tree Information, Education & Counseling in LA; Family Violence Prevention Fund; Family Means in Stillwater, MN; Federation of Behavioral, Psychological & Cognitive Sciences; Federation of Families for Children's Mental Health; FEI Behavioral Health in WI; Florida Families First; Florida Sheriffs Youth Ranches; and Friends Committee on National Legislation.

Mr. President, this is a partial list of the hundreds of names of organizations that support this legislation.

This is the fourth day that I have read into the RECORD names of hundreds of organizations supporting this legislation. This list was prepared for me more than a week ago. It has grown since.

When I finish this list, I hope we will have completed this legislation. But if we haven't, I will come back and read the new names.

This is legislation that is supported by virtually every organization in

America. It is opposed by one umbrella group—the HMOs. They are the ones paying for these ads. They are the ones that are running the advertisements in newspapers and television and now even radio ads the reason being that they have made untold millions of dollars while we delay this legislation.

Every day that goes by is a lost opportunity for physicians to tell a patient what that patient needs and not have to refer to someone in an office in Baltimore, MD, as to what a patient is going to get in Las Vegas, NV.

When I have my income tax done, every year I have an accountant do that. When myself or a member of my family needs to be taken care of, I don't want an accountant doing that. I want a doctor to do that.

That is what this legislation is all about. I am so happy that we have a bipartisan group that the HMOs are not going to be able to stop.

We are going to pass this legislation, send it over to the House, the conference committee will meet, and we will send a bill to the President that he will sign.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

The Senator from Minnesota is recognized.

Mr. DAYTON. Thank you, Mr. President.

Mr. President, I rise today in support of S. 1052, the McCain-Kennedy-Edwards Patients' Bill of Rights legislation. Minnesota, my home State, has one of the largest concentrations of HMO providers in the country. In fact, 90 percent of Minnesotans who are covered by their employers also receive their health care services through HMOs. Also, historically, the HMO concept originated in Minnesota by a Minnesota physician who has now renounced what HMOs have become.

Originally, HMOs were going to herald in a new age of health care, with greater emphasis on prevention, on primary care, more efficient referrals, coordinated and integrated medical care, all leading to a better quality of medical services for patients at lower overall costs to our health care system.

Integral also to their arguments was their conceit that the private sector always does it better than the public sector, that the large public health systems of Medicare and Medicaid, and other public reimbursement programs, were largely the ones to blame for these skyrocketing health costs, and that private-sector HMOs and insurance companies could manage health care dollars so much better than Government and provide better quality for less quantity of dollars.

However, once they got into the profession, they found that it was not

quite that easy, that quality care costs money. There is always some con artist in this country who claims we can have something for nothing, or at least more for less. But the reality is, quality health care costs money. Well-qualified, highly trained, life-saving doctors, nurses, and attendants deserve to be well paid; and that costs money. Advanced lifesaving diagnostic equipment costs money. State-of-the-art, well-staffed hospitals and clinics cost money. And providing enough of all of the above, to take care of all the patients across this Nation, costs money, more money than most of these health care delivery or insurance systems wanted to spend.

So HMOs became what I call them "HNOs": The way to save money became to say no; deny care; deny treatments; deny claims. Health care providers became health care deniers. As these HMOs became larger and larger, business operations—whether for-profit or nonprofit—their "no" bureaucracies became bigger and more important. Stock prices, executive compensations, retained earnings all became dependent on their ability to grow and to say no, deny patient care to produce profits at cost savings, to grow to produce ever more profits.

The PRESIDING OFFICER. The time of the majority has expired.

Under a previous agreement, the time until 3:30 was to be equally divided between the majority and minority. The time of the minority has expired.

Mr. GREGG. Mr. President, how much time does the Senator think he needs to make his statement?

Mr. DAYTON. I say to the Senator from New Hampshire, another 10 minutes. But I will return to speak another time.

Mr. GREGG. No. We have no speakers at this time. I am happy to yield 10 minutes to the Senator from Minnesota. And I ask unanimous consent for 10 minutes to be added to our time.

The PRESIDING OFFICER. Is there objection?

Mr. BYRD. Reserving the right to object.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. BYRD. I wonder if I might be able to have the floor to speak.

Mr. GREGG. What amount of time does the Senator from West Virginia need?

Mr. BYRD. Thirty minutes.

Mr. GREGG. I have no problem with that on my side, as long as our side will receive an equal amount of time. So that would be 40 minutes; 10 minutes to Senator from Minnesota, 30 minutes to the Senator from West Virginia; and then 40 additional minutes to be added to our side's time. And the Senator from West Virginia be recognized after the Senator from Minnesota.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Minnesota.

Mr. DAYTON. I would be happy to yield the floor to the Senator from West Virginia.

The PRESIDING OFFICER. Does the Senator from Minnesota wish to conclude his remarks?

Mr. DAYTON. I yield to the Senator from West Virginia.

The PRESIDING OFFICER. The Senator from West Virginia is recognized for up to 30 minutes.

Mr. BYRD. Mr. President, I thank both Senators.

(The remarks of Mr. BYRD are located in today's RECORD under "Morning Business.")

Mr. DAYTON. Mr. President, I thank the great Senator from West Virginia for his erudite discourse on the trade agreement which gives me remarks as I shall present them to my constituents in Minnesota. I thank the distinguished Senator.

Mr. BYRD. Mr. President, I thank my colleague. I thank him very much.

Mr. DAYTON. Mr. President, to continue where I left off, a great American once said that a house divided against itself cannot stand. Our Nation's health care providers unfortunately are fundamentally divided against themselves. Their avowed purposes are to provide health care to their members, their clients, and their patients. Yet their financial success depends increasingly on not providing health care to their members, their clients, and their patients, and their members, clients, and patients are increasingly the victims of their own health care providers.

Why do we even need a Patients' Bill of Rights to protect us from our own health care providers?

The fact we even need this legislation, the fact we are debating it in the Senate today, says how badly our Nation's health care system has deteriorated. A Patients' Bill of Rights, even if necessary, should consist of two words: Doctors decide. Doctors decide what diagnostic procedures, what treatments, what surgeries, hospitalizations, and rehabilitation therapies are needed. The health care providers provide them, and the insurer pays for them. It is that simple. It is that sensible. It is that lawsuit free.

Our distance from it today is a measure of our social insanity. It is the measure of our health care idiocy. But that is where we are today.

There is a term used in sports these days, trash talking. There is a lot of trash being talked about this legislation. It will explode the costs of health care; it is going to cost employees their health care coverage; it will drive businesses into bankruptcy. Those are the same smears and scare tactics that were used against Social Security, against Medicare, against workers' compensation, against unemployment compensation, and against family leave. Is there anything that is good for the American people that is not bad for American business?

I don't entirely blame them, because those business men and women have been talked trash to, as well, by their partners in these health care enterprises. Many businesses across this country are bedeviled by increasing costs of their health care. They want to do the right thing for their employees, but they are not in the business of administering health plans. I am sympathetic to this. But I say to those big leaders, if you want to get out of the business of providing health care coverage for your employees, then you need to actively support a better alternative, a separate system of true national health care which is devoted to providing care, not to avoiding costs.

Last Saturday in Minnesota, along with my distinguished colleague from Minnesota, Senator WELLSTONE, and our majority leader, Senator DASCHLE, we heard from several families who expressed their support for their legislation and the critical need for it from their life experiences. There was a father who spoke eloquently and powerfully about his 4-year-old daughter named Hope. Hope was born with spina bifida. As part of her treatment, six doctors—six physicians—including one at the Mayo Clinic, prescribed certain physical therapy treatments for her. Yet her HMO was unwilling to provide or pay for those prescribed treatments. It took 8 months of banging their heads against this bureaucratic wall, paying for the treatments that they could afford out of their own pockets, forgoing other treatments that they knew were in the best interests of her young life, until they finally were able to break through and get the care she needed.

A mother spoke of her 21-year-old daughter who died of an eating disorder. As she so powerfully stated last Saturday in St. Paul, MN, young people aren't supposed to die of eating disorders. But her insurance company refused to pay for the necessary evaluation of her daughter's illness, it refused to refer her to a specialist who might have made the correct diagnosis, and that young woman is dead today. Her life has been snuffed out, taken away from her family. Her mother set up a foundation just for this purpose, to advocate for the care that should be provided for anyone else in that situation. What a horrible way for a parent to be pulled into this debate, by losing a daughter unnecessarily to a disease, an illness that should not have been fatal except for the lack of proper medical care, medical care that was available in our country and was not made available to her by her insurer.

Finally, we heard from the wife of a husband and father of five children, a healthy, active, middle-aged man who suddenly, over the course of just a few months, was caught with some debilitating disease and confined to a wheelchair. For 8 months she and her husband tried to get their primary physician at an HMO to make a diagnosis that could lead to successful treatment. For 8 months this primary phy-

sician at the HMO was unable to make the diagnosis and refused to refer this man to a specialist elsewhere for that evaluation. He finally said to this patient, father of five, devoted husband: "Maybe there is something you need to confess."

Can you believe the absurdity of that? "Maybe there is something you need to confess"—as though there were some religious curse. This was a primary physician at an HMO. They could not escape the vice, the trap of that bureaucracy.

Finally, on their own initiative, the wife was so desperate, they decided to risk their entire life savings and drove to the Mayo Clinic in Rochester, world renowned clinic, and signed papers saying they would pay personally for the costs of whatever treatments were necessary. The physician there made a diagnosis of a viral disease, an invasive disease, prescribed the necessary treatments, medications, and this man is now at least partially recovered. He tires easily and cannot stand for extended periods of time but is out of a wheelchair and hopefully back to a full recovery. It cost this family \$25,000 out of their own pocket to get the medical care they needed. The HMO finally agreed to pay 80 percent of that cost.

This legislation is not about lawsuits, it is about lives. It is not about trial lawyers but people, patients, mothers, fathers, children. I am not interested in lawsuits. I hope there is never a lawsuit as a result of this legislation because that would mean there would never be the need for them. It would mean all Americans were receiving the health care they need, the health care they deserve, the health care for which they paid.

I support this legislation, and I strongly urge my colleagues to support this as well.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. JOHNSON). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. KENNEDY. Mr. President, we encourage and invite colleagues who have amendments to come to the floor. Having talked with Senator GREGG and others, I anticipate we will have an amendment dealing with the issue of medical necessity. That is an issue which is of very considerable importance in the legislation. It was the subject of a good deal of debate the last time we debated this legislation. It was the subject of a good deal of debate when we were in the conference. It was actually one of the few issues that were resolved in the conference.

At this time, we have language in the McCain-Edwards legislation, of which I am a cosponsor, as well as in the Breaux-Frist measure, which is virtually identical. There are some small

differences in there, but they are effectively very much the same. There will be an amendment to alter and change that issue. I will take a few moments now to speak about the importance of what we have done with the underlying legislation, and hopefully the importance of the Senate supporting the construct we have achieved.

It is my anticipation that the amendment will probably be offered at about 5 o'clock this evening. We will have debate through the evening on that measure. Hopefully, we will have a chance to address it. There are several other amendments dealing with the issue of the scope of the legislation, as well as on liability. I understand we may very well have the first amendments on liability a little later this evening as well.

This issue on medical necessity is of very considerable importance. I want to outline where we are and the reasons for it for just a few minutes.

The legislation before the Senate closes the door against one of the most serious abuses of the HMOs and other insurance plans, and the ability of a plan to use an unfair, arbitrary, and biased definition of medical necessity to deny patients the care their doctor recommends.

My concern is that the amendment we are going to see before the Senate is going to open that possibility again. We closed it with McCain-Edwards and also with the Breaux-Frist measure.

The issue before us is as clear as it was when we started the debate 5 years ago; that is, who is going to make the critical medical decisions—the doctors, the patients, or HMO bureaucrats?

It is important for every Member of the Senate to understand how we got where we are on this issue. We started out by placing a fair definition of medical necessity. The plan would have to abide by the Patients' Bill of Rights itself. It was a definition that was consistent with what most plans already did.

Every Democratic Member of the Senate voted for that approach. I still think it has much to commend it. But we heard complaint after complaint from the other side that putting a definition into law would be a straightjacket for health plans, it would prevent them from keeping pace with medical progress, and so on.

So Congressmen JOHN DINGELL and CHARLIE NORWOOD changed that provision. They removed the definition of medical necessity from the law. Instead, they said, let the plans choose the definition that works best for them. But if a dispute went to an independent medical review, the reviewers would need to consider that definition. But they would not be bound by it in cases involving medical necessity; that is, they would be able to use in the review their own judgment in terms of the medical necessity. They would make the decision based on the kind of factors all of us would want for ourselves and our families—the medical

condition of the patient, and the valid, relevant, scientific and clinical evidence, including peer-reviewed medical literature, or findings, including expert opinion.

Mr. GREGG. Mr. President, will the Senator yield for a question?

Mr. KENNEDY. Yes.

Mr. GREGG. I understand the Senator's time has expired. I ask unanimous consent that whatever time the Senator consumes, an equal amount of time be added to our time.

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

Mr. KENNEDY. Mr. President, at the time of these appeals, they would make the decision based on the kinds of factors all of us would want for ourselves and our families—the medical condition of the patient, and the valid, relevant, scientific and clinical evidence, including peer-reviewed medical literature, or findings, including expert opinion.

Those factors essentially say that the independent medical reviewer should strive to make the same recommendation that the best doctor in the country for that particular condition should make. It is a fair standard. It is a standard all of us hope our health plan would follow.

The Senate should understand that this was not only a bipartisan compromise between Congressmen JOHN DINGELL and CHARLIE NORWOOD, it was a compromise on which every member of our conference signed off in the last Congress, from DON NICKLES and PHIL GRAMM to JOHN DINGELL and myself. In fact, this concept of letting the external reviewer consider but not be bound by the HMO's definition of medical necessity is also included in the Frist-Breaux bill endorsed by the President.

On this issue, the legislation before the Senate is clearly the middle ground. It is the fair compromise. But my concern is that the amendment we will face will tilt us away from that compromise and more to the HMO's.

Now the authors of this amendment claim that they have just provided a safe harbor for HMOs that want to be able to maintain a fair definition of medical necessity throughout the entire process. But our list of the factors that must guide the external reviewers' decision is already consistent with every fair definition of medical necessity. The fact is that this amendment may create a safe harbor for HMOs, but it tosses patients over the side into the storm-tossed seas. It would allow HMOs to adopt some of the most abusive definitions ever conceived. It ties the hands of the independent medical reviewers. It puts HMO bureaucrats in the driver's seat—and kicks patients and doctors all the way out of the automobile and is not in the interest of the patient.

Our concern is that the amendment we anticipate will be offered will say that HMOs could adopt any definition used by a plan under the Federal Employees Health Benefits Program that

insures Members of Congress and the President, by a State, or developed by a "negotiated rulemaking process." Each of these approaches is fatally flawed, if our goal is to protect patients.

The Federal Employees Health Benefits Program plans can change their definitions every year. An administration hostile to patient rights can accept any unfair definition it chooses. To be perfectly frank, even administrations that support a Patients' Bill of Rights have not paid much attention to these definitions, because they have so many other controls over the way the plans behave. And Senators and Congressmen can always get the medical care they want, regardless of the definitions in the plan's documents, but ordinary citizens cannot.

So the Federal employees' plan can change these definitions. It is important that we establish the definitions so it is very clear to the patients about how their interests are going to be protected.

States often provide good definitions of medical necessity, but sometimes they do not. Do we really want, after the tremendous struggle we have gone through to pass this legislation, for consumers to have to fight this battle over this definition again and again in every State in the country year after year? I do not believe so. Administrative rule-making is only as fair as the participants. An administration hostile to patients' rights and sympathetic to plans can appoint any unfairly stacked set of participants that it wants.

And finally, under the amendment, the plan gets to choose any one of these options. That is what we anticipate of the format of the amendment. So it could seek out the worst of the worst. But consumers get no comparable rights to demand the best of the best.

If we look at the options that would be immediately available to health plans under the amendment, it is obvious why the disability community, the cancer community, the American Medical Association, and other groups who understand this issue are so vehemently opposed to that as an alternative—and why it is supported by no one but the health plans.

There are no health groups that support that option—none, zero. All of the health groups effectively support what was worked out in the compromise last year and has been included in the legislation before us which, as I mentioned, I think is the real compromise.

One Federal plan defines "medical necessity" as "Health care services and supplies which are determined by the plan to be medically appropriate." That is a great definition. If the plan determines the service your doctor says you need is not appropriate, you are out of luck. There is nothing to appeal, because the plan's definition of "medical necessity" controls what the external reviewers can decide.

Another plan uses different words to reach the same result. It says, medical

necessity is “Any service or supply for the prevention, diagnosis or treatment that is (1) consistent with illness, injury or condition of the member; (2) in accordance with the approved and generally accepted medical or surgical practice prevailing in the locality where, and at the time when, the service or supply is ordered.” Doesn’t sound so bad so far, but here is the kicker. “Determination of ‘generally accepted practice’ is at the discretion of the Medical Director or the Medical Director’s designee.” In other words, what is medically necessary is what the HMO says is medically necessary.

Among those who have been most victimized by unfair definitions of “medical necessity” are the disabled. Definitions that are particularly harmful to them are those that allow treatment only to restore normal functioning or improve functioning, not treatment to prevent or slow deterioration.

That is a key element in terms of the disabled community. Most of these definitions, even for Federal employees, say that they will permit the treatment just to restore the normal functioning or to improve functioning. So many of those who have disabilities need this kind of treatment in order to stabilize their condition, in order to prevent a deterioration of their condition; or if there is going to be a slow deterioration, to slow that down as much as possible.

The only definition that really deals with that is the one which is in the McCain-Edwards and the Breaux-Frist legislation, which was agreed to because it does address that. That is why the disability community is so concerned about this particular amendment.

Every person with a degenerative disease—whether it is Parkinson’s, Alzheimer’s, or multiple sclerosis—can be out of luck with this kind of definition.

For example, in the clinical trials, you have to be able to demonstrate that the possibilities, by participating in the clinical trial, are going to improve your condition. There are other kinds of standards as well, but that happens to be one of them: to improve your kind of condition. We find that the Federal Employees Health Benefits Program uses language that is very similar to that.

As I mentioned, when we are talking about those that have some disability—when you are talking about Parkinson’s disease, Alzheimer’s disease, multiple sclerosis—you have the kind of continuing challenge that so many brave patients demonstrate in battling those diseases, but you want to make sure that your definition of “medical necessity” is going to mean that really the best medicine that can apply to those particular patients, based upon the current evolving development of medical information, is going to be available to those patients.

Another issue which should be of concern to every patient, but especially to

those with the most serious illnesses, is the allowing cost-effectiveness to be a criterion for deciding whether medical care should be provided. The question is always, cost-effectiveness for whom, the HMO, or the patient? It was cost-effective for one HMO to provide a man with a broken hip a wheelchair rather than an operation that would allow him to walk again. It was cost-effective for another HMO to amputate a young man’s injured hand, instead of allowing him to have the more expensive surgery that would have made him physically whole. It may be cost-effective for the HMO to pay for the older, less effective medication that reduces the symptoms of schizophrenia but creates a variety of harmful side effects rather than for the newer, more expensive drug that produces better cures and less permanent damage—but is it cost-effective for the patient and her family? Is this really the criterion we want applied to our own medical care or the care of our loved ones?

And on a practical level, how in the world is an independent review organization ever supposed to judge cost-effectiveness. Its members under all the bills are health professionals, not economists. They have the expertise to decide on the best treatment for a particular patient, but they cannot and should not be asked to evaluate its cost-effectiveness. To paraphrase our opponents, when your child is sick, you want a doctor, not an accountant. But here we have one of the State plans saying, in its definition of medical necessity, “cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention.”

I urge my colleagues to stay with us on this definition and to resist an amendment to alter and change it. The amendment that we anticipate will reverse a bipartisan compromise broadly supported by Members of both parties. It is included in the bill the President has endorsed. The anticipated amendment will stand the whole goal of this legislation on its head.

I think this is very likely to be a litmus test on the whole issue for the Senate. What we want to do is to make sure ultimately that it is the doctors who are going to make the best medical decisions, based on the information that they have available to them. That is what this legislation does, the McCain-Edwards, as well as in the Breaux-Frist. We do not want to change that. That has been basically supported by the President. It was supported in the conference. It represents basically the mainstream of the views of the Members of this body. We should resist any alteration or change of that particular provision.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KERRY. Mr. President, I ask unanimous consent I be permitted to speak as in morning business on the time of the Republicans.

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

Mr. KERRY. Let me begin by thanking my colleague, the senior Senator from Massachusetts, for his extraordinary leadership on this critical issue for our country with respect to the Patients’ Bill of Rights. That is without any question the most important business before the country and the most important business before the Senate. I will return to the floor of the Senate either later today or tomorrow to share some thoughts with respect to that.

(The remarks of Mr. KERRY are located in today’s RECORD under “Morning Business.”)

Mr. KERRY. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. THOMAS. Mr. President, we have some time to speak on the bill on this side; is that correct?

The PRESIDING OFFICER. The minority controls the next 41½ minutes.

Mr. THOMAS. I thank the Chair.

Mr. President, we have been on this bill now, it seems, for a very long time. It is very important, and indeed we should be on it. On the other hand, we also ought to be making some progress. It appears we are not. We hear all this talk about how we can get together, let’s put it together, and we can agree. But I see nothing of that nature happening. It seems to me we continue to hear the same things coming forth. I hear a recitation of a great many people who are opposed to the bill listed off name by name. I suppose we can do that for the rest of the day.

Here is a list of people opposed to the Kennedy bill. There are over 100 names of businesses and organizations. I could do that, but I don’t know that there is great merit in doing that. We have talked about what we are for, and I think, indeed, we Republicans have certain principles, and we have talked about that: Medical decisions should be made by doctors; patients’ rights legislation should make coverage more accessible, not less; coverage disputes should be settled quickly, without regard to excessive and protracted litigation.

Most of us agree that employers that voluntarily provide health coverage to employees should not be exposed to lawsuits. That is reasonable. Congress should respect the traditional role of States in regulating health insurance. That is where we have been and what works. We intend to stand by those principles. I don’t think that is hard to agree with. We have talked about the President’s conversations with some of the people on the other side of the aisle who apparently say he wants a bill and they think we can get together. But I don’t see any evidence of that.

It seems to me if we are going to do that, we ought to do it. Instead, it seems we are in this kind of bait and switch sort of thing that we hear. I think the McCain-Edwards-Kennedy bill, as described by the sponsors, is a far cry from what is written. How many times have we been through that? The sponsors promise it would shield employers from lawsuits, that it would uphold the sanctity of employer health care contracts, and require going through appeals before going to court. However, when you look at the language of the bill, that is not what is there.

One of the sponsors says: We actually specifically protect employers; employers cannot be sued under the bill. Yet you find in the bill itself exclusions of employers and other plan sponsors, and it again goes into causes of action. And then, unfortunately, the next provision says certain causes of action are permitted, and then it goes forward with how in fact they can be sued. They say, first of all, we specifically protect employers from lawsuits. Then it says in the bill that certain causes of action are permitted to sue them.

So we don't seem to be making progress and meeting the kinds of agreements we have talked about. What we simply do is continue to get this conversation on the one hand, which is endless, and it isn't the same as what is in the bill. I don't know how long we can continue to do that.

I am hopeful we can come to some agreement. I think people would like to have a Patients' Bill of Rights that ensures that what is in the contract is provided for the patient. I think we can indeed do some of those things. However, I have to say it seems to me if we intend to do it, we need to get a little more dedicated to the proposition of saying, all right, here is where we need to be on liability and let's see if we can work out the language to do that. We have been talking about it now for a week and a half. It is not there. All right. We are talking about the opportunity for holding to the contract, not going outside the contract. We need to have that language.

So I think most of us are in favor of getting something done here, but we are getting a little impatient at the idea of continuing to recite the same things over and over again when in fact the bill does not say that. We ought to be making some propositions to be able to make the changes that indeed need to be made if that is our goal.

Frankly, Mr. President, I hope that it is.

I see other Members in the Chamber. I will be happy to yield the floor.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. GREGG. Mr. President, I yield back such time as I might have at this point.

The PRESIDING OFFICER. The Senator's time is yielded back.

Mr. REID. If the Senator will yield for a brief statement, there are efforts being made now to work out what some deem to be better language on the McCain amendment. If that is not possible, the Senator from New Hampshire and I have said we might be able to voice vote that anyway. I personally do not expect a recorded vote on that, but time will only tell.

I ask unanimous consent that the McCain amendment be set aside and the Senator from Missouri be recognized to offer his amendment.

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

The Senator from Missouri.

AMENDMENT NO. 816

Mr. BOND. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Missouri [Mr. BOND] proposes an amendment numbered 816.

Mr. BOND. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: to limit the application of the liability provisions of the Act if the General Accounting Office finds that the application of such provisions has increased the number of uninsured individuals)

On page 179, after line 14, add the following:

SEC. _____. ANNUAL REVIEW.

(a) **IN GENERAL.**—Not later than 24 months after the general effective date referred to in section 401(a)(1), and annually thereafter for each of the succeeding 4 calendar years (or until a repeal is effective under subsection (b)), the Secretary of Health and Human Services shall request that the Institute of Medicine of the National Academy of Sciences prepare and submit to the appropriate committees of Congress a report concerning the impact of this Act, and the amendments made by this Act, on the number of individuals in the United States with health insurance coverage.

(b) **LIMITATION WITH RESPECT TO CERTAIN PLANS.**—If the Secretary, in any report submitted under subsection (a), determines that more than 1,000,000 individuals in the United States have lost their health insurance coverage as a result of the enactment of this Act, as compared to the number of individuals with health insurance coverage in the 12-month period preceding the date of enactment of this Act, section 302 of this Act shall be repealed effective on the date that is 12 months after the date on which the report is submitted, and the submission of any further reports under subsection (a) shall not be required.

(c) **FUNDING.**—From funds appropriated to the Department of Health and Human Services for fiscal years 2003 and 2004, the Secretary of Health and Human Services shall provide for such funding as the Secretary determines necessary for the conduct of the

study of the National Academy of Sciences under this section.

Mr. BOND. Mr. President, it is clear that all of us agree that protection for patients of health care delivery systems is very important. Patients need to get quick, independent second opinions when their insurance company or their HMO denies care. Women need unimpeded access to obstetricians or gynecologists. Children need pediatric experts making decisions about their care and providing them care. Patients need to go to the closest emergency room and be confident that their insurance company or HMO will pay for the care.

Those things ought to be understood as the basis on which we all agree. To say, as some have, that those of us on this side of the aisle are not concerned about patients is just flat wrong.

I have spoken in the past about patients who are employees of small business, who are owners of small businesses, who are the families of small business owners. They do not get patient protection because they cannot afford insurance. They cannot even be patients because they do not have the care.

We need to figure out how we can assure patient protections, get more people covered by health care insurance, health care plans, HMOs, and give them the protections they need within those plans.

This bill is about balance. As we provide patient protections, we need to be concerned about how much we increase the cost of care because at some point these costs will start to bite. At some point, employers, particularly small business employers, will not be able to offer coverage to anyone so their employees cannot be patients. In addition, as prices go up, the employees or patients may not be able to afford their share of the insurance costs. The results: Fewer people with health care.

It is generally understood that for every percent increase in the cost of health care, we lose about 300,000 people from health care coverage. It is a fact of life. No matter what we do here, no matter how much we expound and gesticulate and obfuscate, we cannot repeal the laws of economics. When something gets more expensive, you are going to get less of it. The question is, How far do you go? How much is too much?

The folks on my side of the aisle have said we need to give patients basic, commonsense protections, such as the ones I mentioned in the beginning: Independent second opinions, access to emergency care, access to OB/GYN care, access to pediatric care, and many more. But that is not enough. Some of our friends on the other side have insisted on going forward. In addition to the consensus patient protections, they want to add an expensive new right to sue that poses a huge threat to runaway health care costs.

There are some people who are very interested in the right to sue. Those

people are called trial lawyers, and they do really well at bringing lawsuits. They get a lot of fees from winning those lawsuits, particularly if the judgment is high and they have a good contingency fee contract. At the same time, those costs ultimately can deny people health care coverage because to pay these judgments, the companies involved have to raise costs.

As we have debated this legislation, I have tried to focus on what patient protections are needed and on the other crucial questions: What will this bill do to employers' ability to offer health care insurance to their employees? How many health care patients might lose their coverage?

I know proponents of this version of the bill do not want to talk about the people across America, the patients, who will lose their health insurance because this bill as a whole, including the new lawsuits, may cost more than a million people their health care coverage. We need to talk about it. We need to focus on it because over 1 million people who have health insurance today—men and women who are getting their annual screenings, mothers-to-be who are receiving prenatal care, and parents whose children are getting well-baby care—will be losing care because of this bill, and how many of them can we afford to lose?

We will be losing health care coverage for seniors who are taking arthritis medicines, men and women who are being treated with chemotherapy or kidney dialysis, families waiting for a loved one to have heart bypass surgery. These are the lives that will be disrupted, even devastated, as a direct result of this bill. Whom will they have a chance to sue then? What good is the right to sue a health plan if I have lost my health plan in the first place? It does not do me much good.

I have said in the past we know there are going to be people who lose their insurance coverage as a result of this bill. In the past several days, I have brought to the Chamber a chart that keeps a running total of the number of patients who will lose their health care coverage because their employers have told us that if the provisions of the current McCain-Kennedy bill with the right to sue employers are enacted into law, they will have no choice but to drop health care. They want to provide health benefits to their employees. They are important benefits, they are attractive benefits and ensure the employers get good work from employees, and they take care of the patients who are the employees and the families of the employees.

These small businesses have told me if they are faced with lawsuits from one of their employees or dependents who do not get the right kind of health care, they cannot afford to take that risk. Health care costs are too much already. Health care costs are going up. They are seeing more and more of the costs burdening their ability to provide health care.

In the past, I have read from letters from small businesses in Missouri that are fearful of losing health care coverage for their employees and their employees' dependents. These are real life examples of people who have written in, saying they are very worried about the provisions of the McCain-Kennedy bill.

I read yesterday a letter from a fabricator company. Today I have a letter from an accounting group. They are a small business, currently insuring four employees at a cost of \$1,935 a month; they pay 100 percent of the premiums. Last year, their health care coverage costs went up 21 percent. They note there has been a steady increase over the past few years. They have had to pass these costs on to clients to cover the charges for their employees. At this rate, providing health insurance may become impossible. If the new Patients' Bill of Rights proposed by Senator KENNEDY expands liability and results in employers being held responsible for medical court cases, they will certainly be forced to cancel this employee benefit.

They go on to say:

I do small business accounting every day. These are small mom-and-pop businesses that cannot exist if they are treated in the same way as large businesses with regard to employee benefits. Sometimes Congress forgets that mom-and-pop businesses of America are simply people who are working hard, day in and day out, just to maintain a moderate lifestyle. While they are not poor, they are not employers in the same sense as major corporations.

Please help us keep our businesses and try to provide for our employees.

That is one thing we need to remember. As we look at things on a grand scale and look at large employers, we cannot forget the mom-and-pop businesses providing a living for mom and pop, their families, their employees, and their employees' families. We want all of them to be able to get good health care coverage. We want them to have rights that they can exercise if the HMO or the insurance company denies them coverage. But we certainly don't want to throw them out of health care coverage.

Here is another company in Missouri. They write:

I have been doing business in Missouri for over 15 years and have been providing health insurance to my employees since November of 1993. At that time, counting myself, I insured four employees at an average cost of \$78.50 a month. I now insure five at a monthly cost of \$199.60, with the same high deductible coverage. My cost has increased over 250 percent, way beyond the rate of inflation and way beyond the growth of my business. I have just had to absorb this increased cost in the bottom line. This bill Senator KENNEDY has now in committee looks like a disaster ready to happen. I am not alone as a small business owner wondering if I might be able to continue to offer this benefit to my employees in view of the rising costs of the policies. If I would be legally responsible for medical court cases, I might as well just toss in the towel and close my business.

Those are the mom-and-pop operations, the small businesses, the life-

blood of our economy, the dynamic, growing engine of our economy that provides the jobs and the well-being and meets our needs for services and goods that everybody wants to talk about and everybody loves as the small businesses. But we need to be sure we are not pricing them out of business or even costing them the ability to cover their employees' health care costs.

Right now, our toll is 1,895 Missourians losing their health care coverage from what their employers have told us about the burdens they expect from the McCain-Kennedy bill. One can argue they may be wrong. I can make an argument based on reading the pages I have read before of exceptions under which an employer can be sued. But they would be well advised, if they cannot stand the costs of a lawsuit, to give up their health insurance. You can argue about it one way or the other, but 1,895—almost 1,900—employees will be thrown out of work, according to their employers who have communicated directly to us, if this measure is unamended and goes into effect.

What are we going to do about it? I hope we can work on the liability sections. I have heard people want to compromise. I haven't seen that compromise yet. So I will offer a very simple proposal. My amendment says one simple thing: At a certain point, enough is enough. If more than one million Americans lose health care coverage because of this bill, the most expensive part of this bill, the right to sue, should be reevaluated.

The beautiful thing about this amendment is, all of the disagreements that exist about how much the McCain-Kennedy bill will increase costs and how many people will lose coverage won't matter. We will never get an agreement on this floor, I don't believe, on just how many people will be knocked out. So we won't rely on predictions. All that will matter is what actually happens.

Health economists assure this analysis can be done, they say, over a 2-year period, and we will look at employment patterns, inflation, health regulations, or policy measures other than patient protections and other factors that affect employers and employees' ability to purchase coverage. Economists can estimate how many people lose coverage due to a major piece of health legislation. The Institute of Medicine has more than enough expertise and brain power at its disposal to do this.

The amendment I have proposed says not later than 24 months after the effective date, and thereafter for each of the 4 succeeding years, the Secretary of Health and Human Services shall ask the Institute of Medicine of the National Academy of Sciences to prepare and submit to the appropriate committees of Congress a report concerning the impact of the act on the number of individuals in the United States with health care insurance.

Then, if the Secretary, in any report submitted, determines more than one

million individuals in the United States have lost their health insurance coverage as a result of the enactment of this act as compared to the number of individuals with health insurance coverage in the 12-month period preceding the act, then the liability section shall be repealed, effective on the date 12 months after the date on which the report is submitted. The Department of Health and Human Services is authorized to get funding for the conduct of the study, the National Academy of Sciences.

It is very simple. If it throws more than a million people out of health care coverage, then we repeal the liability section. Then Congress comes back and looks at it and says: Can we do a better job? We don't have to rely on any estimates or predictions. We can find out how many people have lost their coverage. I think a million people is a lot. But granted, anything we do is going to have a cost. What constitutes too much? I propose that as a starting point we say that 1 million people losing coverage is too much.

The two key issues in this debate are: First, access to care; second, access to coverage.

Patients need access to care without undue managed care interference. Thus, we need a patient protection bill. That is the external appeal. That is the right to see certain specialists, and the very important provisions we have in it. But the patients also need access to coverage. Are we going to get more people covered? Are we going to knock more people out of coverage?

The ability to sue HMOs sounds nice. But at what price? If the ability to sue HMOs and the ability to sue employers is too high, and if the price is 1 million Americans who lose coverage, then that price is too high.

I urge my colleagues to accept this amendment. I believe it is one way to make sure that we have a fail-safe mechanism to make sure that we observe that basic principle of medicine: first do no harm. I think a million individuals losing health care coverage is harm. That is why I suggest that we should agree to the amendment.

Mr. President, I yield the floor. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. GREGG. Mr. President, I rise in support of the excellent idea of the Senator from Missouri.

One of the big concerns that has been heard expressed throughout this entire debate has been the effect especially of the plethora of lawsuits which would be created under the present bill as it is structured on employers, especially small employers, and their willingness to continue to offer health insurance to their employees.

The real issue for most people is, first, do they have health insurance. When someone goes to find a job, one of the key conditions that most people look at is if that job has a decent health insurance package that is coupled with it. This is an extraordinarily big problem for not only people working at high-level jobs but especially people who work at entry-level jobs and in between.

You can take large employers in the retail industry or large employers in the manufacturing industry. In all of these areas, employees see as one of their primary benefits the pay they receive, obviously, but additionally the fact that they have good health insurance from their employers.

Then with the smaller employers, people who run small restaurants or small gas stations, or small mom-and-pop manufacturing businesses, the people who work for those folks also appreciate greatly the fact that they might have a health insurance package that is coupled with their employment. This is especially true for families. I don't think there is anything a family fears more than having a child get sick and not having adequate coverage, and not being able to get that child into a situation where they can be taken care of, or alternatively having their savings wiped out by the need to do something to take care of that child who has been sick, or a member of the family.

Quality insurance is absolutely critical.

We should not do anything that undermines the willingness of manufacturers, of employers, of small businesspeople, of mom and pop operators to offer insurance to their employees. It should almost be a black letter rule for this bill that we do not do something that is going to take away insurance because, as I have said before in this Chamber, there is no Patients' Bill of Rights if a person does not have insurance. They have no rights at all because they do not have any insurance.

So what the Senator from Missouri has suggested is a very reasonable approach. If this bill, as it has been proposed, is such an extraordinarily positive vehicle in the area of giving people rights for their insurance and is such a positive vehicle in the area of allowing people who interface with their health agencies to get fair and adequate treatment from their health agencies, then the authors of this bill should have no objection to the amendment offered by the Senator from Missouri.

Because the Senator from Missouri isn't suggesting that the bill should be changed in any way. He is simply saying, if the effects of the bill are that people are thrown out of their insurance and no longer have the ability to hold insurance because their employer says, "We are not going to insure you anymore; we can't afford it because of the number of lawsuits that are going to be thrown at us as a result of this

bill," if that is the case, and more than one million people in America—and that is a lot of people—lose their insurance, then the liability section of this bill will not be effective. It does not affect the underlying issues of access and does not affect the underlying issues of the ability to go to your own OB/GYN or your own specialist or the various other specific benefits which are afforded under this bill, most all of which there is unanimous agreement on in this Senate.

All it simply says is, listen, if the liability language in the bill simply isn't going to work because it throws a million people out of their insurance and, therefore, a million people lose their rights versus gain rights under this bill, then we basically do not enforce liability provisions until that gets straightened out. The Congress can come back at that time and take another look at the liability provisions and correct them. At least nobody else will be thrown out of the works because of the liability provisions; they will essentially be put in a holding pattern by this amendment.

That is an entirely reasonable approach. Instead of saying we are going to function in a vacuum in this Chamber, where essentially we throw out ideas that we think are good but don't know what is going to happen, this is essentially saying, all right, if we think we have ideas that are good, we are going to hold those ideas to accountability.

We heard the Senator from Massachusetts talking about accountability in another section of this bill. He brought up the education bill, which we talked about for the last 7 weeks before we got to this bill. And the issue was accountability. Does it work? The education bill we passed has language in it that essentially took a look at what had happened in order to determine what would occur in the future. What Senator BOND has suggested is that we do that under this bill. It is a very practical suggestion. He is saying if a million people lose their insurance, then we will put the liability language in the bill on hold until we can straighten it out. Actually, it would be sunsetted.

The practical effect of that is, I presume, Congress would come back and say, listen, we didn't intend to have a million people lose their insurance. Our purpose in this bill was to give people more rights, not to give them less rights. You give people less rights if they lose their ability to have insurance.

So by taking this language we will be in a position of being sure that what we are doing in this Chamber, and what we are doing in the isolation of the legislative process—although we get input, we never really see the actual events—will have a positive impact. We will know that if it isn't having a positive impact, there will be a consequence. The consequence is that that part of the bill, which has created the

negative impact—throwing people out of their insurance—will be held up or stopped or sunsetted until we can correct it.

So the Senator's concept in this amendment makes a huge amount of common sense. It is truly a common-sense idea. I guess it comes from the "show me" State. Nobody has used that term today on this amendment. I do not think they have described it that way. This is a classic "show me" amendment. This says: Show me how the bill works. If the bill does not work, OK, we are going to change it to the idea of having this trigger, which establishes whether or not the bill is positive or whether the bill is negative. If the bill is negative—"negative," meaning over a million people losing their insurance as a result of the effects of this bill—then we sunset the liability language.

I do think it is important to stress that this amendment does not sunset the whole bill. It just focuses on the liability sections within the bill, which sections I have severe reservations about and have referred to extensively in this Chamber, which I think are going to have unintended consequences which will be extraordinarily negative on employees in this country where a lot of people are going to lose their insurance.

This amendment just goes to that section of the bill. It doesn't go to the positive sections of the bill that there is general agreement on. It does not even go to those sections of the bill where there isn't general agreement on, such as the scope issues of States' rights or the contract sanctity issue, for that matter.

But it does go to this question of, if you have people losing their insurance because their employers are forced to drop that insurance because it has become so expensive as a result of the liability provisions of this bill, then, in that case, where that happens to a million people—a million people, by the way, is essentially the population of the State of New Hampshire. It is not the population of Missouri, but essentially we have 1,250,000 people in New Hampshire, so we are talking about not an inconsequential number of people; it is pretty much the whole State in New Hampshire. So it is a reasonable threshold.

If a million people lose their insurance because employers cannot afford it, because the liability costs have driven them out of the ability to ensure their employees, then we should stop that; we should end that liability language and take another look at it as a Congress and correct it.

So I congratulate the Senator from Missouri for offering this classic "show me" amendment. It is very appropriate that is has been offered by the Senator from Missouri, from the "show me" State. It makes incredible common sense. I also would say it is a "Yankee commonsense" amendment. So we shall claim it for New England also. I

join enthusiastically in supporting this amendment.

Mr. President, I yield the floor and suggest the absence of a quorum.

THE PRESIDING OFFICER (Mr. DAYTON). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. SANTORUM. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

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

Mr. SANTORUM. Mr. President, I rise in support of the Bond amendment. I commend the Senator for standing up and trying to mold patient protection legislation to comply with a fundamental principle that he has repeated many times today: The first order of business in medicine is to do no harm. And building on this principle, as I continue to iterate so many times when I come to this Chamber to speak, we cannot afford to ignore what I believe to be the No. 1 problem in health care today: the fact that we have anywhere between 42 and 44 million people who do not have health insurance.

I will state again for the record—and I am happy for anyone to come forward and tell me differently—there is not one thing in this bill that increases the number of insured people in America, not one thing. This is a pretty good-sized bill. It has 179 pages to it. Not one page, not one paragraph, not one sentence, not one word will cover one additional person in America.

For many of the people who are the greatest critics of the health care delivery system in this country, the paramount feature of which they are most critical is the number of uninsured in our society. If there is a criticism levied by people around the world against America's health care system, it does not have to do with quality of care. I think everyone will agree that America pretty much sets the gold standard in terms of the quality of care delivered to patients. I think most people say, yes, the best health care in the world is available here in the United States. But the critics around the world will say, it may be the best system but you have 42 to 44 million people in this country who are not insured.

Do you think the first health care bill we are considering here in the Senate should consider what most people see as the greatest problem with America's health care system? Most people in this country would say, yes, that is what we should be considering. But this bill doesn't do that. Interestingly enough, what does this bill do? It provides patient protection. That is great. I am for that. There are a group of people in this country, people who have health insurance plans that are regulated solely by the Federal Government, who have very few patient protections afforded to them because they are not covered under State patient protection laws. So we should pass a Federal Patients' Bill of Rights to cover those people. I am all for that,

and we should have adequate protection.

But what this bill does, what the Senator from Missouri is trying to really focus on, is it does a whole lot of other things that will cause at least one million more Americans to become uninsured. Now, I am pleased that the President of the United States has vowed to veto this legislation should it come to his desk in its present form for signature. But if for some reason it is enacted into law, maybe over the President's objections, this will result in millions more being uninsured.

You can put all the benefits aside. Let's assume this is the greatest patient protection bill in the history of the world, that as a result of this bill, patients will be supremely protected, a notion, of course, with which I take issue. I don't believe that will occur. But let's assume it does. The result of this bill will be millions more uninsured. In particular, if the liability provisions of this bill are enacted, which allow employers to be sued—and that is really the issue that is at heart of the Bond amendment, if it allows employers to be sued, to practically an unlimited extent—you won't have a million or 2 million people who won't have insurance as a result of this bill. You will have tens of millions of people who will lose their insurance. Why? Do I say I am against employer liability because I love employers? No. Employers are nice people. Employees are nice people. They are all nice people. The question is, What is the effect of holding employers liable? The effect of holding employers liable is employers who voluntarily provide health insurance as a benefit, will simply stop providing that benefit because it will jeopardize their entire business. If they can be sued for a decision that is made with respect to a benefit they voluntarily provide one of their employees, the provision of which is not the core function of their business, they are simply going to stop providing that benefit.

That is what the Senator from Missouri is trying to get at. If we cause, as a result of the employer liability provisions, and some of the general liability provisions, and some of the contract provisions, which basically allow outside entities to rewrite contracts in litigation and in appeals, if we open up this Pandora's box of problems for employers to continue to provide insurance to their employees, employers will do what employers must do: first, protect the survival of their business. And this will be a direct threat to the survival of their business.

What is now a pleasant benefit that you can provide to your employees and something that you can help to attract employees with by providing good health care insurance will become a serious liability risk that a business simply cannot afford to take.

The Senator from Missouri is saying, very simply: We have a great patient protection bill here, but we have the

very real potential of having a tremendous downside, in really hurting people.

I am very sympathetic about all the cases being brought forward, about the need for patient protection. I think you will find fairly universal agreement on this side that we want to provide those protections. But the first protection should be to preserve the possession of insurance in the first place. If we deny them that protection, all these other protections don't matter, really, if they lose their insurance. This could be a great bill, but if you don't have insurance, then this bill doesn't help you. In fact, it can hurt you because it can cause the loss of your insurance.

What the Senator from Missouri is saying is: Let's go through, and we will work on some more amendments. We will try to get this thing honed down until we have a good patient protection bill. If we can't fix the liability provisions, which I don't know whether we will be able to or not, at least let's say that if the liability provisions are what we believe they are, in other words, problematic to the point of causing devastation to millions or at least a million people in losing their insurance, then we should have a trigger.

You are seeing all of these kinds of comments by folks who are supportive of this bill and supportive of the liability provisions in the bill saying: Hey, this isn't going to hurt anybody. We are not going to cause any problems with this. No, no, no, employers aren't going to drop their coverage. Health care costs are not going to go up. Millions more won't be uninsured.

They will make that statement and have made that statement over and over again. Fine. They may be right.

What happens if they are wrong? What happens? What happens if past experience is any guide, if we are right and millions do become uninsured? Should we have to wait for an act of Congress for this body generally to realize that we made a mistake and have to come back through this whole legislative process to repeal the problem here? Should we have to wait for that? Or should we just simply have a trigger that says, look, if we made a mistake, if we made a mistake, if we were wrong, then we are going to immediately cancel that portion of the bill that is causing the problem upon recognition that we have a problem of a million uninsured.

As the Senator from New Hampshire said, a million people is a lot of folks, a lot of children, a lot of families. It is a lot of people who are going to go without health care. If what we really care about is providing good, quality health care, the first thing we should care about is to get them an insurance policy in the first place.

One of the things that strikes me most about this bill is blithe references as to how we are going to go out and get the HMOs. These HMOs are a bunch of bean counters who don't care about people. There is all these horrible cases about HMOs.

My understanding is that the liability provision that allows you to sue your employer, that allows you to sue your insurance company, does not just apply to HMOs. It applies to PPOs. It applies to all insurance contracts. Obviously, if it is a fee-for-service contract and there is no limitation on what provider you want to go to, that is one thing. But in most insurance plans today that are not HMOs, there is some limitation of some sort, certainly some limitation on procedures that are covered. But that is not what is talked about here, folks. What we talk about, when they talk about this liability provision, they are talking about these nasty HMOs.

What they don't tell you is that it ain't just the nasty HMOs that can be sued under this bill, it is any insurance company who provides any insurance product and any employer that provides any insurance product.

Oh, that is a different story, isn't it? You don't hear them up there railing against those nasty fee-for-service plans or those nasty PPO plans because they don't poll as well as going after those nasty HMOs. But this isn't just about nasty HMOs, this is about all insurance products. There is no way out of this liability provision unless, of course, you just want to say to your employees: We will cover everything. Doesn't matter what you want, where you want to go, we will just pay for everything you want. Of course, we all know what an exorbitant cost of that would entail, and so this is neither practical or realistic.

The point is, this bill has serious consequences for millions of people who are on the edge, whose employers are sitting there right now saying: Well, I have a 13 to 20 percent increase in my premiums this year. The economy is flattening out a little bit. I am looking forward. I will tighten my belt a little bit more, and we will continue to provide health insurance to our employees. Then this bill comes along, which will increase costs more and potentially expose them to liability for doing what is right by their employees and providing insurance to them.

I haven't talked to an employer yet, I have not talked to an employer yet who told me that if this bill passes and they are liable for lawsuits simply because they are providing a health benefit to their employees, I haven't talked to one employer who has told me that they will keep their insurance.

They can't. How can they? In good conscience to their shareholders or the owners of the company, how can they keep providing a benefit that simply opens up a Pandora's box of liability, 200 causes of action, in State court, Federal court, unlimited damages, unlimited punitive damages, and allow clever lawyers to forum shop all over the country so as to find that good court down in Mississippi in a small county there that is used to handing out \$40 million or \$50 million jury awards.

I ask you, whether you are an employer or employee, put yourself in the shoes of a small businessperson who has 20 employees, barely making ends meet, running a small business—maybe a family business—their employees are like members of the family. You have lots of businesses like that across America. They want to do well by their employees because they are like family. So they provide good benefits, good pay, and even before family and medical leave, they gave time off when their employees were sick or they needed to take care of their children who were sick at school.

Now comes this bill that says if one person has a problem with the health care system and the insurance policy that employer offered didn't give them everything they wanted, and some savvy lawyer decides he or she can get you everything you want and more, and all of a sudden that family business that employs 20 or so people in the community all of a sudden that business is on the hook. And maybe they may even prevail against a lawsuit, but how many tens of thousands of dollars is it going to take, or hundreds of thousands, simply to defend the lawsuit? We are talking about big awards. I can tell you that a lot of companies are just going to be worried about fighting the lawsuit in the first place, about being dragged into court to prove positive against the liability ambiguities in this legislation?

I am just telling you that what the Senator from Missouri has put forth is a reasonable amendment. We will have amendments on the floor dealing with employer liability. We must do something about it. I believe if we allow this employer liability provision to stand, we will destroy the private health care system in this country—the employer-provided health care system. It will go away.

I know there are some Members on the floor right now who are against the private health care system, who want a Government-run, single-payer health care system. Fine.

Mr. GREGG. If the Senator will yield, I advise Members that it is very possible we will have a vote around 6 o'clock. So Senators should be aware of that.

Mr. SANTORUM. As I was saying, I know there are many people in this Chamber who believe a single-payer health care system is the best way, the most efficient way, the most compassionate way—to use these wonderful, glorious terms—to provide health insurance in this country. Obviously, I disagree, but it is a legitimate point of view. I think we should have that debate.

We had that debate in 1994 with the Clinton health care proposal, and we had a good debate on the floor of the Senate about the kind of health care delivery system we should have. But it was a deliberate debate about how we can change the health care system by a direct act of the Congress. The problem

with this legislation is that we are going to severely undermine one health care system, which is a health care system that is principally funded through employer contributions, and we are not going to replace it with anything.

You see, as many of my colleagues well know, if employers stop providing health insurance, then people are going to have to go out with their aftertax dollars and buy health care, and the costs will be prohibitive. If you don't believe me, I would ask any of my colleagues to drop their federal health insurance plan today, and to endeavor to purchase health insurance with aftertax dollars. It is very difficult.

One of the things I hope to accomplish—and maybe we can work on this in this bill—is to create refundable tax credits for those who do not have access to employer-provided health insurance, so they can get help from the Government equivalent to the subsidy that the government offers for employer-provided health insurance. We give a deduction for the business. In other words, if I am an employer and I provide health insurance to my employees, I get to deduct the cost of that off of my earnings, my income. We also subsidize it on the other end. If you are an employee and you have employer-provided health insurance, you don't have to pay taxes on the money that your employer uses to purchase that insurance. In other words, let's say it is a \$5,000 family policy. That is a benefit to you. That is compensation to you. It is \$5,000 of insurance costs that your employer pays for you, but you don't have to pay taxes on it. It is tax-free compensation to you. So, in that sense, we subsidize you by not taxing you on that benefit. So the employer gets subsidized and the employee gets subsidized.

But if you are an individual who does not have access to employer-provided health insurance, you have to take the money that is left after you pay all your taxes—after you pay Social Security taxes, income taxes, State taxes, local taxes, and Medicare taxes—and then you can take your money and try to buy health insurance.

That is a pretty rotten system. If we are going to do anything about the problem with the millions of uninsured in this country, we are going to have to start treating people who don't have access to employer-provided insurance the at least as well as we do with those who do have it. None of that is in this bill, there is no tax equity.

I will say it again. There isn't one paragraph in this bill that will increase the number of insured in this country. There are, unfortunately, pages and pages and pages and pages in this bill that will result in more and more and more people losing their insurance. But we can mitigate that—or at least a big part of it—if we adopt the Bond amendment.

The Bond amendment says if we have a problem, let's not wait for an act of Congress to admit our mistake. I know

those who are listening might find this hard to believe, but sometimes Congress is a little slow in admitting we made a mistake. Sometimes we don't own up to the fact that it was our fault. I know some within the sound of my voice will find that to be almost an incredible proposition on my part—that somehow Congress doesn't immediately come in and say, yes, we understand we made a mistake; we are sorry America, we blew it. Everything I said the year or two before about how this wasn't going to cause a problem, you are right; it did. My mistake; we are going to repeal this.

I just ask my colleagues, when was the last time that happened? I know some in this room will remember the last time it happened. My recollection is that it happened back in 1988, when it came to Medicare catastrophic coverage. Congress tried to pass catastrophic prescription drug coverage for seniors, and quickly found out that seniors really didn't like what Congress did. Seniors rose up and screamed and hollered, and within a year or so—I wasn't there at the time, but I recall Congress repealed it. That was about 12 years ago. I can't think of any instance since and, frankly, I can't think of anything before that.

So let's just assume—I think it is a pretty safe assumption—that the people who are saying that this liability provision will not cause a problem are wrong. They will be in very good company if they go on to insist that they aren't wrong in the future—that even though we may have evidence of millions more uninsured as a result of this provision, somehow or another they will avoid blame and will point to something else that caused this problem, not the liability provisions. So it will be some sort of contest here as to whether we even take up this issue again.

The Bond amendment avoids all that. It says, look, if the GAO says this provision, the liability provision, has caused a problem of causing more than million additional uninsured, then that part of the bill sunsets, the rest of the bill stays in place. Patient protections stay in place.

Patient protections stay in place. It affects just the liability provisions. The internal-external reviews stay in place so there is patient protection. What does not stay in place are the provisions that are causing massive damage to millions of American families.

I am hopeful, No. 1, we can fix these liability provisions because we should not pass a bill that is going to cause this kind of severe dislocation, this kind of trouble for millions of American families. We should not consciously do harm to people, particularly when we understand it is the No. 1 problem facing our health care system today, which is the lack of insurance for 42 to 44 million people.

We should not do this. We should not pass flawed liability provisions. I know

the Senator from New Hampshire and Senators on both sides of the aisle are trying to see if we can get a good provision. But should we not get a good liability provision, the Bond amendment is a very prudent stopgap measure so as to ensure that we do not go down the road of making what is the worst problem facing health care today even worse.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. BOND. Mr. President, I thank my friend from Pennsylvania for making a very compelling argument. I very much appreciate his support because we are talking about something that should be of concern to every American who wants to be sure that they and their families are covered by health insurance. If you price it out of range and lose your health care, it does not matter how many independent reviews might be provided in the law. If you do not have a plan, they do not do you any good.

The basis for our trigger, our safety valve, is, let's just see if this bill has a cost. We say that the Institute of Medicine within the National Academy of Sciences can figure it out. It has been indicated they can rely on work that has already been done by the General Accounting Office, CBO, and other congressional bodies. But for constitutional purposes, the ultimate responsibility of this study has to be in the executive branch, and that is why it is in the Institute of Medicine. We know from our work with the GAO and CBO the kind of format, the kind of approach that can be taken. We move that function into an executive branch area.

We say if this bill throws more than 1 million people out of their workplace health care coverage or their own health care coverage, then we sunset the most expensive part, the liability part.

I said earlier that the general rule of thumb is that 300,000 people will lose their health care coverage if health care costs go up 1 percent. I ought to be a little more specific and explain something. As I understand it, when the costs of this bill are calculated, it is impossible to determine how many dollars will be added to the health care costs from the liability provisions themselves. Basically, the additional responsibilities that go into the bill—setting aside the liability questions—the Congressional Budget Office estimated a previous and substantially equivalent form of this bill would raise private health insurance premiums an average of 4.2 percent. That comes from the mandates in coverage, external review, and all those other things.

This 4.2 percent would mean that over 1 million people will be thrown out of work. But that does not deal with the number of people who would lose their health care coverage because of the exposure to liability or because of the costs of liability judgments.

We probably will not have liability judgments in the first couple of years. It will take some time for cases to work their way through the court system. But you can bet if a couple of juries come in with the billion-dollar judgments that some juries are coming in with now, those costs are going to have to be factored into the health care premiums for everybody, whether it is an employer, whether it is the employee-paid provision of it, and there are going to be a lot of people who are not going to be patients because they are going to lose their health care coverage.

Then there are those, such as the small businesses I have referenced from Missouri, who say: I cannot take the chance; I cannot put my business at risk of one of these multimillion-dollar judgments, a tort action or contract action—tort action most likely—brought against me as an employer because I provide health care insurance or health care coverage or a health care plan; I am going to drop the plan.

We know what happens when they drop the plan. Most of the time the employee cannot pick up health insurance for her or his family and self. They are going to be out of business. They are going to be out of the health coverage that their employers provided. That is over and above the directly calculated costs CBO comes up with to say that a similar bill would increase health care costs by 4.2 percent.

The cost of this bill is 4.2 percent plus whatever the impact of the liability exposure would be, and we think that is much more significant even than the costs of the mandates in the bill. That is why we say if 1 million people are thrown out of health care coverage as a result of this bill—the National Academy of Sciences Institute of Medicine will make that report to the Secretary of Health and Human Services—then the liability provisions sunset in 12 months and Congress gets to review this measure and say: How can we make it work better?

That is a reasonable approach. It does not require us to make judgments, but it does say if 1 million people are thrown out, we need to revisit our work.

Mr. President, I yield the floor.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant bill clerk proceeded to call the roll.

Mr. REID. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Ms. CANTWELL). Without objection, it is so ordered.

Mr. REID. Madam President, what is pending before the Senate?

The PRESIDING OFFICER. The amendment of the Senator from Missouri, Mr. BOND.

AMENDMENT NO. 812

Mr. REID. I ask unanimous consent that amendment be set aside and we turn to McCain amendment No. 812.

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

If there is no further debate on McCain amendment No. 812, the question is on agreeing to the amendment.

The amendment (No. 812) was agreed to.

Mr. REID. I move to reconsider the vote by which the amendment was agreed to, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. Madam President, I ask unanimous consent that at 6:05 p.m. this evening the Senate vote in relation to the Bond amendment numbered 816, with no second-degree amendments in order prior to the vote; further, that following the vote, Senator Nelson of Nebraska be recognized to offer a Nelson-Kyl amendment regarding contract sanctity and there be 1 hour for debate this evening, with the time divided in the usual form; further, following the use or yielding back of time on the Nelson-Kyl amendment this evening, the amendment be laid aside and Senator ALLARD be recognized to offer an amendment regarding small employers, with 1 hour for debate this evening, equally divided in the usual form; further, that when the Senate resumes consideration of the bill at 9:30 a.m. on Wednesday, there be 60 minutes of debate in relation to the Allard amendment prior to a vote in relation to the amendment, with no second-degree amendments in order prior to the vote; further, following the vote in relation to the Allard amendment, there be 60 minutes for debate in relation to the Nelson of Nebraska-Kyl amendment, followed by a vote in relation to the amendment, with no second-degree amendments in order prior to the vote.

Mr. GREGG. Reserving the right to object, it is my understanding there will be no additional amendments this evening other than these two.

Mr. REID. I also say to my friend if any Member feels the necessity this evening to debate more, we have no objection.

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

Mr. GREGG. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk called the roll.

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

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

VOTE ON AMENDMENT NO. 816

Mr. GREGG. I ask for the yeas and nays on the Bond amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 816. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from New York (Mr. SCHUMER) is necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 93, nays 6, as follows:

[Rollcall Vote No. 198 Leg.]

YEAS—93

Akaka	Durbin	Lott
Allard	Edwards	Lugar
Allen	Ensign	McCain
Baucus	Enzi	McConnell
Bayh	Feingold	Mikulski
Bennett	Feinstein	Miller
Bingaman	Fitzgerald	Murkowski
Bond	Frist	Murray
Breaux	Graham	Nelson (FL)
Brownback	Gramm	Nelson (NE)
Bunning	Grassley	Nickles
Burns	Gregg	Reed
Byrd	Hagel	Reid
Campbell	Harkin	Roberts
Cantwell	Hatch	Rockefeller
Carnahan	Helms	Santorum
Carper	Hutchinson	Sarbanes
Chafee	Hutchison	Sessions
Cleland	Inhofe	Shelby
Clinton	Inouye	Smith (NH)
Cochran	Jeffords	Smith (OR)
Collins	Johnson	Snowe
Conrad	Kennedy	Specter
Craig	Kerry	Stabenow
Crapo	Kohl	Stevens
Daschle	Kyl	Thomas
Dayton	Landrieu	Thompson
DeWine	Leahy	Thurmond
Dodd	Levin	Torricelli
Domenici	Lieberman	Warner
Dorgan	Lincoln	Wyden

NAYS—6

Biden	Corzine	Voinovich
Boxer	Hollings	Wellstone

NOT VOTING—1

Schumer

The amendment (No. 816) was agreed to.

Mr. BOND. I move to reconsider the vote.

Mr. HATCH. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mrs. BOXER. Mr. President, I voted against the Bond amendment. If this legislation is enacted, as I hope it will be, I believe we should review it periodically and make changes to ensure that it is working to protect Americans against the outrageous practices of some HMOs. An annual review, as required by the amendment, would be a good thing. It would give us insight into what is working and what may not be.

However, this amendment goes beyond an annual review. If the number of uninsured individuals increases by more than 1 million, the Bond amendment gives the Secretary of Health and Human Services the authority to take away a person's right to sue an HMO.

One unelected individual should not have the unilateral power to take away every American's right to hold an HMO accountable for its bad decisions. I am very supportive of efforts to increase the number of people with insurance. I think we need to address that issue. But this amendment does not do that. The problem of the uninsured will not be solved by allowing a single unelected government official to let HMOs off the hook for their actions.

The PRESIDING OFFICER. Under the previous order, the Senator from Nebraska will be recognized.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

AMENDMENT NO. 818

Mr. KYL. Madam President, I have an amendment I send to the desk.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Arizona (Mr. KYL), for himself, Mr. NELSON of Nebraska, and Mr. NICKLES, proposes an amendment numbered 818.

Mr. KYL. Madam President, I ask unanimous consent reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To clarify that independent medical reviewers may not require coverage for excluded benefits and to clarify provisions relating to the independent determinations of the reviewer)

Beginning on page 35, strike line 20 and all that follows through line 8 on page 36, and insert the following:

(C) NO COVERAGE FOR EXCLUDED BENEFITS.—Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, provide coverage for items or services that are specifically excluded or expressly limited under the plan or coverage and that are disclosed under subparagraphs (C) and (D) of section 121(b)(1) and that are not covered regardless of any determination relating to medical necessity and appropriateness, experimental or investigational nature of the treatment, or an evaluation of the medical facts in the case involved.

On page 37, line 16, strike “and”.

On page 37, line 25, strike the period and insert “; and”.

On page 37, after line 25, add the following:

“(iii) notwithstanding clause (ii), adhere to the definition used by the plan or issuer of ‘medically necessary and appropriate’, or ‘experimental or investigational’ if such definition is the same as either—

“(I) in the case of a plan or coverage that is offered in a State that requires the plan or coverage to use a definition of such term for purposes of health insurance coverage offered to participants, beneficiaries and enrollees in such State, the definition of such term that is required by that State;

“(II) a definition that determines whether the provision of services, drugs, supplies, or equipment—

“(aa) is appropriate to prevent, diagnose, or treat the condition, illness, or injury;

“(bb) is consistent with standards of good medical practice in the United States;

“(cc) is not primarily for the personal comfort or convenience of the patient, the family, or the provider;

“(dd) is not part of or associated with scholastic education or the vocational training of the patient; and

“(ee) in the case of inpatient care, cannot be provided safely on an outpatient basis; except that this subclause shall not apply beginning on the date that is 1 year after the date on which a definition is promulgated based on a report that is published under subsection (i)(6)(B); or

“(III) the definition of such term that is developed through a negotiated rulemaking process pursuant to subsection (i).

On page 66, between lines 10 and 11, insert the following:

“(i) ESTABLISHMENT OF NEGOTIATED RULE-MAKING SAFE HARBOR.—

“(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards described in subsection (d)(3)(E)(iii)(IV) (relating to the definition of ‘medically necessary and appropriate’ or ‘experimental or investigational’) that group health plans and health insurance issuers offering health insurance coverage in connection with group health plans may use when making a determination with respect to a claim for benefits.

“(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under paragraph (1), the Secretary shall, not later than November 30, 2002, publish a notice of the establishment of a negotiated rulemaking committee, as provided for under section 564(a) of title 5, United States Code, to develop the standards described in paragraph (1). Such notice shall include a solicitation for public comment on the committee and description of—

“(A) the scope of the committee;

“(B) the interests that may be impacted by the standards;

“(C) the proposed membership of the committee;

“(D) the proposed meeting schedule of the committee; and

“(E) the procedure under which an individual may apply for membership on the committee.

“(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice described in paragraph (2), and for purposes of this subsection, the term ‘target date for publication’ (as referred to in section 564(a)(5) of title 5, United States Code, means May 15, 2003.

“(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—Notwithstanding section 564(c) of title 5, United States Code, the Secretary shall provide for a period, beginning on the date on which the notice is published under paragraph (2) and ending on December 14, 2002, for the submission of public comments on the committee under this subsection.

“(5) APPOINTMENT OF NEGOTIATED RULE-MAKING COMMITTEE AND FACILITATOR.—The Secretary shall carry out the following:

“(A) APPOINTMENT OF COMMITTEE.—Not later than January 10, 2003, appoint the members of the negotiated rulemaking committee under this subsection.

“(B) FACILITATOR.—Not later than January 21, 2002, provide for the nomination of a facilitator under section 566(c) of title 5, United States Code, to carry out the activities described in subsection (d) of such section.

“(C) MEMBERSHIP.—Ensure that the membership of the negotiated rulemaking committee includes at least one individual representing—

“(i) health care consumers;

“(ii) small employers;

“(iii) large employers;

“(iv) physicians;

“(v) hospitals;

“(vi) other health care providers;

“(vii) health insurance issuers;

“(viii) State insurance regulators;

“(ix) health maintenance organizations;

“(x) third-party administrators;

“(xi) the medicare program under title XVIII of the Social Security Act;

“(xii) the medicaid program under title XIX of the Social Security Act;

“(xiii) the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code;

“(xiv) the Department of Defense;

“(xv) the Department of Veterans’ Affairs; and

“(xvi) the Agency for Healthcare Research and Quality.

“(6) FINAL COMMITTEE REPORT.—

“(A) IN GENERAL.—Not later than 1 year after the general effective date referred to in section 401, the committee shall submit to the Secretary a report containing a proposed rule.

“(B) PUBLICATION OF RULE.—If the Secretary receives a report under subparagraph (A), the Secretary shall provide for the publication in the Federal Register, by not later than the date that is 30 days after the date on which such report is received, of the proposed rule.

“(7) FAILURE TO REPORT.—If the committee fails to submit a report as provided for in paragraph (6)(A), the Secretary may promulgate a rule to establish the standards described in subsection (d)(3)(E)(iii)(IV) (relating to the definition of ‘medically necessary and appropriate’ or ‘experimental or investigational’) that group health plans and health insurance issuers offering health insurance coverage in connection with group health plans may use when making a determination with respect to a claim for benefits.

Mr. KYL. Madam President, this amendment is offered on behalf of myself and Senator NELSON. It is an amendment that deals with the definition of “medical necessity” under the bill and is intended to provide a safe harbor for those who comply with certain requirements. I should also say this amendment is also offered on behalf of Senator NICKLES. I apologize to my colleague from Oklahoma.

First, let me offer some general views on S. 1052, the Kennedy-McCain Patient Protection Act, and then I will discuss this amendment.

As you know, President Bush has reiterated his intention to veto this legislation because, in his view, it “would encourage costly and unnecessary litigation that would seriously jeopardize the ability of many Americans to afford health care coverage.” None of us wants that result. As a result, we are trying to do our best to work with the sponsors of the bill to make some changes that would make it palatable to both the President and to most of us in this Chamber.

My concerns include the fact that it will undoubtedly raise premium costs due to new lawsuits and increased regulation, that it will undermine the States’ traditional role of regulating the health insurance industry and make employers who voluntarily provide health care coverage to their employees vulnerable to frivolous lawsuits, and that it will violate the terms of the contract between the employer and the health plan. This latter issue is

the one the Nelson-Kyl-Nickles amendment is intended to address.

Under S. 1052, the external reviewer is “not bound by” the “medical necessity” definition contained in the plan document. And there is no substitute definition provided, so there is really no standard for review.

Let me put in context what this means. What we have provided for here is a method by which people will actually get the care they believe they have contracted for and deserve. The object is not to create a lawsuit to try to pay the money after the fact for some injury they suffered but, rather, to get the care for them upfront. That is what this should all be about.

So we have a review process by which first somebody within the company, and then an external reviewer, takes a look at the case and says: All right, this is what the contract means. This is what medical care would require under this circumstance as called for under the contract, and therefore the patient is entitled, or is not entitled, to this particular procedure.

That review process is supposed to occur quickly so that the patient receives the care he or she has contracted for and deserves under the circumstances.

In order for an external reviewer to know whether or not a particular procedure or treatment is called for, there has to be some standard by which to judge that. The Presiding Officer and the other lawyers in this body will know that anytime you ask some reviewer to determine whether or not something has to be done, you need to provide some standard upon which that reviewer can base a decision.

The bill right now contains no standard, and it needs such a standard. Our amendment supplies that standard. We believe it supplies a very fair and reasonable standard. The language in S. 1052 gives the external reviewer a free hand to disregard the definition of “medical necessity” contained in the contract and, as I say, supplies no substitute definition.

As in all of the bills, this external review requirement is the last process prior to going to court. But, as I said, the external reviewer is “not bound by” the contract’s key definition of “medical necessity” or “experimental and investigational.” As a result, the external reviewers can simply make up their own definition of “medical necessity.”

Private contracts negotiated between the parties—insurers and employees, or insurers and individual consumers—would become virtually meaningless in this circumstance, and the financial obligations of the health plan could become totally unpredictable.

The plan or insurer could become obligated to pay for items or services based on definitions outside the contract, even potentially including contractually excluded items that were deemed to be medically necessary by the reviewer. The “not bound by” pro-

vision, therefore, would have the effect of eliminating the ability of the parties to negotiate the key terms and conditions of health insurance contract agreements.

Madam President, in addition to vitiating legal contracts, the “not bound by” language would have the following negative effects.

First, inconsistent standards: The standards used by reviewers would vary with each review panel and with each case within the same plan. We are trying to create some degree of uniformity with this legislation, but under the bill you could have the potential for a wide variety of very arbitrary decisions because of the lack of a standard.

Second, quality of care: The mere threat of contract nullification could prompt some plans to pay for all claims regardless of the cost and the impact on the quality of patient care.

Solvency and stability: The use of unpredictable outside definitions of medical necessity will impose costs for unanticipated treatments not reflected in actuarial data used to determine the amount of the health care premium.

And finally, cost increases: Solvency concerns would result in increased cost for employers and increased premiums for employees.

The net result of that, of course, will be to remove more people from the rolls of the insured.

Under S. 1052 as written, these contracts, negotiated between the parties and often approved by State insurance regulators, will be voidable, not by a judge or a court of law but by an unrelated nonjudicial third-party reviewer. This will undermine the principles of the contract as well as due process.

So, as I said, to address this problem we have sponsored an amendment that would allow the plan to adopt a widely accepted safe harbor definition of medical necessity as its contract definition. If a plan utilized this safe harbor definition, then the external reviewer would be bound by it when hearing a patient’s appeal of denial of coverage.

Safe harbor definitions contained in the amendment are basically at three different levels. First, we take the definition from the Federal Employee Health Benefits Plan that currently covers about 73 percent, as best we can calculate it, of the employees under the Federal Employee Health Benefits Plan. Over 6 million Federal employees and Members of Congress are covered by this definition.

It is important to recognize—I think some of our friends on the other side misunderstood and thought we were offering an amendment that had been offered a couple years ago; I want to make it very clear—this definition is not the FEHBP or Office of Personnel Management definition for managed care plans, for HMO plans.

This definition is the definition for the fee-for-service plans. As a result, it is a more strict definition. The insurance companies are going to have to

provide a higher quality of care under this definition than they would under the HMOs that provide some coverage to roughly one-fourth of the people served under the FEHBP program.

So, first of all, we have this definition. I will actually read it in just a moment.

Secondly, there are going to be some States that already have a binding State statutory definition. There are 13 of them. Of course, a legally binding State definition of medical necessity would apply to claims filed in those States. That would constitute a safe harbor for the companies that use that definition. Obviously, it would be only prospective, not an after-the-claim adoption of the definition. So obviously that would have to apply.

Third, if there is a question about whether this first FEHBP definition works or that people like it, we have established a negotiated rulemaking process under the bill which would involve all of the stakeholders involved—the plans, the employers, providers, and consumers—and they could arrive at a definition that is different if they felt that it could be improved.

If the rulemaking failed to arrive at a definition, then, again, you either have a State definition or the FEHBP definition we provide. But if the rulemaking did achieve a definition that all agreed to, that then would supplant the FEHBP definition we have.

I will ask staff to give me the actual language now since I gave the copy of my legislation to the clerk. I would like to read the elements of this definition now. This is the definition, as I say, that already applies to, we know, about 49 percent of the employees, and we think it applies to another 23 or 24 percent as well.

First of all, the determination provides whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are, No. 1, appropriate to prevent, diagnose, or treat your condition, illness, or injury—obviously, very straightforward and, No. 2, probably the most important point, consistent with standards of good medical practice in the United States. That is the key. If the employee argues that something is being denied in the way of treatment or care and good standards of good medical practice in the United States would call for that treatment, then that treatment will have to be provided under this definition. So standards of good medical practice is the same standard essentially that would be used in a court case. It is the same standard that is used for most of the Federal employees. It is obviously a good standard to use.

There are three other aspects of it. I will read each of the three. They deal with very specific situations: Not primarily for the personal comfort or convenience of the patient, the family, or the provider; No. 4, not part of or associated with scholastic education or vocational training of the patient; and No. 5, in the case of inpatient care,

cannot be provided safely on an outpatient basis. That would enable the treatment to be provided on an outpatient basis if it could be done.

It is a very straightforward definition. It is one that has been used literally hundreds of times. It covers a significant portion of the 6 million people covered, and we think it is a good definition to be included in this legislation.

We think it represents a reasonable compromise on the one hand between requiring an external reviewer to be bound by a too narrow definition in a “rogue” plan contract and, on the other hand, affording a majority of the plans that operate in good faith the opportunity to adopt a widely accepted safe harbor definition of medical necessity to which the external reviewer would be bound.

Madam President, we think this is a good compromise. It is clearly important for us to include some kind of definition in the legislation. We had hoped that the sponsors of the legislation would be willing to work with us to include this definition. So far they have declined to do so. But I am hopeful that we can continue to talk with them, and perhaps we can reach some understanding that would enable us to substitute this definition for the lack of a definition in the legislation right now.

At this point, I yield time to the co-sponsor of the amendment, BEN NELSON, the Senator from Nebraska.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. NELSON of Nebraska. Madam President, I rise today to offer, along with my colleague and friend from Arizona, Senator JON KYL, an amendment to protect the sanctity of health insurance contracts, to provide certainty and clarity so that both the issuer and the insured can know what coverage they have.

This amendment will preserve a patient's right to receive the health benefits that they paid for while keeping insurance premiums affordable. In more colloquial terms, this amendment is what is needed to see that the people who pay for health care coverage get it. It may sound extraneous, and this is anything but exciting language, but I know from my experience as a State insurance commissioner in Nebraska two decades ago that this amendment is essential for the preservation of what I believe is an extraordinarily fundamental patient right.

Before I elaborate further on this point, let me state that I think a Patients' Bill of Rights is not only a good idea; it is an excellent idea. I believe Congress should be acting in the best interests of all Americans to enact such legislation.

We need a Patients' Bill of Rights to ensure that doctors make medical decisions. We need a Patients' Bill of Rights to protect patients and federally regulated health care plans that are currently unprotected and have

been unprotected for more than two decades. We need a Patients' Bill of Rights to guarantee patients' access to independent and external medical review and, only as a last resort, to guarantee them access to the courts.

There is no shortage of reasons why this legislation merits passage.

But before my support for a Patients' Bill of Rights is misconstrued as an “anything goes” approval, I want to be clear that while I believe the Senate should approve a Patients' Bill of Rights, I think that some improvements are justifiable. And right now, we have the opportunity to make those much-needed improvements which will ultimately increase the effectiveness of the Patients' Bill of Rights.

I believe the bill needs to carefully consider matters such as the issue addressed by this amendment pertaining to the sanctity of health insurance contracts. And I hope that the sponsors of the legislation will look very favorably on this matter and that we will be able to work out an arrangement or agreement to get it included as part of the bill.

First, this amendment would ensure that patients receive the care that they are entitled to under the plans to which they subscribe. External reviewers would be required to assess treatment options based on the contract that exists between the patient and the plan.

Patients would be entitled to the care outlined as a provided benefit within the contract that exists. External reviews would not be able to circumvent the contract to force employers to expand coverage for any particular patient unless the patient was entitled to the care as specified by the care contract.

This will help keep down the high cost of health care and, at the same time, will enable employers to continue to provide their employees with the best care possible.

More importantly, this amendment will provide three safe harbors for employers with respect to protecting them against unnecessary litigation over treatment. While patients will have the right to sue under this bill, this amendment will more clearly define the parameters by which treatments can be determined as “medically necessary” and thus will provide a safeguard of medically necessary standards for employers that administer their own health plans.

The McCain-Edwards-Kennedy bill contains something that I think would currently require external reviewers to abide by the standard for the determination of medical necessity included in the bill, but it doesn't bind the reviewers by the insurers' definitions for medical necessity. This is problematic as it relates to the existing contract between patient and provider and provides a great deal of unclarity and uncertainty.

So to remedy this situation, this amendment proposes to identify three

separate and distinct sources of definitions that employers could choose to use in the contract by which reviewers will be bound. The three options that we create for the plans are:

One, a definition that plans are required to use by State law. This would protect the previously existing and any newly created State laws that require plans to use a definition put forward by the State.

Second, any definition used by a plan which is codified by the language in the fee-for-service agreement that is currently covering maybe 50 to 75 percent of the Federal employees under the FEHBP, or the Federal Employees Health Benefit Program, would be used by the plans covering those who would be covered under these ERISA plans. What that means is, if it was good enough for Members of Congress and Federal employees, this certainly ought to be good enough for everyone else.

Three, a definition that is to be developed through negotiated rulemaking. This option requires the Secretary of Labor to develop a rulemaking committee that will seek public comment to develop a definition of “medical necessity.” In other words, State laws will be recognized and respected. Secondly, there will be a definition that is now included as a fee-for-service definition in the current Federal Employees Health Benefit Program. And in the event that a rulemaking process is negotiated through the Department of Labor, the rulemaking committee will seek public comment to develop a definition of what is “medical necessity.”

The negotiated rulemaking committee, the third item of this three-pronged approach, will consist of at least one individual representing each of the following groups: Health care consumers, small employers, large employers, physicians, hospitals, other health care providers, health insurance issuers, State insurance regulators, health maintenance organizations, third party administrators, the Medicare Program, the Medicaid Program, the Federal Employees Health Benefits Program, the Department of Defense, the Department of Veterans Affairs, and the Agency For Health Care Research and Quality. That is quite a list of individuals for public comment and public input.

This committee would have until 1 year after the general effective date of the bill's implementation to propose a rule to the Secretary. The Secretary, then, would be required to publish the rule within 30 days of the receipt.

Madam President, our goal is to ensure that all patients have access to all treatment options available under their plans. We need to provide this access without undermining the integrity of the contract between the patient and the provider. Without some standard for a definition on “medical necessity,” these objectives would be impossible to obtain. Both parties are entitled to certainty and predictability.

This will provide it. Without passage of this amendment, there will be both uncertainty and a lack of predictability and neither party will be benefited.

I ask my friends and colleagues to consider this amendment as one that will improve the McCain-Edwards-Kennedy HMO reform bill. I ask for their support.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Madam President, I reluctantly have to rise in order to oppose the amendments of my good friends on the issue of medical necessity. I outlined earlier in the day the basic judgment and basic history of how we reached the language that we have included in our bill.

First, let us look at what will be the standard that is in both the McCain-Edwards bill, as well as in the Frist-Breaux bill. Effectively, both treat this particular issue of medical necessity the same. This is a result of the fact that this issue had been debated 2½ years ago when we considered the Patients' Bill of Rights here and in the House of Representatives. We tried to define the test on medical necessity during that period of time. What we resolved is to permit, at the time of the external review, the kind of test that we have included in our language here and in the Frist-Breaux language. This was actually the language which was agreed to in the conference last year, a conference that never resulted in an overall outcome of the legislation. Nonetheless, we had agreed on a handful of different areas of dispute. That was agreed to by my colleagues, Phil Gramm, Don Nickles, myself, and others, after a good deal of negotiation.

It seems wise to continue that particular proposal because basically this is what we are doing. At the time of the appeal of any of these medical necessity issues, we are permitting for the standard of determination in our bill, on page 35: "The condition shall be based on the medical condition of the participant." That is obvious. No. 1, what is wrong with the patient? And then it talks about "valid, relevant, scientific evidence and clinical evidence, including peer-reviewed medical literature and findings, including expert opinion."

Basically, the reason for that is to allow for the possibility that we find out there are new kinds of discoveries, new kinds of techniques, new kinds of treatments for various health conditions. In order to not use a stagnant kind of proposal, we included that language. This language which was agreed to is supported by the American Medical Association and other medical groups.

So in the legislation that we have here in the McCain-Edwards proposal, which I support, and the Frist-Breaux proposal, which others including the President of the United States support, and in the agreement that was made by Republicans and Democrats alike, we agreed effectively to this language.

This agreement occurred after considering all the different kinds of proposals. It raises questions of why we are today attempting to alter that particular proposal.

The argument is, first of all, that we can offer three different options. One would be that the administration can propose an administrative group, a commission that can make some recommendations about what that standard would be.

That may work out, but it may not work out very well if we have an administration that is not as sympathetic to the protection of patients' and doctors' decisions as we have tried to be in this undertaking. That is one way of doing it.

Second, the results of State actions can be the criteria. In some States the protections have been very good, and other States have left a lot to be desired.

I understand the basic thrust of this legislation is to establish minimum standards. If States want to have higher protections for consumers, they are welcome to do it. What we are trying to do is ensure that all Americans, all American families are protected.

In the area of scope, all Americans being protected—actually, every Republican proposal that was considered in the House of Representatives included all Americans—we were attempting to ensure that there was going to be a minimum standard. However, we can use another standard, such as the good Federal employee standard to which the Senator just referred.

It is interesting, though, that the Office of Personnel Management does not use the Federal employee standard on their reviews. What do they do? They do something very similar to what we have done. They permit the doctor to make the ultimate decision and not be bound by some definition. The reason for this is because they do not believe that that should be the restrictive definition for all appeals.

In turn, there is a Federal employee program of which all of us are a part. In our program if there is going to be an appeal, this is a different standard. Basically, it is a standard that permits the doctors to make the judgments and decisions.

I find it difficult to be convinced at this hour. We waited a good deal of time. I know we were all pressed with the different proposals. I have had a chance to talk to my friend and colleague, Senator NELSON, on a number of different provisions. From personal experience, I can tell that this is a Senator who has spent a good deal of time on this legislation and has been willing to spend a great deal of time visiting with me and with others, and also talking extensively with the House Members who are interested in various provisions. I know a good deal of thought has gone into this matter.

My final point is the underlying commitment of this legislation to make

sure that doctors are going to make the decisions. Trained medical personnel and families are going to make these judgments and decisions. It seems to me that when we have included in the legislation's language—in fact, insisted on—permitting the doctor to use the best medical information and judgment of this decision making and will permit them to also take advantage of the latest ideas, new conclusions, new consensus of the treatment of various medical conditions, this is the best way rather than a review being bound up in some process.

We do not know tonight, for example, whether the board is going to be overly sensitive to the consumers and patients. There is a wide variety of interpretations in many of the States.

This is unlike other parts of this legislation where there is a difference between what we have proposed, what is included in Breaux-Frist, and what the President has recommended. In these areas, the McCain-Edwards proposal, the Breaux-Frist proposal, the conference committee by Republicans and Democrats alike, and the President have reached similar conclusions. This is one of the most important areas of the legislation. It seems to me what we have in the underlying legislation is completely consistent with what the President has indicated would be key to this legislation.

Mr. President, I yield 10 minutes to my colleague.

The PRESIDING OFFICER (Mr. DURBIN). The Senator from North Carolina.

Mr. EDWARDS. Mr. President, I start by thanking my two colleagues, the Senator from Arizona, my good, dear friend from Arizona, for his work on this issue, and now my friend from Nebraska, with whom I have had occasion on this specific bill to work many days and many hours. As the Senator from Massachusetts has suggested, he has great expertise in this area, both in his time as insurance commissioner and his time as Governor. He and I have worked together on a number of issues, such as employer liability which we will be offering an amendment on hopefully tomorrow. We have talked about a number of other issues, such as the scope of the legislation, and medical necessity is another issue in which the Senator has been actively involved.

I specifically thank him for his work on this issue on behalf of the people of Nebraska whom he represents. He has been extraordinarily diligent and involved in this very important issue of the Patients' Bill of Rights and patient protections. I thank him very much for all of his work and will continue to work with him. He has had terrific ideas all the way through the discussion.

As to this specific amendment, I announce to my colleagues that we have negotiated during the course of the day with other Senators besides the sponsors of this amendment and have reached an agreement on a compromise

that we believe accurately and adequately reflects a balance between recognizing the sanctity of the contract language while at the same time giving medical reviewers the flexibility they need to order care in those cases where the care needs to be ordered.

Tomorrow we anticipate an amendment being offered by Senators BAYH, CARPER, and perhaps others, that will reflect the results of those negotiations. We feel very pleased we were able to resolve that issue with some of our colleagues.

For that reason, we will not be able to support this particular amendment, but I believe our amendment goes a long way toward addressing the same issues that my colleagues are trying to address with this amendment. Their work is helpful and productive, and we appreciate it very much.

Tomorrow morning we will be offering the results of the work we have done with Senators BAYH, CARPER, and others which, as I indicated, properly reflects the balance between the importance of the language of the contract and showing deference to that language while at the same time recognizing that in some cases the medical reviewers will need some more flexibility to do what is necessary for a particular family or for a particular patient.

Mr. KENNEDY. Will the Senator yield?

Mr. EDWARDS. Yes.

Mr. KENNEDY. Will the Presiding Officer let us know when we have 5 minutes remaining?

The PRESIDING OFFICER. The Chair will do so.

Mr. KENNEDY. As I understand it, and I can be corrected, under one of the provisions, HHS establishes a board. At some time the board tries to work out the definition, but we do not know how that will work out, what the framework will be, or how many patients, consumers, and HMO personnel will be on the board. That board will have a meeting, and they will work out some definition of "medical necessity" which creates a degree of uncertainty.

Second, we have questions about the States, some of which have adopted various criteria about what is medical necessity.

Third, we have the Federal employees health program, which, as I mentioned, is not the standard which is used on review by the Office of Personnel Management. They don't use that. They use a standard much closer to what we have. Even on that standard, many cancer groups are very concerned about possible restrictions on palliative care, care which is enormously important to cancer patients. We have heard from a number of cancer organizations about their serious concern regarding this particular point. On the other hand, they are in support of the language we have included in the Edwards bill.

First, we know we have something that the American Medical Association, the medical professionals, pa-

tients, the doctors, and the health care delivery system have said is a good standard. Our opponents offer a standard that may turn out to be fine in the future but we don't know. And secondly, as another standard which has serious problems with the cancer community because it raises questions, doesn't the Senator agree with me, we ought to use what is now agreed to by Republicans, by Democrats? Most importantly, ought we not use the standard endorsed by those within the medical profession? If this standard does not work, we will have an opportunity to take a look down the road in terms of altering and changing. Is that a preferable way to proceed?

Mr. EDWARDS. I agree with the Senator.

As the Senator knows, the legislation offered by the Senator, myself, and Senator MCCAIN, this specific language is supported by the medical groups from around the country involved with this issue on a daily basis that have a first-hand understanding of what works and what doesn't work. We have been working with those groups to fashion this language. That is the reason that language exists. We know from the American Medical Association and all the health care groups around the country that they support the language we have in the bill.

That having been said, I say to the Senator, in order to try to address some of the concerns raised, my colleagues who are the sponsors of this amendment have been working with a group of Senators today to fashion an alteration to this language that makes it clearer that the contract language will be respected but balances that against the need for flexibility with the review panel. I believe we will have an amendment tomorrow to offer on that subject.

I end by thanking my colleagues from Arizona and Nebraska. While I will not be able to support their amendment, we understand the issue. We believe our bill is adequate on this issue, but we will have an alternative to propose tomorrow. Ultimately the point of this, of course, is to protect patients, make sure patients get the care they need. I think the language in our bill plus the language in the amendment will accomplish that purpose.

I yield the floor.

Mr. NICKLES. Mr. President, I rise in support of the amendment and I urge my colleagues to support it. I will make a couple of comments about some of the statements that were made.

I appreciate Senator EDWARDS' comments saying we are willing to have an amendment tomorrow to try to fix part of the problem. We heard that earlier today when we had an amendment to exempt employers.

There were statements made by many proponents of the language, employers can't be sued under this bill. That is a direct quote. So earlier today

we tried to make sure employers couldn't be sued, and people voted against the amendment. But we heard: Well, there is an amendment coming that will protect employers.

We understand this bill language, and there is a section that deals with employers that says employers shall be excluded from liability, and then there is an exception. As a matter of fact, on page 144, causes of action against employers and plan sponsors are precluded, paragraph (A).

Paragraph (B) says:

CERTAIN CAUSES OF ACTION PERMITTED.—Notwithstanding subparagraph (A), a cause of action may arise against an employer or other plan sponsor. . . .

We tried to make sure employers would be exempted, and unfortunately that amendment didn't pass. But we did hear assurances from some of the sponsors, we have an amendment and we will protect employers. But, yes, employers can be sued because obviously the Gramm amendment didn't pass. So I just mention that.

We raised the point, and it was raised well by Senator KYL from Arizona and Senator NELSON of Nebraska, that said we are not bound by contracts, and there is all kinds of language here dealing with contracts. You don't have to have coverage for excluded benefits. That sounds very good, but there is language "except for," language that says you have to cover benefits that are excluded from a contract. Then I heard my colleague from North Carolina say we will have an amendment tomorrow to take care of that.

There are several major provisions with this bill that are wrong, one of which is the liability is far too generous and one which says the contracts don't mean anything. So we are wrestling with the liability.

We tried to exempt employers today and were not successful. Now we are working on contract sanctity. I hope all Democrats and Republicans will look at the language that is in the bill and realize how far it goes and think about what is getting ready to happen. I use for an example President Clinton's appointment of a bipartisan commission to make recommendations on this issue. They said in the report:

The right to external appeals does not apply to denials, reductions, or terminations of coverage or denials of payment for services that are specifically excluded from the consumer's coverage as established by contract.

In other words, the report to the President by the Advisory Commission on Consumer Protection and Equality in Health Care says if it is excluded in the contract, you don't have the right to even have an appeal. That is not appealable. In other words, if the contract says don't cover it, it shouldn't be covered.

Yet in the language in the bill, did we adhere to the President's commission? No. If you look at the language on page 35 of the bill:

No COVERAGE FOR EXCLUDED BENEFITS.—Nothing in this subsection shall be construed

to permit an independent medical reviewer to require that a group health plan, or health insurance issuer offering health insurance coverage, provide coverage for items or services for which benefits are specifically excluded or expressly limited under the plan or coverage in the plain language of the plan document—

If it stopped there, it would be great, but it doesn't stop there, if you read the additional language:

and which are disclosed under section 121(b)(1)(C) except to the extent that the application or interpretation of the exclusion or limitation involves a determination described in paragraph (2).

In other words, you don't have to pay for an excluded benefit "except for."

Wait a minute, you have a contract, and a medical provider says, I will provide this list of contracts and I will charge so much per month to provide these contracts, and this bill says we are not going to overturn that exclusion. That is what the first part of the paragraph says. And the second part of the paragraph says "except for," and you have to ask, well, what do you mean "except for"? Start reading: except for medically reviewable decisions, and it turns out anything is a medically reviewable decision.

So anyone can say it is medically reviewable if the denial is based on medical necessity and, appropriately, denial based on experimental or otherwise based on evaluation of medical facts. The net result is, bingo, anything is covered. You have a lottery.

I heard my colleague from Massachusetts—and I have great respect for him—say we had an agreement last year and basically Senator NICKLES in the conference committee agreed to this language.

We did not. I will make a few comments to get specific on the language. We came close in a lot of areas. But I will refresh my colleagues on things we did agree to that do not appear in the bill today.

I have a document, agreed-to elements of the external appeals section, dated April 13, 2000, 6 o'clock. We agreed to many items which were not in the underlying bill. I don't think you can say we agreed to one provision—whoops, we forgot to say we agreed on a lot of other things.

We agreed that a patient should have access to independent reviews for any denial of claim of benefits, No. 1, if the amount of such item or service exceeds a significant financial threshold or, No. 2, if there is a significant risk of placing the life, health, or development of the patient in jeopardy.

I see in the bill we have before us there is no such thing as a financial threshold. This clearly violates the so-called agreement that was entered into last year.

Further, the language regarding the "denial creates a significant risk of placing the life health or development of the patient in jeopardy" is not in the bill before us. It is not in the McCain-Kennedy-Edwards bill.

It is interesting; that language was in the original Senate bill, S. 6. It was

also in President Clinton's report on quality. But it is not in the bill that we have before us. It is not in the McCain-Kennedy-Edwards bill. My point is, before we had included some language to try to make sure we would have some protections and that was disregarded.

In addition, last year we agreed to a \$50 filing fee to discourage frivolous filings. I see this particular agreement was also absent from today's version. The bill before us has a \$25 filing fee. One of the reasons why we had a \$50 filing fee was because we did not want frivolous filings. We didn't want people to say:

I will appeal. Maybe I will get lucky; maybe I will have extra benefits, more coverage; maybe I can lay a predicate for lawsuits in the future. What do I have to lose? If you had a little more of a threshold, it may discourage frivolous suits.

We also agreed at one time to consider expert opinion if it was by informed, valid, and relevant scientific and clinical evidence. The language we have before us on page 35 talks about the standard for determination. It says we are going to review:

... valid relevant scientific evidence and clinical evidence, including peer-reviewed medical literature and findings including expert opinion.

But it did not include everything we had agreed to in the past.

What I do recall is last year we did agree that both sides maintained there was a goal to maintain the sanctity of the contract and not establish appeals which allowed for the coverage of any excluded benefit. In fact, the very basis for today's debate is ensuring that patients are not denied promised benefits. It is not a debate to create a process to resolve and order unpromised benefits.

I think the language we have before us in the McCain-Kennedy-Edwards bill does just that. It is the legislative process that we would make where people could get unpromised benefits, to get items that in some cases are contractually prohibited to be covered benefits.

That is a stretch. Federal employees do not have that; Medicare does not have that; Medicaid doesn't have it. There is a list of covered benefits and there is also a list of excluded benefits.

I will give an example and I will put this in the RECORD. This is from CHAMPVA. It has a list of about 25 items that are excluded, specifically, from VA coverage. I will mention a couple of them: acupuncture, air conditioners, humidifiers, exercise equipment, eyeglasses, and contact lenses.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. NICKLES. I ask unanimous consent to proceed for another 6 minutes.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered. The Senator may proceed.

Mr. NICKLES. Health club memberships, hearings aids or hearing aid exams, homemaker services, hypnosis, massage therapy, physical therapy con-

sisting of general exercise programs, plastic and other surgical procedures primarily for cosmetic purposes, smoking cessation programs, and several others.

My point is, here is a Government plan for veterans that has specifically excluded items that should not be covered. I will venture to say every private health care plan has excluded items as well. Under the bill we have before us, it says you don't have to cover excluded items except for—and then it opens the door. That, to me, says do not pay any attention to the contract. Contracts do not mean anything.

What is the net result of that? If people who have contracts are not bound by the contracts, then the cost of providing health care is going to go way up. There is no real definitive way of knowing how much the coverage is going to cost because it is not defined coverage. There is nothing you can bank on.

I compliment my friends and colleagues from Arizona and Nebraska for their leadership in putting this amendment together. This amendment is equally as important—maybe not quite as easy to understand but very much as important—for containing the cost of health care as anything we have considered so far. Are we going to allow people to have contracts? Are we going to live by those contracts? Or are we going to take the language in this bill and say: Contracts? We don't care. Are we going to violate what the President's Commission on Health Care said? They said you should not cover items that are excluded from contracts. Are we just going to ignore it as does the underlying McCain-Kennedy-Edwards bill? Are we going to have a medical necessity definition that is the same thing Federal employees have on their fee-for-service plans, which is a quality plan which most all of us are in and most all of us are happy with? Isn't that good enough? Can't we give some assurances that those are things that people can rely on?

Again, I compliment my colleague from Nebraska, Senator NELSON, for his expertise. He brought this to my attention when I was discussing this legislation. He was exactly right. He said this has to be fixed. We are working to fix it. We can fix it.

I urge my colleagues, let's not just be voting on remote control, on how some leaders tell us how to vote. Let's look at the language. Do you really want to have language that basically abrogates contracts, ignores contracts, not telling how much it can cost and also, incidentally, have liability?

You could have, under the McCain-Kennedy bill, a situation where somebody doesn't provide a service that is contractually prohibited and they can be sued because some expert might determine it is medically necessary. This expert might be a acupuncture specialist and they might determine that what you need to solve your back problem is acupuncture and even though

your contract, as VA's, says you do not have to cover it, you have to cover it because that is a solution and under the bill it says expert opinion. So maybe it should be covered.

If you think that is a stretch, it is not a stretch. You can find experts to say almost anything in the medical field and sometimes in the legal field.

My point is this bill undermines contracts in a way in which I think we should be very, very wary. We should not do this. My colleagues from Nebraska and Arizona have come up with a good fix, a good solution. I appreciate that the Senator from North Carolina said he is amenable to fixing this problem. The way to fix it is to pass the Kyl-Nelson amendment. I urge my colleagues to vote for this amendment tomorrow morning.

I thank the indulgence of my colleagues I yield the floor, and ask unanimous consent the CHAMPVA list be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

OTHER MEDICAL SERVICES . . . WHAT IS NOT COVERED

(Not all-inclusive—see Specific Exclusions)

Acupuncture.

Acupressure.

Air conditioners, humidifiers, dehumidifiers, and purifiers.

Autopsy.

Aversion therapy.

Biofeedback equipment.

Biofeedback treatment of ordinary muscle tension or psychological conditions.

Chiropractic service.

Exercise equipment.

Eyeglasses, contact lenses, and eye refraction exams—except under very limited circumstances, such as corneal lens removal.

Foot care services of a routine nature, such as removal of corns, calluses, trimming of toenails, unless the patient is diagnosed with a systemic medical disease.

Health club memberships.

Hearing aids or hearing aid exams.

Homemaker services.

Hypnosis.

Medications that do not require a prescription (except for insulin and other diabetic supplies which are covered).

Massage therapy.

Naturopathic services.

Orthotic shoe devices, such as heel lifts, arch supports, shoe inserts, etc., unless associated with diabetes.

Physical therapy consisting of general exercise programs or gait analysis.

Plastic and other surgical procedures primarily for cosmetic purposes.

Radial Keratotomy.

Sexual dysfunction/inadequacy treatment related to a non-organic cause.

Smoking cessation programs.

Transportation services other than what is described for ambulance service under What Is Covered in this section.

Weight control or weight reduction programs, except for certain surgical procedures (contact HAC).

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, how much time remains?

The PRESIDING OFFICER. The Senator from Massachusetts has 12½ minutes remaining.

Mr. KENNEDY. I yield myself 4 minutes.

Mr. President, we have had a good discussion coming back, once again, to what I think is one of the fundamental aspects of this bill. We have gone through this. I have taken the time to go through this evening what the criteria were going to be for the medical officer at the time of the external appeal. Those criteria have been supported today by the overwhelming majority of the medical profession because they understand that, with those criteria, we are going to get a medical decision that will be in the best interests of the patient. That is really not challenged.

What is being suggested are three different options that might be used. The one we offer has the support of the medical community. It has the overwhelming support of the medical community. That is the first point.

With all respect to my friend and colleague from Oklahoma, regarding the provisions, when it comes down to what is and is not going to be permitted, clearly if there is an exclusion in the contract there will not be the right of the medical officer to alter and change that. Let me give an example on the issue of medical necessity under the criteria that we have, where it might very well be interpreted by a medical officer. Say a particular HMO excluded cosmetic surgery.

The question came down to a child that had a cleft palate, and the medical officer said: Well, they are excluding cosmetic surgery, but a cleft palate for a child is a medical necessity. That medical officer, I believe, ought to be able to make that judgment. Under the language that we have, that medical officer would be able to do it.

If, on the other hand, the HMO had put in the contract that they will not permit a medical procedure for a cleft palate, then clearly that would be outside of the medical judgment, and outside of medical necessity.

That is the example that is really reflected in the language which we have included. But the fact is those are exceptional cases. They are not unimportant. But the most important aspect of the case is that the judgment that is going to be made by the medical officer is going to be based on the medical needs of the particular patient and the best medical information that is available.

That is what has had the broad support. There may very well be a new commission established under HHS made up of a number of different stakeholders which may come up with some recommendation that may be a better one. That might be so. If that is the case down the road, maybe we can have the opportunity to consider it and bring some change to it. But as we have heard earlier, and as we have seen, the Federal employees standard that is used is not permitted to be used in terms of appeals procedure. The reason, evidently, is because they believe

the medical officer ought to be able to use the criteria which brings into play the latest information and the latest scientific information that is available, and the best information that would be helpful to that medical profession.

Finally, there is the question, What are we going to do? Are we really going to ultimately let their judgment and decision be made by the medical professional with enough flexibility so that they can bring to bear medical judgments on this, and also consider the best information that is available to them and apply that best medical information available to benefit the patient?

I think we have a good process and a good way of proceeding. That is why I believe that we ought to stay the course with what is included in the legislation and resist the amendment.

Mr. President, I know we have another amendment that we are going to debate this evening. If there are others who want to speak on this, we welcome them.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, if this side has run out of time, I ask unanimous consent to speak for what time I might consume. But I don't expect it will be over 10 or 12 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. KENNEDY. I don't intend to object. Is this in favor of the amendment?

Mr. GRASSLEY. Yes. I am sorry I didn't say that. I am in favor of the amendment.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I want to address what I believe is a very fundamental, fatal flaw in the legislation before us. That flaw relates to how the bill treats health plan contracts, and the precedents that this treatment sets for all contracts, not just those between health plans and employers.

As currently drafted, the bill states that specific definitions and terms in health plan contracts can be entirely thrown out in favor of another definition made up by a third party charged with reviewing a plan's decision to deny care.

This basically invalidates all contracts between health plans and employers and makes them non-binding.

Putting the terms of health plan contracts on the chopping block undercuts the very purpose of the health plan contract itself.

If these contracts are not binding, the health plan will have no way of knowing what standard it should follow in making coverage decisions, the employer will have no way of knowing what its costs will be, and the patient will have no way of knowing what kinds of items and services are covered.

In short, the contract won't be worth the paper it's printed on.

How do you do business without a contract? Quite frankly it's almost impossible to imagine doing business at all without a binding agreement.

The Kennedy-McCain bill forces managed care plans to do business in a way that no other industry is forced to do—by that I mean without a binding and valid contract.

Now, let me stop here for a minute and talk about these health plan contracts.

First, contracts between health plans and employers are actually negotiated with all parties involved.

Employers, usually with the help of unions and other worker representatives, bargain for specified coverage in order to meet the unique needs of different employees. Every contract is different.

What's more, these contracts are typically reviewed and approved by state insurance regulators before they become effective. The whole process is deliberative, time consuming and, all told, is truly a "meeting of the minds."

The Kennedy-McCain bill says, in effect, to heck with that meeting of the minds. The bill gives unrelated third parties reviewing patient complaints unprecedented authority to take out contract terms that were bargained for in good faith and literally throw them in the trash.

This authority to override contracts at any time and for any reason goes far beyond the authority given even to judges, who in all but the rarest instances are obliged to apply the terms of a contract.

And where judges must explain their rationale in opinions and are generally accountable as public officials, these third party reviewers as outlined in the Kennedy-McCain legislation are private citizens and are not accountable to anyone at all.

I do believe that every patient should have a right to an independent, external review of a health plan's decision to deny care. But that right cannot be without some rationality and accountability.

Third parties charged with reviewing patient complaints should have broad discretion to thoroughly assess, and even overturn, a plan's decision so long as that authority is exercised within the four corners of the contract.

Kennedy-McCain authorizes third parties to veer far, far away from those four corners, and to tear up the contract altogether.

I encourage my colleagues to think about what it would be like if the contracts that they live by everyday contracts for life insurance, home mortgages, even car leases could be torn up and rewritten by an unaccountable third party at any time.

Moreover, I encourage my colleagues who know small business owners or who were themselves small business owners, to think about doing business without the security of a binding contract.

I believe that those of my colleagues who do think about this will come to understand that the consequences of allowing contract terms to be thrown out could be disastrous, and that all

contracts, whether involving a health plan or not, deserve the deference that our laws traditionally give them.

I urge my colleagues to reject the Kennedy-McCain approach to health plan contracts and to support the Kyl-Nelson amendment—which is an approach that honors both the integrity of the contract itself, as well as the intent of the parties to it. In the end, it is the patient who wins under this amendment.

Thank you.

The PRESIDING OFFICER. Under the previous order, the Senator from Colorado is to be recognized to offer an amendment.

AMENDMENT NO. 817

Mr. ALLARD. Mr. President, I call up amendment No. 817.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Colorado [Mr. ALLARD], for himself, Mr. BOND, Mr. SANTORUM, and Mr. NICKLES, proposes an amendment numbered 817.

Mr. ALLARD. Mr. President, I ask unanimous consent reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To exempt small employers from causes of action under the Act)

On page 148, between lines 23 and 24, insert the following:

"(D) EXCLUSION OF SMALL EMPLOYERS.—

"(i) IN GENERAL.—Notwithstanding any other provision of this paragraph, in addition to excluding certain physicians, other health care professionals, and certain hospitals from liability under paragraph (1), paragraph (1)(A) does not create any liability on the part of a small employer (or on the part of an employee of such an employer acting within the scope of employment).

"(ii) DEFINITION.—In clause (i), the term 'small employer' means an employer—

"(I) that, during the calendar year preceding the calendar year for which a determination under this subparagraph is being made, employed an average of at least 2 but not more than 50 employees on business days; and

"(II) maintaining the plan involved that is acting, serving, or functioning as a fiduciary, trustee or plan administrator, including—

"(aa) a small employer described in section 3(16)(B)(i) with respect to a plan maintained by a single employer; and

"(bb) one or more small employers or employee organizations described in section 3(16)(B)(iii) in the case of a multi-employer plan.

"(iii) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subparagraph:

"(I) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

"(II) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(III) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

a reference to any predecessor of such employer.

On page 165, between lines 14 and 15, insert the following:

"(D) EXCLUSION OF SMALL EMPLOYERS.—

"(i) IN GENERAL.—Notwithstanding any other provision of this paragraph, in addition to excluding certain physicians, other health care professionals, and certain hospitals from liability under paragraph (1), paragraph (1)(A) does not create any liability on the part of a small employer (or on the part of an employee of such an employer acting within the scope of employment).

"(ii) DEFINITION.—In clause (i), the term 'small employer' means an employer—

"(I) that, during the calendar year preceding the calendar year for which a determination under this subparagraph is being made, employed an average of at least 2 but not more than 50 employees on business days; and

"(II) maintaining the plan involved that is acting, serving, or functioning as a fiduciary, trustee or plan administrator, including—

"(aa) a small employer described in section 3(16)(B)(i) with respect to a plan maintained by a single employer; and

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"(III) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

Mr. ALLARD. Mr. President, I am offering an amendment to S. 1052 that would prevent frivolous, unnecessary, and unwarranted lawsuits against small employers. That is what my amendment is all about. It exempts small employers that have 50 or fewer employees in their firm. I think this is an important provision. I plan on sharing with my colleagues in this Senate Chamber some of my experiences as a small businessman.

I have had the experience of having to start my business from scratch. I worked with fewer than 50 employees. Believe me, from personal experience, I know what happens when you are a small employer and you have too many mandates on your business and you do not have all the staff and accountants and lawyers in your firm to help you along, and you have to go to an attorney or accountant outside your business. I know the impact it can have as far as cost is concerned.

Believe you me, I know what it feels like to have taxes increased on you as a small businessman because you are in the dollar game; every dollar makes a difference on what your bottom line is going to be.

Contrary to what many Members of the Senate are trying to argue, S. 1052 does not exempt small employers from lawsuits. Under S. 1052, employees could sue their employers when an employer—and I quote—“fails to exercise ordinary care in making a decision.” That is from page 140 of the bill.

Mr. President, 72 percent of small employers in the United States provide health care that Americans need. They do not have to provide that coverage, but they choose to on their own. The Senate should honor that. The Senate should respect that. S. 1052, however, undermines that.

Allowing small employers to be liable for health care decisions would unduly burden a small employer. It would force them to drop health insurance coverage for millions of America’s small business employees. At the very least, it adds a new burden to the businessperson who already spends too much time dealing with Government mandates and paperwork.

Without our amendment, S. 1052 places medical treatment decisions in the hands of lawyers and judges and will trigger a plethora of lawsuits against small employers, in my view, creating a field day for trial lawyers. The Senate should not support legislation that allows unwarranted lawsuits that hurt small employers.

This year, employers are trying to cope with a 12-percent increase in health care costs that employers experienced last year. Now, as we move forward into another year, they are looking at somewhere around a 13-percent increase.

I have a recent survey that was jointly put together with the consulting firm Deloitte & Touche and the industry of business and health that reveals that health premiums increased more than 12 percent last year and are expected to increase 13 percent in both 2001 and 2002. So this is a burden with which small employers are faced.

With the passage of this bill, the Congressional Budget Office has estimated it would increase premiums another 4 percent. That would have a very adverse impact on small employers. We have heard it is likely we will have an additional 1 million who are uninsured with the passage of this Patients’ Bill of Rights. I suggest to the Members of the Senate, a large part of that million is going to come from the very small employers, those with 50 employees or fewer.

S. 1052, as it is currently written, would cause further increases in health care costs for American families, workers, and businesses across the board. The Congressional Budget Office has estimated that the previous version of S. 1052, which is substantially identical to the current bill under consideration, would increase the Nation’s health care costs, as I mentioned earlier, by more than 4 percent. This is above and beyond the additional 13-percent increase in health care costs employers will face this year. Moreover, this year’s in-

crease would be the seventh annual increase in a row.

If S. 1052 passes, many small employers will stop providing health care for their employees and the number of uninsured Americans will increase. The country cannot afford this. The small businesses of America cannot afford this. The country cannot afford S. 1052 in its current form.

I personally know the costs of providing health care to employees. As I mentioned earlier, for 20 years I practiced veterinarian medicine and provided health care insurance to my employees. I can speak from personal experience: Providing health care was costly. If I were still practicing veterinarian medicine as a private employer, I could not begin to imagine the burden S. 1052 would place on me, my employees, and everybody’s families involved in that business.

I believe we should pass a Patients’ Bill of Rights, not a lawyers’ right to sue. Our bill should focus on expanding access to affordable health care for the Nation’s 43 million uninsured, not on taking steps that will cause more Americans to lose their health insurance and further burden small business.

I also bring up the point that in this particular piece of legislation there are four exemptions. There is an exemption for physicians, an exemption for hospitals, an exemption for a record-keeping function in health care, as well as an exemption for some insurance providers.

The point I make is that if you are beginning to provide an exception for certain businesses, then why not provide that exception for those people who are going to be most adversely impacted by this particular piece of legislation? Those 1 million or so that will be uninsured are going to come out of that small business sector because small employers will have to make the tough decision as to whether they can afford it or not, and many of them are going to say: We can’t afford it, so we are going to have to make some adjustments.

One of the major adjustments because of the threat of a lawsuit—and I point out to the Presiding Officer that not only is it the lawsuit itself when you happen to get a judgment against you that is such a problem; it is the threat of a lawsuit because your margin of profit is so narrow that you cannot afford to pay for the professional help, the attorneys to defend you. So small employers will make the decision not to provide health care insurance.

My amendment to S. 1052 would exclude small business employers from being the victims of frivolous lawsuits. I urge my colleagues to consider the consequences of the small employer liability provisions in S. 1052 and to support this amendment.

I think at a time when our economy in this country is struggling, and at a time when I think everybody in this Chamber understands how important it

is to have a vital small employer sector—it is the small employers that have come up with new ideas; it is the small employers that are the backbone of economic growth in many of our small communities, particularly in rural areas; it is the small employers that so many of us look to, to be the leaders in our communities—I hope there remains a sensitivity to what the small employer contributes in the way of competition, in the way of developing new ideas, and in the way of making sure we have stronger family-oriented communities. It is a pool of leadership that not only strengthens our communities and our States and our Nation, but it is something around which our whole economy evolves because the importance of competition, and using the dollar and the marketplace to allow the consumer to predict the best services is an important concept in this country.

I don’t want to see us lose that by moving constantly towards larger businesses and a corporate-type of society. There is no doubt that small business is important to this country. I hope Members of the Senate will join me in making sure the small employer, those with 50 employees or less, is exempted from the liability provisions in S. 1052. I ask for their support of this amendment.

THE PRESIDING OFFICER. Who yields time? The Senator from Massachusetts.

MR. KENNEDY. Mr. President, I thank the good Senator for his amendment and his thoughtful explanation of it. I will oppose the amendment. I will state briefly why this evening.

Basically, we have a number of definitions of small business. We are taking now the definition of 50 employees or less. That is about 40 percent of the workforce. It might be as high as 43 percent. So with this amendment, effectively we are undermining 40 to 43 percent coverage for all those employees across the country. If we believe in the protections of this legislation, that is a major exclusion.

What are those protections? Those protections are very simple. They are very basic and fundamental. For example, doctors ought to be making the decisions on medical care and not the HMOs. The employees who work in these businesses and where the HMOs are selling these policies are being hurt just as those who are above the 50. Excluding them from these kinds of protections is unacceptable.

Their children are going to be hurt. Their children should be able to get the kind of specialty care that others can. The wives of those who work in those plants and factories ought to be able to get into clinical trials if they have breast cancer. They ought to be able to have an OB/GYN professional as a primary care physician, if that needs to be so. They ought to get the prescription drugs they need, if a drug is not on the formulary. They ought to be able to get the continuity of care they need.

This care protects expectant mothers from losing a doctor during the time of their pregnancy, if the employer drops the coverage with an HMO. These are very important kinds of protections we are discussing.

If we accept the Senator's amendment, we are effectively excluding 40 percent of the population.

The Senator makes a very good point about cost, particularly for small business. I am always amazed in my State of Massachusetts. You go down to 15, 20 employees and still the small businessmen are providing health care coverage. What is happening, they are paying anywhere from 30 to 40 percent more in premiums every single year. This occurs because they are not able to get together with other kinds of groups and get the reductions that come from the ability to contract with large numbers of employers. They are getting shortchanged in those circumstances. Many of the firms they work with are in the business one year and out of the business a second year.

The point the Senator makes about the particular challenge for small employers to offset health coverage for their employees is very real. We ought to help them. There have been a number of different proposals which I have supported and others have supported in terms of deductibility and helping those companies. That is an important way of trying to get about it. But the suggestion that is underlying the Senator's presentation is that the cost of this particular proposal is what is really going to be the straw that breaks the camel's back.

He talks about a 4-percent increase in premiums. That is a percent a year, as we have learned. The alternative percent is around 3 percent. It is 3 percent over the period of 5 years. The CBO points out that the cost of the various appeals provisions and the liability provisions are eight-tenths of 1 percent over the 5 years. And in the alternative bill, it is four-tenths of 1 percent.

I mentioned earlier in the day that the largest CEO salary of an HMO was \$54 million a year, and \$350 million in stock options. This constitutes a benefits package of \$400 million. That adds \$4.25 to every premium holder, small business premium holder, \$4.25 a month. Our proposal adds \$1.19 a month. That is just one individual. I am sure, in this case, he does a magnificent job. But when you are talking about the cost of this, we have also brought in the fact that the average income for the 10 highest salaried HMO CEOs is \$10 million a year. Their stock options are in the tens of millions of dollars a year. The profits are 3.5 percent a year, \$3.5 billion last year in profits. And still they ratcheted up their premiums 12 percent to maintain their profit margin. They made \$3.5 billion.

Yet they cannot make sure that we are going to be able to provide protections for their employees. They cannot

make sure that they are not going to overrule doctors in local hospitals and community hospitals, in the urban hospitals, and in rural hospitals trying to give the best medical attention to the children and the women and their workers? We can't say that we want to provide that degree of protection for them?

I just can't accept that. I would welcome the opportunity to work with the Senator in the area of small business. But that isn't what we are about this evening. The Senator's amendment, as I said, would effectively exclude 40 percent, 43 percent of all the employees. It makes the tacit assertion—more than tacit, explicit assertion—that the increased premiums that are going to be included in this bill are just going to be unbearable. I suggest there are ways of getting cost savings on this.

We have 50 million Americans now that have the kinds of protections that we are talking about. They have the liability protections. We don't see their premiums going up. We see the right to sue in the States of Texas and California, and the premiums aren't going up. There is very little distinction between the 50 million Americans now who have the liability provisions and those who do not.

We are talking about a major assurance to families all over the country. When this bill passes and families go in and pay their premiums for health insurance, they will know they are getting coverage for the kinds of sickness, illness, and serious disease. Without this legislation, they may think they are covered. Then, at a time of great tension and pressure—they may have cancer for example—they are told by their primary care doctor that even though there is a specialist, an oncologist down the street who is the best in the country and is willing to treat that child, they are told they cannot have that specialty care.

They are also told that they can't appeal that once the HMO makes that decision. They are being denied that, when we know what a difference it can make in terms of saving that child's life and in terms of that child's future.

We want to make sure every parent knows that when they sign onto an HMO, they are going to be able to get the best care that is available for their child, for their wife, for their mother, for their son, for their grandparent, and not have these medical decisions overridden by the HMO.

So it seems to me that those protections ought to be there for the 40 percent of the workers, as well as to the other 60 percent. We ought to get to the business of paying attention to, helping, and assisting the smaller businesses. One of the best ways is for these major HMOs to stop spending the millions and millions of dollars they are spending every single night, right now, in distorting and misrepresenting the truth. Evidently, they are flooded with money because they are spending so much of it in order to defeat this legislation.

This isn't an industry that is hard pressed. They are ready to open up all of their wallets and pocketbooks to distort and fight this legislation. And, they have the resources to be able to do it. They are not short on those resources. We do not see cutbacks on executive pay. We do not see cutbacks on stock options and the other hefty perks of being an HMO CEO. The idea that this particular legislation is going to be the straw that breaks the camel's back doesn't hold up. It is a smoke-screen. It is not an accurate representation!

I think that those 40 percent of American workers are entitled to coverage and protection.

(Mr. CORZINE assumed the Chair.)

Mr. DURBIN. Will the Senator yield for a question?

Mr. KENNEDY. Yes.

Mr. DURBIN. I listened to the Senator from Colorado present his amendment on behalf of small businesses and employers. I recall, before my election to Congress, running a law office and buying health insurance for myself and my employees. I recall the experience when I went to one of the larger health insurance companies to cover my employees. So the belief that small businesses only do business with small insurance companies I am not sure is an accurate description. I think that small businesses often do business with large insurance companies.

If I understand the Senator from Massachusetts and the amendment of the Senator from Colorado, if one employer has 49 employees here and is doing business with a large insurance company, that large insurance company doesn't have to offer the same protections to the small business' employees that it might offer to the business next door with 60 employees. So the people who are losing are not the small business owners but the small business employees who don't get the benefit of the same protections that we are trying to guarantee to all Americans. Is that how the Senator from Massachusetts sees it?

Mr. KENNEDY. The Senator is quite correct on this. That, of course, raises competitive situations. You are going to have competition on the dumbing down of protections for employees, rather than establishing a standard in competition in terms of the quality of the product. It is a race to the bottom, so to speak.

Mr. DURBIN. So this will, in fact, limit the protections for employees of small businesses across America so that if you go to work for a small business, you just won't have the right to specialty care, to the drugs your doctor thinks are necessary to cure your disease, the right to a specialist in a critical circumstance, access to emergency rooms—all the things we are trying to guarantee in this bill. What the Senator from Colorado does say we are not going to provide those protections if you are one of the 40 percent who works for a small business in America. Is that what the Senator understands?

Mr. KENNEDY. The Senator is correct. I will make the case tomorrow, but it is my judgment that you will find that there are greater abuses in the areas of these smaller companies, smaller HMOs, appealing to smaller companies, rather than some of the larger HMOs which are tried and tested and have the reputation within a community to try and defend. We have had many that do a credible job, but you are going to find, I believe—and I will get to this more tomorrow morning—that the workers who are the most vulnerable are going to be workers in these plants.

Mr. DURBIN. May I ask another question of the Senator from Massachusetts?

Mr. KENNEDY. Yes.

Mr. DURBIN. While I listened to the Senator from Colorado explain the increase in premiums, he suggested premiums had gone up 12 percent last year, and they anticipated they would come up 13 percent nationwide this year and the following year, which suggests that in a 3-year period of time, the Senator from Colorado tells us, we are going to see a 38-percent increase in health insurance premiums.

Going back to a point earlier, how much will the Kennedy-Edwards-McCain bill increase premiums each year over the next 5 years if we are going to have 38 percent in 3 years, just the natural increase in health insurance; how much will this legislation we are debating add to that cost?

Mr. KENNEDY. Well, according to the Congressional Budget Office and OMB it will be less than 1 percent a year over the next 5 years—much less, closer to 4 percent. So, effectively, it is 4 percent.

As we pointed out earlier in the debate, under the alternative proposal that the President supports, it is effectively 3 percent over 5 years. As the Senator is pointing out, it is somewhat less than 1 percent a year against what the Senator from Colorado mentioned—12 percent last year and 13 percent this year. That is what is happening already, without these kinds of protections.

Mr. DURBIN. I think that really addresses the issues raised by the Senator from Colorado. First, we are saying to employees of small businesses that you are not going to receive the protection of others with health insurance. Secondly, even though the cost is less than 1 percent a year to give these added protections, we are not going to ask the small businesses to accept this, even in the face of an increase in premiums, which the Senator from Colorado tells us was 38 percent over 3 years.

I thank the Senator from Massachusetts.

Mr. KENNEDY. I thank the Senator for his helpful comments.

Mr. REID. Will the Senator yield?

Mr. KENNEDY. Yes.

Mr. REID. I know the Senator is in a rush. I just want to make two brief

comments. First of all, to make it plain English so somebody from Searchlight, NV, where I was born, understands it, the Congressional Budget Office says S. 1052 would result in a premium increase of only 4.2 percent over 5 years. The cost of the average employee would be \$1.19 per month. This would be 37 cents per month more than the legislation that really gives no coverage at all on the other side.

I want to say one last thing to my friend. We were here on the floor earlier today. We know one of the things that is trying to be injected into this is that this is a terrible thing for small business. That is what this amendment is all about—that the Kennedy-Edwards-McCain legislation is bad for small business. I read to the Senator earlier today—and I am going to take 1 minute to read a communication I got from a small businessman in Nevada today:

As a small business owner—

Less than 50 employees—

and as a citizen, I urge you to support the upcoming bill commonly known as the “Patients’ Bill of Rights.” I also would like to state that I support your and Senator McCain’s version of the bill. If the HMOs can afford to spend millions on lobbyists and advertisements, then they can afford to do their job correctly, preventing the lawsuits in the first place . . .

. . . I am willing to pay to know that what I am purchasing from my HMO will be delivered, not withheld until someone is dead, then approved postmortem. While a believer in the market and freedom, I feel that we need a better national approach to health care. As the richest nation in the world, as the only real superpower, why do so many Americans get Third World levels of health care, even when they have insurance?

Thank you for your time. Michael Marcum, Reno, NV.

This is a small businessperson. He doesn’t have millions of dollars to run TV ads, radio ads, and newspaper ads, but he has the ability to contact me, as hundreds of thousands of other small businesspeople can do. This legislation that you are supporting is good for small business, and this is only one of the other ploys to try to distract from the true merits of this legislation.

Mr. KENNEDY. I thank the Senator because in his statement he has really summarized the importance of resisting this amendment. Those 40 percent of workers deserve these kinds of protections. These are not very unique or special kinds of protections.

They are the commonsense protections we have illustrated during the course of this debate—access to emergency room care based upon a prudent layperson standard, protections of specialty care, clinical trials, OB/GYN, continuity of care and point of service. So patients are able to get the best in specialty care and formulary, the new medicines, and making sure their doctors, American doctors, are the best trained in the world. These doctors have committed their lives to benefit patients, and they are trained to do so trained to make the medical judgments.

That is what American families believe they are paying for when they pay the premiums, but we have a group of HMOs that feel they can put the financial bottom line ahead of patient interests and shortchange millions of Americans. We should not let the 40 percent that will be affected by this amendment be excluded.

The PRESIDING OFFICER. The Senator from Colorado.

Mr. ALLARD. Mr. President, I want to respond to some of the comments that were just made. The fact remains if you survey employers, half say they will drop employee coverage if exposed to lawsuits. I can understand that having been a small businessman, and I understand how one tries to deal with the bottom line of that business, usually a very marginal business.

Again, I agree with the Senator from Massachusetts when he says we are talking about 40 to 45 percent of the workforce in this country. It points out how important that small business sector is. Those were 50 employees or less. They are a vital part of our economy. We want to make sure they have an ability to attract employees into their business. We want to make sure they can meet the bottom line. We want to make sure they stay in business.

I want to share a quote with the Members of the Senate made by William Spencer, who is with the Associated Builders and Contractors, Inc. We all know many times builders and contractors are small businesspeople, sometimes, at least in my State, frequently 4 and 5-man operations, rarely over 10, particularly in the subcontracting area:

Many of the ABC’s member companies are small businesses, and thus the prospect of facing a \$5 million liability cap on civil assessments is daunting. Financial reality is that if faced with such a large claim, many of our members could be forced to drop employee health insurance coverage rather than face the potential liability or possibly even shut their business down.

I think he is right on, and I agree with him. The question is, how do you respond as a small employer when you are faced with an untenable exposure from a lawsuit or costs or regulatory burden? You try to figure out a way you can move out of that liability you are facing. What I did, and I think many small employers will do, is go back to their employees and say: Look, there is no way we can cover your medical insurance. There is no way we can work with a program, whether it is an HMO or whatever, to provide you with medical insurance.

If you are a small employer such as I was—I had part-time employees working for me. Many who came to work for me had never held a job in their life. They were just out of high school, in many instances, and going to college. I was going to give them their first experience in the workplace.

I had to make a decision as to what we were going to do in a case where I had increasing costs in my small business. Many of them were as a result of

insurance premiums. I decided that I was going to approach my employees and say: I would much rather pay you extra to work in my business and leave it up to you to line up your own health care coverage.

Again, they were part-time employees who we expected, in many cases, to work for us for 3 months, sometimes 2, 3 years, and then they would be moving on.

By taking this approach, I also gave them portability. In other words, when they left my business, they were not faced with the issue of what is going to happen with my insurance when I get to a new employer; what is going to happen, from the employee's perspective; what am I going to do when I am no longer working for my current employer as far as health coverage is concerned.

That is how I decided to handle it. I think most small employers will view it the same way I did. When they see that untenable exposure, they are going to decide not to have coverage for their employees. In order to stay competitive, they might decide to pay them more or some other way to compensate them for that loss in health care coverage.

The fact remains, from my own personal experience, it is not hard for me to believe that many small employers, as many as half, will elect not to provide health care coverage for their employees.

We need to do everything we can to encourage the small business sector to survive. This is not the only place where we draw a bright line, where we recognize how important the small business sector is to us. In other places in the law, we have tried to define what a small business is. In some cases, we drew it at 150 employees or less; in some cases, 100 employees or less; or maybe, in some cases, 50 employees or less. In fact, in some cases, they even tried to define the very small employer of 15 employees or less.

It is not an unusual policy for the Senate in legislation to draw a bright line to define what a small employer would be. In this particular instance, it is entirely appropriate to make that at 50 employees or less, and if you have 50 employees or less, you would be exempted from the provisions of the Senate bill that is before us.

Small businesses are important for the economic growth of this country. Small businesses are important to generate new ideas. When an American has a great idea, many times they go into business for themselves, and they try to market that idea. If it works, it may eventually grow into a large business. If it does not work, they may eventually end up having to work for another employer. But many times they are contributors to their communities. They are contributors to the employee base. They are contributors to the leadership within that community and help make that community a better place in which to live.

I believe we need to be sensitive to what small employers can contribute to our economy and the vital role they play. I believe this mandate, this bill will make it much more difficult to stay in business, and, consequently we will begin to lose that pool of talent that is so vital to the health of this country.

The PRESIDING OFFICER. Who yields time?

Mr. REID. Mr. President, under the order that is now before the Senate, if the Senator from Colorado yields back his time, we will do so and finish this debate in the morning under the time that is scheduled.

Mr. ALLARD. Is the Senator from Nevada yielding back his time?

Mr. REID. Yes.

Mr. ALLARD. I will yield back the remainder of my time.

Mr. REID. We will complete the debate in the morning. The Senator from Colorado will have an hour in the morning.

Mr. ALLARD. That is my understanding, there will be an hour.

Mr. REID. Evenly divided.

I yield back our time and the minority has yielded back their time.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. REID. Mr. President, I ask unanimous consent there be a period of morning business, and Senators be permitted to speak for up to 5 minutes each.

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

PRESIDENTIAL TRADE NEGOTIATING AUTHORITY

Mr. BYRD. Mr. President, I am very much concerned about our loss of direction with regard to Presidential trade negotiating authority. Many Members of the House, and some of my colleagues here in the Senate, advocate a wholesale surrender—a wholesale surrender—of Congress' constitutional authority over foreign commerce, as well as the evisceration of the normal rules of procedure for the consideration of Presidentially negotiated trade agreements.

I am talking about what is commonly known as “fast-track,”—fast track—though the administration has chosen the less informative moniker—the highfalutin, high sounding “trade promotion authority.” “Trade promotion authority” sounds good, doesn’t it? “Trade promotion authority,” that is the euphemistic title, I would say—“trade promotion authority.” The real title is “fast-track.”

What is this fast-track? It means that Congress agrees to consider legislation to implement nontariff trade agreements under a procedure with mandatory deadlines, no amendments, and limited debate. No amendments. Get that. The President claims to need this deviation from the traditional prerogatives of Congress so that other countries will come to the table for future trade negotiations.

Before I discuss this very questionable justification—which ignores almost the entire history of U.S. trade negotiating authority—I think we ought to pause and consider—what?—the Constitution of the United States. I hold it in my hand, the Constitution of the United States. That is my contract with America, the Constitution of the United States.

Each of us swears allegiance; we put our hand on that Bible up there. I did, and swore to support and defend the Constitution of the United States against all enemies, foreign and domestic.

Each of us swears allegiance to this magnificent document. As Justice Davis stated in 1866:

The Constitution of the United States is a law for rulers and people, equally in war and in peace, and covers with the shield of its protection all classes of men, at all times, and under all circumstances. No doctrine, involving more pernicious consequences, was ever invented by the wit of man than that any of its provisions can be suspended during any of the great exigencies of government.

Ex Parte Milligan, 71 U.S. 2 (1866). This was the case that refused to uphold the wide-ranging use of martial law during the Civil War.

Thus, Mr. President, let us review the Constitution to see what role Congress is given with respect to commerce with foreign nations. Article 1, section 8, says that “The Congress shall have power to . . . regulate commerce with foreign nations, and among the several states, and with the Indian tribes . . .”

This Constitution also gives Congress the power “to lay and collect . . . Duties, Imposts, and Excises.” The President is not given these powers. Congress is given these powers. There it is. Read it. The President is not given these powers. These powers have been given to Congress on an exclusive basis.

Nor is this the extent of Congress’s involvement in matters of foreign trade. It scarcely needs to be pointed out that Congress’s central function, as laid out in the first sentence of the first article of the Constitution, is to make the laws of the land. Were it not for that first sentence in this Constitution, I would not be here; the Presiding Officer would not be here; the Senator from the great State of Minnesota, Ohio, Florida, the great States, Alabama, we would not be here. Congress makes the laws of the land. Some people in this town need to be reminded of that.