United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 107th CONGRESS, FIRST SESSION

Vol. 147 WASHINGTON, WEDNESDAY, JUNE 27, 2001 No. 91

Senate

The Senate met at 9:30 a.m. and was called to order by the Honorable HILLARY RODHAM CLINTON, a Senator from the State of New York.

PRAYER

The Chaplain, Dr. Lloyd John Ogilvie, offered the following prayer:

Gracious Father, You give us inner eyes to see You and Your truth. Today we celebrate the birthday of Helen Keller, born on this day in 1880. Thank You for her courageous life. With Your help she overcame tremendous obstacles of being born blind and deaf. We are grateful for people like Anne Sullivan who taught her to read braille so that later she could attend Radcliffe College and eventually become a prolific author.

Our spirits are lifted today as we ponder Helen Keller's words, ''I thank God for my handicaps, for, through them, I have found myself, my work, my God.'' We intentionally adopt for our lives four things Helen Keller urged us to learn in life: ''To think clearly without hurry or confusion; To love everyone sincerely; To act in everything with the highest motives; To trust God unhesitantly.'' And for our work, Keller's words ring true: ''Alone we can do so little; together we can do so much.'' Thank You, Father, for the memory of this great woman. Help us today to use all that we have to do as much good as we can in as many circumstances and to as many people as we can. You are our Lord and Saviour. Amen.

PLEDGE OF ALLEGIANCE

The Honorable HILLARY RODHAM CLINTON led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, June 27, 2001.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable HILLARY RODHAM CLINTON, a Senator from the State of New York, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mrs. CLINTON thereupon assumed the chair as Acting President pro tempore.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order the leadership time is reserved.

RECOGNITION OF THE ACTING MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The acting majority leader is recognized.

BIPARTISAN PATIENT PROTECTION ACT

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will now resume consideration of S. 1052, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1052) to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

Pending:

Kyl amendment No. 818, 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.

Allard amendment No. 817, to exempt small employers from certain causes of action.

THE ACTING PRESIDENT pro tempore. Under the previous order, there will now be 60 minutes of debate in relation to the Allard amendment, No. 817, prior to a vote on or in relation to the amendment.

The Senator from Nevada.

SCHEDULE

Mr. REID. On behalf of Senator DASCHLE, the Senate is advised that the Senate will resume consideration of the Patients' Bill of Rights that has been called by the Chair. There is going to be an hour of debate on the Allard amendment and thereafter on the Kyl amendment. There will be votes on those two matters this morning.

Madam President, I have been advised by the managers of this bill that there has been progress made during the night. If things go as expected, we should be able to meet the deadline that has been set by the leadership; that is, we are going to finish this bill by the Fourth of July break and we can also do the supplemental bill and organizing resolution.

Mr. ALLARD. Will the Senator yield?

Mr. REID. I will be happy to yield.

Mr. ALLARD. My understanding is we have an hour for the Allard amendment equally divided between both sides; is that correct?

Mr. REID. That is true.

I would just say, Madam President, the managers of this legislation, the Senator from Arizona, Mr. MCCAIN, and the Senator from North Carolina, Mr. EDWARDS, and the Senator from Massachusetts, Mr. KENNEDY, have done outstanding work. Senator GREGG and the people he has been working with have been very cooperative. I think this is a good sign for this legislation and movement of this legislation generally.

The ACTING PRESIDENT pro tempore. Who yields time?

Mr. ALLARD. Madam President, I would like to yield 2 minutes to the senior Senator from Arizona.

The ACTING PRESIDENT pro tempore. The Senator from Arizona.

Mr. MCCAIN. I thank the Senator from Colorado. I will be very brief. I would just like to say to all my colleagues, on this issue I think we have made significant progress. Overnight we have the outlines of an agreement, thanks to Senators SNOWE and DEWINE, NELSON, LINCOLN, and others, on the issue of employer liability. We hope we can get the final details of that ironed out soon. I thank those four Senators and others on this issue.

On the issue of scope, I think we are close to an agreement on that major issue.

I thank all involved, including Senator FRIST and many others, for the serious negotiations that have been ongoing.

We may end up with a couple of issues that simply require votes on the floor to resolve them and the majority of the Senate will prevail. But I am very hopeful, and frankly very pleased at the progress we have made. All parties are seriously negotiating. That is the only way you can resolve an issue that has this much detail and this much complexity associated with it.

Again, I echo the sentiments of the Senator from Nevada. I think we could easily complete this in the next couple of days with the kind of willingness that has been displayed so far.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Nevada.

Mr. REID. One thing I forgot to mention, Senator KENNEDY and I, late last night, spoke to Senator JUDD GREGG—well, it wasn't late; it was in the evening. He indicated he would try today to get a list of amendments so we would have a finite list of amendments so we could work through those. If we can do that, it will be very easy to schedule what we will be doing in the next couple of days. If that doesn't happen, there is no question we will have to work late tonight and tomorrow night. Everyone should be advised Senator GREGG said he would try to get a finite list of amendments to us this morning.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts.

Mr. KENNEDY. If I could just proceed for a moment, I just thank all our Members for their cooperation. We have made some progress. There is a lot of work to do on this. We are encouraged by the cooperation of all our Members. But having been around here a long time, we have a lot of work to do. We have to keep at this job. There are very important matters before us.

We ought to just recognize we have a lot of work to do and we will have a chance to see where we are as we take this step by step. We have important debates this morning, and we have some additional issues on employer liability that we will address, on medical necessity, and hopefully on the areas of scope.

Those are being worked out; I hope are being drafted. As we all know, the key is in the details. I don't want to have any false sense of anticipation. We have still some very important policy issues that have to be resolved. But we are making progress. We are very grateful to all the Members for their help and cooperation, and we look forward to this morning's debate.

The ACTING PRESIDENT pro tempore. The Senator from North Carolina.

Mr. EDWARDS. Madam President, I want to echo the words of my colleagues, the Senator from Arizona and the Senator from Massachusetts.

There is certainly significant work to be done. Important issues need to be resolved. But we spent a good part of the day yesterday working on the issue of scope, making sure that every American is covered by this bill. I think we have, in fact, made great progress on that issue.

On the issue of medical necessity, which is one of the pending amendments—the Kyl-Nelson amendment—we expect to offer our own compromise amendment on that issue later today, something that was worked out yesterday through the process of discussions. As I think everyone knows, Senators SNOWE, DEWINE, and NELSON have worked very hard, along with the three of us, to work out an agreement on employer liability—all of us believing that employers all over this country need to be protected. That is not what this legislation is about. It is about giving patients rights and putting health care decisions back in the hands of doctors and patients and not in the hands of big HMOs. All of us are in agreement that in that process it is important to protect employers so they continue to provide coverage for employees all over this country.

So I echo the words of my colleagues. I do think it is true that we have made great progress. I think it is also true there is work left to be done. We will continue to work diligently with our colleagues. We have had colleagues on both sides of the aisle working on all these issues. We will continue to work on them as we go forward with these votes and this debate. But we are optimistic that we will be able to conclude this bill this week.

I yield the floor.

The ACTING PRESIDENT pro tempore. Who yields time?

The Senator from Colorado.

Mr. ALLARD. How much time does this side have?

The ACTING PRESIDENT pro tempore. Twenty-eight and a half minutes.

Mr. ALLARD. Madam President, I yield 18 minutes to the junior Senator from Arizona. And I would like to reserve the last 10 minutes for myself.

The ACTING PRESIDENT pro tempore. The Senator from Arizona.

AMENDMENT NO. 818

Mr. KYL. Madam President, I do not intend to take the full time right now. There may be others who wish to speak.

Senator ALLARD has been kind enough to allow those who support the Nelson-Kyl-Nickles amendment to take some of the time right now. I would like to change the subject back to that amendment which we brought before this body last night and debated for about an hour, and then we will also have an opportunity to conclude the debate on it after the vote on the Allard amendment. But now that we have a few moments, I would like to discuss that.

For those who were not in this Chamber last night to hear the debate, let me make it clear that there were two essential problems that we saw that needed resolution. We had worked with Senator KENNEDY, Senator EDWARDS, and others—and Senator NELSON had extensive conversations—about how to resolve these issues. One of the issues has apparently been resolved by agreement, although no amendment has yet been proposed to deal with it; and that all has to do with reviewing a case by the external reviewer. In other words, the insurance company has an internal review of an issue, and then if that isn't resolved, it goes to an external reviewer.

I think everybody agrees that if we can resolve the case at that stage and not have to go to litigation, it is better for everybody. So the question is, what exactly can be considered by that independent reviewer? The first problem that we saw was that the independent reviewer actually had the authority, under the bill, to order that benefits be provided to a patient that were excluded by the contract—legally excluded. The insured bought a certain set of benefits, and there were certain benefits excluded, but the independent reviewer would theoretically have the right to order excluded benefits to be provided for a patient.

I think everybody realized that was not what was intended, and it is at least the representation of those on the other side—and specifically Senator EDWARDS has made the point—that there is a way to fix that, and a very specific way, which we all understand. If that amendment is offered, then I think it will be a satisfactory conclusion to that particular matter.

The other matter that remains has to do with the other kind of issue that can come up. There is a benefit which is covered but the question is, what exactly is the appropriate medical service in this case? Here is a very simplistic example. The plan says: We are not sure exactly what is wrong with this person. We will take an x-ray to find out. But the doctor and the patient say: Look, we already had an x-ray, and the x-ray was not definitive enough. We think we need a CAT scan or an MRI.

Those are pretty expensive. The plan says: Look, we just don't think we need the MRI.

That is the dispute. There is no question that the diagnostic service is covered. The question is, which diagnostic service is appropriate or medically necessary in this particular case? So it goes to the internal reviewer. Let's say the internal reviewer says that an x-ray is good enough, but that is not what the doctor or the patient wants to hear. So they go to the independent or external review and make their case.

What is the standard for the external reviewer to decide whether or not an x-ray is good enough or whether or not there should be a CAT scan or an MRI, for example? There should be some kind of standard that is relatively uniform, unless the States have adopted a specific standard for review of plans within their particular State.

I will read the language in the bill that causes us concern because this is the deficiency as we see it. It is on page 37 of the bill. Under ''Independent Determination.—'':

In making determinations under this subtitle, a qualified external review entity and an independent medical reviewer shall—

Let me read the two subparagraphs here.

(i) consider the claim under view without deference to the determinations made by the plan or issuer or the recommendation of the treating health care professional . . .; and

(ii) consider, but not be bound by the definition used by the plan or insurer of ''medically necessary and appropriate'' or ''experimental or investigational''. . . .

''Consider, but not be bound by the definition used by the plan''—of course, that could raise a question of abrogation of contract. When the insurer says: Look, this is the insurance that you bought, and here is the definition under the plan, who has the right to go in and change the definition? So we think that language is inappropriate. The independent reviewer should not be able to just ignore the definition in the plan. But that then raises the question of whether or not a plan's definition could be overly restrictive.

What we basically agreed to, at least some of us believe is an appropriate compromise, is to say: You have to use the definition of the plan, but the plan has to have a reasonable definition. What would that definition be?

First of all, if a State mandates certain language, then obviously we need to use that language. So for the 13 or so States that actually mandate language, that would have to be applied. But for the rest of the States, there would be a definition, and the definition that we use is the definition that the Federal Employees Health Benefits Plan has used, approved by the Office of Personnel Management for fee-for-service plans.

So, Madam President, you and I, and the other Members of this body have an opportunity to acquire health insurance through the Federal Employees Health Benefit Plan just as all other Federal employees do. And there are basically two standards that they use for these contracts. One is for managed care. We consider that to be insufficiently protective of the patients. The other is for the fee-for-service. It is a more strict standard. That is the standard that we use.

For 49 percent of the people who are covered by a Blue Cross-Blue Shield contract—and that language, we believe, is also used by another 23 percent. So almost three-fourths of the people are covered by very specific language. That is exactly the language we have included in the bill.

There are five specific elements of it. The one that matters the most is the second one, which is: ''Consistent with standards of good medical practice in the United States.''

So the reviewer—if you are in a State that does not have a mandatory definition—would then apply this definition. You might say: ''Consistent with standards of good medical practice.'' That is pretty broad. That could be almost anything. It is not almost anything. What it is is good medical practice. And good medical practice can be determined by experts in the field, based upon the standards of the community, what literature suggests should be done in a particular case, and at least affords an opportunity for the independent reviewer to decide whether or not the patient needs the MRI or the CAT scan, in this case, whether good medical practice would ordinarily call for that, or whether, based on the circumstances of this case, it is just not that difficult and an x-ray ought to be good enough.

There are four other elements to it as well, but that is the key one.

There is a third opportunity here. If people do not like that definition, even though it covers three-fourths of us under a Federal plan, then we provide for a negotiated rulemaking procedure whereby all the stakeholders can get together and figure out a definition. I do not know what that would be. If they can all agree on a definition, we provide a mechanism for them to do so. And if they do, then that supplants this other definition. One year after that is agreed to, then this other definition is gone.

So there is an opportunity to come up with something that all of the parties agree is better if, in fact, they can do that. In the meantime, this is the definition that would apply. We think that is reasonable. We think it is an improvement on the legislation. Certainly something has to be done with this particular section.

Senator KENNEDY last night talked to both Senator NELSON and me about some possible changes in that. We are very open to that. I am hoping that in the remaining hour of debate on the Allard amendment—and then we will have the vote on the Allard amendment—and then we have an hour of debate on the Nelson-Kyl amendment—I am hoping in that 120 minutes or so we can come to an agreement as to what exactly this language should be. If we can, we are very willing to change the amendment and adopt whatever we can agree to. Senator KENNEDY had one particular idea last night that both Senator NELSON and my staff are exploring right now.

If we can do this, then we will announce it to the body. We will explain what it is, and hopefully we will have an agreement that everyone can support. If not, then obviously we will need to proceed with this language. In any event, we have identified a problem. We have a reasonable solution to the problem. If somebody has a better idea, we are open to consider what that might be.

I urge my colleagues who are interested to come to the floor and speak to it. We not only have a few remaining minutes under Senator ALLARD's time, but we have additional time when the amendment is debated after the vote on the Allard amendment.

I reserve the remainder of the time. Again, I invite anyone who is interested in speaking to this matter to come to the Chamber and address it.

The ACTING PRESIDENT pro tempore. Who yields time?

Mr. KENNEDY. Madam President, how much time do we have on our side?

The ACTING PRESIDENT pro tempore. Twenty-six minutes.

Mr. KENNEDY. I yield myself 10 minutes.

The PRESIDING OFFICER. The Senator from Massachusetts.

AMENDMENT NO. 817

Mr. KENNEDY. At the start of this discussion, we ought to understand the significance of the sort of carve-out that is offered by the Senator from Colorado. This effectively would eliminate 45 percent of all the workers in this country from the kind of coverage and protections we are trying to ensure through the Patients' Bill of Rights.

It seems to me if you work for a company that employs 48 employees and you happen to have a child who needs a specialist, you should not be denied that protection by an HMO making bottom line decisions more in the interest of profits rather than in the interest of the child and the medical decision.

That is what this issue is all about. Are we going to say if you work in a company with 49 employees, you are not covered, but if you work in a company with 51 employees, you are covered? What kind of fairness is that for the families of America?

We recognize that small business—although employing 50 is probably somewhat larger than most of the small businesses we have in our State—needs help. They pay 30 or 40 percent more in terms of their premiums. They don't deal, in most instances, with the largest of the HMOs, many of which act responsibly. They are dealing with the marginal HMOs that are more driven by profits and the bottom line rather than services to patients.

We know at the present time small businesses have additional burdens in terms of affording health insurance. We

ought to address that. I am all for addressing it. But excluding them from this coverage is not addressing that particular problem. It is not going to change the premiums for this kind of coverage. That is the bottom line. If the Senator wants to give help to those small businesses in terms of additional kinds of financial incentives, or helping them get into various groups so they could purchase their health insurance at more reasonable levels, we are all for it. But first, this is not the way to go.

As the Senator from Colorado pointed out last night, the HMO's premiums have gone up 13 percent last year, 12 percent this year, with the best cost of our proposal being less than 1 percent a year. It is a gross misrepresentation and a distortion to think that this is going to solve their particular problems; it will not.

What we will be doing, if we accept the Allard amendment, is exposing working families all over the country. Families who are working should get the kind of protections we want through this legislation, the kind of protections they thought they were getting when they bought their health insurance. This amendment effectively puts these families on the sidelines and frees them from any of the protections of this legislation.

Mr. EDWARDS. Madam President, will the Senator yield?

Mr. KENNEDY. I am glad to yield to the Senator from North Carolina.

The ACTING PRESIDENT pro tempore. The Senator from North Carolina.

Mr. EDWARDS. Madam President, as the Senator is aware, we are continuing to work very aggressively with Members on both sides of the aisle, led by Senators SNOWE, NELSON, and DEWINE on this issue, specifically to provide protection for employers, including small employers. As somebody who has been involved with this issue for many years, I wonder if the Senator believes we can have a real patient protection act, real Patients' Bill of Rights, if, in fact, we exempt almost half of the employees in the country from the legislation?

Mr. KENNEDY. The Senator is quite right. Of course, we cannot. That is effectively what we are doing to about 43 or 44 percent. In addition, many of those who have looked at the amendment think there will be larger companies that will break down into units of 50 or fewer in order to escape the protections of this legislation. That can go on ad infinitum. We are talking about 40, 45 employees per employer. It may be a lot more.

The Senator is quite correct: This is a position that I do not think even the President supports. In the President's list of particulars and principles, he is for holding the employers accountable that are going to be involved in making medical decisions that ultimately work to the disadvantage and the harm of the various patients. That isn't what this is all about. More likely than not, and I will let others comment on this—if you are a hardware store owner who has four employees and you are paying your premium, you are not involved in making medical judgments and decisions. That defies any kind of ordinary understanding of what is happening with small businesses. They are not the ones doing it.

The concern we have is that employers who provide HMO coverage to several hundred employees could say to the HMO: Let me know anytime there is going to be an expense over $50,000 or $75,000 because I want to know about it. When the HMO calls them up, they say: Don't provide the service. That is the real world, not the smaller business men and women.

This is an amendment which undermines a basic concept. If the good Senator can explain to me, the proponents, why should families in small companies be put at more risk? Why shouldn't the family members of a company that has less than 50 employees be able to get the specialists they need? Why shouldn't a woman worker in a smaller company be able to get to the OB/GYN as a primary care physician? Why should the wife in a smaller company not be able to get the clinical trial that will save her life from cancer?

What is the answer from the other side? What is possibly the answer from the other side? Well, the premiums have gone up.

We have talked about the issue of premiums. The President understands that. It seems to me, with the Allard amendment, we are putting the workers in these plants and factories at enormous risk. Whatever the problems are today, once we give them carte blanche, the problems are just going to increase a thousandfold. These employers are going to be immune, effectively, from any kind of action.

We are opening the barn door and inviting any employer to go with any HMO. It won't make any difference because there will not be a remedy for the workers. Is that what this whole debate and discussion is about? I don't think so.

I hope this amendment will not be accepted. It is a carve-out. As the Senator from North Carolina has stated, there are Members on both sides of the aisle who are working—Senator SNOWE and others—to tighten the language included in the basic document. We have talked about and debated the language during this time, in terms of the role of the employer and to ensure that there won't be unwarranted additional burdens on the employer. That is in the process. That is what we are dealing with as the way to go. We are going to have the opportunity to consider that later in the day.

Now we have an amendment that is going to effectively eliminate responsibility for almost half of the employees in this country. The protection for those employees is not warranted and justified with the legislation.

How much time do we have remaining, Madam President?

The ACTING PRESIDENT pro tempore. Seventeen minutes.

Mr. KENNEDY. I yield to the Senator from North Carolina.

Mr. EDWARDS. Thank you, Madam President.

I would like to speak briefly to the Allard amendment. Let me say first to my colleague, the sponsor of the amendment, who is in the Chamber, I have no doubt that his intentions in this amendment are nothing but good and he is trying to accomplish something he believes is important. The problem is this approach is extreme. It is extreme, it is outside the mainstream of all the work, essentially, that has been done on this issue.

The McCain-Edwards-Kennedy bill deals specifically with protecting small employers. The competing legislation, the Frist-Breaux bill, also deals with that issue, without this kind of extreme carve-out. The Norwood-Dingell bill that passed the House of Representatives by a wide margin did not have this kind of language in it. The American Medical Association, the medical groups from all over the country would not support this kind of carve-out. The reason is, it is impossible to have a real Patients' Bill of Rights so all patients and families across this country are protected if in fact you exclude almost half the employees in this country.

The more sensible approach, the more mainstream approach, which is the one we are taking in our legislation and as we speak, is to make sure you provide the maximum protection you can, keeping the interests of the patient in mind, for these small employers. That is the reason we are continuing, as we speak, working across party lines, to craft language that we believe is appropriate to the purpose of protecting employers in general and specifically to protecting small employers. But to exclude almost half of the employees in this country from this legislation means we have essentially left half the country out of patient protection, which I do not think anyone thinks is a sensible solution to the issue.

So I understand the concern. It is a concern we believe we have addressed in our legislation, which is to protect small employers. But we are working to go further with colleagues on both sides of the aisle, Republican and Democrat, to make sure small businesses all over the country are protected. But the solution is not to penalize almost half the families in this country and not provide them with the same rights that all other Americans would have.

It just makes no sense to have no patient protection for employees who work at a firm of 48, 49 employees and for a firm with 60 employees, in fact, the protections are there. That is just illogical; it doesn't make any sense. Most important, it is an extreme response to a legitimate issue. The legitimate issue that is raised we believe we

have adequately responded to in our legislation by specifically protecting employers. But in addition to that, we are taking further steps to make sure all employers, and specifically small employers, are protected.

So I say to my colleagues, if you are concerned about employers, if you are concerned about small employers, we have protections for that group in our legislation. We are going further on that issue as we work across party lines on another amendment that will be offered, we expect, later this afternoon.

But this measure is totally outside the mainstream. It is outside what we have done. It is outside the Frist-Breaux bill. It is outside the Norwood-Dingell bill. It is outside anything the American Medical Association or medical groups across this country would ever support.

So while I understand the issue being raised by my colleague, this measure is extreme and it penalizes almost half of the families in this country and leaves them out of patient protection. Those families will still be in the same place they are today, which is HMOs can deny them coverage and they cannot do anything about it; they are simply stuck. Women will not have the right to go to their OB/GYNs; children will not have access to specialists; there will be no emergency room protection if they need to go to the nearest emergency room; and there will be no way to challenge any decision that an HMO has. That 45 percent of American families, almost half of American families, under this amendment would be totally left out. They would continue to be in the place where the HMO held complete control over their health care.

That is what we are trying to do something about. It is not the right thing to do, to exempt almost half of America from this patient protection. Not that the concern is not legitimate, because it is, but this response is extreme and totally outside the mainstream of the work and thinking that has been done by everyone in this area.

The PRESIDING OFFICER (Mr. NELSON of Nebraska). The Senator from Massachusetts.

Mr. KENNEDY. Will the Senator be good enough to yield for a question?

Mr. EDWARDS. Yes.

Mr. KENNEDY. Can the Senator conceive of a situation where the employer got hold of the HMO and said: Look, I have a worker who has been hurt. I know it is going to be a costly process to bring that worker back to good health, and I don't want you to spend more than $25,000 on this. I want to put a limit on this. We are not going to spend more. I don't want you to spend more.

The HMO is going to say, if I am going to keep this as a client, I am going to follow that client.

Let me ask you this. If the Allard amendment is accepted, and the worker was seriously injured because of the failure to give the kind of medical treatment that the doctors have recommended and suggested, would that patient be able to hold that employer accountable under the Allard amendment?

Mr. EDWARDS. In answer to the Senator's question, not only under this amendment the employer couldn't be held accountable, in fact the HMO couldn't be held accountable because they would both be exempted from the legislation. So the family and the patient would be completely left out. That was my point earlier in responding to the Senator, in my comment that this is an extreme response. We have a response, both in our legislation and legislation on which the Senator has been very actively involved, that provides adequate protection, will make sure small employers are protected, but does not punish almost half the families in the country.

Mr. KENNEDY. If the Senator will yield further, this is almost an invitation, is it not, to employers, such as the mom-and-pop stores that have half a dozen employees, that basically are just paying the premium and are not making the decisions? Someone will say to them: Look, not only do you get your health insurance but you can just tell your HMO not to spend more than $10,000 or $15,000. You can do that and be completely immune and save yourself in terms of the additional premiums, although in that way you put at risk your workers. Could they not do that?

Mr. EDWARDS. Not only that, but I say to the Senator, having worked for and with small businesspeople for many years, I know they care about their employees. They care deeply about their employees, the vast majority of small businesses around this country. They do not want their employees to be in a position that they have no rights against the HMO.

To small businesspeople all over this country, their lifeblood is their employees. They need those people to come to work every day, enjoy the work, and be productive. One of the critical components of that, as the Senator well knows after all his years of work on this issue, is that they have quality health care. The small employers in this country who care about their employees—in my judgment, the vast majority—will want to make sure their employees have the best product they could possibly have. They will want them to have the same protections.

Those small employers will want to be protected from liability. That is a reasonable concern, and that is the concern, as the Senator knows, that we have addressed in our legislation and we are continuing to address with even stronger language with colleagues from across the aisle.

Mr. KENNEDY. Finally, if I may yield myself 30 seconds—under the proposal that we anticipate and support, I will make the assertion that under this proposal and Senator SNOWE's proposal later in the afternoon, which will be introduced with the good support of the now Presiding Officer, we will ensure those employees are going to be protected. That is the way to go. That is what we want to achieve, to give real protection to those employers. That is the way to proceed.

I think it is a much more effective way, efficient way for the employers, a more fair way for them, and certainly a great deal more fair for their employees.

The PRESIDING OFFICER. The Senator from Colorado.

Mr. ALLARD. Mr. President, I yield myself 5 minutes and then, following my 5 minutes, yield 5 minutes to the Senator from Missouri.

The PRESIDING OFFICER. The Senator is recognized.

Mr. ALLARD. I think we ought to just take a little time out here and summarize where we are in this debate on whether or not we exempt businesses of 50 employees or fewer. And this is the way I want to lay it out. The Democrats are arguing that 41 percent of small business employees will lack protection from HMOs. That argument is wrong. Forty-one percent of small business employees will be subject to increased health care premiums or even losing their health maintenance insurance altogether. They will not be insured.

So this argument that there is a line being drawn between 48 and 51 employees, the fact is, when you expose small employers and small businesses to increased lawsuits when they take on a program, they are not going to take on the program. So employees will not be insured.

Moreover, an employee does not get protection from HMOs from suing their employer. If they need to sue, they should sue their HMO, not the employer, who happens to be, by the way, kind enough to offer the health insurance.

Under S. 1052, employee health costs will increase $1.19 per month. Again, I believe this argument is irrelevant, and because of S. 1052 we will see, in my view, more than 1 million Americans will lose their health insurance. At least the Senate can do something to help out small employers by exempting them from these unnecessary lawsuits. I am talking about businesses with less than 50 employees.

S. 1052 will allow a small business of five employees, for example, to be sued for unlimited economic, unlimited noneconomic damages, and up to $5 million in punitive damages. Now, that is not protecting the small businessman. That is not protecting those businesses that have 50 or fewer employees.

According to a recent survey of 600 national employers, 46 percent of the employers would be likely to drop health insurance coverage for their workers if they are exposed to new health care lawsuits, plain and simple.

I will ask to print in the RECORD a Denver Post editorial from June 21,

2001. I will quote a small section of it. It says:

The competing Democrat bill, in our view, goes too far and includes a provision that will allow employees to sue their employers for denial of a medical request if the employer helped make the decision.

We think this type of language would have the effect of encouraging more lawsuits and driving up costs instead of encouraging quick, early resolution of disputes.

It went on to say:

We also find fault with the provisions that would authorize individual lawsuits to produce punitive damage awards in the multimillion-dollar range. Compensatory damages are one thing; punitive damage awards are quite another.

I ask unanimous consent that this editorial be printed in the RECORD.

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

[From the Denver Post, June 21, 2001]

WEIGHING PATIENTS' RIGHTS

As we are so often reminded, the demands for medical care are infinite while supply is not. HMOs arrived on the scene some years ago and quickly became the primary form of medical insurance precisely because they were designed to hold down medical costs. Employers, who provide the lion's share of insurance, liked them for that reason.

Now, but a few short years later, public opinion polls suggest the general public believes HMOs provide an inferior form of insurance.

Enter Congress.

The U.S. Senate is considering bills that would establish a Patients' Bill of Rights and specifically authorize a patient to sue the HMO for damages incurred when medical care is denied.

The issue for the Senate and for the nation is how wide to open the doors to the courts.

President Bush has offered what seems to be a sensible compromise. He supports a bill sponsored by Sens. John Breaux, D-La., Bill Frist, R-Tenn., and James Jeffords, former Republican turned independent from Vermont. The bill would establish an independent review process to resolve disputes before a lawsuit could be filed. Thus, a person who wants a particular medical service and is denied would be required first to submit his complaint to a review panel, which, in turn, would consider the facts and make a timely decision.

This approach recognizes the legitimate interest of the medical provider in controlling costs by delivering only necessary medical treatments. At the same time, it provides for a second set of eyes to review the quality of the decision.

The competing Democratic bill, in our view, goes too far and includes a provision that would allow employees to sue their employers for a denial of a medical request if the employer helped make the decision.

We think this type of language would have the effect of encouraging more lawsuits and driving up costs instead of encouraging quick, early resolution of disputes. We also find fault with the provisions that would authorize individual lawsuits to produce punitive damage awards in the multimillion-dollar range. Compensatory damages are one thing; punitive damage awards are quite another.

It would be nice if we could all have medical care provided on our terms alone. Somewhere a balance must be struck.

We favor something closer to the president's position than to that endorsed by the Democratic leadership, but remain optimistic that—given the high political stakes—the nation will see a bill signed this year.

Mr. ALLARD. Mr. President, the employer is not protected. In fact, he is exposed to more lawsuits—multimillion-dollar lawsuits. In order to protect himself, he is not going to provide health insurance. That means the employees will not be covered. The argument was made, why don't you provide coverage for small employers? Why don't you provide coverage for emergency service? Why don't they provide coverage for medical needs that occur in families and what not? The employer isn't going to provide that coverage if he has to face lawsuits. It is optional. He will decide not to offer health insurance.

I was a small businessman and I had to face the challenge of medical costs. We had between 10 and 15 employees. The health care costs were eating us alive. So finally we went to the employees and said what we would like to do is this: We can't afford this, so we will pay you more in a salary and then, hopefully, that will be enough of an increase that you can buy your own health insurance. We could not afford to do that. That was in times that weren't as challenging as they are today.

We are seeing horrendous increases in premiums to small business employers. Now we are going to tack on top of that these mandates and increased costs and the increased threat of a lawsuit. It is not hard for me to believe that we are going to have at least a million more workers out there who are not going to be insured if this bill passes.

Now, it is 41 percent of the workforce that we are talking about with this amendment. But I look at it a different way. I think we are helping assure that they will have health care coverage with this amendment because we are exempting them from the lawsuits.

I think this amendment is a very responsible one. It is needed. If it is not adopted, the small business community of 50 employees or less will suffer.

I yield 5 minutes to the Senator from Missouri.

Mr. BOND. Mr. President, I thank my friend from Colorado and I commend him for this amendment, which I think is very important because it goes to one of the real key areas in this Patients' Bill of Rights.

We want to make sure that people have good health care coverage and that they get what they deserve from their HMO, their insurance company. That is what this debate is all about. How do we get there? One of the most important parts of that question is how we deal with the small businesses that provide health care coverage now for their employees and who may not in the future.

My colleagues on the other side of the aisle insist that employers will not drop coverage due to the McCain-Kennedy bill. For some employers, that is probably true. Virtually all large companies offer health care, and even if we pass this legislation and dramatically increase costs, they will probably have to do so. They will have to pay more and their employees will have to pay more. But they are likely to have coverage. But from everything I am hearing from the small business community, it is much less likely that small businesses—even those who now provide health care coverage—will be able to do so.

I heard a colleague on the other side of the aisle say that the McCain-Kennedy bill has taken care of small employers—the small employers health care provision. Right. Just like a herbicide takes care of a bed of flowers, it is going to kill small business health care at the roots. I know what ''taken care of'' means in that context. I have sprayed herbicide; I know what they do to a flower bed or a lawn. That is how McCain-Kennedy takes care of the health care coverage of small business. They drive them out.

Small businesses are the ones that are struggling to survive. Small businesses are the ones that struggle to provide health care. They are at the heart of the problem that the McCain-Kennedy bill totally ignores—the 43 million Americans who have no health insurance. Of that 43 million Americans who have no health care insurance, approximately 60 percent are small businessowners, employees and their dependents, the family members. That is 25.8 million Americans, either small businessowners, employees, or family members, who are not covered by health insurance. They can't be a patient under the Patients' Bill of Rights. In Missouri, we have 570,000 uninsured, and 342,000 are in families headed by a small businessperson, man or woman.

If we drive more of the small businesses out of health care coverage, those numbers are going to go up. That is a disaster. That is the wrong way to go. Many small businesses do not offer coverage. Why is that? Well, there are still many barriers to small businesses providing health care coverage.

First, they have higher premium costs.

Second, they have higher annual premium increases.

Third, there are more difficult administrative hurdles. In mom and pop operations, neither mom nor pop usually has the administrative skills to set up health care and other benefit plans.

Limited deductions for the self-employed, we voted on that last week. Unfortunately, my colleagues chose to turn a blind eye to the needs of the self-employed and their families and said we are going to skip them in this bill. That is one more mistake in this bill. Here are the problems. Under McCain-Kennedy, there would be a 4.2 percent cost increase—slightly more. That is going to make health care coverage more expensive for the small

business and the small business employee. That means fewer patients, because 300,000 lose coverage for every 1 percent increase.

Exposure to liability is the big one. Employers throughout Missouri are writing: we cannot afford the continuing cost increases in health care and we will not tolerate those plus exposure to liability.

The PRESIDING OFFICER. The Senator has used 5 minutes.

Mr. ALLARD. I yield the Senator an additional 3 minutes.

Mr. BOND. I ask for 1 minute.

Most small businesses in America are only one lawsuit away from going out of business. This lawsuit, under the multitude of causes of action provided in the McCain-Kennedy bill, could drive any single small business out of business. They are one lawsuit away from going out of business. Small businesses are smart enough to know if they are one lawsuit away from going out of business because they provide health care, they are one McCain-Kennedy bill away from getting out of the health care coverage business.

The 43 million Americans who are now uninsured—watch those numbers increase. Yesterday I noted 1,895 Missouri employees of small businesses would lose health care coverage because their small business employer could not take the risk. That number is going to be higher. It is much higher nationally.

I commend the amendment offered by my colleague from Colorado. I offer this as a suggestion: If Members care about small businesses and the health care coverage they provide their employees, vote for the Allard amendment. This is the only way to save small businesses from a knife in their back, making health care coverage for their employees unaffordable.

Mr. ALLARD. I yield 2 minutes to the Senator from Texas.

Mr. GRAMM. Mr. President, I congratulate Senator ALLARD. Yesterday we had an amendment on exempting employers from being sued. That amendment was important. This amendment is important, as well.

Our basic point yesterday was, when an employer, because they care about their employees and because they want to attract and hold good employees, puts up their own money to help people buy health insurance, we should not reward that voluntary activity by making them liable to being dragged into court and sued.

The bill before the Senate is a classic bait and switch bill, make no doubt. It says you cannot sue employers, and then it says you can sue employers, and it has 7½ pages of conditions under which employers can be sued, including conditions where they exercise control, which is a little trick phrase because ERISA, the program that governs employer benefits to employees, guarantees that the employers are always deemed to be in control. So the bill before the Senate is written to guarantee every employer in America can be sued. If anybody doesn't understand that, it is because they don't want to understand it.

This amendment does not fix the problem. This amendment simply makes a plea that if you are going to force companies such as Wal-Mart to cancel their insurance—at least they have smart lawyers and they have lots of money and can figure out a way to get around this provision by changing their plans. Some of them won't. They will cancel their health insurance. And the proponents of this bill will be back a year from now, 2 years from now, saying, well, the number of uninsured has gone up and we need to have the Government take over and run the health care system.

This amendment is simply a last gasp effort to introduce some reason into this bill which says while clearly this bill is aimed at allowing employers to be sued, and clearly large employers are going to be hit with this liability and they are going to be forced either to drop their plan or change it, they have some ability to make a change. It is not smart. It is counterproductive. It is hurtful to America. But that is the way it is. That is the majority position.

The point is, this amendment says, if the company has 50 or fewer employees. We are talking about small business; we are not talking about companies that can go out and hire a legion of lawyers; we are not talking about companies that have the ability to junk their health care plan and to figure out a clever way to try to get around the devastating provisions in this bill. If you vote against this amendment, you are saying to every small business in America, we don't care if you are sued; we don't care if you provide health insurance.

It is unimaginable we would not adopt this amendment and say that while we are willing in the name of bringing lawsuits to the doorstep of every employer in America, we are not willing to destroy the ability of small business to provide health insurance, and therefore we are going to adopt this amendment. This does not fix the problem. This is an amendment that should bring out some degree of shame as to what we are willing to do. I urge my colleagues to vote for this amendment.

I yield the floor.

Mr. ALLARD. How much time remains?

The PRESIDING OFFICER. Two minutes, and the other side has 7 minutes 16 seconds.

Mr. KENNEDY. I yield myself 4½ minutes.

Mr. President, the issue is the protection of these workers. We have had 22 days of hearings; we have had this legislation for 5 years, trying to get it before the Senate; and now we have the opportunity to provide real protections to families in this country.

Now this amendment wants to say, we will provide protections for some but we will eliminate 45 percent of the protections for families in this country. What possible sense does that make?

There is a representation that somehow employers will be at risk. They will not be at risk unless they are making medical decisions that will result in harm or injury to the patient. If they are not, they are free, in spite of all the agitation we have heard from those supporting this amendment.

I have been around here long enough to realize that when we take on the special interests—and that is the HMO in this case—we hear dire consequences. When we worked on the Family and Medical Leave we heard the estimates that it would cost American business $25 to $30 billion a year. That was all malarkey. We worked on the Kassebaum-Kennedy bill regarding portability of health insurance, particularly for the disabled. They said it would increase the premiums 30 percent, it would be the end of small business and the end of the American economy. That was a lot of baloney. We worked on increasing the minimum wage. We heard it would put small business out of business, and that there would be hundreds of thousands out of work all over this country. That was baloney.

The burden we hear that would be put on small business is baloney. They have nothing to fear. They have nothing to fear in this. But the HMOs have something to fear if they are not going to permit doctors and nurses and trained personnel to provide for their patients.

The facts belie these representations that have been made. If you look at the States that have tough HMO legislation, as we have gone through repeatedly, the message should become clear. For instance, in Texas with their tough HMO law, there have been 17 cases in 5 years.

California has a tough law that has been in effect now 9 months, and no cases. No cases. Do you hear me? No cases. No small businessmen, nobody with 50 or less, none, no cases on it. And what has happened? The employees are getting the protections they need.

Now we hear, well, what about the premiums? I read into the RECORD yesterday that the total cost of this amounts to 1 percent a year over the period of the future—4.2 percent over 5 years. That amounts to about $1.19 a month. Let me tell every premium payer in this country about what is happening in terms of their premiums, why they are going up.

We have Mr. McGuire, United Health Group, who got $54 million in compensation last year and $357 million in stock options for a total compensation of $411 million. That is $4.25 a month for every premium. We are talking about $1.19 a month.

You want to do something about the increase in terms of your premiums, tell Mr. McGuire he does not need $411

million a year in annual compensation and stock options. We know what is happening. They had $3.5 billion—$3.5 billion—in profits last year. Fine. Well and good. But when you see the millions of dollars that they are spending out there on the airwaves every single day, don't cry crocodile tears in this Chamber about what is going to happen to the HMOs.

We are going to ensure that small businesses will be protected. I will join with the Senators from Colorado and Texas if they want to try to assist small business with help through the Tax Code to offset the 25 to 30 percent increase in premiums. The reason they are getting that 25 or 30 percent increase is because they are getting gouged by the major HMOs. That is the real reason. That is what we ought to be about, the real business of that, not taking it out on the injured patients in this country who are not getting the health care they need. How much time do I have?

The PRESIDING OFFICER. Two minutes forty seconds.

Mr. KENNEDY. I yield that time to the Senator from North Carolina.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Let me just conclude from our side by saying a couple things about what the Senator from Colorado is trying to accomplish. We understand his concern about this issue. We do not believe this is the appropriate response or the appropriate measure. This is an extreme response to a legitimate issue. The legitimate issue is making sure small business people all over this country are in fact protected. We have provided in our legislation that unless they make an individual medical decision, which small businesspeople do not, then they are immune from responsibility.

No. 2, in addition to that, we are continuing to negotiate with our colleagues—Senator SNOWE, the presiding Senator, and others—on this issue, and we expect to have an amendment to offer later today that also will provide further protection for small businessmen.

I know that the Presiding Officer and many others on both sides of the aisle care deeply about this issue. This is an extreme response. It will have an extraordinarily bad effect on almost half of the employees in this country. It is outside the mainstream, outside our legislation, outside the Frist-Breaux bill, outside the Norwood-Dingell bill, not supported by the American Medical Association, not supported by any of the health care groups in this country. This is not what needs to be done. So I urge my colleagues to defeat this amendment, to vote against it, to vote with the patients, and we will continue to address the issue of ensuring that small businesses all over America are protected.

I thank the Chair.

Mr. ALLARD. Mr. President, has time expired on the other side?

The PRESIDING OFFICER. The majority has 42 seconds. The Senator from Colorado has 1 minute 50 seconds.

Mr. ALLARD. I reserve my time until the majority has used their time on the amendment.

The PRESIDING OFFICER. Who yields time?

The Senator from North Carolina.

Mr. EDWARDS. Very quickly, with the remaining 40 seconds that we have, we urge our colleagues to vote against this amendment. We are doing the things necessary to protect small businesspeople all over this country, but that can be done without leaving almost half of the families of America uncovered by the necessary patient protections that are in our legislation. For that reason we urge our colleagues to vote against the Allard amendment.

We yield back the remainder of our time.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Colorado.

Mr. ALLARD. Mr. President, I yield myself the remainder of the time.

First of all, I would like to thank my colleagues from Texas and from Missouri for their very cogent comments on small business and the adverse impact of this particular bill on small business. My particular amendment exempts businesses of 50 employees or less. This is important because what we do in this bill is we expose businesses to more lawsuits. The consequences are that businesses will not insure their employees. They will not provide health coverage. The other side is trying to make the point that somehow or the other this amendment will hurt health care coverage for employees. Just the opposite will happen. If this amendment is not adopted and the bill is passed, small employers all over America will cancel their health care coverage and turn to the employee and ask them to provide for their own health care coverage. That is not more health care coverage; that is less health care coverage.

I am a small businessman. I have had to face those tough decisions, and it is not hard for me to believe that a million employees will lose health care coverage if this particular bill is passed. I am going to ask my colleagues in this Chamber to vote for this Allard amendment because we want to make sure that we have a viable small business community in America. We want to assure that coverage for employees now covered by health plans of their small business employers continues.

If this bill passes, there is a good chance they are going to lose that coverage and that is going to mean less health care coverage for employees, not more.

This is a key amendment. It is a key vote for the small business community.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. ALLARD. I ask Senators to join me in supporting the Allard amendment. It is important to the small business community. It is important to health care in this country.

The PRESIDING OFFICER. All time has expired.

Mr. ALLARD. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The question is on agreeing to the amendment No. 817. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from Delaware (Mr. CARPER) and the Senator from New York (Mr. SCHUMER) are necessarily absent.

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

The result was announced—yeas 45, nays 53, as follows:

[Rollcall Vote No. 199 Leg.]

YEAS—45

Allard	Frist	Murkowski
Allen	Gramm	Nickles
Bennett	Grassley	Roberts
Bond	Gregg	Santorum
Brownback	Hagel	Sessions
Bunning	Hatch	Shelby
Burns	Helms	Smith (NH)
Campbell	Hutchinson	Smith (OR)
Cochran	Hutchison	Specter
Collins	Inhofe	Stevens
Craig	Kyl	Thomas
Crapo	Lincoln	Thompson
Domenici	Lott	Thurmond
Ensign	Lugar	Voinovich
Enzi	McConnell	Warner

NAYS—53

Akaka	Dodd	Levin
Baucus	Dorgan	Lieberman
Bayh	Durbin	McCain
Biden	Edwards	Mikulski
Bingaman	Feingold	Miller
Boxer	Feinstein	Murray
Breaux	Fitzgerald	Nelson (FL)
Byrd	Graham	Nelson (NE)
Cantwell	Harkin	Reed
Carnahan	Hollings	Reid
Chafee	Inouye	Rockefeller
Cleland	Jeffords	Sarbanes
Clinton	Johnson	Snowe
Conrad	Kennedy	Stabenow
Corzine	Kerry	Torricelli
Daschle	Kohl	Wellstone
Dayton	Landrieu	Wyden
DeWine	Leahy	

NOT VOTING—2

Carper	Schumer

The amendment (No. 817) was rejected.

Mr. REID. I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. BYRD. Madam President, could we have order in the Senate.

Mr. STEVENS. Madam President, it is a very serious matter we would like to discuss with the Senate. I do hope the Senate will come to order.

The PRESIDING OFFICER. The Senate will be in order. Members will take their conversations off the floor.

The Senator from West Virginia.

SUPPLEMENTAL APPROPRIATIONS

Mr. BYRD. Madam President, I have asked for recognition at this time so

that I might inquire of the joint leadership as to when we might expect to take up the supplemental appropriations bill. That bill was reported from the Appropriations Committee several days ago. It is on the calendar. We only have a little time left this week.

The administration has asked for this bill. The amount in the bill is within the request of the President of the United States—not one cent, not one thin dime over the President's request.

The bill has had the joint support of the distinguished Senator from Alaska, Mr. STEVENS, and myself, and our respective sides.

I will be able, at a later time, to compliment the members of the committee. Right now I want to inquire. This is a very serious matter. The administration says it wants this bill before we go out because of the need in the military for moneys for services, for training, and so forth. I do not want us to be out through this recess and have this bill hanging out there, and have it there when we get back.

Now we are ready to go. I would suggest we try to get a time agreement that would be amenable to the feelings of the two leaders and our respective sides. I think we can do that. I have every confidence we can do that. I just take the floor now to inquire as to what the chances are for us to move this supplemental appropriations bill before we go home for the Independence Day recess.

Mr. STEVENS. Will the Senator yield for one moment?

Mr. BYRD. I gladly yield.

Mr. STEVENS. Madam President, I just received word from the House of Representatives that they are scheduling two appropriations bills on the floor, and they have bipartisan agreement to finish by Thursday night. That is why this dialog right now is very important. We do have to go to conference with the House before they leave.

I join the Senator in making the inquiry.

Mr. BYRD. Madam President, I thank the distinguished Senator.

Mr. DASCHLE addressed the Chair.

Mr. BYRD. Madam President, I yield to the distinguished majority leader.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. DASCHLE. Madam President, I thank the distinguished chairman for yielding.

I reply that it would be my intention to complete the supplemental prior to the time we leave. I do not think we ought to leave Washington prior to the time the supplemental has been satisfactorily disposed of. I do not think we ought to take vacation until this legislation has been completed.

I have indicated, just now, to Senator LOTT that if we could reach some agreement—a finite list of amendments remaining on this bill, with an understanding of how long these amendments would require for debate—that I may be willing to enter into something I was not prepared to do earlier, which is to move to the supplemental prior to the time we complete our work on the Patients' Bill of Rights. We will complete our work on the Patients' Bill of Rights this week, and we will finish the supplemental this week, and the organizing resolution this week —or before we leave, whatever time it takes.

I hope our House colleagues will choose not to leave town until the conference has been completed and until we have been able to deal with the conference as well. It should not take long in conference. But clearly that work must be done. As I say, if we could reach that agreement with regard to a finite list, I would be prepared then to find a way with which to schedule and then perhaps take up a unanimous consent agreement that would allow us to consider the supplemental over a designated period of time.

Mr. STEVENS. Will the Senator yield?

Mr. BYRD. I yield to the Senator.

Mr. STEVENS. Madam President, the leader is correct about the timing. We should all stay until we finish this matter. But if we don't finish it by Thursday, and the House is already scheduled, I can tell you, you are not from as far west as I am, but you can't get reservations out of this place over the Fourth of July now. It is going to be very difficult for all of us and our staffs to get out of town for the Fourth of July unless we know now what we are going to be able to do. I am confident they will stay if they know we are sincere about finishing.

I am prepared to stay tonight. We have a Republican dinner tonight, but I think we can stay tonight. That would be a time when we normally would not have votes, but we can have our debates on whatever amendments might be offered and get an agreement to vote tomorrow at the leader's discretion. We have to get this bill to the House by tomorrow noon or it is not fair to ask them to stay to complete it. We should not expect them to just stay here, cancel all their reservations, not knowing whether we are going to finish by Thursday.

Mr. DASCHLE. Madam President, will the chairman yield?

Mr. BYRD. I yield to the distinguished majority leader, with the understanding I not lose my rights to the floor.

Mr. DASCHLE. I thank the chairman for yielding.

Let me just say, the whole purpose in my announcement early last week that we would have to finish the supplemental, the organizing resolution, and the Patients' Bill of Rights was to accommodate Senators who had reservations. It is not my desire to inconvenience Senators or Members of the House with regard to this schedule. I do believe that the President believes, and many of us believe, that vacations are important, reservations are important, but not as important as finishing the supplemental, not as important as the Patient Protection Act, certainly not as important as the organizing resolution. We will stay here. I hope our House colleagues will share the same view we have with regard to the importance of getting our work done on the supplemental.

I announced that last week. I don't know if people believed I was serious about it, but we are serious. We are resolute. That will be the order for whatever length of time it takes to complete our work.

I thank the chairman for yielding.

Mr. STEVENS. Will the Senator yield?

Mr. BYRD. I thank the distinguished majority leader.

I yield to my counterpart.

Mr. STEVENS. I know the Senator from Oregon wishes to have a conversation. I am prepared—I think the Senator should be prepared—to present to the Senate now our wishes with regard to the agreement.

From my own point of view, we have a very limited managers' amendment which Senator BYRD and I are working on, and I think we disclosed it with most people. But other than that, I know of only one amendment that is certain to be offered. That is an amendment of the Senator from Arizona.

I am prepared to enter into an agreement of no more than an hour on an amendment, and amendments be disclosed here by noon. We will debate them tonight and vote tomorrow.

Mr. BYRD. Madam President, may I first yield to the distinguished Senator from Oregon who has been waiting. Then I want to respond to the distinguished Senator from Alaska.

Mr. SMITH of Oregon. I thank the chairman of the Appropriations Committee. Senator BYRD does not have a bigger fan in this Chamber than I when it comes to the way he defends the people of West Virginia.

I am one of those who would like not to be holding up this bill, but I am looking at a situation in the Klamath Basin of Oregon and California that is in a drought condition. Drought is typical in the western United States. It is regular. You can count on it. Unlike past droughts, the people of Klamath Basin have had the Government magnify their drought by cutting off every drop of water. There are probably 1,500 farm families who have no income because of a Government policy which has exalted a bottom-feeding sucker fish above their welfare.

That is the Government's choice, if it wants to save the sucker fish, but my plea is that in this bill, as the President has asked, that at least the $20 million he has asked for be included or else I can't get out of the way.

I do this in the spirit of ROBERT BYRD and the way I have seen him operate. I admire it so much because I can't go home and look into the faces of these desperate people who are without now because of the Federal Government. The truth is, they need $200 million, if

we want to be right by them. But the President only asked for 20. I am asking that we do at least that much.

I thank the Senator for his consideration.

Mr. BYRD. Madam President, I know about the Klamath problem. I would be happy to discuss that. I also know that the administration wants this bill. I hope the Senator will not stand in the way of final action on it. There are many things I have wanted over the years, and the Senator has every right to stand on the floor as long as his feet will hold him and speak as long as he wants. I will be here listening when he speaks. I have a sick wife. She has been in the hospital now for 10 days—9 days, but she is on the mend. I will be here as long as the Senator wants to talk. If he wants to stay in the way of the bill, I will be here listening. But we will talk about this.

I am not saying no, but I am saying that when anyone wants to stand in the way, they are going to have the administration to compete with there. The President wants this bill. And my friend TED STEVENS and I have busted a gut to get this bill to the floor and to keep it within the President's limits.

If any Senator is contemplating calling up an amendment, if it is a money amendment, that Senator ought to be ready to find an offset in the bill. That Senator ought to be ready to have the administration call that amendment an emergency on this bill. Now, if the administration wants to call it an emergency or if there is an offset, I am sure the Senator probably won't have a great deal of trouble. But I want to do what the President has asked for in this instance. This money is needed now.

That is a long story, but I say to the distinguished Senator from Oregon that he won't be by himself if he wants to hold up the bill.

Mr. LOTT. Madam President, will the distinguished Senator from West Virginia yield?

Mr. BYRD. Yes, I will.

Mr. LOTT. I apologize to my colleagues for not being here to hear the discussion earlier. I have been briefed on basically what has been said.

I commend the chairman of the Appropriations Committee and the ranking member for the work they have done on this very important defense, and other issues, supplemental appropriations bill. They have worked hard. They did bust a gut to get it out, and they held it within the area of the President's request. They have done a credible and formidable job.

I would like to get a time agreement, a tight time agreement, and a limit on amendment or amendments, and would, in spite of the fact that there is a very important conflict tonight, be willing to work with the managers of the legislation to see if we could get an agreement to do it tonight so that a conference would be possible with the House and this very important matter could be completed in the conference and the money be available for the needs of our defense and the health care of our military men and women.

I will be glad to work with the Senator from West Virginia and with his leader, the majority leader, and to work with Senators who do have concerns to make sure we address those, that they are heard.

The important thing is that we push to try to get this done. I appreciate that effort. I know the President wants it. I have spoken to him, and Senator DASCHLE has spoken to him. Clearly, we need to get this business done. I make my commitment to the Senator that I will work with him and others to see if we can't work out an agreement to handle the bill tonight and then we can do the conference tomorrow. I will be working on that and will confer with Senators as we go forward.

Mr. BYRD. Madam President, I thank the Republican leader. Let me close by urging that our respective staffs—I thank both leaders for the assurances they have given of cooperation and of desire to get the bill finished. I would like to suggest that the proposal by Senator STEVENS go forward, that our respective staffs get together, work out a time agreement, and any Senators who want to offer amendments under the constrictions that have been stated here, by which we are bound, let's have those Senators come forward by noon today and tell us about their amendments.

Mr. REID. Madam President, if the Senator has finished——

Mr. BYRD. I thank all Senators.

Mr. STEVENS. If the Senator will yield for a moment, because of my negotiations with the House, I urge that we set a time limit on when we are coming back, if that is agreeable to the leadership, and that we announce that amendments must be presented to us at the desk by noon.

Mr. BYRD. Madam President, I make that request.

Mr. REID. Reserving the right to object and I will object, I haven't had an opportunity to confer with the majority leader. He should be in on this. We will be happy to try to work something out. I object until Senator DASCHLE is apprised of this.

The PRESIDING OFFICER. Objection is heard.

Mr. BYRD. Madam President, I still have the floor. I don't lose it on an objection to a unanimous consent request. Let me simply say that I will just express the hope that we can know by noon. I have discussed this with our leader during the break. I certainly want to work with our distinguished whip between now and then. There hasn't been any Democratic whip in my time here that is any better, and few have been as good as Mr. REID. I am not one of those who is any better. I am one of those who hasn't been as good a whip as Mr. REID. So I thank him. I am sure that we will work together.

Mr. STEVENS. Will the Senator yield for one more inquiry?

Mr. BYRD. Yes.

Mr. STEVENS. Is there some way to set a time limit so we can go to the House and let them know? They have schedules to meet, too. I urge that we have some way to get an agreement that we have this bill called up tonight and we debate any amendments tonight and all amendments must be debated tonight and that we vote tomorrow. That seems to be agreeable with the majority leader. I hope it is. But the main thing is to get us some way that we know how many amendments are out there, I say to my good friend. I spent 8 years as a whip. I know your task is difficult. I think we have a right to ask for disclosure of the amendments that would be offered to the supplemental and have it done by a specific time today.

Mr. REID. If the Senator from West Virginia will yield.

Mr. BYRD. Yes, but I retain my right to the floor.

Mr. REID. I say to the two chairmen, I am also a member of that committee, and I would like to finish the business at hand. Senator DASCHLE has been very clear. He has stated for more than a week now that we must move forward with the Patients' Bill of Rights. We are doing that. He said this morning—and I have been in conference with Senator KENNEDY and Senator EDWARDS. I have spoken to JUDD GREGG, manager of the Patients' Bill of Rights bill. I indicated to him we need a finite list of amendments on the Patients' Bill of Rights. That seems simple. We are very interested in doing that, and that should be able to be accomplished quickly. Everybody knows the contested issues on this matter. We need a finite list of amendments.

When that is done, Senator DASCHLE said he would be happy to work with the two Senators and work out something that is fair. We can do that as quickly as possible. I think there could be a finite list given to us in the next hour. It should not be very hard to do at all.

Mr. BYRD. Madam President, I want to make sure the distinguished whip understood my request. My request was not that we take up the bill by noon. My request is only that Senators who have amendments make it known by 12 noon, that we close out after they have made it known as to what amendments they want to call up, and that we close out the amendments at that point. The leader would still retain, of course, his right to call up the bill whenever he wishes.

Having said that, might I make the request again?

Mr. REID. Madam President, as the Senator knows, I have come to him on many occasions on various bills saying we need to enter into an agreement when the amendments can be filed. We want to do this. I am saying that we will do this as quickly as possible. You need not be on the floor. I will try to get the agreement as soon as possible. We have time limited to the supplemental, but there are certain people I

have to check with, and we will do that as quickly as possible.

Mr. BYRD. I yield to the Senator from Alaska.

Mr. STEVENS. My question to the distinguished whip is plain and simple. Is the Senator from Nevada saying that the finite list of amendments to the Patients' Bill of Rights must be reached before we can get the finite list for the supplemental?

Mr. REID. No. If the Senator allow me to respond.

Mr. BYRD. I yield for that purpose.

Mr. REID. We need a finite list on the Patients' Bill of Rights so a time can be arranged to do the supplemental.

Mr. STEVENS. Respectfully, that is not how I understood my discussion with the majority leader. We discussed doing this bill tonight. There will be a window. This is the night of the Republican dinner. Some of us have agreed to stay and debate the amendments on the supplemental so that it might be voted on in a very short window tomorrow and get it to the House tomorrow so they can finish it so we can get it back by Thursday or Friday. Unless we do that today, I for one am going to give up on the supplemental.

Mr. REID. If the Senator from West Virginia would allow me to answer.

Mr. BYRD. Yes.

Mr. REID. First of all, probably if you are something like me, that would be a good excuse so you would not have to go to the dinner if you had to be here.

Mr. STEVENS. Better not said, but you are right.

Mr. REID. But there is no reason that we cannot have a finite list of amendments on the Patients' Bill of Rights within the next hour or so. I am sure Senator DASCHLE would be happy to work with Senator LOTT and arrange a time. Give us a little time on this.

I repeat to my friends again, the question on the list of amendments should be filed and we will work on that very quickly.

Mr. BYRD. Madam President, I hope we have reached an understanding. I have been at this work for many years. I have learned a long time ago that when you are within reach and you have both leaders having expressed their desire for a unanimous consent request, and with the work that the Senator from Alaska and I have already done with respect to arriving at such a request, that other amendments, other Senators, and other requests can come out of the woodwork. I would like to get this nailed down by noon, or earlier, because the longer we wait, the more Senators there will be that will say, ''This is my chance.''

In closing, I hope we can go forward with this request soon. I yield the floor.

AMENDMENT NO. 818

The PRESIDING OFFICER. Under the previous order, there will now be 15 minutes for debate on the Kyl-Nelson amendment No. 818.

The Senator from Arizona is recognized.

Mr. KYL. Madam President, I will speak and then yield time to Senator NELSON of Nebraska, my colleague on this amendment. In discussing this proposed amendment with some of the stakeholders involved, a couple questions have been raised. I want to clarify my intention and turn the time over to Senator NELSON.

One question asked was, With respect to the external review, is this a de novo hearing? That is to say, does the external reviewer begin with whatever record is before it, but can bring in other witnesses, or consider other material or other factors or records in addition to that which may have been considered by the internal reviewer. The answer to that question is yes. I believe that is what the underlying bill provides. Our amendment intends the same. To the extent that would need to be clarified, we are willing to do that.

Secondly, there is concern that with respect to the negotiated rulemaking procedure that is provided for in the amendment, that the composition of the stakeholders be fair.

Obviously, we believe that should be fair. We believe that the providers need to have adequate representation in such rulemaking procedure, that all stakeholders should be represented.

I do not know what we can do to make our commitment any more firm, but to the extent anyone has a suggestion about how we ensure that fairness, it would certainly be our intention to do so.

In summary, we have identified a specific problem with the bill, a need to add a standard that is uniform and to ensure that the two extremes do not represent what occurs here. One extreme is that the external reviewer has no guidance and can just ignore the contract. The other extreme is that an HMO can draft a contract that is so strict that the reviewer has no ability to provide medically necessary care for the patient.

We are proposing a standard of care that can be utilized by the external reviewer to ensure that the patient receives the necessary care and that neither ignores the terms of the contract nor is so pinched that it would not be able to provide the care. That is why we have chosen the terms that apply to over 73 percent of Federal employees under the FEHBP that serves all the Members of Congress, our families, as well as other Federal employees. That is the language we have.

I ask my colleague, Senator NELSON, to speak to this. Senator NELSON has probably as much experience as anybody in this body with insurance contracts at the State level from his previous positions in Nebraska, as well as being Governor of the State of Nebraska.

It has been a pleasure for me to work with Senator NELSON who had the idea for this and brought a group together and expressed his idea. It made sense to me at the time. The more I work with him, the more sense it makes to me, and what he is proposing is desirable for us to do.

I urge my colleagues to respect the experience he brings to this issue from his perspective from the State of Nebraska which, I might add, is my State of birth. I am very pleased to have worked with Senator NELSON on this. Again, I just hope my colleagues respect the experience he brings to this particular issue.

I yield to the Senator from Nebraska.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. NELSON of Nebraska. Madam President, I appreciate the opportunity to join with my colleague, Senator KYL from Arizona, to support and pursue the opportunity for making certain there is a definition and a standard in the Patients' Bill of Rights legislation that will give certainty and clarity to the standard by which medical claims can be submitted and the providing of medical care can be made.

There is some concern about whether or not the Federal Employees Health Benefits Plan definition of ''medical necessity''—which is essentially the definition, the standard, if you will, that is being proposed in our amendment—is something where the Office of Personnel Management would be bound by the plan's determination.

We have never said that the plan, in this case the medical reviewer, would have to be bound by the plan, but they would have to be bound by the definition. That is what this is about. It is making certain there is certainty, clarity, and an understanding, a meeting of the minds, about what will be covered and to what extent, always subject to outside standards, outside review.

I support having a Patients' Bill of Rights that provides the kind of patient protections that are included within this bill. I support the opportunity for a patient to have a review from the internal side and from the external side, and I support the opportunity and the right of the patient to sue the HMO to ensure the medical decisionmaker in conjunction with any questions that are provided for in the level of support that is provided within the current bill.

It is important as the decisions are made about the claims that there is at least certainty and clarity as to a standard. I do not think even the proponents of the legislation would deny it is important to have a standard. As a matter of fact, I understand the history of this bill to some degree, and I know that in the past there was an effort to arrive at a standard. There were two groups with two different pieces of legislation, and they could not quite achieve an understanding as to what the standard should be or the definition. Perhaps out of frustration, and certainly out of not coming together, the decision was made to leave this open.

The problem with leaving it open is there is no basis of a standard; there is

no way to know what the definition of ''medical necessity'' can be. It can be about anything. When you have a contract and when you have two parties to it, an insurer and insured, you need some degree of certainty. That is what we are asking for, so you can know of what medical necessity truly consists.

As to the question about whether or not this language, which is taken right out of OPM's definition that is included in the Federal Employees Health Benefits Plan—as to whether or not that is adequate language, it seems to me there should be no question about it. This is to what the Federal employees are subject. You and I, those who are insured, are subject to the language, the standard, and the definition that is included within this amendment.

I find that it would be unusual if somebody objected to this standard, but our plan provides, even if there is a concern about this standard, that under the rulemaking and the negotiations of regulations another standard could be arrived at with the stakeholders to this legislation. The stakeholders, about 19 of them, would all be assembled, and if they did not like this particular standard, then they could achieve, upon agreement, another standard.

This is about having a standard, and there seems to be very little concern about whether or not the current standard that is included within this amendment is an adequate standard, certainly from the standpoint of Federal employees. In other words, if it is good enough for me, it ought to be good enough for other people. If it is good enough for the thousands of Federal employees, then it ought to be good enough to be included.

What does it provide? It provides that the determination of services, drugs, supplies, be provided by hospital or other covered provider appropriate to prevent, diagnose, treat, a condition, illness, or injury, and that they must be consistent with standards of good medical practice in the United States. That is a standard we can all live by because we cannot ask for more than having care that is consistent with standards of good medical practice in the United States.

There are some other requirements as well, but they are essentially the same as what I just read.

I cannot imagine anyone would want to argue for not having a standard or having a contract that is open-ended and not know that would, in effect, leave uncertainty, a lack of clarity, and an openness that nobody wants to propose or support.

I hope my colleagues will take a look at this as we fight to keep down the high cost of health care, the availability of health care, and that we work toward making this standard the kind of standard that can be included as part of the Patients' Bill of Rights.

Anything that establishes clarity and certainty is desirable in the context of this legislation, and certainly that is included within this amendment.

There are some who thought the standard might consist of something such as a cost benefit. This does not involve any kind of cost-benefit analysis regarding medical care. There are some who were concerned about that. I would be concerned about that. This does not do that. There is some concern that somehow the plan might not be bound by the decisionmaking. It is not, but it ought to be bound by the definition.

I realize this is a very complex area that the average person is not going to deal with every day, so I apologize for the complexity, but I do not apologize for having something that will simplify it, that will give us the certainty and the clarity of having a definition and a standard that we can all understand and one with which we can agree and against which good medical care, under good medical practice in the United States, might be compared. That is what we are looking for.

There is a proposal that I understand will be coming forth for consideration this afternoon that will solve part of this problem, but it does not solve the problem of the standard of care and the definition.

The PRESIDING OFFICER. Who yields time?

Mr. NELSON of Nebraska. I yield time to the Senator from Oklahoma.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. NICKLES. Madam President, I compliment my friend and colleague from Nebraska, Senator NELSON, for his expertise in this field. He and Senator COLLINS are probably more qualified in this field because they both worked in their respective States in their insurance departments, I think, as commissioners of insurance and they also have expertise in the field from years of experience. When Senator NELSON or Senator COLLINS talk about medical necessity, or being bound or exempt from contracts, they have a certain degree of expertise that the rest of us do not have.

I remember visiting with Senator NELSON and he brought up the medical necessity and the fact this bill before the Senate unfortunately voids contracts. It goes so far as to even say you have to cover things that are excluded.

Page 35 of the bill says: No coverage for excluded benefits.

That sounds fine.

But page 36 says: Except to the extent . . .

In other words, you don't have to cover items excluded in contracts. Except to the extent somebody considers it medically necessary—and so on, even if specifically excluded in contracts. Part of the Nelson-Kyl amendment clears that up.

On contract sanctity, I concur 100 percent. I mentioned a few things excluded under the CHAMPUS program for VA, specifically excluded in contracts under this bill someone might have to pay. They might even be sued if they do not provide a benefit specifically excluded in their contract. That sounds absurd but in reading the language, that could happen. The Nelson-Kyl amendment fixes this. Things excluded under CHAMPUS include: Acupuncture, exercise equipment, eyeglasses, contact lenses, hearing aids, hypnosis, massage therapy, physical therapy consisting of exercise programs, sexual dysfunction, smoking cessation, weight control or weight reduction programs.

The point is, almost every medical health care plan says we will pay for this list of benefits; we will not pay for these benefits. Those benefits would be excluded. This bill says they will be excluded, but maybe they should be paid for anyway and they will be subject to review. And if the reviewer says it is needed, it should be paid.

Part of Nelson-Kyl says no, we will strike the language that deals with ''except to the extent,'' allowing contracts to be contracts that would not cover excluded benefits.

That is exactly what the Federal Government does. Many people want to model private health care after the Federal employees health care benefits. We have many different plans. They work. Employees are happy.

Federal employees cannot sue their employer, and Federal employees have to be bound by the contract. If you look at the consumer bill of rights and responsibilities, in OPM's guidelines dealing with the Federal Employees Health Benefit Program, it says if someone wants to appeal, OPM seeks to determine whether the enrollee or family member is entitled to the services under the terms of the contract. It is bound by the contract.

Blue Cross/Blue Shield, 2001, it says OPM will review your disputed claim requests and use the information it collects from you to decide whether our decision is correct. OPM will determine whether we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send a final decision within 60 days. There are no other administrative appeals.

Interesting to note, the Federal Employees Health Benefits Plan, they appeal to OPM, appeal through their employer. This is not an independent review entity. Again, OPM will make their determination based on the contract.

The Senator from Nebraska and the Senator from Arizona say a contract should be a contract. We should adhere to the contract and have contract sanctity. We should have some definition, some certainty in the definition, and we even use the definition for Federal employees' fee-for-service plans as one option, as well as the rulemaking process that the Senator from Nebraska spoke about.

I think there are too many people voting ''remote control,'' thinking, I will vote with Senator KENNEDY or

with Senator MCCAIN on this issue. I hope they look at this amendment. Should you have contract sanctity? Should you look at the guidelines we use in the Federal Employees Health Benefits Plan to have some contract sanctity? It is obliterated by the underlying bill. I think so.

This is an excellent amendment, an important amendment. If you want a bill that preserves some sanctity of contract, I think it is most important we pass this amendment. I urge my colleagues to vote in favor of the Nelson-Kyl amendment.

Mr. ENZI. Will the Senator yield 4 minutes?

Mr. NELSON of Nebraska. I yield.

Mr. ENZI. Madam President, I thank the Senator from Nebraska for the care and concern that has gone into this amendment. I support it along with him. I know how important it is for businesses to be able to nail down the prices so they can provide this voluntary insurance to people. If they don't know how much it will cost, if it is going to rise astronomically, I guarantee the small businesses will bail out. That is what the discussion has been about this week and last week—how to continue to have insurance for people.

I am an accountant, the only accountant in the Senate. I like dealing with numbers. The people who really deal with numbers are the actuaries. They are the ones who have to figure out what the odds are that something is going to happen to people. The smaller the plan, the tougher it is to figure the odds. But those odds have to be calculated in order to figure out the price. If the actuary said figure the whole universe of things that could happen, normally we exclude the ones that are difficult to calculate, but you don't get to exclude those anymore. You have to figure it as though those could happen to the person, and some reviewer will charge your plan with that. So we cannot tell you what you are going to have to pay. We guarantee it will have to be a higher number because of the uncertainty.

It is extremely important we avoid the Russia syndrome or the China syndrome, where they don't have contracts worth anything. In this country we maintain the sanctity of contracts. It is time to do that again. It is time to do that, particularly to protect the people working for small businesses in this country so they will continue to have insurance.

This amendment is particularly important because it does several things. First, it allows both the employer and the employee to be certain about what benefits are covered under the health plan. If they can't know that, then what's the point of the contract. Second, the amendment will virtually guarantee that all health plan contracts will now have a great definition of medical necessity, which is the clause in a contract that's used to make many decisions on claims for benefits. If a health plan or employer chooses not to adopt a strong definition, as defined in this amendment, then they forgo their right to rely on that definition in making decisions on claims for benefits. That's achieved by allowing the independent reviewer in the external appeals process to ignore that definition if it's not among those listed in the amendment.

This amendment brings to bear two important consequence that go a long way helping this bill become law. Again, the contract, upon which not just the breadth of benefits is determined, but also the cost of health coverage to both the employer and employee is based, is made whole. And, the quality of health care in this country is set at a standard that will assure patients receive medically necessary care as determined by the standards in the best programs, namely the Federal Office of Personnel Management's definition for fee-for-service plans.

Mr. President, I again commend my colleagues for their work. Enacting this amendment is as important to preserving the employer sponsored health care system as anything else we may do on this bill. There's simply no reason why Members would vote to undo a health plan contract or against requiring that health plans adopt a strong definition of medical necessity.

Mr. NELSON of Nebraska. We reserve our time.

Mr. KENNEDY. We have 30 minutes?

The PRESIDING OFFICER. That is correct.

Mr. KENNEDY. I yield myself 10 minutes.

I agree with our friends and colleagues, the Senator from Oklahoma, about the competency of my good friend, Senator NELSON, as well as the Senator from Wyoming, Senator ENZI. I learned, as I worked with Senator ENZI on a number of different issues, including OSHA, about his enormous capabilities as an accountant in dealing with numbers. I have also had the good opportunity to work with Senator NELSON on this issue. I think there are few Members of this body outside the committee or inside the committee that have taken more time than the Senator to understand the details of this legislation. He has a commanding knowledge of this legislation and a very healthy understanding and respect about what is happening in the State and local communities. He has been enormously attentive to detail and concept.

We do not always agree on every provision, but I have certainly developed a deeper understanding of the impact of this legislation from my conversations with him.

Even though we differ on the substance on this particular issue, which I think is an important issue, I have enormous respect for what he has brought to this whole debate on the Patients' Bill of Rights. I value, very much, his continued involvement in this debate.

I will mention briefly what we have in the legislation and why I believe it is wise to retain the approach we have currently. It has the complete support of the American Medical Association, the cancer organizations—I will refer to those later—and the overwhelming support of the medical community. It has evolved over a period of time. I will reference that in just a moment or two as well.

But it does, I think, meet the standard that has been mentioned here about certainty, clarity, and predictability. That is what the proponents of this amendment have asked for. We have just done that on page 35, in establishing the particular details of our standard. I will give brief reasons that we ought to retain this.

The McCain-Edwards-Kennedy bill allows the doctors, not the HMO accountants, to make the important medical decisions and it prohibits the HMOs from using arbitrary definitions of medical necessity. Unfortunately, the proposed amendment would undermine this crucial protection and allow plans to use definitions of care that may harm the patients.

Our legislation asks every Senator the basic question: Do you support the doctors making the critical medical decisions or do you want the HMOs to continue to deny care based on language that puts dollars before lives?

The independent medical reviewer should consider the definition decided by the health plan. However, we should not bind their hands by arbitrary definitions by an HMO. Senators MCCAIN, BAYH, and CARPER will offer an amendment later today that reflects the bipartisan belief that reviewers cannot approve services that are not explicitly covered under any circumstances. If a plan covers 30 days of hospital care, a plan cannot say they should cover 100 days. This amendment underscores the premise in our bill that a reviewer should not be bound by an unfair HMO definition of medical necessity. In circumstances where explicit coverage decisions are subject to interpretation, the reviewer should have the opportunity to weigh all the relevant medical facts.

I gave the example last evening. If the plan says ''no cosmetic surgery'' and there is a cleft palate on a child, I could see an independent reviewer saying as a matter of medical necessity it is imperative that we correct the cleft palate and would be justified in doing so. If, in the plan, it said ''no cosmetic surgery and no cleft palate,'' the medical reviewer would be prohibited from doing so. So there is that degree of interpretation in terms of medical necessity, that aspect of judgment that we want to give to the doctors in dealing with this issue.

The Kyl amendment, once again, I believe gives the HMOs the opportunity to deny critical care by allowing them to use definitions of medical care that are stacked against the patients. This amendment also prevents independent

reviewers from weighing all the relevant factors needed to make a fair decision. In addition, the amendment proposes to institute a complex rulemaking process to define medical necessity. However, administrative rulemaking is only as fair as the participants. If the participants are hostile to patients' rights and sympathetic to HMOs, they could undermine care for millions.

As CHARLIE NORWOOD said, if reviewers are forced to wait on regulation at the speed HCFA moves, leeches might still be considered medically necessary and appropriate.

Also, under this amendment the plan gets to choose any of the numerous definitions for medical necessity. It can seek out the worst of the worst, but consumers get no comparable rights to demand the best of the best. All you have to do is look at the range of definitions and it is easy to see why the disability community, the cancer community, the American Medical Association, and other groups are so vehemently opposed to this amendment. It fails to protect the patient and allows the health plans to continue to deny medically necessary care. That is why the overwhelming number of medical groups support our language.

Some of the standards that they could pick from say cost-effectiveness should help determine whether care should be provided. It might be cost-effective, for example, for an HMO to amputate a young man's injured hand, but what about the cost of having to spend the rest of your life without the full use of limbs? It might be effective for an HMO to pay for older, less effective medication for depression, but what about the cost to a mother trying to raise her family while dealing with the harmful side effects that could have been prevented by newer medication? Why should we subject the American people to them?

I urge my colleagues to reject this amendment. Passing it would reverse the strong bipartisan efforts we have worked out in this legislation.

Let me mention here the letter from the National Breast Cancer Coalition:

> On behalf of the National Breast Cancer Coalition and the 2.6 million women living with breast cancer, I am writing to urge you to oppose the Kyl amendment and to support the McCain-Bayh-Carper amendment on medical necessity. The National Breast Cancer Coalition is a grassroots advocacy organization made up of more than 600 organizations and 10,000 individual members all across the country who are dedicated to the eradication of breast cancer through advocacy and action. With regard to the enactment of a strong, enforceable Patients' Bill of Rights, the NBCC believes the determination about what is medically necessary must remain in the hands of physicians, not HMOs. The coalition is concerned the Kyl amendment would weaken the provisions in the McCain-Edwards-Kennedy Patients' Bill of Rights and would allow financial decisions to override the medical judgments on patient care.

Let me just mention some of the definitions which have been used. Here is a definition that is used in terms of medical necessity. As I mentioned, the history of this is that we did have a definition in the previous legislation that was passed. What we used for medical necessity at that time was this:

> Medically necessary or appropriate means a service or benefit which is a generally accepted principle of medical practice.

That is what virtually every Democrat voted for. That gives the maximum flexibility to the doctor.

When we got to the conference and began to work this out, the HMO industry said this definition was so broad and wide, in terms of interpretation, that it could mean anything. Therefore, it would completely override the contract terms of the HMOs.

Then we altered it and said: In the internal review they will use the definition of the HMO, but in the external we will use a different definition. That is what is in the legislation. That is basically what is in the Breaux-Frist, as well as in the McCain-Edwards-Kennedy.

Basically, it says ''a condition shall be based on the medical condition of the participant''—therefore you look at the medical condition of the principal—''and valid, relevant scientific evidence and clinical evidence including peer review, medical literature or findings, and including expert opinion.''

The PRESIDING OFFICER. The Senator's time has expired.

Mr. KENNEDY. I yield myself 3 more minutes.

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

Mr. KENNEDY. The expert opinion is critical. The essential element of that—which I know has been questioned—was talked about and essentially agreed to in the conference last year.

This is the concern we have. Here are some of the definitions which have been used in various HMOs, and even in Federal health insurance. The difference, in Federal health insurance is if there is an appeal of it, they leave it completely open. I asked staff to get the standard that is used. It is completely left to the doctor. That is where we want it, to the greatest extent possible. We have limited it as I have defined it. But these are some of the concerns.

This is in SIGNA, in terms of medically necessary:

> . . . that are determined by our medical director to be no more required than to meet your basic health needs.

So this definition is going to be what the plan's medical director decides. Clearly, they are going to be biased in the HMO.

This is the Hawaii State plan: Cost effective for the medical condition being treated compared to alternative health intervention, including no intervention.

Cost effectiveness is unacceptable. It is more cost effective for the HMO to put someone in a wheelchair rather than for them to have hip surgery. But it is more effective to the individual to have the hip surgery.

Here is another one:

A treatment that could reasonably be expected to improve the member's conditions or level of functioning.

Even though it is used by the Health Alliance HMO in the Federal health insurance, the problem is that for people with disabilities, the treatment may not be for a condition that can improve, but it certainly may improve the quality of life.

Here are the Pacific Care Health plans furnished in the most economically efficient manner.

''Economically efficient'' is a problem.

Again, it is what procedures are the most cost effective.

We have to be very sure about what we are going to have. We have a good definition in this proposal. It is supported by McCain-Edwards and myself and is also essentially the provision in Breaux-Frist.

It has the overwhelming support of the American Medical Association, as well as the Cancer Association, and is spelled out in this legislation. So there is certainty.

If there is a change on this, we can come back and revisit it. I give the assurances to my friends that we can. But the idea that we are going to give the authority to a panel that will be set up by the Secretary—the makeup of which we don't know—which can propose something, still indicates that we don't know what is going to come out. That doesn't seem to me to be the way we ought to go in giving predictability and certainty to patients. If we are interested in that, we ought to get criteria that is sound, responsible, and gives medical professionals the ultimate ability to make judgments to protect the patient.

That is what we do in this legislation. That is why I don't believe we should alter or change the proposal.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Madam President, how much time remains on our side?

The PRESIDING OFFICER. Ten minutes.

Mr. KYL. I yield myself 2 minutes.

I am very sorry to have to say this, but the amendment that Senator KENNEDY has just proposed is not our amendment. I want to be very clear about what our amendment does. The amendment that Senator KENNEDY has been talking about was part of last year's bill.

When Senator NELSON came forward this year, he said: Let's try to come up with something new. We did that. So the language we have before us today is not the language to which Senator KENNEDY has been referring.

When he talks about the Signet language and the other plan language, that would be absolutely prohibited by what we are talking about here. That was last year. We would absolutely prohibit that. When he talks about the

plans choosing from among a range of definitions that could include cost effective, that would be absolutely prohibited under our language. That was last year.

Let me again restate what we did this year.

Mr. KENNEDY. Will the Senator yield on my time?

Mr. KYL. Absolutely.

Mr. KENNEDY. What I read here is ''what is determined by our medical director to be no more required than to meet your basic needs.'' That is in the Federal health insurance program. That would be included. The language I have read is ''the treatment that can reasonably be expected to improve the member's condition or level of functioning.'' The Federal employees' plans are included.

The last one, ''furnish in the most economically efficient manner,'' that is Federal employees. That is included. All three are included because the Federal employees' insurance has been included as well.

What is not included is discretion that is given to the medical doctor. The review of that is provided in the Federal employees' plans, and OPM is using it. It is not included in the underlying.

Mr. KYL. If the Senator will allow me to answer, that is a factual matter. I will not argue with his answer. I think I can explain the reason for the confusion. But the answer to the Senator's question is no. What the Senator said is not correct. That was correct a year ago because a year ago the language of the amendment was that you took the FEHBP standard. And the Senator would have been correct a year ago because it was both the fee-for-service standard as well as the managed care contract standard.

So the criticism that the Senator levels would have been correct criticism a year ago. And to some extent, I agree with the Senator from Massachusetts about that criticism. We threw that aside. Instead, we asked: What is the contract that governs the fee-for-service FEHBP plans? The contract that governs, we think, 73 percent of the people—in other words, about 6 million people—is the language that they have approved for the Blue Cross/Blue Shield fee-for-service contract, as well as some others. We didn't want to allow any discretion whatsoever. So we took the five specific provisions of that contract. Those are embodied in the legislation. There is no discretion.

If you want a safe harbor now under this amendment, you would have to write your contract with those five items, and only those five items. That is what the reviewer then would be able to review.

If I could just continue on with respect to the negotiated rulemaking, it was our idea that if anyone didn't like those five items, and all of the stakeholders would want to get together and negotiate something different, we would be very amenable to that. So we set up this voluntary rulemaking procedure.

If the Senator from Massachusetts and others think there is something wrong with that and they would not want to create that option in the bill, we are very amenable to dropping that out. We thought we were doing people a favor by putting that option in so that if somebody didn't like these five items, they could engage in this negotiated rulemaking. But anybody in the negotiations could veto it so that it wouldn't go into effect.

But if people somehow fear that, it is not our intention to try to superimpose some nonspecific standard.

If the Senator would like to engage further on that, we can certainly discuss that. I indicated to the Senator last night our willingness to discuss that. I hope I have cleared it up. I understand the reason for the confusion because that was last year's amendment.

Our amendment language was only available a couple of days ago. So it is understandable that one might not have been able to read our amendment language. But I assure the Senator that our language is very specific and very different from that which he criticized.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. NELSON of Nebraska. Madam President, I understand the passion of my colleague from Massachusetts. He has done such great work in this area, and I truly appreciate and respect what he has done and the fact that he has taken a very careful look at what we are proposing.

I suspect, though, that he would maybe look at me as a person who came to the party late and wants to rewrite the invitation. You can't try to change something where there has been such a history without encountering some resistance to it. I understand there is resistance to wanting to change this because it was dealt with last year. But you don't weaken this bill by making it more certain.

I don't believe there is a problem. But if there is a problem within the Federal Employees Health Benefits Plan because there is not a good standard there, we can correct that by passing this amendment and this Patients' Bill of Rights, and make Federal employees subject to the Patients' Bill of Rights.

My colleague from Massachusetts mentioned that there is perhaps a different manner of review for Federal employees where they have to go directly to the Office of Personnel Management rather than getting an internal or external review. We can correct that. We can make that plan subject to the Patients' Bill of Rights, and we can correct that. Or we ought to take a look at that independently.

But this does not change anything that would be detrimental to those individuals my colleague from Massachusetts mentioned.

For example, of the list of people, such as a person with a cleft palate, the only question about a person with a cleft palate is whether that treatment, in the judgment of the medical professional, the doctor, would be consistent with the standards of good medical practice in the United States. That is the dynamic, and I am sure that it would. There is nothing static about this definition. It will continue to change as the good standards of medical practice in the United States change.

My good friend also mentioned something about making sure that we have our loved ones well protected. I agree with him and include the Federal employees as part of our loved ones. I think we want these standards to apply to all Americans. The way in which you can do that is by adopting this amendment on medical necessity.

What it does not do is, it does not change the doctor's decisionmaking in relation to what kind of care to provide. What it does say is that it has to be consistent with the standards of good medical practice in the United States.

I, for the life of me, do not see what the resistance to this language is, other than the fact that we tried to do it a year ago. We had the Stanford definition. We talked about other definitions a year ago. Now we have come up with a definition which I think is an excellent definition that will do it, that will establish the standard for certainty, for predictability. And now we are saying it may weaken the Patients' Bill of Rights. But certainty will strengthen this. There is no effort here to do anything that would not be consistent with—as a matter of fact, the language requires that the medical profession do something consistent with the standards of good medical practice. Whether it is an amputation, whether it is a cleft palate, whether it is deciding on cancer care, or whether it is deciding on other kinds of care, all we are saying is it ought to be subject to these standards. That is the only point that is being made.

Mr. President, how much time remains?

The PRESIDING OFFICER (Mr. CARPER). The Senator from Nebraska has about 4½ minutes remaining. The opposition has 13 minutes remaining.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I am glad to yield——

Mr. MCCAIN. Will the Senator allow me a couple minutes of time?

Mr. KENNEDY. Yes. Absolutely. The Senator from North Dakota was looking forward to talking, but whatever.

Do you want me to yield 3 minutes?

Mr. MCCAIN. How much time?

Mr. KENNEDY. I yield 3 minutes to the Senator.

Mr. MCCAIN. I thank the Senator from Massachusetts, and also the Senator from North Dakota. I would be glad to wait until after the Senator from North Dakota speaks, if he prefers.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. Mr. President, I have major concerns about the Kyl-Nelson amendment and unfortunately, must oppose it. While I certainly respect the intentions of my dear friend and follow Arizonian, JON KYL, I respectfully disagree with him regarding this proposal.

I simply can't support mandating a Federal statutory definition of ''medical necessity'' that is vague and creates further confusion and barriers for patients attempting to get the medical care their doctor deems appropriate, and is covered by their HMO plan.

This amendment would put into statutory language a vague definition that allows health plans to determine whether services, drugs, supplies, or equipment are appropriate or necessary to prevent, diagnose, or treat a patient's condition, illness, or injury.

While this appears reasonable, it simply is not.

One of the major hurdles currently facing patients is the repeated denial of their medical care on the basis that it is not medically necessary based on a vague or constraining definition. The health plans are intentionally denying care to constrain costs by hiding behind cleverly crafted definitions.

This amendment would allow this practice to continue.

For example, part of the definition allows a plan to determine whether the recommended medical care is, ''primarily for the personal comfort or convenience of the patient, the family or the provider . . .''

It sounds reasonable, but it is not. This is already being used to prevent patients from receiving palliative care for managing the intensive pain they encounter while battling cancer or other serious illnesses.

Another portion of the proposed definitions reads, ''Consistent with standards of good medical practice in the United States'' . . .

Again, appears harmless, but it isn't. Who establishes the standards of good medical practice? What basis is used for developing them? How current, considering the pace of new technology and medical research will these standards be?

Another portion of the proposed Kyl-Nelson Federal definition reads, ''In the case of inpatient care, [the care] cannot be provided safely on an outpatient basis . . .''

Legally, this creates an opportunity for retrospective reviews by HMOs thereby leaving the patient and/or medical provider responsible with the incurred costs from the inpatient care that the HMO determines should have been provided on an outpatient basis.

These are just a few of the problems facing patients if this amendment is adopted.

I wholeheartedly agree with my colleagues that we can't create a method that obviates health plan contracts and that is not what our bill does.

Our bill does not empower the independent medical reviewer to override existing health plan contracts or force HMOs to cover anything and everything despite a service being specifically excluded in the contract.

Our bill relies on the independent medical reviewer to give patients a second medical opinion when such a medical opinion is necessary to interpret the plan's coverage, but it does not empower them to disregard the plan's specific coverage exclusions and limitations.

I will be offering an amendment after the scheduled vote on the Kyl-Nelson amendment that will further clarify this and protect the sanctity of the plan's contract with a patient.

I urge my colleagues to reject the Kyl-Nelson amendment and allow patients to have their medical decisions made by doctors and nurses and not by HMO lawyers or bureaucrats.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, how many minutes do I have remaining?

The PRESIDING OFFICER. The Senator from Massachusetts controls 10½ minutes.

Mr. KENNEDY. I yield 8½ minutes to the Senator.

The PRESIDING OFFICER. The Senator from North Dakota is recognized for 8½ minutes.

Mr. DORGAN. Mr. President, this is a well-intentioned amendment, but it must be defeated because it is aimed right at the heart of this patients' rights bill, right at the core of the bill. The question is, Who is going to make the decisions? Who will make decisions about medical care? An MBA or an MD? Who do we want to make the decisions about medical care?

The McCain-Edwards-Kennedy bill allows doctors and patients to make fundamental decisions about their care. It will be based on medical necessity and appropriateness and supported by valid, relevant scientific and clinical evidence. In other words, if an HMO makes an arbitrary decision about some kind of a treatment they believe is not medically necessary, based on its own inadequate definition of ''medical necessity,'' the reviewers would be able to overturn that and advocate treatment.

Under this amendment put before the Senate, the patient would be bound to the HMO's decision and have literally no options; the independent reviewer would have no authority whatsoever to recommend treatment if it was needed.

The Senator from Massachusetts read a list, and he was challenged on that list. But the fact is, the list he read is absolutely correct.

Let met do this in English, if I can. The amendment, as I understand it, allows an HMO or managed care organization several different approaches to deal with the issue of what is medically necessary. How do you define medically necessary? Several different ways. One is a mechanism described by the Senator from Massachusetts. He read some of those definitions. He was accurate about that. But there are two other mechanisms by which an HMO could describe what is medically necessary.

Do any of us think the HMO will pick the more stringent approach? Of course not. They will pick the least effective approach, the approach that poses the least cost to them. They will pick the weakest of the options. That is what the Senator from Massachusetts was saying.

Give the HMO the opportunity, and they will pick the least possible option, the least costly option for themselves. That is why we are in this Chamber with this patients' protection bill. This amendment strikes a blow right at the heart of the patients' rights legislation. The reason we are in this Senate Chamber is to work on providing patients' rights, not take them away.

Let me do this in a bit more dramatic way.

One of our colleagues has used this photo from time to time. This photo shows a young baby with a cleft lip and cleft palate, which is a very severe problem. We are told that about 50 percent of the time fixing this would be described as ''not medically necessary'' by an HMO. Can you imagine a health care plan saying: ''No, fixing this disfiguring defect is not a medical necessity, therefore, we will not cover it''.

Let me describe what this child will look like with that problem fixed. This photo is of a child with reconstructive surgery. This other photo is of a child with the severe problem before it is repaired. Fifty percent of the time managed care organizations have told those requesting reconstructive surgery for a cleft lip or palate: ''No, you are wrong. This is not medically necessary. And we will not cover it''.

Is that how we want our health care system to operate? It will be allowed if this amendment is adopted.

Let me describe another case. I am going to describe how this case relates to this amendment.

This is a photo of Ethan Bedrick. We have spoken about Ethan before. Ethan was born on January 28, 1992. He had a partial asphyxiation during birth, a very significant problem in delivery. He has suffered from severe cerebral palsy and spastic quadriplegia, which impairs motor functions in all his limbs. At the age of 14 months, his managed care organization abruptly cut off coverage for all of his speech therapy, and limited his physical therapy to 15 sessions in a year. A doctor from his managed care organization performed a ''utilization review.'' He said that there was only a 50-percent chance of Ethan being able to walk by age 5, which is ''insignificant'' and, therefore, they would restrict coverage.

So let me say that again. A 50-percent chance of being able to walk by age 5 was ''insignificant'' and, therefore, they would not cover the therapy.

His parents went to court 3 years later. A judge said:

The implication that walking by age 5 . . . would not be ''significant progress'' for this . . . child is simply revolting.

But in the meantime, it took 3 years, and this child did not have the therapy he needed for 3 long years.

My point about this is, young Ethan Bedrick, or a young child with a cleft lip and a cleft palate, running into a plan that has a provider service saying: ''These are not medically necessary procedures, and we will not cover them,'' will have no ability to have an independent reviewer overturn that under the amendment that is offered today.

Mr. KENNEDY. Will the Senator yield?

Mr. DORGAN. I am happy to yield.

Mr. KENNEDY. For the benefit of the membership, we had scheduled a vote at 12:30. With the agreement of the leadership, that vote will be postponed until 2. At 1 o'clock, Senator GREGG will be here to offer an amendment for himself. At 2, it is the anticipation of the leadership that there will be two rollcall votes. We have not made the unanimous consent request yet, but that is the intention of the agreement of the two leaders. After the time expires, we will make that unanimous consent request.

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

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. From 12:30 until 1 o'clock there will be general debate on the bill.

Mr. MCCAIN. If the Senator will yield?

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. I note the presence of the Senator from New Hampshire on the floor. We really have an issue of scope, an amendment we need to bring up, and of course the so-called Snowe compromise amendment as well. I hope we will be able to put both of those in some kind of order in some way today.

Mr. REID. Mr. President, the Senator from Arizona is absolutely right. Progress has been made but not nearly enough. Since Senator GREGG is here, I wonder if we could restate the unanimous consent request and have that entered at this time. The only suggestion I would make to Senator KENNEDY is that we should have general debate from 12:30 to 1 on the legislation.

Mr. KENNEDY. That is fine.

Mr. GREGG. Is there a unanimous consent request pending?

Mr. KENNEDY. As I understand, the time will expire in how many minutes for the debate on this amendment?

The PRESIDING OFFICER. The Senator from Massachusetts has 3 minutes to go, and the other side has 4 minutes.

Mr. KENNEDY. As I understand it, there has been agreement to vote on that amendment when the time is used or yielded back; am I correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. KENNEDY. I ask unanimous consent that the vote on that amendment be put off until 2 o'clock.

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

Mr. KENNEDY. It is the anticipation of the leadership that between 12:30 and approximately 1 o'clock there will then be general debate on the legislation. At 1 o'clock an amendment will be laid down by the Senator from New Hampshire or his designee. It is anticipated there will be a second vote at 2 which will be on that amendment.

Mr. GREGG. Mr. President, I can't guarantee that there would be a second vote at 2 on that amendment, unless the parties to that amendment are agreeable to that.

Mr. KENNEDY. Then I withdraw my request. I was asked to make that request; if there was going to be no objection, that was going to proceed. Otherwise, we will go ahead.

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

Mr. KENNEDY. I had asked if the Senator would yield. The Senator from North Dakota has the floor.

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

The PRESIDING OFFICER. The Senator from North Dakota has about 2 minutes.

Mr. DORGAN. Let me continue by saying, I understand that those who have framed this amendment will not agree with my assertion. But I also understand that they are trying to craft something that defines what is medically necessary in a manner that would give a managed care organization three different options to restrict care.

In my judgment, the managed care organization will clearly select the option that has the least amount of coverage or the least cost to them. That is precisely why we are here in the first instance. We are trying to see if we can create a Patients' Bill of Rights that allows a doctor and health care professionals to make judgments about what kind of treatment is appropriate. We have story after story after story about health care professionals making a decision about what kind of health care is necessary for a patient only to be told later that someone 1,000 miles away an insurance office decided, no, this was not medically necessary at all, and we won't cover it. We don't agree the physician's decision or recommendation for treatment.

The reason the AMA and nurses and others support this legislation of ours is they believe very strongly that health care professionals ought to be the ones practicing medicine. The American Medical Association is very strongly opposed to this amendment.

I ask unanimous consent to print a letter the AMA has sent objecting to this amendment in the RECORD.

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

[From the American Medical Association, June 26, 2001]

AMA OPPOSES KYL-NELSON AMENDMENT THAT LETS MBAS—NOT MDS—MAKE MEDICAL DECISIONS

AFTER 7 YEARS, THE DEBATE HAS SUDDENLY COME FULL CIRCLE

WASHINGTON.—Today the American Medical Association (AMA) called on Congress to defeat a Kyl-Nelson amendment that would negate a core provision of the patients' bill of rights. This new medical necessity amendment would allow insurance company bean counters to make medical decisions.

''Today, after seven years of debate, it seems some lawmakers want to start over at the beginning, with the core question: Who should make your medical decisions—MDs or MBAs?'' said Dr. Thomas R. Reardon, MD, AMA past president. ''For patients and physicians there's no debate: Decisions about the health care a patient needs must be left to those who are focused on patients—not on the bottom line.''

''The Kyl-Nelson amendment uses a medical necessity definition that allows health plans to determine whether services, drugs, supplies or equipment are appropriate to prevent, diagnose or treat a patient's condition, illness or injury.'' Dr. Reardon said. ''This is a big step backward.''

Insurers and business have repeatedly opposed defining medical necessity in legislation: ''A federal standard of medical necessity will raise premiums, threaten quality, and jeopardize efforts to prevent abuse.'' (Blue Cross/Blue Shield, 2/99); ''We fear a congressionally mandated definition of medical necessity, and therefore do not support it.'' (Ford Motor Company 2/99).

''It's clear that health plans put profits before patients when they define medical necessity as the 'shortest, least expensive or least intense level of treatment,' Dr. Reardon said. ''People get health insurance so that they're not limited to the cheapest care—no matter what the outcome.''

''The McCain bill allows physicians to make medical decisions and allows an independent panel of reviewers to determine disputes. AMA calls on the Senate to reject the Kyl-Nelson amendment that guts the patients' bill of rights,'' Dr. Reardon said.

Mr. DORGAN. They are opposed precisely because they understand this amendment absolutely unravels the central and vital section of this bill dealing with medical necessity. Our patients' rights legislation provides a structure by which doctors make decisions and then you have the opportunity for independent review if needed. But in the circumstance as proposed in the amendment up for debate, if we create definitions that allow diminishment of the level of care in terms of what is medically necessary, the independent reviewer will have their hands tied and patients will not get the care they deserve or need.

This is a very carefully drafted bill. I am not in any way ascribing mal-intent to anyone who offers this amendment. This amendment will unravel the bill in a very significant way. We must defeat this amendment. We should defeat this amendment and preserve the patients' protections legislation that we have brought to the floor of the Senate. This has been going on 5 years. This is good legislation. We ought to pass it and defeat the amendment.

I yield the floor.

The PRESIDING OFFICER. The time controlled by the manager of the bill has expired.

Mr. KENNEDY. Mr. President, I think the Senator has 2 minutes. I have 2 minutes; is that correct?

The PRESIDING OFFICER. The sponsor of the amendment has 4 minutes remaining. All time has expired in opposition to the amendment.

Mr. DORGAN. Mr. President, that cannot be the case. The Senator from Massachusetts allotted 8 minutes to me. At that point, he had 10½ minutes remaining. It cannot be the case that we have exhausted our time.

The PRESIDING OFFICER. The time of the colloquy back and forth between the Senator from Massachusetts and the Senators from New Hampshire and Nevada was charged to the manager.

Mr. GREGG. I ask unanimous consent that the Senator from North Dakota have another 10 minutes, if he desires.

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

Mr. DORGAN. Mr. President, I yield my time to the Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I will take the 2 minutes which I otherwise might have had if we hadn't entered into the request.

Here we go again with greater hope in our hearts that we will be successful.

After the yielding back of the time, we intended to vote on the Nelson amendment. At the request of the leadership, I ask unanimous consent that that vote be put off until 2 o'clock.

Mr. REID. Reserving the right to object, I have been informed that there will be a motion to table made on the amendment. That will be done at the appropriate time.

Mr. KENNEDY. At 2 o'clock. It is anticipated that at 1 o'clock there will be an amendment from the Senator from New Hampshire or his designee. I am informed that it will probably be the Senator from Tennessee, Mr. THOMPSON; and that we will begin the debate on that at 1 o'clock and that the time between 12:30 and 1 will be used for general debate.

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

Mr. KENNEDY. Mr. President, I apologize to my friend for the interruptions because the Senator has been patient during his presentation and is typically kind and generous to permit the workings here.

I believe we have a good, solid definition in terms of medical necessity that has been reviewed, evaluated and has gotten broad support. It has bipartisan support. It also has the very, very strong support of the medical community: The American Medical Association, all of the cancer organizations, as well as the disability community. They all have great interest in what that definition is.

In too many instances in the past there have been definitions that have been offered and accepted that work to the disadvantage of patients. For example, definitions have been made that do not include palliative care for patients who have cancer or don't recognize the very special needs of the disabled.

We have a definition here. It is defined in the legislation. It has been reviewed. It is careful. It is predictable. It is certain. It does provide for doctors to exercise their best medical judgment. It is completely consistent with the purposes of the legislation.

As I mentioned, I have great respect for my friend and colleague. I think on this we should stay with the language which should be included and which has the broad support, virtually the unanimous support of the medical community.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. NELSON of Nebraska. Mr. President, I appreciate the opportunity to engage in a dialog with my colleague from Massachusetts. As I indicated earlier, I respect his work and many years of effort in this field. I certainly respect his judgment. If I would disagree with him, it would be that somehow there is a standard that is currently in place. As a matter of fact, last year they tried on numerous occasions to achieve a standard. They could not come up with one where they agreed. So they agreed to disagree and left the standard out.

We have an opportunity now to come up with a standard that is good enough for Federal employees and put that in this bill. If it is good enough for Federal employees, then of course I think it ought to be good enough for the rest of America.

As to the charts that were shown, I ask, is there anybody in this Chamber today who believes that under the definition of consistent with standards of good medical practice in the United States, any doctor would not have ordered that the cleft palate be treated?

I understand the importance of having charts. I understand the importance of having faces put on the patients. But I think it is important that, as we do that, it be very clear that we understand that these cases would be treated appropriately under the standards of good medical practice in the United States. So I think we really have an opportunity today to provide more clarity, so that doctors who will have the opportunity to make medical decisions and order care will be able to do so consistent with standards.

There is no way that this amendment today is designed to take away any of the authority of the doctor at all, or any other health care provider. All that it is aimed at providing is a standard. If they had come up with a standard last year and it were included in the bill, I would not be raising the question this year. This issue today is about whether to have the standard or not. I can't imagine we are even debating it. We ought to be debating what the standard is. That isn't the debate we have today.

As a matter of fact, some of the objections raised earlier about this amendment could be equally said of an amendment that I suspect the Presiding Officer will be supporting today a little later, and that is to make sure you don't have those exclusions from a policy, those exclusions from a contract, ignored by a medical examiner in the whole process of the review.

The important point here is that this will provide an opportunity, upon an internal or external review, for a medical reviewer to make good decisions consistent with good medical practice, consistent with the needs of the patient, so that the conditions in those pictures that were shown here—very vivid descriptions—can and will be taken care of and will not be left open without a definition, without a standard. The boundaries would be set, but they would be far broad enough to cover that and any other condition that was discussed here as an example this afternoon.

It seems to me it is important that we establish a standard, and if I wanted to oppose what I am proposing today, I would come in and I would say that it was going to do something bad, that it was not going to permit something good. But that doesn't make it so. It is important to point out the language and deal with the reality of the words of this amendment, rather than setting up a straw man to attack and say that it is doing something or it won't do something that it is in fact doing.

Mr. President, how much more time is there?

The PRESIDING OFFICER. The Senator has about 8 seconds.

Mr. NELSON of Nebraska. I ask my colleagues to support this amendment and move forward with the important work of the Patients' Bill of Rights. We can do that. This will improve it and will not detract from it.

The PRESIDING OFFICER. The Senator from New York is recognized.

Mrs. CLINTON. Mr. President, I have the greatest respect for my good friend, the Senator from Nebraska, and I rise reluctantly, but firmly, to oppose the amendment he is sponsoring, along with Senators KYL and NICKLES, because I am concerned not only about the general issues that have been raised by other opponents, I am concerned also by the American Medical Association's very strong and vigorous opposition to this amendment, which they have made very clear to me and my office, as well as, I believe, every other Senator, because of their deep concern that this would be a step backward, permitting health plans to determine the services, drugs, supplies, or equipment necessary to prevent, diagnose, or treat a patient's condition, illness, or injury.

But I have a very specific reason for opposing it. I direct this to my good friend from Nebraska because this is something that deeply concerns me. This amendment allows health plans to define ''medically necessary and appropriate'' in a way that poses a great threat to all patients and families who

require hospice and palliative care to treat the suffering associated with terminal illness.

The Washington Post, just a week ago, published a story outlining the various ways in which recent advances and end-of-life care have not yet reached children with terminal illnesses, causing an enormous amount of suffering for dying children and their parents and loved ones who have to watch that suffering at the end stages of a terminal illness. The article quotes one mother who says, looking back on her daughter's death, that ''pain is such a huge problem.''

There are two specific phrases within the safe harbor of the ''medically necessary care'' language in the Kyl-Nelson-Nickles amendment that directly undermines the needs of dying patients. First, the amendment declares that care provided ''for the comfort of the patient'' is not medically necessary care.

Any health care professional—or really any person, such as myself—who has stood at the bedside of a dying friend or a loved one knows that comfort of the patient is absolutely necessary and is often the most appropriate goal of care in those last days, weeks, and even months sometimes. At the very center of palliative care, and particularly in the hospice movement, is the belief that each of us has a right to die free of pain and with our human dignity as intact as possible.

The Institute of Medicine released a ground-breaking report in 1997 that concluded ''too many people suffered needlessly at the end of life.'' A second Institute of Medicine report released last week also concluded that patients are suffering unnecessarily. Furthermore, studies have shown that specific types of patients—patients who are elderly, female, African-American, or children—are less likely to have their pain adequately controlled at the end of their lives.

The Kyl-Nelson-Nickles amendment is legislation that could be termed as declaring that the comfort of dying patients is not a legitimate goal of medicine. But to me, that has it backwards. Isn't the relief of suffering exactly what doctors are supposed to be concerned about?

A second and related problem is that this amendment allows plans to define as ''medically necessary'' care that is appropriate ''to treat a medical condition, illness, or injury.'' This narrow definition compromises the delivery of appropriate care to dying patients by failing to recognize the legitimacy of care that focuses on the palliation of pain rather than a cure. This definition actually encourages overuse of invasive—and often futile—medical treatment and the underutilization of hospice and palliative treatment.

The Institute of Medicine report released this month concludes that ''policies and practices that govern payment for palliative care hinder delivery of the most appropriate mix of services.'' A chapter of that report focuses on the terrible effect these policies have had on children. It found that services necessary to provide dying children and their parents with comfort and counseling are not recognized and certainly not even reimbursed by many insurance programs.

I believe the definition of ''medically necessary care'' proposed by this Kyl-Nelson-Nickles amendment would further obstruct access to hospice and palliative care services for patients suffering from terminal illness.

We have not done enough to relieve pain and suffering at the end of life. I served for many years on the board of a children's hospital. Back in those days, the idea of giving strong medication to a dying child was really not even considered a possibility for many reasons. People were not sure about the appropriate dosage. Some people were worried even with a dying child that the child might become addicted to strong pain relief medicine.

I have also seen friends who, at the end of their lives, had to cry out for and demand pain relief from an almost unbearable burden. They did not want to leave this wonderful life, but they knew that was going to happen and they wanted to do it in a way that relieved both them and their loved ones of the agony that comes at the end of so many devastating illnesses.

There are many wonderful hospice programs in our country, and many academic development centers are developing comprehensive palliative care programs specifically to focus on patient comfort at the end of life.

The Kyl-Nelson-Nickles amendment places the comfort of dying patients and their families beyond the language of the legislation, really rendering it illegitimate; providing this comfort would no longer be medically necessary or appropriate.

I ask unanimous consent to print in the RECORD the article I referred to earlier from the Washington Post called ''Children of Denial.''

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

[From the Washington Post, June 19, 2001]

CHILDREN OF DENIAL—RECENT ADVANCES IN END-OF-LIFE CARE HAVEN'T REACHED THE YOUNGEST PATIENTS

(By Abigail Trafford)

The leukemia had come back. Liza Lister, 5, leaned on her mother's shoulder. As her mother later recalled, Liza asked, ''Will I die soon?'' She quickly went on, ''I want to die on your lap. I want to have my lullaby tape on.'' Just days after her fourth birthday, Liza had been diagnosed with acute lymphocytic leukemia. Now her last chance for a cure, a bone marrow transplant, had failed.

Her parents, both physicians in New York City, had access to the most advanced therapies to wage war against her disease. But when a cure was no longer possible, they found themselves outside the mainstream of modern medicine.

Hospitals had no formal support system for families caring for a child who was going to die. There was no one health professional to offer consistent guidance throughout the up-and-down course of Liza's illness. The medical team never mentioned a hospice program.

At a time when strides have been made in easing the pain of death for adults, most children who die of chronic illness do not receive state-of-the-art care at the end of their lives—mainly because no one wants to admit they're dying. The majority die in hospitals, often in intensive care units where they are hooked up to life support machines. Drugs that could ease pain go unprescribed.

Yesterday the Institute of Medicine, in a report on end-of-life cancer care, called for a stronger focus on children, for better relief of suffering, education of doctors and changes in health plans to cover supportive services.

''Kids are suffering. The ones who are sensing they are dying and haven't been told are suffering from loneliness, from a lack of permission. Kids are suffering pain because people are reluctant to give narcotic pain relief to children,'' said pediatric oncologist Joanne Hilden, who founded the end-of-life care task force for the Children's Oncology Group, a national network of pediatric cancer specialists.

''Parents are suffering because they feel they have failed their child. Doctors and nurses are suffering for wanting to do better in a system that is getting in the way at every turn.''

THE INVISIBLE DEATH

Death in childhood can be a taboo subject in the United States. The roughly 28,000 children who die every year of chronic illness such as cancer, heart disease, degenerative disorders and congenital anomalies are like medical orphans in a health care system dedicated to cures and longevity.

''Childhood death is completely invisible,'' said nurse Cynda Rushton, director of the palliative program for children at John Hopkins Children's Center. ''People don't want to be reminded of it. The grief is so profound, it's almost unspeakable.''

The medical team generally recognizes that a child is dying several months before the parents do—but doesn't usually tell them. In a study published last November in the Journal of the American Medical Association, physicians tended to realize there was no chance of recovery nearly seven months before a child's death from cancer; parents, on the other hand, did not come to that realization until about 3½ months before. Only about half the parents learned it in a discussion with the doctor.

The communication gap between physicians and parents is a major barrier to quality end-of-life care, pediatric specialists said.

No one at the hospital could bear to discuss death with Liza Lister. She had pressed her doctors: ''What will happen when I die? How will I know I'm dying?'' Her oncologist promised to let her know when death was imminent. But on the final night, as she lay in her mother's arms next to her father and older sister, and everyone knew the end was near, Liza asked, ''Why didn't the doctor call to tell me?''

The Listers were able to put together hospice care for Liza for the last three months of her life. But fewer than 10 percent of children who die in the United States receive such care, according to the National Hospice and Palliative Care Organization.

Palliative programs, focused on pain control and quality of life, are aimed at making patients comfortable rather than curing their disease. In addition to doctors and nurses who treat pain and other symptoms, counselors, social workers and spiritual advisers address the patient's emotional and developmental needs. The team also supports

the parents and siblings, and helps the bereaved family after the child dies.

A study published last year in the New England Journal of Medicine concluded that many children with cancer ''have substantial suffering in the last month . . . and attempts to control their symptoms are often unsuccessful.''

Researchers interviewed the parents of 103 children who had died between 1990 and 1997 and were cared for at Boston's Children's Hospital and the Dana-Farber Cancer Institute. Nearly half the children died in the hospital—half of those in the intensive-care unit. Overall, nearly 90 percent of the children suffered ''a lot,'' according to the parents.

Thirty years ago, when childhood cancer was generally fatal, ''we were experts in end-of-life care,'' said oncologist Joanne Wolfe at Dana-Farber, an author of the study. Today, 70 percent of patients survive. ''We have to turn our focus on the percent who are not cured,'' she said. ''We have to focus on palliative care.''

A more recent review of children who died in hospitals in Canada showed similar results. These children suffered from a range of conditions including AIDS, organ failure, cystic fibrosis, heart disease and cancer. Of the 77 patients studied, more than 80 percent died in the ICU and most were attached to tubes and ventilators. The children were rarely told they were dying, according to the report in the December issue of Journal of Pain and Symptom Management.

MOMENT OF DECISION

When a life-threatening illness is diagnosed in a child, most families start out with aggressive treatments.

Terri Wills, a single mom in the East Texas town of Newton, thought her son's swollen face was due to allergies. It turned out to be a rare, devastating kidney disease called focal segmental glomerulosclerosis.

Adam, 5, was treated with heavy doses of corticosteroids and other drugs. He gained weight from the drugs, his height was stunted, his moods were in flux. He lived for almost 10 years with his disease—and lived well, his mother said, pitching for his baseball team and trying not to ''let anyone see he was sick.''

In 1996, at the age of 12, Adam went into renal failure and had a kidney transplanted from his mother. The disease recurred almost immediately. A second transplant failed in 1998. At that point Wills and her son knew his death was inevitable. ''I'd rather he die on a bicycle than in the hospital,'' she told his doctors at the Children's Medical Center in Galveston, and she took him home.

For many other children, the prognosis is not so clear. Chronic conditions are highly unpredictable. Many formerly fatal diseases are now curable. Parents are naturally eager to give their child every chance for survival.

Derrick Csati, 9, of Angola, N.Y. has been battling brain cancer since he was 2. His first surgery lasted 17 hours. Since then, he's had several relapses and more surgeries, courses of chemotherapy and radiation, experimental therapies including monoclonal antibodies and a round of stem cell transplants.

He's now on his way to Duke University to receive another stem cell transplant, his fifth in the last year. His family has declared bankruptcy and his mother quit her job to stay with him.

The Csatis are supported with home care nurses and social workers from the Center for Hospice and Palliative Care in Buffalo. They have been on the brink before. Four years ago. Derrick relapsed with tumors invading his spine, causing horrific pain. They were offered several options; one was to stop aggressive treatment and make him comfortable. They chose instead an experimental regimen of chemotherapy and radiation. The tumors disappeared.

''He's had four years of quality life,'' said his mother, June Csati. Derrick goes to school and has a close relationship with his older brother, Ben. His mother knows ''we could always tell them we're done.'' But ''I keep the faith. I think he could pull this off. He's willing. He's not being hurt by this.''

''How can you stop? It's so worth fighting.''

THE PAIN FACTOR

For many families, the crucial decision of whether to treat aggressively or let go takes place in the pediatric intensive-care unit (PIC). Doctors and nurses on the front lines remember the hard cases: The teenager with aplastic anemia who was in so much pain she couldn't be touched. The 13-month-old who was born prematurely and stayed on life-support machines virtually all her life until the technology was turned off.

''I wouldn't put my own children through what we put children through here,'' said Ivor Berkowitz, Director of the PICU at Johns Hopkins. ''It is very wrong when you look at it in retrospect.''

But he quickly adds that each case is unique and that there are no overall guidelines on how to treat patients with advanced illness in an era of expanding biomedical options. Many children survive crisis that would be fatal for adults.

''At what point do you change your goals?'' Berkowitz continued. ''Where do we set the bar? This is the biggest struggle in the ICUs.''

''The discussions are hard,'' said cancer specialist Hildenof the Cleveland Clinic Foundation. ''Are we going to do experimental chemo for leukemia? Or shall we stop? Do you want to go on or off the ventilator? That's the down-and-dirty stuff. That's not a 10-minute conversation.''

Nor is it covered by insurance, Hilden noted. ''How politically incorrect is it to say I don't get paid to talk to parents about the death of their child?''

All the while, children with debilitating illness need the medical team to address symptoms such as fatigue, nausea, shortness of breath and depression.

Managing pain is difficult in children, especially in those who are not able to talk. Physicians get virtually no training in pediatric palliative care. Doctors and nurses watch for increasing heart rates, crying, agitation, irritability.

''It's very hard to tell what they're feeling,'' said physician Charles Berde, director of pain treatment services at Children's Hospital in Boston. ''The parents say, 'My child screams all the time.' Is the child screaming from pain or something else?''

''Pain is such a huge problem,'' remembered psychiatrist Elena Lister, who described her daughter's death in the March issue of the Journal of Pain and Symptom Management. Liza, who died four years ago, suffered severe bone pain even in her skull.

When Liza was in the hospital, one of the doctors raised the concern that narcotic pain medicines are addictive. ''To me—who the hell cares?'' said Lister. ''She is going to die. The pain is such an inhibitor for any remaining pleasure.''

CONTINUITY OF CARE

Several studies have shown that the involvement of the same physicians and nurses from beginning to end helps to minimize a child's pain and suffering.

''Continuity of care was key. To which I say, 'Duh?' '' said neonatologist Suzanne Toce, director of the palliative Footprints program at Cardinal Glennon Children's Hospital. Whether a child is cured or succumbs to a life-threatening condition, ''we need to integrate palliative care into mainstream medicine,'' said Toce.

Sometimes when parents want to stop aggressive therapies before their physician does, they have to change doctors—accelerating their sense of isolation and abandonment at a crisis point in the child's illness.

That's what happened to Kevin and Brandi Schmidt of St. Augustine, Fla. When their daughter Kourtney was 4 months old, she was diagnosed with a severe form of spinal muscular atrophy, a rare inherited disease. The Schmidts quickly learned that such children die within a year. As the muscles weaken, the child can't eat, swallow, cough, even breathe.

Kourtney underwent surgery to have a feeding tube inserted. She received extra oxygen to breathe. She was revived several times.

But the Schmidts did not want to put Kourtney on chronic ventilation. ''We went to see a little boy. He was 2 years old and hooked up to a machine. We couldn't see doing that to Kourtney,'' said Brandi Schmidt. ''We wanted her to have a better quality of life. We didn't want to do any measures that would only extend her life.''

The low-tech approach did not sit well with their physicians, especially the lung specialist. ''It was like all or nothing,'' said Schmidt. ''He wanted to take the big guns out.''

When the Schmidts refused to use more technology to take over Kourtney's breathing, the lung specialist withdrew from the case, ''I don't have the knowledge and experience to counsel the family,'' he said, and he recommended hospice care.

That meant the Schmidts had to find a new physician. The local hospice program was not geared to children. The hospice nurse was afraid to touch Kourtney. After negotiating a special arrangement with their health insurance, the Schmidts were able to keep their home care nurse and still receive hospice benefits.

Kourtney died in her parents' king-size bed. She was 8 months old. ''She wasn't in any pain,'' said Schmidt. ''It was very peaceful.''

FOCUS ON CHILDREN

In a national survey by oncologist Hilden, bereaved parents were asked what they most wanted from their doctors in a palliative care program. She summed it up:

''Tell us exactly what different options mean. . . . Some parents, for example, didn't know that patients could talk on a ventilator. . . . Tell us you can control pain, even at home. . . . Tell us that not pursuing curative therapy is okay. . . . Tell us the truth about prognosis. . . . Tell us you won't abandon us. . . . Tell us how to prepare for the funeral.''

The American Academy of pediatrics called last summer for regulatory changes in Medicare, Medicaid and private health plans to improve access to end-of-life services for children. Several comprehensive programs have been developed in such cities as St. Louis, Seattle, Buffalo, Boston and Baltimore. These programs offer supportive care from the time of diagnosis and follow some children for years. A study on end-of-life care for children is underway at the Institute of Medicine.

''We have to acknowledge that some kids are going to die,'' said Houston pediatrician Marcia Levetown, founder of the palliative Butterfly Program in Texas.

Research suggests that when children have an opportunity to discuss death, they are less anxious and feel less isolated from their parents and caregivers.

''What Liza taught us was not only can you talk about this, you must,'' said psychiatrist Lister. ''Otherwise, the child dies and there's never been a chance for intimacy.''

For many families, the intimate bonding that can occur during the dying process is what constitutes a ''good'' death.

Teenager Adam Wills of Texas lived another year and a half after the second kidney transplant failed. ''When I die, you wear hot pink or bright red,'' he told his mother. He got a new bike. He made friends at the dialysis center. Just before he died, he gave an elderly man at the center a harmonica. Then he ordered a lemon tree for his mom.

''He was saying his goodbyes,'' said Terri Wills. Adam suffered a massive stroke in October 1999, and was rushed to Children's Hospital in Galveston, where he died in his mother's arms in the Butterfly room. ''It was the most beautiful thing I've ever experienced,'' she said. At Adam's funeral, the elderly man from the dialysis center played the harmonica. Four months later, the lemon tree arrived.

Mrs. CLINTON. Mr. President, I urge my colleagues to oppose this amendment not only for all the reasons others have enumerated but for this very specific issue. We are at the beginning of work that needs to be done in hospice care and palliative care, and I would hate to see us turn back the clock before we really started the race to determine what we should do to care for those who are in the last stages of life.

I urge all of my colleagues to join me in opposing this amendment and to support the ongoing efforts to provide more pain relief, more palliative care and, yes, more comfort to those who are leaving this life.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, I want to make two points. One has to do with a colloquy that was underway when I had to leave to introduce someone in committee about moving to the Defense supplemental appropriations and an effort to tie limitation of amendments on this bill to that effort. I also want to address the underlying amendment.

It never ceases to amaze me that when we debate these issues, we talk all around the issue, but we never get to the heart of the issue and why it is important. We have 1,001 examples of terrible things that happen to good people, but we never talk about what is the issue.

Let me make it clear that I am going to vote for the pending amendment. I think there is a better way of fixing this problem than the way they fix it. I am working on what might hopefully be a compromise to fix the problem, but I want to be absolutely certain that it is clear to anyone who has any intent to be objective that there is a big time problem with the bill on this issue. Let me clearly define the problem.

The question is: For example, I have entered into a contract on behalf of my family with standard option Blue Cross/Blue Shield. I could have bought the high option, but I looked at cost and benefits. I made what I thought was a rational judgment, and I decided not to pay more to get the extra coverage. I made a decision, and it involved cost and benefits.

Every day in America, people enter into contracts to buy health care. Obviously, a big question in the bill before us is: Are those contracts binding? Are they binding on the purchaser of the health care? Are they binding on the seller?

As is usual with this bill, on page 35, gosh, it sure looks like they are binding. On page 35, line 14, it says in a bold headline: ''No Coverage For Excluded Benefits.''

Then you read on. It says:

> Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan, or a health insurance issuer offering health insurance coverage, provide coverage for items or services for which benefits are specifically excluded. . . .

Gosh, it seems in this bill they are saying contracts are binding, but when you read on, as is true over and over in this bill, you find that exactly the opposite is true. When you read on, it says:

> . . . except to the extent that the application or interpretation of the exclusion or limitation involves a determination described in paragraph (2).

Then you go back two pages to find paragraph (2) and you find that paragraph (2) has to do with anything that is medically reviewable and anything that has to do with necessity or appropriateness.

Let me explain what this language says. This is a classic bait and switch. The language says that if something is precluded in a contract, it is not covered, except if it is medically reviewable—and all medical decisions are medically reviewable—and unless it has to do with ''necessity and appropriateness.''

What this provision actually says is the contract is not binding. The medical reviewer can determine that someone needs care, and even if it is precluded by the contract, the plan is required to provide it.

Gosh, that may sound wonderful to some people. Let's take the standard option Blue Cross/Blue Shield policy. I have a limit of 60 days in the hospital. Let's say I have the misfortune or someone in my family does that they are in for 90 days. The plan says you are not covered. I go before a reviewer and say: Look, I want the medical reviewers to determine as to whether I need this care or not. They determine I need it, they override the contract, and so I paid for the standard option Blue Shield policy, but I got the high option. Is that great and wonderful?

What do you think is going to happen when it is time for me to renew that insurance policy? What is going to happen is then I am going to have to pay for the high option. That is not going to be such a big deal for me because I can afford to pay the high option, but what about millions of Americans who cannot pay the high option?

If we let these external review committees decide what people need, independent of the contract they entered into to provide care—I got a lower price by saying I did not want heart and lung transplant services in my policy, and yet I come down with an acute heart problem and my physician stands up in front of this board and says, I am going to die if I do not get this surgery. Then the review committee says it is medically necessary and under this bill it is covered, even though my plan I paid for did not include it. The net result of this is to cause health insurance costs to skyrocket.

Also, if I am a health care provider as an employer and I have joined my employees in buying health insurance, now the contract is not binding, so the health insurance company obviously is going to want to change the amount they charge us because they are not going to have the protections of their contract.

I do not think the way we are doing this is the right way to do it. I think there is a cleaner way to do it. I hope to do it better later if this succeeds or fails, but this brings us to a fundamental question of this bill, and that is, Are contracts binding?

What we are saying in this bill is, no, not if they relate to health care. I think that is very dangerous. This is another reason, if we don't fix it, the explosive cost of this provision unfixed is greater than the liability cost about which we spent most of our time talking.

I hope my colleagues vote for this amendment.

Now the final point. Senator BYRD and Senator STEVENS were talking about the necessity of passing a supplemental for national defense. I am for this defense supplemental. I want it to come forward. I don't see why we can't do it tonight and get it over with, provide the money for national security. I know there will be one controversial amendment. I intend to vote against it; maybe some will vote for it. However, there is no reason that tonight we cannot settle this issue and vote first thing in the morning.

Several of the people who spoke on the issue suggested we will not be allowed to go to that defense supplemental bill unless we have set out a limit on amendments to this patients' bill of rights. I urge the majority leadership to not commingle this bill with the defense supplemental. It may well be that in the end we will reach compromises on the 6 to 10 major issues on which we will have to reach some accommodation to see the bill go forward. I am encouraged by the willingness of Senator MCCAIN to sit down and talk. I hope it is the beginning of a recognition that this bill is not perfect and it can be improved.

This morning when we voted down an amendment that exempted small employers with 50 or fewer employees

from this massive liability burden that they can be sued for simply helping their employees buy health insurance, I took that as a very bad sign for this bill. I have to congratulate the majority. Oh, that I could be in an army that had that kind of discipline. I can't imagine there is a city in America where Members could defend the provisions of this bill, which basically say that if you are covered by ERISA, you are subject to being sued as an employer for helping people buy health insurance.

There was an amendment that said just exempt the little employers because they will almost certainly have to cancel their health insurance if they are subject to lawsuit. I don't believe there is a city in America that any Member of the Senate could go into and successfully defend a vote against that provision. Yet that provision was defeated. I am afraid we are moving in the wrong direction in terms of building a consensus.

I want to see this bill completed. I don't think anybody benefits from holding this bill up. There are going to have to be certain accommodations. If we don't deal with some of these issues, the President will end up vetoing the bill, and what have we achieved? unless your objective is simply a political issue so one can say, well, we were for this bill, the President was against it, Republicans were against it.

If we really want to pass this bill, we are going to have to deal with the sanctity of contracts, we are going to have to come to grips with suing employers and the liability question, we are going to have to come to grips with scope.

If States have good functioning plans, should they be able to stay under their own plan or should they be forced under the Federal plan? There are a handful of issues that could be counted on your 10 fingers on which we will have to come to some accommodation.

My concern is, the clock is running. Today is Wednesday. Unless we begin to reach an accommodation on these issues, we are headed for a train wreck at the end of the week, and it is because of that I urge those in positions of leadership to please not try to tie stampeding Members on this bill, by limiting their rights to offer amendments, to passing a defense supplemental appropriation that I assume we are all for.

Why not pass this bill? I would be willing to pass it on a voice vote so it could be done tonight, get it over with, and then focus our attention on this bill. I hope we don't have an effort to tie limiting our rights on this bill to even bringing up the defense supplemental. If that happens, the net result will be the defense supplemental will not be brought up. No one will benefit from that. It is not good public policy. I urge the two not be tied together.

I yield the floor.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. I will respond to the plea from my friend from Texas, his plea that we finish this bill. No one wants to finish this bill more than the authors of the bill, Senators MCCAIN, KENNEDY, and EDWARDS. They have been working to compromise; they have been working with Republicans. That is the reason we are winning these votes on amendments, because we are getting Republican and Democratic votes and carrying the majority. We also want to finish this bill and do things the right way.

Why do folks stand up and talk about issues that are already taken care of in this bill? I know there is a disagreement on the fine print. That is what the frustration level is. I hope my friend will work with Senator SNOWE as she seeks to craft a bipartisan amendment dealing with the employer liability.

Right now, as I read the bill, employers do not have liability; they cannot be sued unless they personally make the decision to withhold care from the patient. Most employers do not do that. They contract with providers, and those providers will be held responsible.

I find it very interesting that my friends on the other side of the aisle—most of them, certainly not all of them; and we are happy to have Senator MCCAIN and other Senators joining with us on many of these amendments—I find it intriguing that they keep talking about these poor HMOs and insurance companies. We know, and we have said it a number of times, all we want is to see HMOs treated the same way in our society as we treat every other business, every other individual. If any of us goes outside this Chamber and we knock into someone and we hurt them, we are responsible. We are held accountable if it was our fault.

The reason we have the safest products in the world is that we have the toughest liability laws and they act as prevention. People make safe products, one, because most of them in their hearts want a good, safe product. But we have harsh laws if you intentionally hurt someone. If the brakes on the car don't work, if the crib bars are too wide, wide enough so a child can be strangled, we have laws on the books. All we are saying to HMOs is, if you in fact hurt people, you should be held accountable as well.

Members can stand up and pick apart one sentence in the bill, but the fact is this debate goes much deeper. It is not about paragraph 1 on page 2; it is about the essence of what we are trying to do. Do patients deserve care that is prescribed by their physician or should they be at the mercy of some accountant wearing a green eyeshade saying, no, that is money we cannot spend because our CEO will not make his $200 million this year.

Patients deserve to have their care prescribed by physicians. Certainly, physicians are making that statement to us, and almost every group in the country, and certainly every respected group, makes those decisions to support the McCain-Kennedy-Edwards bill. Patients deserve to be able to know their doctor is taking care of them. You would not go to a doctor to get a tax form filled out; you would not go to an accountant to get your health care. We should keep medicine with the people who went to school, with those who know what good care is, and we should keep the bean counting and the bookkeeping with the people with the green eyeshades; they don't have white coats. I would rather go to someone in a white coat if I am in trouble and need a course of treatment.

Do patients deserve the medications the doctor prescribe? The HMO says: We have another one we can substitute. If the doctor believes you need a certain medication, you should have it.

Do patients deserve to get into a clinical trial if, in fact, they have no other recourse? Absolutely they do. That is why the McCain-Edwards-Kennedy bill is so important.

Let's face it; HMO executives are making millions of dollars while denying needed care to our people. This is about who you stand up for, who you fight for. I have many stories.

I ask the Chair what is the order now? It is 1 o'clock.

The PRESIDING OFFICER (Mr. WYDEN). The Chair advises that the Senator from Tennessee is expected to be recognized to offer an amendment.

Mrs. BOXER. I will yield then in 1 minute, if I might, and leave the floor at that time. But I want to sum up.

On Monday morning early I held a hearing in San Francisco. I had patients and families of patients testify. I had doctors testify. I heard stories that absolutely brought tears to my eyes—not just to my eyes but to those of everyone in that room.

No. 1, a husband whose wife was diagnosed with breast cancer had to literally put his work aside. He is in his 50s. He had to fight for her to get the treatment she deserves and needs because the HMO was trying so hard to save money. He had to threaten to go to the Los Angeles Times and tell his story—threaten—in order to get the care she needs.

I had the mother of a little girl who was diagnosed with cancer in her eyes. She had to struggle and fight. She said: I gave up everything else I was doing. I could not be with my daughter.

This is wrong. Senators can offer amendments until the cows come home and I know one thing: It is delaying passage of this bill. It is delaying the chance to vote on a strong Patients' Bill of Rights.

Bring your amendments on. We are voting them down, most of them. If some of them are good, we will support them. But we want a strong Patients' Bill of Rights that says to our people: You are paying for this care. You deserve this care. If you are turned down for care, you deserve the right to a

speedy appeal, and then for sure we want to hold the HMOs accountable if they hurt you or your family. We say: Treat them as we would anyone else in society.

I am grateful for the honor to speak on behalf of the underlying bill. I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

AMENDMENT NO. 819

Mr. THOMPSON. Mr. President, I do intend to offer an amendment shortly. I believe it is being finalized as we speak. We will have that before the Senate in a moment.

Listening to the debate, listening to the discussion this morning, I am once again reminded of what passes for policy discourse nowadays. I was reminded of the article that was written by David Broder in the Washington Post yesterday. Mr. Broder is obviously one of the most respected members of the press corps. Some refer to him as the dean. He is certainly not right of center. I don't know what you would call him except a very thoughtful, highly respected individual.

As I listened to this debate this morning, I thought a few of his words would be appropriate. He says this:

> The Senate debate over the Patients' Bill of Rights has become, in large part, a battle of anecdotes. . . . Backers of the Kennedy-McCain-Edwards bill, the sweeping legislation President Bush has threatened to veto, come armed each day with stories about the youngsters whose brain tumor was missed because an HMO denied his parents' request for a specialist referral or the mother whose breast cancer was ignored until it was too late.

Mr. Broder goes on later in the article and says:

> Would that the issue were that simple and straightforward. But it is not. Anecdotal evidence, no matter how powerful, gives no guidance to the scope of the problem being addressed.

Later on in the article he says:

> Still less do the anecdotes define the proper remedy. Instead, by narrowing the question to dramatic horror stories, they pull the debate away from the genuine policy tradeoffs that must be made.

I could not agree with him more. The incessant recounting of horror stories and the using of these poor and helpless people as instruments in this debate, indeed, pull us away from the genuine policy decisions that have to be made.

I would like to discuss one of those briefly this morning. That is the subject of the amendment I intend to introduce. It has to do with the exhaustion of administrative remedies.

That sounds to be an arcane legal issue that should not be of much interest to very many people. I think the contrary is the case. Basically what the exhaustion principle is saying is that under the law, generally speaking, if you have a remedy before you get to court, go ahead and use it before you go to court. The importance of that principle of exhausting your administrative remedies—going through the administrative process before you leap to court—is firmly embedded in our system. We see it working all the time with regard to run-of-the-mill kinds of lawsuits.

We have lawsuits in State court where you have to go through a commission or some body or some bureau has a chance to make a determination—usually because that entity has some expertise in the area. We give the entity, under looser rules of evidence and a lot less expense for litigants, an opportunity to take the first pass at this problem. In the process of doing that, a lot of things shake out, a lot of frivolous claims are made obvious and are dropped at that level. A lot of times the merits of a particular claim are seen and the State or whoever it is—oftentimes it is in the State system—sees that and they settle.

It is designed to have someone with some expertise, some objectivity, hash out the facts in a way that would be much faster than a court system, much less expensive than a court system, and would be to the benefit of everyone involved. It still doesn't mean you can't go to court later, but a lot of things get winnowed out in the process.

We know how clogged up our court systems are in many cases. In our Federal system, under the speedy trial act, the courts have to consider all the criminal cases first. With all the drug cases we have in Federal court and everything else, sometimes in some jurisdictions it takes a long time to get your case heard in the Federal court system. So this administrative process before you ever go to court, in winnowing those cases down to the ones that really belong in court and providing expedited expertise to the litigants, is very important.

In our system, also, when we go through that process and we get that determination made by those who have the first look, so to speak, with the expertise, then you give some credence to what they found. Then you can go to court, but you do not turn your back on the fact that this process has been followed and they came up with a certain result. The court can live with that result, usually, or it doesn't have to if it doesn't want to. But it is out there and it has served its purpose.

That is the general, overall system we have through our system. Not everything goes through this administrative process before it goes to court, but a lot of things do. This Health Care Bill of Rights we are considering today does that.

It sets up independent decisionmakers to consider these claims in a rather elaborate and detailed way before they ever get to court. The process that is set out in this bill is a good one. It sets forth a several-step process where experts who are independent and objective have a chance to take a look at a claim. We all know, with as many horror stories as are paraded around here by those who support this bill, that we cannot cover everything, all the time, for everybody, at any cost whether or not it is in the plan or it is something you have contracted for or something your employer covers or not.

If we did that, the cost would be so high that nobody could afford insurance, and nobody would be covered for anything. So it is a tradeoff. It is the kind of tradeoff that David Broder is talking about. Yes, we want these pitiful people to have coverage, but we also want to have it so that people are not totally driven out of the market because the cost doesn't match the benefit for the amount of money they expend.

That is the process and the balance that we are trying to achieve.

We got into the health care business because the medical costs were going up at almost 20 percent. We created their managed care system. We like to deride it now, but we created it because health care costs were going up at almost 20 percent and we tried to respond to that.

Assuming that, if it is not in the plan, if it is not in the deal, and if it is not in the contract, there will be some cases that are legitimately, after being looked at by all experts, not appropriate, this bill assumes there will properly be some cases that are not. If you are going to have some that aren't and some that are, what do you do? You set up a process to find out what is just. You set up a process to find out what is right.

How do you do that? This bill does a lot of things. It has an internal review process. It is an internal process, first of all, to even grant or deny a claim.

Let's say under the plan that someone comes in and their claim is denied. Maybe they haven't worked there long enough. Maybe they don't even work there at all. Maybe a determination is made that this is not a medical procedure that is covered or it is experimental. For whatever reasons, there are many cases that are denied.

Under this bill, there is a process to review that denial, even at the internal stage when the employer still has some say-so with regard to some of these plans. Especially even at that stage, this bill begins to set up expertise and objectivity.

At the internal review level, it says the person making that review cannot be associated with the prior decision. He has to be someone who is independent of that prior decision. It also says it has to be someone with expertise. It also says if it is a medical issue, it has to be a physician.

Even before we get to the external review, while it is still an internal review, this bill sets up expertise and independence in the process to make sure this claim is adjudicated or decided in an appropriate manner. All right. You go through that.

Let's say the claim in this external review process is still denied. This person denies the claim. Then, under this

bill, there is an external review process. At this stage of the game, the person is totally independent of the plan. The legislation demands that he be totally independent, that he have expertise, and that he have nothing to do with the plan or the employers or anybody else. The bill spent several pages of setting up a procedure whereby he is objective and independent.

The Secretary here in Washington has authority to review what he is doing and to look at the cases he has considered to make sure he is not prejudiced in any way, where it looks as though maybe he is denying too many claims or something such as that. There are elaborate processes to make sure this external appeals process is fair, independent, and objective. All right.

Let's say we go through that level. Let's say that entity decides that there is a medical issue. Then they hand it over to yet another level of independent review. That is the independent medical review.

Once again, the bill sets up someone who is totally independent, totally objective, sets forth supervision by the Secretary, and sets forth how he is to be compensated to make sure he is well qualified.

That is the third level, you might say, in terms of some degree of independence and objectivity—totally at the last two levels and somewhat at the first level.

You have the internal review; you have the external review; and you have the independent medical review—all set up to make sure that someone who comes with a medical claim gets fair consideration, and you don't have these big, bad, mean HMOs that we hear so much about making these decisions. They are not. These people are under this act.

What we do, and what we say in this amendment that I am going to submit is, let's use it. What I have just described, let's use it.

After setting up this process that ought to be used because it is a good process, this bill also says it can be circumvented at any time. It can be. A claimant can stop it if he doesn't like the way things are looking and go to court by alleging that they have received irreparable injury or damage—not that they are about to but that they have received it.

There are two things wrong with that: No. 1, you obviously lose the benefit of the administrative process. For example, part of the problem could be or may be the sole problem could be a question of coverage. You have this process set up. You are maybe in the middle of it. Why not just decide whether or not you are really covered under this bill? It is a factually intensive exercise under this plan: how long you have been working here, and that sort of thing.

The second thing that is wrong with the bill as it is now, and allowing them to circumvent this process that I have discussed by alleging irreparable injury—they do not use the word ''allege,'' but it is the same thing. The only way you can get into court is by ''alleging.'' That is the way you get into court. It is a low threshold.

You can circumvent this plan at any time, or this process at any time along the way.

The second thing wrong with it is it doesn't have a claimant in it because we are talking about money damages. To circumvent this process in order to allow a claimant to go over here in the middle of it and file a lawsuit for money damages, all he is doing is getting in line over at the courthouse. He doesn't get any expedited treatment for that. It doesn't help him. Why would you do that when you are in the midst of this, admittedly, excellent, objective, costly administrative process?

I don't think that it makes any sense. Costs are relevant because it is going to show up in somebody's price for insurance.

This plan costs money. This process is expensive to set up. If you are going to have it, you ought to use it. Of course, if the result goes in the claimant's favor, it is binding on the plan. But if the results of the independent process go against the claimant, then of course he can go to court.

But my problem this morning or today is not that he can go to court. It is that he can go to court before he exhausts administrative remedies.

My friends who oppose this—I am going to anticipate this a bit because we have had some prior discussions about this. Some of my friends have pointed out that there obviously can be a need from time to time for emergency care. What if you are in the midst of this process and you have some kind of an emergency situation that ought to justify your circumvention of it?

My first answer is, the bill, as drafted now, is not going to help any claimant with regard to an emergency because, as I say, we are talking about money damages. All he can do is file a lawsuit. If that makes him feel better, 2 years later he may get into court to try his case. That might help him. But other than that, that is not going to help the person with some kind of an emergency.

What will help that person, though, is in this bill. It is already provided for. In the first place, you have a provision that is in ERISA, that we adopt in this amendment, that says you have all of the coverage that is given under ERISA, which allows you to go into court at any time to recover benefits that are due you, to get a mandatory injunction or to whatever you might be entitled under ERISA, under current law. That remains. That will be the same. We have adopted that and made that clear in this bill.

The second thing is, under section 113 of the bill, the claimant has access to emergency care. There is a provision in the bill that if you have an emergency—of course, the general law requires hospitals to take care of you anyway, but if it is an emergency-type situation, under this bill already, under section 113, an emergency is taken into account.

What if you have a situation that is not an emergency, not an immediate thing, but you do not want to go through the administrative process for just and reasonable reasons? What kind of situation could that be?

That could be a situation in the middle that is not an emergency but maybe you are entitled to an expedited review or determination. There is a provision in the bill that covers that situation also, under section 103 on internal appeals.

At the internal appeals level, if the initial claim is turned down and if a person believes they are entitled to an expedited determination, even at that level, they can go forth and pursue that. Then, at the next level, at the external appeals level, if they believe they are entitled to an expedited determination, if a physician certifies that they are entitled to expedited consideration—at either of those levels—they can get that. So the claimant is covered.

The claimant is covered under those situations, which allows us to go back to the basic legal proposition that I mentioned in the very beginning in relation to the exhaustion of the administrative remedies, which work so well in so many aspects of our judicial system, which is set up under this bill but then has massive carve-outs. That process should be allowed to work.

There is one other point in this amendment, and then I will offer it; and that is, after you go through this process, after you exhaust your administrative remedies, after you go through the internal appeal, the external appeal, the independent medical review, and after you get a result—whatever that result is—the trier of fact, when you go to court, ought to know about that result. It is not determinative on the trier of fact—whether it be the judge or the jury in the court—but it is relevant.

If you are not going to do that, you are really wasting a whole lot of time, money, and expertise and creating additional problems for yourself in terms of cost in reaching a just result. So that is what it does.

I think we all agree we want doctors making medical decisions. When these claims are made, in this review process, if it is a medical claim, doctors are going to be making that medical decision. But if you do not like it, then you can go to court. But let that doctor, let that independent, qualified physician make the first determination before you go to court.

Are we so desirous of speeding everything to court, with the attendant costs that we know are going to come about? And these are not costs to some HMO, these are costs to the American

people. We have 44 million people who already are uninsured in this country. Even if we add just 1 million to the uninsured in this country because of what we do here, that ought to bother us. We should not be in the business of doing that.

So let's let doctors make that initial determination instead of lawyers. This is one of those issues that is doctors versus lawyers.

If you want to go to court, if you want to rush to court at any time in the process, regardless of what has happened—regardless of whether or not anybody independent has had a chance to look at this—you are going to decide, with a lawyers' bill, to do that. The way it is constructed right now, you can sue anytime, for anything, in any amount. We can discuss those issues later.

But with regard to this issue, exhausting administrative remedies, let's let the doctor, let's let the medical people have the first crack at it. Who knows. When we get that result in, it might resolve a lot of these potential lawsuits.

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

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Tennessee [Mr. THOMPSON] proposes an amendment numbered 819.

Mr. THOMPSON. 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 require exhaustion of remedies)

On page 150, strike line 17 and all that follows through page 153, line 8, and insert the following:

''(9) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102 and 103 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

''(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) or paragraph (10)(B), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

''(C) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

''(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

''(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

The court in any action commenced under this subsection shall take into account any receipt of benefits during such administrative processes or such action in determining the amount of the damages awarded.

''(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 103 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal court proceeding and shall be presented to the trier of fact.

On page 165, strike line 15 and all that follows through page 168, line 3, and insert the following:

''(4) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102, 103, and 104 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

''(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) unless the requirements of subparagraph (A) are met.

''(C) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

''(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

''(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

''(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 104 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal or State court proceeding and shall be presented to the trier of fact.

Mr. THOMPSON. Mr. President, the amendment has been offered. I have made my statement. I hope we have adequate time to deliberate with regard to this important amendment.

I yield back my time and yield the floor.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. TORRICELLI. Mr. President, during my nearly 5 years in the Senate I have heard the debate of managed care reform many times. I have participated in repeating statistics, engaged in legal analyses, participated in political analyses, all of which convinced me a long time ago of the need for this Patients' Bill of Rights.

But there is no substituting that which many of my colleagues have brought to this Chamber; that is, the life experience of American families with the system as it is currently designed and how it has dealt with the tragedies of their own lives.

Many of my colleagues have brought the experiences of frustrated families: People who get up every morning, go to work, pay for medical insurance, and participate in a managed care plan, only to find that in a moment of crisis in their own families, that which they purchased, that which they have relied upon, was not available to them.

As do my colleagues, I want to now share with you just two stories that give meaning to all the statistics and illustrate all the failures of the system.

I begin with Kristin Bollinger, a young girl from Spottswood, NJ. Kristin's experiences illustrate some of the troubling practices of HMOs and how ineffective and unresponsive they can be in dealing with the needs of a child who requires long-term care when chronically ill.

Kristin suffers from a unique condition of seizures and scoliosis, both of which can be managed with proper treatment and care. Her family was forced in an HMO by their family's employer in 1993. Kristin's parents have been fighting to ensure their daughter receives specialized services ever since.

The HMO told Kristin's family she could no longer see a pediatrician and the specialists who had treated her all of her life. From birth, she had this condition. She saw a certain specialist, received specialized care. When Kristin needed to see a neurologist and other specialists, her parents had to pay for the specialists because they were not in her managed care plan. After a major surgery in 1997, Kristin's specialized nursing care was canceled without notice. She wasn't even told. The HMO even discontinued coverage for physical therapy because it was deemed medically unnecessary.

Eventually, after fighting months and even years, the care was restored. But here is a family dealing with repeated seizures, a child who was not able to function, massive medical bills, although they were in a managed care plan, an inability to get the specialists who were deemed medically necessary, and they had to fight their way back to coverage while caring for a child—case in point.

What would have worked? First, a right to get to a specialist; second, after you have been receiving care from a specialist and your plan changes, the right to keep the specialist; third, when you are denied the right to an appeal, for someone without an interest to hear your need where you can explain the need. In three important ways, this Patients' Bill of Rights would have addressed Kristin's problem and dealt with the problem of her family. None of those three rights exists in law, and so she was failed three times.

Second, Morgan Earle, a 10-year-old from Chatham, NJ, born with cortical dysplagia, a devastating developmental

brain injury that causes severe seizures. Morgan's parents, like any parents, were unprepared for dealing with the care of an infant experiencing these seizures—sometimes every 6 minutes—making it impossible for her to even eat or sleep.

When Morgan was 3 months old, her parents sought treatment from a team of pediatric neurologists and neurosurgeons to develop a strategy for dealing with Morgan's lifelong medical needs. By the time she was 8, Morgan had endured extensive tests, clinical trials, and two major brain surgeries.

Through the unbelievable genius of medical science, her team of specialists reduced her seizures that were interrupting her life. But in 1999, one of the specialists who headed Morgan's medical team, through changes in his own career, abruptly transferred to another hospital in Chicago. Morgan's parents were shocked to learn that the specialists selected by her new medical team were not part of the HMO. Throughout her life, she had relied upon these same doctors. Medical science had found a way to control these continuing seizures that were interrupting her own life and the life of her family. She had found an answer. But the new team was not part of her managed care.

Imagine the frustration, that the genius of medical science found a way to deal with the suffering of your child in continuous seizures only to find that now you could not avail yourself of it.

Morgan's parents appealed the decision to the HMO. They were denied. Doctors wrote that they and only their specialists could provide an answer. They were denied. In fact, the doctors report their letters weren't even answered.

The HMO provided Morgan's parents instead with a list of in-network specialists. They were not even board certified. They could not perform. They were not capable. They could not even understand the kind of medical care Morgan was receiving.

Last Friday, after 2 years of fighting an appeal, Morgan's parents received a two-sentence e-mail from her HMO that her original specialists, the doctors they had requested, would now be covered—2 years, no money, no care, no answers. It isn't right. It is not a system that anyone in this Chamber can defend, to Kristin, to Morgan, to her parents, or to millions of other Americans who are paying for this managed care or whose employers are paying for it, believing they are covered, and tomorrow morning they are but a single tragedy in life away from Morgan's or Kristin's experience. It could be anyone in this Chamber. It could be anyone we represent. That is what this legislation is about.

It is not a gift. It is not some benefit provided by the larger society, as if that in itself would not be right or fair. It is something that has been earned and paid for, but it is not being provided. That is why we call it a Patients' Bill of Rights. It is not a gift. It is a right. It is a contract. And it is our responsibility to provide it.

That is what this legislation is about:

One, ensure that patients with disability conditions have standing referrals to specialists so they don't have to get permission; the 2-year wait of suffering and bills and lost care never happens.

Two, allow patients in these circumstances to designate a specialist as their primary care doctor. It is right, and it is efficient.

Three, require HMOs to allow access to out-of-network specialists, if in-network specialists are inadequate, at no cost. It just makes sense.

Four, ensure that chronically ill patients can keep their doctors even if they are forced to change plans or their doctors leave the HMO. That is not only right and fair; it is just not being cruel to patients and children in these circumstances.

The truth is, the alternative Republican plan does not allow these decisions to be made by patients and doctors. It means that an HMO that does not have a pediatric neurologist can force a child to see someone who is not trained or capable.

What are the costs of all this? If you take this one element of the Patients' Bill of Rights I have addressed, just this one narrow, critical element for the chronically ill who need these specialists and a continuum of care, if you just take this small element I have addressed, CBO estimates that it would add .2 percent to the cost of insurance.

Is there a family in America, given these circumstances, who would not bear that burden? Is there an employer in the country that would not want their employees to have this peace of mind in coverage, just knowing that what they are already purchasing might now be relevant and available in a moment of need?

Mr. President, I have participated in this debate over these years. I have offered the statistics. I have offered the case. I have argued the politics. I have discussed the merits. I have reviewed the bill. Now I submit Kristin and Morgan's cases as the most compelling cases of all of why there is only one piece of legislation available on this floor that truly addresses these circumstances. It is offered by Senators KENNEDY, MCCAIN, and EDWARDS.

The case is overwhelming, and I urge my colleagues across the aisle to join us. They will be proud and pleased that they did it.

I yield the floor.

Mr. REID. Mr. President, 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. 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, for the benefit of our colleagues, we are now still committed to voting at 2 o'clock on the Nelson amendment which we debated earlier today. We will then return to a conclusion of the Thompson amendment. We just saw that amendment a short while ago, and we are trying to study that more closely.

After the completion of the vote on the Nelson amendment, we will be able to indicate to Members when we will either vote on or dispose of the Thompson amendment.

There has been a proposal made to our colleagues on this side for votes going through the afternoon and times allocated to the different amendments and then into the evening, also being sensitive to the needs of our colleagues on the other side of the aisle for a window, and then returning to the Senate for consideration of legislation.

Hopefully, at the end of the vote at 2:30 p.m., we will be able to give the Members a clearer idea both of the substance and the time for moving the process along. We have had good debates on these issues to date. We still have work to complete on the issue on medical necessity. Also, our colleagues, Senators SNOWE and DEWINE, held a press conference at 11:30 this morning on their proposals, which hopefully we will consider later this afternoon, to tighten up language in the area of employer liability. We are familiar with the thrust of the proposal. It seems to be extremely valuable and helpful in resolving some of these issues.

We will move on hopefully to the issues of scope later in the afternoon and into the early evening.

This is how we hope to proceed. We are never sure until the actual proposal is made, but we want to give assurance to Members we are making progress, and we will continue to move as rapidly as we can on the measure.

Again, the liability issue will be the last outstanding issue. There is still no consensus on that particular proposal. We will consider the alternatives in a timely way and hopefully be able to conclude the legislation in a timely way as the majority leader has stated.

I thank all of our colleagues for their cooperation. These have been good substantive debates. We have had very few interludes. A number of our colleagues welcome the opportunity to express their views on the legislation, and we will try to accommodate as best we can when we see the opportunity to have a focused debate on a particular subject matter and dispose of that matter in a timely way. I thank all of our colleagues.

At the conclusion of this next vote, which we expect will start in just a very few moments, we will then have further news for Members.

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. Mr. 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. 818

Mr. MCCAIN. Mr. President, I move to table amendment No. 818 and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

Mr. NICKLES. I announce that the Senator from North Carolina. (Mr. HELMS), is necessarily absent.

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

The result was announced—yeas 54, nays 45, as follows:

[Rollcall Vote No. 200 Leg.]

YEAS—54

Akaka	Dodd	Levin
Baucus	Dorgan	Lieberman
Bayh	Durbin	Lincoln
Biden	Edwards	McCain
Bingaman	Feingold	Mikulski
Boxer	Feinstein	Miller
Breaux	Fitzgerald	Murray
Byrd	Graham	Nelson (FL)
Cantwell	Harkin	Reed
Carnahan	Hollings	Reid
Carper	Inouye	Rockefeller
Chafee	Jeffords	Sarbanes
Cleland	Johnson	Schumer
Clinton	Kennedy	Snowe
Conrad	Kerry	Stabenow
Corzine	Kohl	Torricelli
Daschle	Landrieu	Wellstone
Dayton	Leahy	Wyden

NAYS—45

Allard	Enzi	Nelson (NE)
Allen	Frist	Nickles
Bennett	Gramm	Roberts
Bond	Grassley	Santorum
Brownback	Gregg	Sessions
Bunning	Hagel	Shelby
Burns	Hatch	Smith (NH)
Campbell	Hutchinson	Smith (OR)
Cochran	Hutchison	Specter
Collins	Inhofe	Stevens
Craig	Kyl	Thomas
Crapo	Lott	Thompson
DeWine	Lugar	Thurmond
Domenici	McConnell	Voinovich
Ensign	Murkowski	Warner

NOT VOTING—1

Helms

The motion was agreed to.

Mr. KENNEDY. I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, it is our understanding that the Senator from Arizona is going to offer an amendment at this time on behalf of a number of our colleagues.

Hopefully, we can have order, Mr. President. This is a very important amendment.

The PRESIDING OFFICER. The Senate will be in order.

The Senator from New Hampshire.

Mr. GREGG. Mr. President, I ask unanimous consent that the pending Thompson amendment be laid aside without prejudice so that the Senator from Arizona may proceed.

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

The Senator from Nevada.

Mr. REID. Mr. President, it is my understanding that the Senator from Arizona would agree to an hour of time evenly divided on his amendment.

Is that right?

Mr. MCCAIN. That would be agreeable. But I think we can do it in a shorter time than that, depending on the view of the Senator from New Hampshire on the amendment.

Mr. GREGG. I am not sure I have seen the amendment.

Mr. MCCAIN. I say to the Senator, I will get it to you right away. Why don't we do that.

Mr. REID. I would also say, it is my understanding, having spoken to all the managers, that Senator SNOWE of Maine is ready to offer the next amendment, whenever the time arrives that we complete this McCain amendment.

Mr. BYRD. Mr. President, would the distinguished Senator from Arizona yield to me so I might ask a question without his losing his right to the floor?

Mr. MCCAIN. I am always pleased to yield to the Senator from West Virginia.

Mr. BYRD. I thank the Senator.

The PRESIDING OFFICER. The Senator from West Virginia.

SUPPLEMENTAL APPROPRIAITONS

Mr. BYRD. Mr. President, earlier today the distinguished Senator from Alaska, Mr. STEVENS, and I entered into a colloquy with several other Senators here anent the possibility of reaching an agreement on the amendments that would be considered at such time as the majority leader calls up the supplemental appropriations bill. I have asked the distinguished Senator from Arizona to yield for that purpose again.

I wonder if it might be possible at this point to get an agreement, or at least to get ourselves on the way to an agreement, that would limit the number of amendments to be called up to the supplemental appropriations bill to those amendments that we have ascertained are out there via the hotline in the Cloakroom and a managers' amendment, the contents of which Senator STEVENS and I are ready to reveal to any Senator who wishes to know what is in the managers' amendment.

May I ask, with the permission of the Senator from Arizona—I am about to lose my voice for the second time in 83 years—the distinguished majority leader for a reaction to this request?

Mr. DASCHLE. Mr. President, I appreciate the chairman's concern for moving the process along. And since we discussed this matter this morning, we have issued a hotline request for amendments. We have now received the response. A number of Senators have indicated a desire to ensure that they have been included in the managers' amendment. Once that confirmation can be made, I think on our side we would be prepared to then enter into a unanimous consent agreement which would take on or schedule the debate with an appreciation for a managers' amendment and a designated list of amendments that could be accommodated.

So we are just about at a position where I think a unanimous consent request could be propounded. If Senators could just check with the distinguished senior Senator from West Virginia and the Senator from Alaska to ensure that the managers' amendment is as it has been reported to them, we will be able to move forward.

Mr. BYRD. Mr. President, I thank the distinguished majority leader. I wonder if we can't set the hour of 3 o'clock as the time when the majority leader could propound a request in this regard.

Mr. DASCHLE. Mr. President, I would be happy to attempt to propound an agreement at 3 o'clock and see what happens. No harm done in making the effort.

Mr. BYRD. Yes. The distinguished Republican leader has already indicated his strong support for such an effort.

So I thank the majority leader. And I thank the distinguished Senator from Arizona for yielding.

The PRESIDING OFFICER. The majority leader.

Mr. DASCHLE. Mr. President, just to clarify, I would be happy to enter into a unanimous consent agreement that would limit the number of amendments and provide for an understanding about how the supplemental would be addressed. But, of course, we cannot schedule the supplemental until we have completed our work on the Patients' Bill of Rights. I know the senior Senator from West Virginia understood that.

Mr. BYRD. Yes, I do.

Mr. DASCHLE. But I wanted to clarify that for the sake of anybody who may have misunderstood.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona.

AMENDMENT NO. 820

Mr. MCCAIN. Mr. President, I have an amendment at the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Arizona [Mr. MCCAIN], for himself, Mr. BAYH, Mr. CARPER, and Mr. EDWARDS, proposes an amendment numbered 820.

Mr. MCCAIN. 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 clarify that nothing in the bill permits independent medical reviewers to require that plans or issuers cover specifically excluded items or services)

On page 36 line 5, strike ''except'' and all that follows through ''(2)'' on line 8.

On page 62, between lines 10 and 11, insert the following:

(V) Compliance with the requirement of subsection (d)(1) that only medically reviewable decisions shall be the subject of independent medical review and with the requirement of subsection (d)(3) that independent medical reviewers may not require coverage for specifically excluded benefits.

On page 62, line 20, after the period insert the following: ''The Secretary, or organization, shall revoke a certification or deny a recertification with respect to an entity if there is a showing that the entity has a pattern or practice of ordering coverage for benefits that are specifically excluded under the plan or coverage.''.

On page 62, between lines 20 and 21, insert the following:

(vii) PETITION FOR DENIAL OR WITHDRAWAL.—An individual may petition the Secretary, or an organization providing the certification involves, for a denial of recertification or a withdrawal of a certification with respect to an entity under this subparagraph if there is a pattern or practice of such entity failing to meet a requirement of this section.

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

(5) REPORT.—Not later than 12 months after the general effective date referred to in section 401, the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning—

(A) the information that is provided under paragraph (3)(D);

(B) the number of denials that have been upheld by independent medical reviewers and the number of denials that have been reversed by such reviewers; and

(C) the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded under the plan or coverage.

Mr. MCCAIN. Mr. President, I say to the Senator from New Hampshire, I hope he and his people will examine this amendment. I apologize for not getting it to him sooner. Perhaps we could agree on this amendment and not have to have a rollcall vote.

Mr. KENNEDY. Would it be agreeable to have an hour, so we could get——

Mr. MCCAIN. Mr. President, I ask unanimous consent that there be 1 hour on this amendment evenly divided.

I withhold my unanimous consent request.

Mr. GREGG. Reserving the right to object, in just a minute I believe I will be able to respond.

Mr. REID. I did not hear the Senator.

Mr. GREGG. I said, I believe we will be able to respond to the Senator in about a minute.

Mr. MCCAIN. I thank the Senator.

Mr. President, concerns have been raised that under this legislation, independent medical reviewers can order a health plan to provide items and services that are specifically excluded by the plan's contract.

The amendment I am offering clarifies that the bill does not do this, and that specific limitations and exclusions on coverage must be honored by the external reviewers.

There are a numerous safeguards already in the bill to ensure that external reviewers cannot order a group health plan or health insurer to cover items or services that are specifically excluded or expressly limited in the plain language of the plan document.

First, the external review entity who is responsible for determining which claims require medical review and which do not, may refer claims to independent medical reviewers only if the coverage decision cannot be made without the exercise of medical judgment.

I repeat: The external review entity, the one that is responsible for determining which claims require medical review and which do not, may refer claims to independent medical reviewers only if the coverage decision can't be made without the exercise of medical judgment. For example, the plan document says that the plan doesn't cover heart transplants. Even if the patient has no other treatment options, the external review entity should not forward the claim for a heart transplant to an independent medical reviewer because no medical determination is needed to understand that the procedure is not covered.

Second, even if the external review entity makes a mistake and forwards to the independent medical reviewer a claim for an item or service that is specifically excluded or expressly limited under the plan, the legislation states that the independent medical reviewer cannot require the health plan or insurer to cover such excluded benefits.

The amendment I am offering clarifies this limitation on the independent medical reviewer to make it perfectly clear that although we are relying on the independent medical reviewer to give us a second medical opinion when such a medical opinion is necessary to interpret the plan's coverage, we are not empowering them to disregard the plan's specific coverage exclusions and limitations.

The third safeguard and the one we are further strengthening with this amendment is designed to ensure the objectivity and quality of the external reviewers. The bill provides already for their certification and sets out factors that must be considered before they can be recertified, including the external reviewer's compliance with requirements for independence and limitations on compensation. To the recertification considerations already in the bill, this legislation additionally requires the certifying authority, before recertifying an external reviewer, to consider whether the external reviewer has breached the other safeguards by ordering a provision of items or services that are specifically excluded by the plan.

The amendment allows a health plan or insurer to petition the certifying authority to revoke an external reviewer's certification or deny recertification and requires the certifying authority to do this upon a showing of a pattern or practice of wrongfully referring for medical review claims that don't require medical decisions or of ordering the provision of specifically excluded benefits.

Finally, the amendment requires the General Accounting Office, within 1 year after the bill takes effect, to report to Congress on the number and the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded under the plan or coverage.

I guess what we are saying here is that we are trying to make the language as tight as possible. We know there may be a temptation on the part of reviewers to violate the plan with regard to those procedures which may be specifically excluded. We will have follow-up action, including a requirement for taking into consideration, on recertification or even revocation of certification, a study by the General Accounting Office which will tell us about the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded.

My friend from Arizona, Senator KYL, had a very good amendment. We could not quite go that far, and we came close to agreement. I hope this amendment does clarify some of the concerns.

It strikes the language on page 36 of the bill that says: Except to the extent that the application or interpretation of the exclusion or limitation involves the determination described in paragraph 2.

This removes what was viewed by many as a possible loophole. So we were willing to strike that portion of the bill in order to try to inspire some confidence that in no way does this legislation expect or anticipate or even allow in any way exclusions on coverage that are not specifically listed in the medical plan, in the insurance plan.

I yield the floor.

The PRESIDING OFFICER. The Senator from Indiana.

Mr. BAYH. Mr. President, before my colleague Senator MCCAIN leaves the Chamber, I thank him for his leadership on this issue. He has demonstrated his courage in battle and in service to country and is doing so again by leading this important battle for patient care for all Americans. I thank Senator MCCAIN for his leadership once again.

I thank my colleague Senator CARPER from Delaware. We served together as Governors for many years, and we now have the privilege of serving in this body. I thank him for his leadership on this issue, for his insight. There is no deeper thinker who cares more about the public policy details of what we do in the Senate than Senator CARPER. He is new to this body but has already made a substantial contribution to the Senate and to the laws that govern our country.

I express my appreciation to Senators EDWARDS and KENNEDY for their leadership in this important battle on behalf of patients. I express my gratitude to two of our colleagues who are not on the floor at this time: Senator NELSON of Nebraska and Senator KYL from Arizona.

In particular, I thank Senator NELSON for his heartfelt work on the last amendment. Although unsuccessful, I know he cared deeply about striking the right balance. We share many of the same objectives, although we differ in terms of how we go about achieving those objectives. I salute Senator NELSON for his work in this regard. I hope our amendment will meet many of his concerns. I believe it does in terms of striking the right balance for the American people.

Our amendment accomplishes both of the important objectives that the American people seek in debating and enacting this Patients' Bill of Rights. First, we ensure that all decisions that involve the practice of medicine, all decisions that involve medical discretion will be fully reviewable by an independent panel to ensure the quality of health care for all insured Americans across our country.

Second, this amendment seeks to accomplish quality medicine at affordable cost, keeping the prices as reasonable as possible for consumers and patients across the country. We do this by removing unnecessary ambiguity from this bill, thereby ensuring that we can accomplish quality medical treatment but keeping the risks, the uncertainty, and therefore the costs to patients and consumers as low as possible.

The bottom line will be quality health care for all Americans at an affordable cost. That is the balance all of us should be seeking to strike in this debate. That is the balance this amendment will help us to accomplish.

Very simply, we seek to honor the original intent of this bill, that doctors should make medical decisions, that lawyers should draft contracts and practice law, but neither should be in the business of practicing the other's profession. We have removed through this amendment ambiguous language that ran the risk of one encroaching on the other's territory.

Specifically, let me read the provisions that will remain in the bill. They are explicit and unambiguous. I quote from the legislation:

> Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan or health insurer offering health insurance or health insurance coverage provide coverage for items or services for which benefits are specifically excluded or expressly limited under the plan or coverage in plain language of the plan document.

Under the bill before this amendment, Mr. President, there had been several exceptions which had consumed the rule, making this clear exception for express limitations or prohibitions under the terms of the contract null and void. We put a period at the end of this language, removing the exception language, thereby making it very clear that the terms of the contract, in terms of contract language, will govern. This helps to keep the costs low because the uncertainty and the ambiguity will be removed.

At the same time, there can be no uncertainty or ambiguity that medical decisions involving the practice of medicine, anything involving medical discretion, will be fully reviewable by the external appeals process, as it should be.

In addition, there are other precautionary measures included in our amendment that I was interested in and I know the Senator from Delaware was interested in. He may elaborate on these provisions in just a few moments. These ensure that the independent reviewers are truly independent. We want to make sure they adhere to the provisions of this legislation, hopefully as amended by this amendment, and that we don't have the risk of panels exceeding their authority by changing the terms of the contract where they are expressly provided for, and there is no ambiguity in the language in terms of limitations or exclusions from the terms of the contract.

Once again, this amendment will ensure that independent review panels do not exceed their authority, inappropriately driving up costs without improving the quality of health care for the American people.

Finally, we have a rare opportunity to achieve bipartisan consensus on this amendment.

Not only is Senator MCCAIN helping to lead the charge once again, for which we are very grateful, but I listened with great interest and gratitude to something that the Senator from Oklahoma, Mr. NICKLES, said last evening. He recited the very same language that I recited about exclusions and limitations in the contract. And then he said if you put a period at the end of those provisions and remove the exception language, that would be—to use his word—''great.''

Mr. President, that is exactly what we have done. We have placed a period there and removed the exception language, thereby removing the ambiguity, the risk, the unnecessary cost to consumers without a health care benefit. Senator THOMPSON, earlier today on the floor of the Senate, indicated that this action we have proposed in this amendment would also go a substantial way toward correcting what he thought was a potential defect in the legislation.

So I ask all Senators, regardless of political affiliation, who seek to strike the right balance between quality health care on the one hand and affordability on the other hand to support this amendment. We have taken a step that some of those who have been concerned about the ambiguity in the language have encouraged us to do, thereby ensuring quality affordable health care for every American. We can accomplish that with this legislation, with this amendment. I urge my colleagues to vote in the affirmative.

I yield the floor, and I thank my colleagues for their patience and attention.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. Mr. President, I rise in support of the amendment. I am pleased to be an original coauthor with Senators BAYH and MCCAIN. The Senator from Indiana is very modest in giving to others the credit, but this is really an idea that I first heard from him. Early this week, Senator BEN NELSON and Senator BAYH and myself were trying to deal with issue of medical necessity. It is a difficult issue around which there are competing interests—doctors, nurses, insurers, patients—who really find consensus hard to reach.

I thank Senator BAYH for helping us to find this middle ground on which I am encouraged that maybe we will have strong bipartisan support. I express my thanks to Senators MCCAIN and KENNEDY and EDWARDS for their leadership in getting us here this day, and to my friend, Senator GREGG from New Hampshire, for his thoughtful comments, as well as those I heard on the floor yesterday, alluded to by Senator BAYH, from Senator NICKLES. As I recited, earlier today PHIL GRAMM of Texas echoed almost those same comments.

Before I return, I want to step back a little bit and go back in time. I used to be State treasurer of Delaware before I was a Congressman, before I was Governor, before I became a Senator. Senator BAYH was Governor of Indiana and was the secretary of state. We worked in those venues before we came here to work. With our State treasurer at the time, we administered benefits of State employees. Among the things I was mindful of was health care costs.

In the 1970s and 1980s, health care costs went up enormously. It was not uncommon to see increases then of 20, 25, or even 30 percent annually in the cost of health care for State employees. These really mirrored increases that inured to other employees outside the State of Delaware.

Along about the late 1980s, a dozen or so years ago, a number of people began working seriously in this town to figure out how to introduce some competition into the provision of medicine. In a fee-for-service approach in medicine, I might see my doctor and he says, ''You are not well; I will order tests A, B, C and D, and to be sure we will order E, F, G and H,'' and he owns the lab where the tests are administered. Then he says, ''Come back and we will see how you feel next week.'' There really wasn't much impetus for containing costs. As a result, costs spiraled out of control.

Managed care was designed and conceived to try to stop that spiraling and introduce some market forces and competition in order to control the cost of

health care. It really succeeded better than I think any of its proponents had imagined. Those costs that were going up 20, 25, even 30 percent, back in the 1980s, by the time we got to the end of the 1990s, were going up by 2, 3 percent, in some years nothing at all. As we went about controlling costs, the concerns switched to a different area, and that different area was quality of health care.

Instead of a lot of our doctors and nurses making decisions, a lot of decisions for the care to be offered or given to us was made within the HMOs running the managed care operation. In some cases, they were doctors and nurses, and in some cases they were not.

What we are trying to do in the context of the Patients' Bill of Rights legislation is restore some balance to the system. We don't want to see costs spiral out of control or employers cutting off health care for employees. By the same token, we want to make sure that more of the medical decisions that affect us if we are covered by an HMO, especially if it falls under a Federal regulation, which ERISA is—we want to make sure we are getting the kinds of protections that inure to folks who are in State HMOs.

How do we do that and not lead us back to spiraling, out-of-control costs in a way that is fair to doctors and nurses, and in a way that is fair to employers and at the same time fair to the HMOs? The issue we are trying to address is this: I am in an HMO; I don't like the decision my HMO renders with respect to my health care. I appeal that decision, and it is reviewed by an internal mechanism within the HMO. If they don't provide a decision my doctor and I like, we can appeal to an external reviewer. In some cases, certainly in my State, an external reviewer can override the HMO's decision and mandate the provision of that health care under a State-regulated plan.

What about in a case where there is a federally regulated HMO, one that falls under ERISA? What do you do in a case when the language of the plan explicitly excludes the treatment that a member of that plan desires? What do we do when the language of the plan explicitly excludes the very treatment that I or the member of a managed care plan desires?

Unintentionally, the language of the bill as drafted says to the external reviewer that you have license to go beyond that which is explicitly excluded in treatment for a patient. That external reviewer can order additional explicitly excluded treatment for a patient. That might be great for the patient, might be appreciated by the patients' doctors and nurses. But how fair is that to the insurer who is trying to cost out a plan, to charge for that plan and have a sum certain to operate with?

What Senator BAYH has fashioned, something that he and Senator NELSON and I worked on, is a way to provide that certainty for the insurer and also to provide certainty for the consumer, the patient, and the health care providers. It is a simple change—one endorsed, at least indirectly, by Senator NICKLES and today by Senator GRAMM. By simply striking a couple lines in his bill and putting a period where a period ought to appear, we helped solve a problem. It doesn't solve all of the problems in this bill, but it solves one of the problems. It is clear, clean, and easy to understand.

Let me close my remarks with some comments about another one of our colleagues who, before he was in the Senate, was a Governor, BEN NELSON of Nebraska. Before he was Governor, he was insurance commissioner for his State. He has forgotten more about these insurance matters than most of us will ever know. His insights and perspectives on these issues have been enormously helpful to me in this debate. I thank him for joining with Senator BAYH and me and others in the conversations that really led to the emergence of this proposal.

Senator NELSON offered an amendment with Senator KYL a little bit earlier today to try to define medical necessity, which is really the kind of issue we are talking about here. People have been trying to do that for years without a lot of success. While we are not going to agree to change the language in the bill with respect to that, we can say here clearly, if a health plan that falls under the jurisdiction of ERISA explicitly excludes a particular kind of coverage, then in all fairness the external review committee in reviewing an appeal, cannot override the explicit exclusion in that health care plan. That is fair; that is reasonable; it provides certainty for the insurer, and I think it is fair to consumers as well.

I am pleased to rise in support of it, and I hope that all of us in this Senate, Democrats and Republicans, and Independent as well, can support this amendment. Thank you very much.

I yield back my time.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Mr. President, before he leaves the floor, I thank my friend from Delaware for all his work on this issue. It is very important to the progress we are making to finally protect patients in this country, along with Senator BAYH, who led this effort, and Senator NELSON and others involved in this issue. We very much appreciate all of their input.

The issue of medical necessity, which means how we determine whether any particular care is covered and is medically necessary for the treatment of the patient, is a critical issue in the bill. We have now agreed on language that we believe appropriately balances the interests of the contract between the insurance company or the HMO and the employer on the one hand, and the interest of the patient and having some flexibility on the other.

Basically what we have said in this amendment is if the contract explicitly excludes a particular treatment, a test, then that will be excluded from care, period, and the independent reviewers are bound by that language.

On the other hand, to the extent we need some flexibility in what is proper and good medical care, we have managed to maintain that. I think we have struck the right balance between the sanctity of the contract on the one hand, so people know they can rely on the provisions of the contract and, secondly, allowing enough flexibility to provide the proper care to patients when they go through the review process.

More important is this is another step in a very important process. When we began last week, we were confronted with trying to get real patient protections in this country with numerous obstacles—disagreement among our colleagues, different issues being raised by Members of the Senate and a written veto threat from the President.

As we have moved forward through the end of last week and through the mid part of this week, we have continued to make progress every step of the way. We keep resolving issues. We keep making progress.

On the issue of employer liability, about which many of our colleagues have expressed concern, making sure that employers around this country are protected from liability, we have worked with our colleagues—Senator SNOWE, Senator NELSON, Senator DEWINE, and others—to work out compromise language that satisfies a large number of Senators on both sides of the aisle so that there is consensus on the need to protect the employers, on the one hand, but keeping in mind the rights of the patients on the other. Issue resolved.

No. 2, scope: What this legislation covers and who it covers. Senator BREAUX and I and others have been working very hard on this issue. We believe we have reached a resolution that will result in an amendment being offered later today that strikes a compromise and a balance between the interests of the States, being able to maintain the work they have done in the area of patient protection, while at the same time making sure every single American has a floor on the level of patient protection.

On the issue of medical necessity, as a result of the work of many of my colleagues, we have been able to reach consensus. On the issue of scope, who is covered, we have been able to reach consensus. On the issue of employer liability, we have been able to reach consensus.

Every day we have continued to make progress, but the importance of this is not for what is happening specifically within this Chamber and what is happening in Washington, DC, and what is happening among Senators. The winners in this process are the

families of America because it is now becoming clearer and clearer that we may finally be able to provide those families with the protections they so desperately need and to which they are entitled.

That is what this debate has been about. That is what all this work among Republicans and Democrats in the Senate has been about. We have shown over the course of the last week that we can work together, we can find ways to provide real patient protection in this country. Up until now, we have a model in problem solving, in trying to give real protection to the families of this country so they can make their own medical decisions. That is what this debate has been about; that is what our work has been about.

We are not finished. We have important issues left to resolve, but I am confident, given the good will and hard work that has already been done, that if we continue in that same way, we will be able to reach a resolution and hopefully be able to put a bill on the President's desk and that he will sign a real Bipartisan Patient Protection Act that gives power to patients and lets them make their own health care decisions.

I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. I thank the Chair. Mr. President, over the past few days of debate on this Patients' Bill of Rights, we have heard the many horror stories of what happens to people when HMOs put profits ahead of patients. We have heard of one man in a wheelchair whose HMO ordered his oxygen tanks removed from his house; we heard of a youngster whose brain tumor was missed because the HMO refused to allow the necessary test; and we heard of others pleading with their HMO to get coverage for critical procedures either for themselves or their families.

These, unfortunately, are not isolated examples. They are happening every day all across this country which is why the people of America are demanding reform and why we are seeing the public surveys now showing support for this legislation to the tune of 81 percent in favor of this legislation.

The people also realize the system is not working for the doctors either. Just last week, I learned of a doctor who is assessing his existing patients a $1,500 annual membership fee for the privilege of continuing their treatment. He wants to cull his current patient list from 3,000 patients down to 600, and by charging this annual membership fee, the doctor shrinks his practice and yet he maintains his profits. The patients who cannot afford the annual membership fee have to find another doctor. I find this outrageous and unethical, and it sets a bad precedent for the future of our health care industry.

All of these incidents and the debate over this legislation have made one thing very clear: Our health care system is failing most of the people in the country.

Mr. President, I rise today to reiterate my strong support for this Bipartisan Patient Bill of Rights. It represents a critical first step, an important first step in a long journey of a thousand miles of reforming America's health care system.

In short, this legislation puts medical decisions back in the hands of doctors and patients instead of HMO bureaucrats. It gives patients the right to see a specialist when needed, fixing a system that so often blocks a woman's access to necessary care. This legislation will ensure direct access for a woman to an OB/GYN if that is who she wants as a primary care physician. This bill gives patients access to the emergency room without first seeking clearance from their health care provider. We have heard many horror stories recounted in the Senate of people denied access to a certain emergency room because they had to go to another.

This legislation also protects the doctor-patient relationship, a very sacred relationship, by ending restrictions on which health care options doctors can recommend. Currently, we know doctors say they fear retribution from the health insurance industry if they pursue more costly medical treatment for their patients.

This bill also prohibits HMOs from offering financial incentives to doctors for recommending limited care. It prohibits HMOs from punishing doctors who seek top-notch care for patients.

What we are trying to do in this legislation is reinject common sense and good medical practice in protecting the doctor-patient relationship so the patient knows the doctor is going to prescribe what is the very best medical treatment appropriate for the circumstances.

In spite of claims to the contrary, yesterday the American Medical Association and other health groups reported in States with recently enacted accountability and legal remedies, the new laws did not produce any documented increase in the number of uninsured, one of the specious arguments that the opponents to this legislation have advanced.

The most crucial issue is whether a patient can seek legal recourse for the wrongdoing by a managed care company. This bill will enable patients to hold their insurance companies accountable for harmful actions. Under current law, if malpractice is committed, if there are grievous wrongs, a patient can recover from a doctor, from a hospital, from other providers, but under current law they cannot recover from an HMO. That is one of the main fundamental principles of this legislation, to change that, so they can hold those HMOs accountable.

Before I came to the Senate, I was the elected insurance commissioner of Florida for 6 years. I saw how some insurance companies—and I don't say all because I am proud of those insurance companies that would stand up for the rights of their patients and would stand up to protect their patients, but I saw how some insurance companies tried to put profits ahead of patients. Unfortunately, many patients often have little or no recourse.

There is no reason why HMOs should have special protection from lawsuits. The AMA has so stated and endorsed a patient's right to sue. It is estimated more than 190 million Americans are enrolled in health plans, and 75 percent of them under current law are unable to sue their health plans for anything but the cost of denied treatment. Clearly, the status quo works for the industry, but it fails consumers. We need this legislation to enable people to be able to redress their wrongs in State courts for damages limited only by State regulations.

It has been a long time coming. It has taken 5 years to get this legislation to the floor because for 5 years special interests have prevented this bill from becoming law. As a result, the people of Florida and the people throughout this Nation have suffered. We must end the industry strangle hold on this legislation and we must take the first meaningful steps toward overall health care reform. I submit that this legislation is a major first step in the overall journey toward health care reform. We must put the people before the special interests. We must put an end to these consumer horror tales that we have heard with all too much frequency during the course of debate on this legislation.

I thank colleagues for the privilege of addressing this issue and for indulging me in my comments.

I yield the floor and suggest the absence of a quorum.

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

The legislative clerk proceeded to call the roll.

Mr. NELSON of Florida. Mr. President, I ask unanimous consent the order for the quorum call be dispensed with.

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

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

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

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

Mr. REID. On behalf of the majority leader, I ask unanimous consent that at 5 p.m. the Senate vote in relation to Senator MCCAIN's amendment No. 820; that prior to that vote, when the

quorum call is ended and the unanimous consent agreement is reached, Senators BREAUX and COLLINS be recognized to offer a first-degree amendment on scope—they can, after the vote tonight, either stop or come back tonight, but we will have a vote at 5 o'clock for the convenience of some Senators—that the Breaux and Collins debate occur concurrently today; and when the Senate resumes consideration of the bill tomorrow, Thursday, at 9:15 a.m., there be 30 minutes for debate equally divided between Senators COLLINS and BREAUX prior to votes in relation to these two amendments; that there be 2 minutes for debate equally divided before each vote with the first vote occurring in relation to the Collins amendment; that upon the disposition of these amendments, Senator GREGG be recognized to offer an amendment relative to liability; that there be 1 hour for debate equally divided prior to a vote in relation to that amendment; that upon the disposition of Senator GREGG's amendment, Senators SNOWE and FRIST each be recognized to offer a first-degree amendment, and that will be on liability; that there be 4 hours for debate equally divided in the usual form to run concurrently; that at the conclusion or yielding back of time, the Senate vote in relation to Senator SNOWE's amendment; that after disposition of her amendment, the Senate vote in relation to the Frist amendment; that no second-degree amendments be in order to any of the amendments listed in this agreement prior to the vote in relation to the amendments.

Mr. GREGG. Reserving the right to object, I ask if the Senator from Nevada would be willing to amend the agreement, so it would be Senator GREGG or his designee.

Mr. REID. Absolutely.

Mr. GREGG. I have no objection.

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

Ms. COLLINS. I ask unanimous consent that the pending amendment be set aside.

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

AMENDMENT NO. 826

(Purpose: To modify provisions relating to preemption and State flexibility)

Ms. COLLINS. On behalf of myself, Senator NELSON of Nebraska, Senator ENZI, Senator VOINOVICH, Senator HUTCHINSON, and Senator ROBERTS, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Maine [Ms. COLLINS], for herself and Mr. NELSON of Nebraska, Mr. ENZI, Mr. VOINOVICH, Mr. HUTCHINSON, and Mr. ROBERTS, proposes an amendment numbered 826.

Ms. COLLINS. I ask unanimous consent reading of the amendment be dispensed with.

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

(The amendment is located in today's RECORD under ''Amendments Submitted.'')

Ms. COLLINS. I am very pleased to join with my colleague from Nebraska as well as the other Senators whom I mentioned in offering this amendment. Our amendment will give true deference to State laws and the traditional authority of States to regulate insurance while ensuring that each State addresses the specific patient protections provided in this legislation.

We should pass a strong, binding Patients' Bill of Rights. We should pass a bill that holds HMOs accountable for promised care and that ensures that patients receive the health care they need when they need it. However, we should do so in a responsible way that does not add excessive costs and complexity to an already strained health care system.

Congress should act to provide the important protections that consumers want and need without causing costs to soar and without preempting State insurance laws. We can do so by passing a carefully crafted bill.

I strongly believe we should not preempt or supersede but, rather, build upon the good work the States have done in the area of patients' rights and protections. States have had the primary responsibility for regulating insurance since the 1940s. For more than 60 years, States have been responsible for protecting insurance consumers. As someone who has overseen a bureau of insurance in State government for 5 years, I know firsthand that our States' bureaus of insurance do an excellent job of protecting consumers' rights.

One of the myths in the debate on this legislation is that unless the Federal Government preempts State insurance laws, millions of Americans will somehow be unprotected in their disputes with HMOs. That simply is not true. For example, as this chart demonstrates, the States have been extremely active in passing patient protections. In fact, they have been way ahead of the Federal Government and they have acted without any prod or mandate from Washington. Look at this activity: 44 States have dealt with the issue of emergency room access; 49 States have passed laws prohibiting gag clauses in insurance contracts that restrict what a physician can tell a patient. Whether it is access to OB/GYNs, continuity of care, or many of the other issues such as internal or external appeals or patient information, the States have been extremely active in this area. Every single State has acted to pass some sort of patient protections.

As is so often the case, it has been the States that have led the way. They have been the laboratories for insurance reform. Moreover, we know one size does not fit all. What may well be appropriate for one State simply may be unworkable or unneeded or too costly in another. What may be appropriate for California, which has a high penetration of HMOs, may simply not be necessary in a State such as Alaska or Wyoming where there is virtually no managed care. In such States, a new blanket of heavyhanded Federal mandates and coverage requirements simply drives up costs that impede rather than expand access to health insurance. That is why the National Association of Insurance Commissioners and the National Conference of State Legislators are very concerned about the language in the McCain-Kennedy bill. The language in that bill will force all States to adopt virtually identical Federal standards.

I recently received a letter from the president of the National Association of Insurance Commissioners. She writes that States have faced the challenges and produced laws that balance the two-part objectives of protecting consumer rights and preserving the availability and affordability of coverage. For the Federal Government to unilaterally impose its one-size-fits-all standards on the States could be devastating to State insurance markets.

I think we should heed that caution. I think we should heed that warning. The Federal Government does have an important role to play in regulating the self-funded plans under ERISA. That is where our effort should be focused.

States are precluded from applying patient protections to these federally regulated plans, and that is why we need a Federal law to ensure that consumers, enrolled in insurance plans beyond the reach of State regulators, have strong patient protections. But the Federal Government should not be in the business of second-guessing and overriding and preempting the carefully crafted patient protections that have been negotiated by our State legislators and Governors to meet the needs of their States' citizens. States which seized the initiative and acted on their own should not have to revise their carefully tailored laws simply to comply with a one-size-fits-all Federal mandate.

Under the McCain-Kennedy bill, the Federal Government would preempt existing State laws unless the State has enacted protections that are ''substantially equivalent to and as effective as'' the Federal standard.

A reasonable person's interpretation of that standard is the States will have to pass new laws wiping out their carefully crafted work, that are virtually identical to the standards in the McCain-Kennedy bill.

The approaches taken by the 50 States to the same type of patient protection vary widely, and with good reason in many cases. Why should States that have already acted on their own to provide strong, workable patient protections have to totally change and make extensive changes in their laws? That is why the National Council of State Legislators supports the Collins-Nelson amendment. It is extremely important to State legislators that they

do not have to spend valuable time recrafting and rewriting and reenacting laws already on the books that meet the needs of their citizens.

In a recent letter to Senator Nelson and myself, the National Council of State Legislators wrote:

[We] support this amendment. States are best situated to provide oversight enforcement of the patient and provider protections established in this legislation. The record of the states is strong. We are looking for an approach that supports the traditional role of States in the regulation of insurance and that recognizes the differences in State insurance plans and provides a mechanism for States to protect those markets.

Again, let me be clear. There is a role for the Federal Government, and that is to make sure that those plans, regulated under ERISA, beyond the reach of State regulators, include patient protections. That is why we need a Federal law to accomplish that goal.

It is all well and good and appropriate if Congress decides it wants to impose a specific requirement or mandate on these federally regulated insurance plans. But the Federal Government needs to be careful in respecting the good work the States have done.

Moreover, let's look at the practical consequences of what would happen under the McCain-Kennedy bill. If a State fails to revise its laws to conform to the Federal standard, under the McCain-Kennedy bill the Health Care Finance Administration, HCFA, would displace the State as the enforcer of insurance patient protection.

Talk about a right without a remedy. If there is no enforcement, there is no protection, and experience has already shown that HCFA is completely incapable of carrying out this responsibility.

The Health, Education, Labor, and Pensions Committee on which I serve has held yearly hearings to examine the problems that HCFA has experienced as it has attempted to implement and enforce the 1996 Health Insurance Portability and Accountability Act. There are many GAO reports. This one is entitled: Progress Slow In Enforcing Federal Standards in Nonconforming States. That is because HCFA is totally ill-equipped to take on this task.

Our States' bureaus of insurance know how to do the job. They have been doing it for 60 years, and they have been doing it well. Consumers should be very concerned, since HCFA has already proven that it is not capable of enforcing existing Federal insurance standards in States that don't conform. In fact, HCFA has shown it cannot even assess the degree of compliance with those Federal laws, where HCFA does play a role. We should be very concerned that we are proposing an empty promise.

The States have the systems, the infrastructure necessary to receive and process consumer complaints in a timely fashion and to hold insurers accountable to ensure that they comply with State laws. To me, the bottom line is very simple. My constituents would much rather call the bureau of insurance in Gardiner, ME, than have to deal with the HCFA office in Baltimore if they have a problem with their insurance.

Another problem of the McCain-Kennedy approach is that it would create a dual enforcement structure that would be extremely confusing for consumers and, frankly, completely unworkable. Under this bill, if some State laws met the new standards but others did not, who would be the regulator? Would it be HCFA or would it be the bureau of insurance? Would it be HCFA for some parts of the insurance contract and the bureau of insurance in the State for other parts of it?

This simply does not work. We would be creating a situation where a patient may have to go to a State bureau of insurance for questions or problems associated with certain patient protections and then try to deal with HCFA if the patient has problems or questions with other parts.

Therefore, Senator NELSON and I, supported by a number of our colleagues, are offering an amendment that will give true deference to State laws and the traditional authority of States to regulate insurance. At the same time, we will ensure that each State considers and addresses the specific patient protections proposed by this legislation.

First, our amendment would grandfather all State patient protection laws that are in place prior to the effective date of this act. That is October 1 of next year. A State would just certify to the Secretary of HHS that it has addressed one or more of the patient protection requirements to be in compliance with the law. This provision would also give States that have not considered these patient protections an incentive to act before the effective date to avoid Federal intrusion and challenges to their laws.

Second, if by the effective date a State has been certified as compliant with all the patient protections in the legislation, it will immediately become eligible for funds from a new patient quality enhancement grant program. States that are not in full compliance by the effective date of the legislation would be required to meet a higher standard in order to be eligible for funds under this new program. If a State has not acted by the effective date, it would have to certify to the Secretary, for each of the remaining protections, that either the State has enacted a law that is ''consistent with the purposes of the Federal standard'' or decline to enact a law because the adverse impact of the law on premiums would lead to a decline in coverage or simply because the existence of a managed care market in the State is negligible; it is just not relevant to that State.

Our amendment would recognize the States are the experts in this area. They have led the way. Consumers are best protected if we continue to respect the work that the States have done and give deference to the State's traditional authority to regulate insurance.

I reserve the remainder of my time but yield to the Senator from Nebraska, my principal cosponsor, who is a true expert in this area. He knows more than any other Senator. I hope my colleagues will listen very carefully. It has been a great pleasure to work with him on this issue about which we both care a great deal.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. NELSON of Nebraska. I thank my colleague from the New England State of Maine for such a glowing recommendation. I hope my colleagues do not think I believe I know more than they do. But it is a subject I have spent a good deal of my life involved in as an insurance regulator and as a Governor, somebody who has dealt with the business of insurance.

I appreciate so much the opportunity to join with Senator COLLINS to bring this amendment to the attention of our colleagues.

It typically is a lot more instructive to talk about the importance of patient care and to talk about those who aren't getting good patient care and certainly to bring to our attention those folks who suffered great injustices under their current health care system. I respect that. I certainly am interested in that aspect. That is why I support a Patients' Bill of Rights. That is why I continue to do that.

But I have found that any bill which comes before this body or that comes before any legislative body is hardly ever such without some amendment and some improvement. I think what Senator COLLINS and I are offering today is in that category of an improvement.

When our founders created this Union they established a system of Government that, pursuant to our Constitution, provided for a divided Government, a Government consisting of our States, and under a well-considered principle of Federalism, a Federal Government. We have been best served by this Government when we have permitted it to work for us. While pursuant to the 10th amendment, the Federal Government may preempt States in certain respects, it seems clear from that amendment and from the practice over the last 200-plus years that such preemption should be limited to those areas where the States have failed to act in some manner. This is not one of those cases.

The bill before us presents a dilemma for me and for my colleagues because most of us believe that, with some modifications, this is a good bill. The same may be said of the Frist-Breaux-Jeffords bill.

At the outset, let me state unequivocally that I support the purpose and the protection of this bill. What I don't support is its preemption of State laws in an unnecessary manner. Let me explain.

As my colleague has indicated by the chart, the States have acted. They have acted rather aggressively and consistently and in many ways. As a matter of fact, they acted so aggressively and so consistently that the best of those protections which the States passed were assembled to create this bill. Let me ask you if that isn't some action on the part of the States.

When Congress passed the ERISA preemption in 1974, it did so because some multi-State employers were having problems complying with the diversity of the State regulation of health insurance.

First, it was described as a pension issue to which they couldn't quite comply. Then they said, as long as we are getting a preemption, let's grant it in the health insurance area as well. So Congress exempted certain plans from State law. That level of exemption involved fewer insured than were continued to be served by State regulated insurance plans.

What we are faced with today is dealing with the problem that began in 1974 with the exemption from consumer protections of these Federal plans. Now we are faced with solving that problem.

Some have said, as long as we are solving that problem, let's move away from diversity and go to uniformity. I am not opposed to having uniformity. But to serve uniformity for uniformity sake and ignore what the States have done, the fact is that under the principles espoused by Thomas Jefferson States have only been acting as laboratories of democracy by experimenting. Fortunately—and thank goodness—the States have experimented because it is from these experiments and from this diversity that we are now able to assemble for the protection of the ERISA plan this group of patient protections.

That is what is important about this. If we look at it to a certain extent that virtually all content is taken from various State laws, that is at least some form of congratulations to the States for their efforts. But they ought not to be rewarded by that great effort by the preemption where it is unnecessary.

The framers of the legislation that is before us as well as those of the Frist-Breaux-Jeffords bill have really worked hard to try to find a way to balance this out. I commend them for that. Their work does not go unnoticed. I appreciate their efforts. But whether the standard is substantially equivalent as in the McCain-Kennedy Edwards bill or in the Frist-Breaux bill consistent with or in a compromise that is under consideration right now which says substantially compliant, the fact is the States are going to have to come to the Federal Government with the plans and say, ''Please let us out'' or they will not be able to get out from under the requirements of this legislation unless they are ''substantially equivalent to.''

''Substantially equivalent to'' means the filings of these State protections would have to be made by their Governors to the health and human services agency, and they will have to find out whether or not the plans they are submitting are substantially equivalent—not whether they are good or bad but whether they are substantially equivalent.

The theory is, if they are substantially equivalent, they are at least as good as or better. But I don't know why we should engage bureaucracies in the Federal Government to try to look over the shoulders of the States that have seriously considered each and every one of these protections.

Why are we doing it? Because we want to solve the problem that exists. Why should we try to solve a problem where there is no problem?

Under the Collins-Nelson effort, we give the States the opportunity to opt out if their plan is consistent with the purposes of this law.

It seems to me that we just simply make it clear that the States can continue to experiment. It is easy to suggest that if you take away the incentive of the State to experiment, the experimentation will either wither or will at least stagnate.

We want to continue to be sure that there are incentives for the States to continue to experiment because I suggest to you right now this is a dynamic process. Over the next several years, we are going to find some better patient protections, and we are more likely going to find those from the States than we are engaged in the body of this legislative Chamber trying to find those answers.

I would prefer that experimentation continue. Then we can pick and choose the best of the class in each case.

I spoke today with the Secretary of Health and Human Services, Tommy Thompson, also a former Governor, and I asked him whether he thought his agency could do this. He said simply that he doesn't think that it can.

Let me add that I think that translates into, ''I can't unless I have a larger bureaucracy of several dozens or more Federal bureaucrats and more staff to look over and second-guess Governors and second-guess State legislatures.''

I asked if that is necessary. Quite frankly, I don't believe that it is. And with the stroke of the pen this bill can be amended so that it won't become law so States can opt out and Governors will have the opportunity, as State legislatures, to decide what is the policy that will work within their State.

We are looking for balance with this legislation. All of us want to balance being able to have the right kind of protection for patients and the availability and affordability of insurance. The last thing we need to do is to tip the balance one way or the other and end up with a more severe problem than we are trying to solve with this effort.

I suggest to you that Thomas Jefferson might be looking at us at the moment. Furthermore, I think he would be pleased if we had a dual system that recognized that this Federal bill and these Federal protections would apply to the Federal plan, and we would allow the States to continue as they have to protect the people at that level and to serve to provide experimentation and better ideas along the way and permit us to allow them to continue as they have to protect the citizens.

I truly believe that government, when it is functioning at the local level, will function best and certainly can function better in this area than we can function.

We have already taken the step of exempting the Federal plans. Let us not now make a mistake of applying what we need to permit for those State plans where there is already much protection and probably even more protection.

Just this week, Delaware added additional patient protections. It seems to me that we ought to continue to support that. We ought not to do anything that detours it or takes away the incentive for the States to continue to do as they have been doing.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I thank the Senator from Nebraska for his comments. He has stated the case extremely well. He has had the experience not only of being a Governor but of actually being a commissioner of insurance.

I spent 5 years in State government overseeing a bureau of insurance. We have confidence in our State's abilities to protect the rights of insurance consumers. Indeed, the States have been way ahead of the Federal Government in this area.

I have shown my colleagues the charts of the numerous laws that the States have passed during the past decade dealing with patients' rights. Each State has taken action on some of these consumer protections. They have done so without any mandate from Washington. They have done so because they want to make sure that in State regulated insurance plans these kinds of protections have been included.

In fact, the States have passed over 1,100 laws and regulations dealing with patient protections. So this is not a case where the States have failed to act and the Federal Government has to come to the rescue. Rather, it is a case where the States have been far ahead of the Federal Government. We have been slow to provide these kinds of State protections to federally regulated plans under ERISA. That should be the primary focus of this legislation.

Both the Senator from Nebraska and I support a strong Patients' Bill of Rights. We want to make sure, in writing this legislation, we do not wipe out the good work of State governments.

Every single State has at least one law on the books dealing with portions

of the McCain-Kennedy bill. But no State law is identical to the provisions in the McCain-Kennedy bill. States have dealt with these issues in different ways, depending on the negotiations between the State legislatures and their Governors, to meet the needs of that particular State. There is no need to impose a one-size-fits-all Federal mandate on the States when they are already doing a good job.

When I was Commissioner of Professional and Financial Regulation in the State of Maine, we had a very active bureau of insurance that lead the way in proposing many reforms in insurance and health insurance that were enacted by our State legislature. In fact, I believe that Maine was the first State in the Nation to pass legislation requiring automatic continuity of coverage, renewability of insurance contracts. We did that way back this the 1980s. We were ahead of the Federal Government by many years in this area.

Why should the State of Maine, which has been a leader in insurance regulation, have to go back and revisit its laws, recraft them, and rewrite them to meet the dictates of the McCain-Kennedy bill? That just does not make sense.

I think we should respect the work that has been done by the States in this area by honoring the laws that already exist and are on the books. We can encourage those few States—and they are just a handful—that have not acted in some area to do so, and then to bring their plan to the Federal Government or to tell us why they chose not to.

Why does it make sense for a State such as Wyoming or Alaska, which has virtually no managed care, to have to adopt a host of new laws that are irrelevant to their insurance market?

States have been strong in this area. They have worked hard to protect their health care consumers. I think we should be assisting them, providing incentives for them to act still further in this area, not preempting their good work.

I yield the floor but reserve the remainder of the time on the Collins-Nelson amendment.

The PRESIDING OFFICER. There is no time on this amendment.

The Senator from Nebraska.

Mr. NELSON of Nebraska. I again commend my colleague from Maine who has a wealth of experience in the regulation of insurance by having dealt with the professional agencies in her State. I suggest to you that she knows exactly of which she speaks, that the States have been active and have taken a very strong role in trying to protect the patients within their States.

The legislatures, the Governors, and the regulators have all worked together to try to create an environment in which patients are protected. They have succeeded in doing that.

The one missing piece, though, is not in what the States have failed to do but in what the Government today at the Federal level, in Congress, is now trying to do, and that is to cover the federally exempted plans.

There would not be any discussion in this Chamber today about this bill if it had not been for the exemption granted in 1974, as a result of Congress' action to exempt certain plans from State laws.

There is no criticism of what the States have or have not done. There isn't any suggestion that the States have not been active or that the States have not attempted to do a good job or that they have not done a good job.

What we have is, overcoming an omission, taking care of something that has not been done; that is, applying these protections to the Federal laws that have been exempt from State law. That is exactly what this is about.

I certainly want to praise, again, Senator KENNEDY, who has been extraordinarily tolerant of those of us who have had something to say about his labor of love. He has been very tolerant. He has been very helpful. And he has been very suggestive about solutions along the way. I want him to know that I personally appreciate that.

I am somewhat embarrassed to be suggesting that I might have some area of improvement, given the fact that he has worked on this for so long. It is a fact that I come fresh. I said this morning, I feel like somebody who came to the party late who now wants to rewrite the invitation.

It seems to me that this bill is such that it can involve some additional improvement. This is an area where I think it could be greatly improved, by giving the States the opportunity to make their case—not that they need to be treated as though their laws are substantially equivalent—but to give them the opportunity to come in and say: We have done this. We chose not to do this in our State after carefully considering it. The Governor may have wanted it, but the legislature, in its infinite wisdom, chose not to do it, or vice versa. It works that way. That system ought to be continued.

It will serve the people of our great Nation very well: The people of South Dakota, the people of Maine, the people of Nebraska, the people of Massachusetts, the people everywhere, because it has served this Nation so very well and has served the people so very well.

That is a minor modification. I think it has major implications, but it is a minor modification to say that the Governors can certify, and they can seek to support that they have attempted to deal with these issues in their way, that they do not have to do it our way. That is the difference.

I hope that my colleagues will see it that way and will find the capacity to continue to recognize that States have done, are doing, and can continue to do a good job. Even though there is an effort made to limit the amount of the preemption, I believe this preemption simply goes further than is necessary and further than we certainly would like to have it go.

That is what the National Conference of State legislatures have said and other State organizations have said. They would prefer to have less preemption and a better recognition of their efforts and a recognition that they will continue to work to increase the level of patient protection.

I yield to my colleague from Maine.

The PRESIDING OFFICER (Mrs. MURRAY). The Senator from Maine.

Ms. COLLINS. Madam President, I know we are about to vote shortly on another amendment.

Let me just summarize this part of the debate—we will be resuming the debate after the vote—by quoting a letter from the National Association of Insurance Commissioners to Senator NELSON and myself. They raise exactly the point that Senator NELSON and I have raised:

> Members of the NAIC are also concerned about enforcement. As you know as a former state regulator, if there is no enforcement then there is no protection. States have developed the infrastructure necessary to receive and process consumer complaints in a timely fashion and ensure that insurers comply with the laws. The federal government does not have this capability, and [these] proposals [before the Senate] do not provide any resources to federal agencies to develop such capability. It has taken the Health Care Financing Administration (HCFA) years to develop the infrastructure required to enforce the Health Insurance Portability and Accountability Act (HIPAA) which included only six basic provisions that most states had already enacted. The proposed patient protection bills are far more complicated than HIPAA and will require considerable oversight.

If we pass the McCain-Kennedy bill without this amendment, we are holding forth a hollow promise to consumers.

AMENDMENT NO. 820

The PRESIDING OFFICER. The hour of 5 o'clock has now arrived. Under the previous order, the question now is on agreeing to the McCain amendment No. 820.

Mr. REID. Madam President, on behalf of Senator DASCHLE, this will be the last vote of the evening. There will be further debate on the two amendments now pending. The next vote will be at 9:45 a.m. tomorrow.

I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second. The clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 100, nays 0, as follows:

[Rollcall Vote No. 201 Leg.]

YEAS—100

Akaka	Bond	Cantwell
Allard	Boxer	Carnahan
Allen	Breaux	Carper
Baucus	Brownback	Chafee
Bayh	Bunning	Cleland
Bennett	Burns	Clinton
Biden	Byrd	Cochran
Bingaman	Campbell	Collins

Conrad	Hollings	Nickles
Corzine	Hutchinson	Reed
Craig	Hutchison	Reid
Crapo	Inhofe	Roberts
Daschle	Inouye	Rockefeller
Dayton	Jeffords	Santorum
DeWine	Johnson	Sarbanes
Dodd	Kennedy	Schumer
Domenici	Kerry	Sessions
Dorgan	Kohl	Shelby
Durbin	Kyl	Smith (NH)
Edwards	Landrieu	Smith (OR)
Ensign	Leahy	Snowe
Enzi	Levin	Specter
Feingold	Lieberman	Stabenow
Feinstein	Lincoln	Stevens
Fitzgerald	Lott	Thomas
Frist	Lugar	Thompson
Graham	McCain	Thurmond
Gramm	McConnell	Torricelli
Grassley	Mikulski	Voinovich
Gregg	Miller	Warner
Hagel	Murkowski	Wellstone
Harkin	Murray	Wyden
Hatch	Nelson (FL)	
Helms	Nelson (NE)	

The amendment (No. 820) was agreed to.

Mr. REID. I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

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

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

AMENDMENT NO. 830

(Purpose: To modify provisions relating to the standard with respect to the continued applicability of State law)

Mr. BREAUX. Madam President, I ask for the reporting of an amendment that is at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Louisiana [Mr. BREAUX], for himself, Mr. JEFFORDS, Mr. KENNEDY, Mr. MCCAIN, and Mr. EDWARDS proposes an amendment numbered 830.

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

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

(The text of the amendment is located in today's RECORD under ''Amendments Submitted.'')

Mr. BREAUX. Madam President, this amendment is offered on behalf of myself, Senator JEFFORDS, Senator KENNEDY, and Senator EDWARDS as well. It attempts to deal with the question of whether States would be allowed to continue their programs dealing with Patients' Bill of Rights or will it be dealt with on a Federal level.

We have tried to bring about an agreement between all of the parties and, to a large extent, we have been successful in the sense that we have taken ideas and concepts that have been brought before this body on previous occasions and implemented them in this amendment, a provision that I think makes a great deal of sense.

A great deal of the credit should go to the staffs who have been negotiating this amendment for several days in order to bring it to the attention of our colleagues.

Most of our colleagues recognize the need that States have addressed this problem in a fashion that guarantees to patients that they will have certain rights, and they should be allowed on a State level to run and manage these programs. Very few people would be suggesting the Federal Government knows the answers to all of these problems.

My State of Louisiana, for example, is a State that has already enacted into law some 39 guarantees under our State program, guaranteeing to patients they will be protected when they deal with their insurance companies and their managed care companies. They can be assured that these rights, in fact, are in place.

There are a number of other States that have done the same thing. The point is that while we in Washington are passing a national Patients' Bill of Rights, there are many States that have already done this. They were ahead of the Federal Government. They did it before us, and these States should be allowed to continue to run their State programs as they see fit.

What we had suggested in the original Frist-Breaux-Jeffords legislation is that a State would not have their programs superseded by the Federal Government if their plans were consistent with the Federal statute.

The Senator from Massachusetts, the Senator from North Carolina, and the Senator from Arizona took the approach that States could only allow their plans to continue if they were substantially equivalent with the Federal program.

Our staffs have come up with a realistic compromise, a compromise between those two standards, something that I think makes a great deal of sense.

The amendment at the desk tries to reach an agreement and compromise that recognizes the role of the States is very important. Our language simply says the State plan will not be superseded by the Federal Government when the State plan substantially complies with the patient protection plan we have written on the Federal level.

Where do we get that language, ''substantially complies''? I think that is very important. ''Substantially complies'' is the test that we instituted when we passed the so-called SCHIP programs for children's health insurance. We basically said in that legislation the States would be able to carry on their State programs for insuring children if it substantially complied with the guidelines of the Federal Government. That language is in the existing law of this Government; it is being interpreted by HHS, and they interact with the States now on the ''substantially comply with'' test. They know how to handle it; they know what it means; they have interacted with the States on this basic test.

We take that language from that legislation and incorporate it into what we are doing with the Patients' Bill of Rights. Senator JEFFORDS was a major author of that SCHIP program, and he will speak to this issue. We took the language, the test of ''substantially comply,'' and we now have that in place in this amendment.

The decision on ''substantially comply,'' whether it is or is not being complied with, is a decision of the Secretary of Health and Human Services, who will look at the State plans and make a determination as to whether or not they substantially comply with the Federal statute. They have time lines within which they have to make that decision. I think that is appropriate so they do not just languish in Washington. They have a certain time period in which they have to make a decision on a request by the State to be in substantial compliance with the Federal statute.

It is important to note we want the State to move in this direction. There has to be an enforcement mechanism. As in the original Frist-Breaux-Jeffords bill and the original McCain-Kennedy-Edwards bill, if the States decide to do nothing, they will have to be in compliance with the Federal standards on a patients' protection bill of rights.

The difference in our approach and my colleague from Maine and my colleague and friend from Nebraska is, if States decide to take a walk on this, if a State decides, we don't care what you are doing in Washington, folks, we are not going to pass any Patients' Bill of Rights in this State, and we are not listening to anything you are suggesting, their bill is defective in that there is no enforcement mechanism to get the States to move in a direction which is in the interests of everyone in this country.

One defect in their amendment is that the only penalty the State can potentially suffer is to have grant money for this program terminated. Therefore, you could have a situation where the State simply thumbs its nose at the concept of a national patient protection right and does not enact anything if they don't want to, and yet I think that would be a serious mistake.

I think it is in the interests of this Nation to have a Patients' Bill of Rights that can be enforced, and what we have offered as a reasonable compromise between the Kennedy bill and the Frist-Breaux-Jeffords bill I think is one that is balanced, it has been well thought out, and uses language that is already in Federal law as the ''substantially comply'' test is already being enforced by the Secretary of Health and Human Services.

I encourage Members, after having a chance to look at what we have offered, to be supportive of this compromise effort.

I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. I will follow up on the Senator's explanation of what we are trying to do, to make sure we have a less complicated situation with respect to who is in charge and with whom to deal.

We have some problems, but the biggest problem, in what was the Kennedy-Kassebaum bill called HIPAA, was we made the mistake of using such language that it ended up that many of the States declined to do anything, in which case the Federal Government, under the bill, came in and tried to do it. That has not worked out. This comes from experience in trying to recognize the States will do good a job and want to do a good job and this is the best place to do it. We will do nothing that prevents that from continuing.

Senator COLLINS has worked hard on this over the year to make sure we come up with something that will be signed into law and allow the President to sign it into law. The protections in the Frist-Breaux-Jeffords Patients' Bill of Rights apply to all 170 million Americans covered by the private sector group health plans, individual health plans, and fully insured State and local government plans. It covers all of them.

At the same time, our legislation recognizes the Federal Government does not have all the answers. States need to play the primary role in enforcing the bill's requirements with respect to health insurers. However, if a State does not have the law or does not adopt the law similar to the new Federal requirements, Federal fallback legislation will apply.

Our amendment strikes a new compromise under scope between the Frist-Breaux-Jeffords standard of ''consistent with'' and the much more preemptive standard in the McCain-Edwards-Kennedy bill that states laws ''be substantially equivalent to'' and ''as effective as'' the new Federal patient protections. This leaves a lot of indefiniteness in the situation. The Breaux-Jeffords amendment uses a new standard that the State law would be certified if it ''substantially complies,'' meaning that the State law has the same or similar features as the patient protection requirements and has a similar effect.

Also, we require that the Secretary give deference—try your best to make sure the State can do it if they want to do it —to the State's interpretation of the State law involved and the compliance of the law with the patient protection requirement. This amendment represents a true compromise. We believe it will make it less likely that the Federal Government will have to enforce these new standards and more likely that it will get signed into law.

I think we have made a good improvement. I am hopeful it will be accepted. I urge its acceptance. I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Madam President, I will make a couple of comments. I compliment my colleagues, Senator COLLINS and Senator NELSON, for offering an amendment which does recognize State roles in enforcement of insurance contracts. Unfortunately, I don't believe that is the case under the Breaux-Jeffords amendment. We will have to make a decision: Do we believe States should regulate insurance? Or should the Federal Government? Do we believe one size fits all?

I understand there is a little change and there may be some improvement over the underlying bill, but the improvement is very small. The underlying bill, the McCain-Kennedy-Edwards bill, has language in it that says all these protections that we are getting ready to tell the States they have to do, the States have to have ''substantially equivalent'' and ''as effective as'' the standards we are getting ready to pass in the bill.

I think the Senator from Maine said there are 1,100 State protections—State protections dealing with ER, State protections dealing with OB/GYN, State protections dealing with clinical trials, and so on. Almost none of the States has identical protections as what we are getting ready to mandate.

Unfortunately, the language that now is being talked about may be an improvement. Instead of ''substantially equivalent,'' it says ''substantially compliant'' with the Federal standard. ''Substantially compliant'' was written under the SCHIP program, and that was, if they did this, they would get a pot of money. That is a little different scenario than coming up with: States, you must do this or we will regulate your State insurance—even though the States have always done it. Historically, the Federal Government has never regulated State insurance.

Under the McCain-Kennedy bill or now under the Breaux-Jeffords substitute, you are still going to have the Federal Government telling the States, comply with what we are telling you substantially or else we will supersede your regulation and the Health Care Finance Administration is going to do it.

There are a couple of problems with that. HFCA can't do it. Maybe nobody cares. Maybe we should just go ahead and pass this. We might just pass it and laugh at it because I absolutely know, with certainty, HFCA can't do it.

The Secretary of HHS, Secretary Thompson, basically made that statement before the Finance Committee on June 19. HFCA is already overloaded. They haven't even enforced the Medicare rules we passed years ago. They are not even enforcing HIPAA that we passed several years ago.

Under HIPAA that is the Kennedy-Kassebaum bill that deals with portability—there are five States that have not complied. We have testimony that HFCA is not enforcing that. They are supposed to. We passed a couple of other bills. Guess what. HFCA is still not enforcing those. There is one dealing with mental parity. They have never enforced it. They never have. They are well aware they are not enforcing it; that they are not compliant. We have records of that. I will submit a bunch of these for the RECORD tomorrow. HFCA cannot do it.

Yet what are we doing? We are getting ready to say if it is not substantially compliant with the new Federal regulations, HCFA is going to come running at the charge and enforce these regulations, which they were not doing.

The National Association of Insurance Commissioners basically says the same thing. These are State insurance commissioners who work on this issue full time. They are not part time. I should not say we are part-time Senators. As Senators, we are working part time on regulating insurance and we are getting ready to mandate a lot of things to the States they will not be able to do, or we are getting ready to say States do it the way we tell you to do it or the Federal Government is going to come charging in and take over. I want everyone to know that is what we are doing and even ''substantially compliant'' is going to have a State takeover.

Here is one of their paragraphs. They say:

> Members of the National Association of Insurance Commissioners are also concerned about enforcement. As you know —

And this letter is written to Senator COLLINS—

> as a former State regulator, if there is no enforcement, then there is no protection. States have developed the infrastructure necessary to receive and process consumer complaints in a timely fashion and ensure that insurers comply with the law. The Federal Government does not have this capability and the proposals do not provide any resources to Federal agencies to develop such capability. It is taking the Health Care Finance Administration years to develop the infrastructure required to enforce the health insurance portability and accountability act, HIPAA, which included only 6 basic provisions that most States already had enacted. The proposed patient protection bills are far more complicated than HIPAA, and will require considerable oversight.

HIPAA had a few patient protections that almost all States already had, a few States still do not have, and HFCA has yet to really enforce those protections. Now we are going to give dozens of protections and have HFCA determine whether or not the States are substantially compliant with our new protections.

I will give an example. In the State of Delaware, they are in the process of passing a patient protection bill. They have an emergency room provision. In the emergency room provision that the State of Delaware is passing, they don't have poststabilization care included in their provision. We do, under this bill. This bill requires ambulance

coverage. Guess what. The State of Delaware did not include ambulance, for whatever reason. So we are going to tell the State of Delaware, a bureaucrat at HFCA is going to say: State of Delaware, you did not do it good enough. Your legislature is going to have to go back, pass a bill, have the Governor sign it, have some expansion to make sure that your ER provision is as good as the one we are getting ready to mandate.

I could go on and on.

There is an OB/GYN patient protection that basically has unlimited access to OB/GYN and gynecologists. Great. Guess what. The protection we have given to beneficiaries, patients in the Federal Employees Health Benefits Plan, gives one visit. It is not nearly as aggressive.

As a matter of fact, that points out something that maybe a lot of people have missed about all these patient protections. I have heard countless people say we want these protections applied to all Americans. I will inform my colleagues, we did not apply them to Federal employees. We do not provide these protections we are getting ready to mandate on every private sector plan in America. We forgot to include Federal employees. We forgot to include Medicare beneficiaries. We forgot to include low-income people such as those on Medicaid. We forgot to include people who work at the Department of Defense. We forgot to include veterans. We forgot to include Indians, who are under Indian Health Care.

All these patient protections—everybody said we want those to apply to everybody. They apply to the private sector, but we did not include the public sector. Did we just sort of forget that, or are we afraid maybe that would cost too much money? We are going to give all these great patient protections and basically have a Federal takeover of State-regulated insurance unless the States are substantially compliant with it or, in other words, States, you do as we tell you or the Federal Government is going to take charge. Can Federal employees sue the Federal Government? The answer is no. Can a military officer who happens to be serving overseas, or maybe in the United States, and they have something go wrong and they have poor care, can they sue the Federal Government? The answer is no.

Are they entitled to the patient protections that are being mandated on every private sector plan in America? The answer is no.

So there are some things that are really wrong. I think one of the things that is wrong is saying we are going to have the one-size-fits-all Federal Government supersede the States. States, you are substantially compliant with what we tell you to do or else we are going to take over.

I have had the pleasure of chairing the conference last year, where we negotiated patient protections. I negotiated them with my friend and colleague from Massachusetts and other Democrats. We came up with a basic agreement on most of the patient protections. But we never agreed whether or not they should supersede the patient protection laws that are in the States. I would never agree with that and I still will not agree with it.

For whatever reason, I fail to see, when you have 44 States, as the Senator from Maine has shown, that have ER protections in their States—I fail to see that we can write an emergency room provision that is so much better than every State, that we know best what should be in Maine or Oklahoma or the State of Washington or in Massachusetts, what should be in the ER provision in those States.

I really do not like the idea of having a bureaucrat at HFCA determining whether or not those laws are substantially compliant and if that bureaucrat determines they are not substantially compliant, then they have to rewrite their law.

There are legislators who were elected in the various States. The insurance commissioners work with these laws and the application of those laws and the enforcement of the laws day in and day out. I doubt we have the infinite wisdom, when we are coming up with mandated provisions, to know we should supersede all those States.

I do not doubt there are a lot of patient protections in the States that do a much better job than what we have done on the Federal level. I don't doubt there are State protections that are not as aggressive and/or not as expensive as that with which we are getting ready to mandate that they be in substantial compliance.

Again, I urge my colleagues to support the Nelson-Collins amendment. I think it is an excellent amendment. It is one that has been well thought out. It is one that is supported by two of our colleagues who had enormous experience in the insurance field. Both Senator COLLINS and Senator NELSON worked as insurance commissioners in their States. They worked at those jobs for years. They know what they are talking about. They know the Federal Government cannot enforce it. They know the Federal Government should not regulate insurance within the States.

Unfortunately, that is what we are getting ready to do. So this is a most important amendment, and I urge my colleagues to use a little common sense. If we end up passing this amendment and, heaven forbid, should it become law, I will just make a little prediction. Two years from now we will be back here saying you know what, the States are not in compliance. They were not substantially compliant, but HFCA could not tell them that. Or if HCFA told them that, they said they still couldn't be in compliance and so you have a lot of States that are theoretically not in compliance. But the Federal Government couldn't really regulate it anyway. So did they get any additional protection? No. They have a verbal assurance: Here is a bill; you are supposed to have this protection. But it is not regulated by the State and it is not enforced by the Federal Government because the Federal Government could not do it.

Tommy Thompson, Secretary of HHS, and HHS enforcement, they have thousands of employees. They spend billions of dollars and they still can't do it.

They still can't do it. They couldn't do it if we gave it to them. I hope we don't give it to them. You didn't actually extend patient protection. What you give is kind of a false protection. It is not real. You have a whole lot of confusion. Oh, wait a minute. The State has been doing this for 40 or 50 years. Now the Federal Government is supposed to be doing it, and they can't do it. There is no real patient protection in the first place. Maybe it makes politicians feel good if we are telling the States to do this. I sure hope they do it. What is the remedy if they don't do it? The Federal Government is going to take over. That is not a very good remedy if the Federal Government can't do it, especially since the Federal Government should not do it.

I want to again compliment my friends and colleagues, Senator COLLINS and Senator NELSON, for offering an outstanding amendment.

I urge my colleagues to vote no, regrettably, on the Breaux-Jeffords amendment.

I think ''substantially compliant'' may be a tad better than ''substantially equivalent,'' but not much. It is still a Federal takeover. It still has Federal enforcement. It still has HCFA making a determination whether or not you are substantially compliant, and that is not a good solution.

I urge my colleagues to support the Collins-Nelson amendment. That would be a giant step, and one which I might mention that Governors around the Nation are going to wake up to. They have been asleep. But Governors around the Nation, Democrats and Republicans, who want to maintain State control and regulation over insurance are going to wake up to what we are doing one of these days and they are going to be coming up saying: What are you doing? Congress, you can't regulate insurance. You haven't been doing that. You don't know how to do it. What in the world do you think you are doing?

We are going to hear from them. I would venture to say that Democratic as well as Republican Governors are going to be outraged should this provision invade the scope, preempting the State, and mandating to the States that the Federal Government knows best when it comes to patient protection—and not even giving real credibility to what the States have already done; not giving them a grandfather. They have already enacted legislation dealing with those particular patient protections. The Collins-Nelson amendment grandfathers States that have

done patient protections. We should recognize what they are doing and give them credit for it—not try to supersede it with a Government-knows-best solution.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Madam President, I rise in support of the Collins-Nelson amendment. I thank them for their foresight and pointing out to this entire body that Washington doesn't always know best. In this particular case, they are not only saying Washington does not always know best but Washington is incapable of doing the job that this bill gives them to do, even if Washington knew best.

This is a very important amendment. The people who are proposing this bill ought to look at the overburdened responsibilities that the Health Care Financing Administration already has and it is not able to do.

It is from that point that I want to speak about my support for the Collins-Nelson amendment.

I want to make very clear that, as most of my colleagues, I believe that any patient protection we pass must be meaningful and enforceable. But the provisions that the Collins-Nelson amendment deals with, and that they strike and change, are the provisions of the bill that delegates most of its new enforcement responsibilities to an agency that is one of the most overburdened bureaucracies in Washington, DC.

The Washington bureaucrats who work there are not going to be able to take the action necessary to give patients the protections that are determined by the authors of this amendment they ought to have, and that we all would agree ought to be there. But it can be done under State supervision, and it can be done much better and much more expeditiously than it can be done through the Health Care Financing Administration.

It is the difference between going to Des Moines, IA, to get the protections or coming to the Baltimore headquarters of the Health Care Financing Administration—because, historically, this agency has been already slow in publishing regulations, and it lacks in its enforcement of existing Federal laws that we passed putting responsibilities on its back.

Of course, I have high hopes that our new Secretary of Health and Human Services, Governor Thompson, and the new Administrator of the Health Care Financing Administration, Tom Scully, will turn things around. While I hope that and I believe that, I don't expect a radical change is going to be necessary for the Health Care Financing Administration to carry out the responsibilities that the authors of this legislation want them to do, nor that it will be radical enough to change overnight to get the job done of administering this portion of their bill the way it should be.

At this time, shouldering the Health Care Financing Administration with a task of enforcing broad new Federal patient protections is clearly inappropriate.

Our new Secretary and Administrator have walked into myriad backlog regulations, hundreds of unanswered letters, and burdensome internal policies that hinder already efficient and effective work that the taxpayers expect to be done by this agency.

Just last week at a hearing we were having on agency reforms before the Senate Finance Committee that deals with this issue, we had Secretary Thompson and Administrator Scully pleading with us to keep new tasks away from the agency so that the catchup work on these existing responsibilities can be done.

I quote Secretary Thompson on that very point. He used the new name, the Center for Medicare Services. He said:

> The Center for Medicare Services right now is overloaded with HIPAA and with the privacy rules and regulations, with Medicare and Medicaid, and SCHIP, and so on.

Rather than listing all of the other responsibilities, he said:

> I do not think we can really take on any more responsibilities.

That is the Secretary who has the responsibility of carrying out the laws that we already passed, along with the regulations that have to be written to enforce those laws. He would like to get those out of the way before he gets any additional new responsibilities.

I want to take just a few minutes to share some important examples of how this agency in the past has been unable to meet its existing obligations.

In 1996, Congress passed the Health Insurance Portability and Accountability Act. That is the act that Secretary Thompson referred to as HIPAA. We passed it. To date, the agency is over 3 years behind on implementing major provisions of that 1996 act.

The agency is almost 2 years behind in implementing a fee schedule for ambulance services that was mandated in the Balanced Budget Act of 1997. There were several more mandates in the Balanced Budget Act of 1997 that have had no regulations published at all, such as how regional carriers will process clinical laboratory claims, and how durable medical equipment suppliers must comply with the surety bond requirements.

And get this: In 1986, Congress passed very sweeping legislation to make sure that the delivery of quality care in the nursing homes of America, and the agency took 8 years, from the date of enactment, to publish the enforcement regulations on the nursing home laws.

Even more egregious, there are no final regulations published for the Medicaid Drug Rebate Program, a program enacted into law over 10 years ago.

So the list goes on and on. I hope you can see this is an agency that is already overloaded and is seriously behind on many Federal mandates Congress has put in place over the last decade; and in the case of nursing home laws, a decade and a half ago.

We cannot expect, nor should we expect, that this agency is capable of enforcing patients' protections under this legislation.

The Secretary of Health and Human Services has already told us they are working 24/7 to improve operations and responsiveness for their existing programs, such as Medicare and Medicaid.

In the end, it is the patient who is going to suffer when patient protection regulations get delayed or are improperly enforced or, in some instances, such as the nursing home laws, for 8 years, not enforced at all.

That is exactly what will happen under the Kennedy-McCain bill where the sole responsibility of enforcing and implementing patient protection certification falls on the agency that formerly was called the Health Care Financing Administration.

I cannot support the Kennedy-McCain bill with these meaningless enforcement provisions. In fact, it would be irresponsible to do so when the agency itself has made very clear to the public that they will not be able to handle any new patient protection mandates.

I do not presume that Senator KENNEDY and Senator MCCAIN meant for this provision of their legislation to be meaningless in its enforcement. But, as a practical matter, if HCFA is already overloaded, and if they are already not writing the regulations for legislation that has been passed over the past 10 years, the ultimate result of passing this bill this way—putting this responsibility on the Health Care Financing Administration—is that it will not be enforced any more than the nursing home laws, which as I said were left unenforced for 8 years.

So I have come to the conclusion that the Collins-Nelson amendment is the right thing to do. Why fool the American people? Washington bureaucrats do not always know best. And we, as Congressmen, if we have not lost touch with the grassroots of America, and if we exercise a little common sense, we ought to be able to show to a majority of this body—and for a majority of this body to understand—that if HCFA cannot carry out the law, if they have not carried out a lot of mandates of the Congress of the United States in the past decade, why would you put more responsibilities on their back? If you want patient protection, then let it be done where it can be done, and that is in those States that have meaningful enforcement laws already for patient protection, because this amendment allows States to maintain the hard-fought patient protections they have put in place for their own citizens. And the amendment encourages States to develop even stronger protections.

So I urge my colleagues to support this approach, one that recognizes the

vital role that States play in tailoring patient protections to best meet the needs of their respective citizens.

I thank the Chair.

The PRESIDING OFFICER (Mr. DAYTON). The Senator from Wyoming.

Mr. ENZI. Thank you, Mr. President.

I appreciate the other side allowing us this opportunity to state our case at the beginning because of some important considerations we have.

I particularly congratulate the Senator from Maine, SUSAN COLLINS, for her tremendous efforts on this entire Patients' Bill of Rights. On any issue in which she gets involved, you will find that she studies it to a greater depth than anyone. She does additional research; she gets all of the help she can; she gets to the point where she understands what she is doing; and then she works with others to make it better. It does not happen a lot around here. But she is one dedicated Senator who is always willing to look at a better idea.

She has teamed up, in this particular instance, with Senator NELSON, a neighbor of mine, from Nebraska. One of the reasons this is an interesting team is that they have both been State insurance commissioners. They both understand the State side of this. They both understand what is in the bill. I would not want to imply that everybody does not, but these are two people who absolutely understand what is going on in the bill. They have teamed up and said there is a way that we can provide the protections, that we can get the States involved, and that we can enlarge the scope. They put it together. I congratulate them for their tremendous efforts.

For 2 weeks, I have been saying that on 80 percent of this bill both sides agree. On eighty percent of it we agree. It is that other 20 percent where there are some philosophical differences.

I have seen—both in legislating that I did before I got to the Senate and since I have arrived—that one of the keys to passing legislation is to put a good title on the bill. That is something we agree on 100 percent: The Patients' Bill of Rights is a great title. What you do with that can be an abuse of the title. And on 20 percent of this bill, there is an abuse of that title.

There are some substantial changes that need to be made. One of those is, who is going to administer it? There are two very different philosophies involved in the administration of this bill. One side says: Washington knows best. Bring it back to Washington. If the bureaucracy isn't big enough now, we will make it big enough. And we will put enough dollars in it that we will be able to solve it.

For anybody in America who has ever had to work with the Washington bureaucracy, picture the difference between Washington and your local and State governments.

When you call Washington, have you ever gotten to talk to the same person twice? That means that when you call in today with a problem that you have to explain, and then when they do not take care of it—because they really do not have the involvement that they do if they know you—you have to call them back. Well, you would not know by tomorrow; you would not know by next week. You would be lucky to know by next month. But next month, when you are sure Washington has not solved your problem, you have to call again. And I guarantee you, you will talk to a different person who will say: What is your problem? And after you have gone through all of the explanation again, they will say: We will get back to you on it. And you are going to spend another month getting back to them on it.

Contrast that with State and local calls that you have had to make. You can almost always talk to the same person again, so the problem that you discussed yesterday they still remember today. And you do not have to wait a month for the decision because they are doing the job efficiently.

There are various ranges of bureaucracies and efficiencies in Washington, also. This bill has chosen to give the jurisdiction to that agency that is doing the poorest job. Don't believe me. Don't believe the debate. What I ask you to do is call your doctor and ask them what they think of HCFA. Call it HCFA; it is the Health Care Financing Administration. But they call it HCFA because that is a four-letter cuss word to them. You will find that your doctor thinks HCFA is a cuss word. That is how impressed they are with the administration of this agency, the one to which we are about to turn over all of the jurisdiction for the problems you have worked with your State on before. We are going to take what the States have been doing, and doing well for over 50 years, where there are people you can talk to every day, and we are going to say, no, you are not doing a good enough job because there is some bureaucrat in Washington who decided that they know better and they want to handle your problem.

Find out how efficient HCFA is. I am certain under the new administration that it will be more effective, but it will be a long time recovering from the problems it has right now. Yes, we can throw more money at it. Is that where you want your tax money to go?

Right now, your States are paying for that. We are going to duplicate and supersede, without saving you a dime and in fact costing you more.

Does the Federal Government do a better job? One of the things I have been working on since I have been here is OSHA. OSHA allows two different processes. One is State plan States. That is where the States do the work. The other is the Federal plan. That is where the Federal Government takes care. I can tell you that the accidents are less in the State plan States for just the reasons I mentioned before. A bureaucracy operating out of Washington, trying to handle the whole country as a one-size-fits-all problem can't do the same job as the people at home in your State.

What are some of the things they have to handle? I will tell you, the new reason that HCFA is going to become a bigger cuss word is called HIPAA. This has to do with portability of insurance. The change in some of my phone calls this week has been calls from doctors and hospitals. They weren't concerned about a Patients' Bill of Rights yet. They were concerned about the HIPAA privacy rules. Ask your doctors and your hospitals what they think about that.

Privacy is important to all of us, but they have managed to muff that one. The same agency that people are calling me and complaining about right now is related to where we are going to turn over, under the opposing amendment, all of the workload.

This week and last week you heard about a number of amendments. One of the things I am very proud of is that all of those amendments were different solutions that needed to be done on this 20 percent of the bill where there is a problem, different approaches. It was not the same amendment time after time after time, which we have seen here before. It was different approaches to different problems in the bill. There are about six problems that we have to get solved, that we have to get some consensus on in order to have a good bill, one that matches up to the title of Patients' Bill of Rights.

What you are seeing here, of course, is us trying to solve in the committee of the whole what could have been done in committee. You are seeing more amendments here than what you might see on the floor with the bill. But that is because normally we have the committee meetings where we get to put forward lots of amendments in a smaller group and, therefore, be able to get them decided with less discussion because there are fewer people.

I mentioned some phone calls. I have to add that I am starting to get some other phone calls now which are from my school districts, wondering how this bill is going to affect them. They know we just finished the education bill and that there might be some more money under the education bill for them. They are asking: But we provide insurance to our employees; is this going to suck up all that money, and how liable will we be?

Again, I congratulate the Senator from Maine and the Senator from Nebraska for the tremendous work they have done in coming up with a solution—one we talked about last year—on which there was a lot of consensus. There was a lot more give, a lot more understanding, and even people supporting this one who seem to think HCFA is a better solution now.

One of the groups supporting the Collins amendment that I want to point out is the National Conference of State Legislatures. They recognize the value of the State handling these insurance problems.

I ask unanimous consent that there be printed in the RECORD after my remarks a letter from the National Conference of State Legislatures.

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

(See Exhibit 1.)

Mr. ENZI. Among the handful of principles that are fundamental to any true protection for health care consumers, probably the most important is allowing States to continue in their role as the primary regulator of health insurance. It is because of my commitment to preserving existing consumer protections that I am glad to be a cosponsor of the Collins-Nelson amendment. Their amendment recognizes a principle that has been recognized and respected for more than 50 years.

In 1945, Congress passed the McCarran-Ferguson Act, a clear acknowledgment by the Federal Government that States are indeed the most appropriate regulators of health insurance. It was acknowledged that States are better able to understand their consumers' needs and concerns. It was determined that States are more responsive, more effective enforcers of consumer protections.

As recently as last year, this fact was reaffirmed by the General Accounting Office. GAO testified before the Health, Education, Labor, and Pensions Committee saying:

> In brief, we found that many states have responded to managed care consumers' concerns about access to health care and information disclosure. However, they often differ in their specific approaches, in scope and in form.

Wyoming has its own unique set of health care needs and concerns. Every State does. For example, despite our elevation, we don't need the mandate regarding skin cancer that Florida has on the books. My favorite illustration of just how crazy a nationalized system of health care mandates would be comes from my own time in the Wyoming Legislature. It is about a mandate I voted for and still support today. Unlike Massachusetts or California, for example, in Wyoming we have few health care providers, and their numbers virtually dry up as you head out of town. We don't have a single city with competing hospitals. So we passed an ''any willing provider'' law that requires health plans to contract with any provider in Wyoming who is willing to do so.

While that may sound strange to my ears in any other context, it was the right thing for Wyoming to do. But I know it is not the right thing for Massachusetts or California. I wouldn't dream of asking them to shoulder the same kind of mandate for our sake when we can simply, responsibly apply it within our borders. That is what States have been doing with the 1,100 laws they have passed dealing with patients' bills of rights.

What is even more alarming to me is that Wyoming has opted not to enact health care laws that specifically relate to HMOs. But that is because there are ostensibly no HMOs in Wyoming. There is one which is very small. It is operated by a group of doctors who live in town, not a nameless, faceless insurance company. Yet the sponsors of the underlying bill insist they know what is best for everybody. So they want to require the State of Wyoming to enact and actively enforce—that is what the opposing amendment does, enact and actively enforce—what they say is the right thing for our State. They want to regulate under 15 new laws a style of health insurance that doesn't even exist in our State.

It requires States to forsake laws that they have already passed dealing with patient protections included in the bill, if they are not the same as the new Federal standard. The technical language in the bill reads ''substantially equivalent,'' ''does not prevent the application of,'' and under the process of certifying these facts with the Secretary of Health and Human Services, the State will have to prove that their laws are ''substantially equivalent'' or some other variation of words. There are a whole bunch of words that could be used there.

There could be a whole series of amendments to undermine the Collins amendment. This is one of them.

The proponents of this language—whichever version you care to look at, except for Collins—say that it won't undo existing State laws that are essentially comparable, but that isn't what their bill requires. Under either amendment—the bill or the Breaux-Jeffords amendment—they are going to force States to change laws that they have already reviewed, that they believe already work in their States.

Is it that the proponents aren't overly concerned with the implementation of the law versus being able to say that their bill meets the political test of covering all Americans, regardless of existing, meaningful protections that State legislatures have enacted? If the laws just have to be comparable, why don't they use that phrase? I will get into this issue in more detail as the debate proceeds. I believe we can compromise. I don't think this is the compromise. I like the language of the Collins amendment. The only hard proof that we have right now is that States are, by and large, good regulators, while the Federal Government has done a lousy job. The General Accounting Office has been reporting to us that since we passed the Health Insurance Portability and Accountability Act in 1996. And that is the ''consumer protection enforcement'' mechanism around which the bill before us is written.

Wyoming currently requires that the plans provide information to patients about coverage, copays and so on, much as we would do in this bill; a ban on gag clauses between doctors and patients; and an internal appeals process to dispute denied claims. I am hopeful that the State will soon enact an external appeals process, too. This is a list of patient protections that a person in any kind of health plan needs, which is why the State has acted. But requiring Wyoming to enact a series of additional laws that don't have any bearing on consumers in our State is an unbelievable waste of the citizens' legislature's time and resources.

As consumers, we should be downright angry at how some of our elected officials are responding to our concerns about the quality of our health care and the alarming problem of the uninsured in this country.

We are talking about driving up the price of insurance and driving people out of the insurance market. I keep mentioning that insurance in this country is provided on a voluntary basis. We have had amendments that dealt with small businesses to see if they could get any kind of relief. Most of them are strained to the maximum. The smaller your business, the higher your potential risk, so the higher the rates you pay. Insurance is risk protection. We discriminate against the smaller businesses on rates because it is actuarially more difficult to calculate that.

Under this bill, we have had some opportunities to provide some relief to those small businessmen. It hasn't happened. They have been ignored. I will be bringing an amendment that will deal with the large businesses. I almost exclusively work with small businesses. Tomorrow, I will be bringing one that deals with the big self-insured, self-administered companies to see if there is going to be any hope of relief for those people who provide the best insurance in this country.

Mr. President, we will be committing two fouls against consumers if we do not adopt the Collins-Nelson amendment. The first would be to eliminate all meaningful patient protections that are not exactly like the Federal law. Second would be to put in enforcement responsibilities with the agency that has already said it can't do the job. Add to that the third foul that the rest of the bill prices millions of people out of health insurance and we have done anything but hit a home run for patients.

I urge my colleagues to consider the valuable experience and wisdom of the amendment sponsors, as well as the urging of the National Council of State Legislatures. Think about the divergence of philosophy. Do you want your health care to be one size fits all in Washington, determined by HIPAA and HCFA, or do you still want your States to be involved? Do you want your States to have the control? Do you want your States to be able to continue the kind of service they have been providing through your State legislatures that can make decisions based on your State and your needs?

I yield the floor.

EXHIBIT 1

NATIONAL CONFERENCE OF STATE LEGISLATURES,
Washington, DC, June 27, 2001.

Hon. SUSAN COLLINS,
U.S. Senate,
Washington, DC.
Hon. BEN NELSON,
U.S. Senate,
Washington, DC.

DEAR SENATOR COLLINS AND SENATOR NELSON: On behalf of the National Conference of State Legislatures, I would like to take this opportunity to commend you for authoring an amendment to S. 1052, the pending Patients' Bill of Rights legislation. Your amendment recognizes the important work states have done regarding the regulation of managed care entities and supports the continued role of states in the regulation of health insurance.

The amendment substantially addresses concerns we expressed in our recent letter to you and your colleagues. In that letter we urged you to: (1) grandfather existing state patient and provider protection laws; and (2) provide a transition period between the enactment of federal legislation and the effective date of the Act to provide each state an opportunity to preserve their authority to regulate managed care entities. This amendment also addresses our concerns regarding the adequacy of the federal infrastructure to enforce the patient and provider protections established in the bill. Finally, it is important to emphasize that the proposed amendment recognizes that insurance markets differ among the states and a ''one size fits all'' approach may have adverse results among states and within regions of a state. This amendment permits a state to certify adverse impact and head off disruption in its insurance market.

NCSL supports this amendment. States are best situated to provide oversight and enforcement of the patient and provider protections established in the legislation. The record of the states is strong. We are looking for an approach that supports the traditional role of states in the regulation of insurance and that recognizes the differences in state insurance markets and provides a mechanism for states to protect those markets.

NCSL supports passage of Patients' Bill of Rights legislation that makes a promise that can be fulfilled. We believe state oversight and enforcement is an integral part of ensuring fulfillment of the promise and we look forward to continuing to work with you to develop legislation that will improve the quality of health care without adversely affecting access to care.

Sincerely,

GARNET COLEMAN,
Texas House of Representatives,
Chairman, NCSL Health Committee.

The PRESIDING OFFICER. The Senator from Maine is recognized.

Ms. COLLINS. Mr. President, I will be brief because I see the Senator from Massachusetts also desires to speak. First, I thank my colleague and friend from Wyoming for his extraordinarily generous comments and also for his excellent statement. As a former State senator, he has a great deal of experience in this area. As a businessman, he knows what it is to provide health insurance and to try to provide good benefits for his employees. I am grateful for his support.

Very briefly, I want to respond to a couple of comments that have been made tonight. The former chairman of the Finance Committee, Senator GRASSLEY, talked about the burden on HCFA. I think this is very important because the McCain-Kennedy bill—and, unfortunately, the amendment offered by my friend from Louisiana continues this problem—is expecting that HCFA is somehow going to be able to step into the role of insurance regulator, which is something the States have performed well for more than 50 years.

Look at what would be required under the Breaux-Jeffords amendment. Let me read you one part of the burden on the Secretary under the provisions called ''Petition Process'':

Effective on the date on which the provisions of this Act become effective, as provided for in section 401, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this title.

In other words, this sets up a process by which the Secretary of HHS is going to be inundated with requests for advisory opinions from anyone who is covered under a State-regulated insurance plan who wants to know whether or not a certain provision of that particular State's laws is superseded by the Federal law. This is just not workable. There is just no way that HCFA is going to be able to take over these responsibilities.

My friend from Louisiana drew the analogy with the State Children's Insurance Plans. I am very proud of that program. I was one of the original cosponsors of the legislation that the Senator from Massachusetts and the Senator from Utah proposed to create this important program to expand access to insurance to low-income children. But these are not analogous situations. We are not talking about a federally funded health program. We are not talking about that. We are talking about the regulation of health insurance.

The Federal Government is not providing funds for this. The Federal Government is not involved in this traditionally. This is entirely different from pointing to a Federal program that happens to be administered by the States but which is federally funded where, of course, it makes sense for the Federal Government to set standards. So it is two entirely different matters.

Finally, I make the point that one should look—and I encourage the Senator from Louisiana to look—at the provisions of his State's laws on consumer and patient protections. They are not identical to the standards in the McCain-Kennedy bill. For example, when you look at the Louisiana law dealing with emergency room access, we find that Louisiana has a law, but that it is crafted in a different way than the McCain-Kennedy bill. So now we have to decide, is it substantially compliant with the provisions of the bill, which would be the standard the Senator from Louisiana would have? It differs in some respects—on reimbursements, on how much is covered, on poststabilization care.

If the State of Louisiana crafted a law dealing with emergency room access, as they have, why should we second-guess that law? Why should we substitute our judgment for the judgment of the good people of the State of Louisiana?

I remind my colleagues that the States have not fallen down on the job. There are more than 1,100 patient protections out there far beyond the confines of this bill.

Unfortunately, while the Breaux-Jeffords amendment is an improvement over the underlying bill, it is still fatally flawed. I urge my colleagues to vote no on the Breaux-Jeffords amendment and yes on the Collins-Nelson amendment.

I thank the Chair, and I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I have great respect for my friend and colleague from Maine, Senator COLLINS. Senator COLLINS is a member of our Health, Education, Labor, and Pensions Committee. As always, she has demonstrated tonight that she is well informed, articulate, and persuasive—I hope in this instance not too persuasive—to her point of view.

As always, she spends a great deal of time thinking through these issues. I commend her for her presentation, and I respect her for her position, although it is a position that I cannot support, and I will urge my colleagues to support the alternative, which is the Breaux-Jeffords amendment.

We have tried over time, although we do not receive great acknowledgment for it, to find ways we can work with the administration. We have had four or five major issues. The administration really did not take a position about the tax incentives in the legislation, although many of us saw that the tax incentives in the legislation, which many of us supported, would have resulted in the end of this legislation for reasons that have been pointed out earlier. The tax-raising power lies with the House of Representatives, and not with the Senate.

Second, on the issue of responsibility of employers, the President made very clear in his statement that he wanted employers who were exercising their judgment in ways HMOs normally do—to bear responsibility if there is injury and harm to patients.

We have been wrestling with that definition for several days. We will have an additional opportunity to wrestle with it, but the President has been very clear about wanting to hold responsible those employers who make judgments that interfere with the medical judgments which adversely affect patients. He wants to hold them responsible. That is what many of our

colleagues have been attempting to do, and they have been doing it in a bipartisan way.

We have had amendments to eliminate all responsibility for employers, and amendments for employers with 50 employees or less. These have been defeated.

The President was talking in ways many of us understood. We may differ as to the language, and we do have differences with the President on the liability provisions, but on those other issues, we are very much along the same lines.

The President, as well, in his support for the Frist-Breaux bill, basically supported the medical necessity provisions we had included in the McCain-Edwards legislation. They are virtually identical to those in the underlying bill, and the President indicated support of the medical necessity provisions. Those are enormously important.

We come to the third of the major issues, and that is scope. Who is going to be covered, and for what particular protections? The President again indicated in his principles for a bipartisan bill that it should apply to all Americans—all Americans; that a Federal Patients' Bill of Rights should ensure that every person—not just some people, not just a few people in some States, not just some who are covered for certain protections in a few States—but that all Americans, every person enrolled in a health plan, enjoy strong patient protections. Those are words that he used.

The Breaux amendment is consistent with that particular principle. It is not drafted exactly the way I would like to have it drafted. It does not go to the extent I would like to have gone to guarantee the strong protections which Americans deserve. But nonetheless, in a very important way, the Breaux amendment complies with this particular provision. It will ensure that all Americans are going to be covered and that they will have strong protections. The Breaux proposal also ensures that protections for Americans will remain in the States. They will be the primary regulator under the Breaux proposal. That is the way it was drafted, and it is a preferable way to ensure not only what the President has stated, but what I think I have heard stated by my good friend, the Senator from Tennessee, our ranking member on the HELP Committee, and others.

As a matter of fact, every proposal that the House of Representatives considered in their debate last year—I believe there were four major proposals offered by Republicans—all of them included all Americans. That was not a debatable point. It is tonight, and tomorrow morning, we will have the opportunity to see where the Senate is going to stand.

I will make a few points, and if I am not correct, Senator COLLINS will correct me—we only received the amendment just prior to the time the Senator offered it, although clearly we were very much aware this amendment was coming and Senator COLLINS told us about that. I will make a statement and a point, and if I am wrong, the Senator from Maine will correct me.

If her amendment is passed tomorrow, or whenever we pass the final legislation, there will no guarantee of one new protection for most Americans. Do my colleagues understand what I am saying? Mr. President, do they understand what I am saying? If the Collins amendment succeeds and is passed, when it goes into law, there will not be one new protection for most people in this country. There will not be any protection for the children who need speciality care; there will not be any new protections guaranteed for women who need clinical trials; there will be no new protections in a wide range of provisions that are included in the underlying legislation. None, unless—unless—the States go about the business of applying and providing them.

Let me be very clear about it, with the passage of her amendment, there is not one new protection from an HMO making the medical decisions they have made in the past.

It seems to me that is why we are here because we have, for the last 5 years, been battling to make sure families in this country receive protections, whether they are in Massachusetts, Nevada, or Maine.

Let's look at what the circumstances are of some of the States. First, there is an authorization for $500 million, a pool—new funds of $500 million. That is in the amendment. Where we are going to get the money for those funds is not in there. We have authorized funds on many other issues and they have not been appropriated. Welcome to the club. This relies on a $500 million appropriation.

When this is passed, there will still be 39 States that do not require any access to clinical trials. In the United States, you might work in Massachusetts today, and maybe you will be transferred to Nevada next year, and then transferred to another State after that. Let me make it clear to you and your family you had better make sure they are one of the 11 States that have clinical trials. Most of the states that have clinical trials are for cancer, but don't include other life-threatening diseases.

When I came to the Senate, you worked at the shipyard, your father worked there, and your grandfather worked there. You graduated from high school and had a good life. Those in the workforce today may have nine different jobs over the course of their life, moving all over the country. We ought to get a dartboard to find out where the protections are in the various States for you and your family, moving from one company to another.

There are 39 States that do not require clinical trials. Zero States affirmatively require timely access to specialists. If we pass the Collins amendment, there will be a signing ceremony at the White House—hopefully and after the bill is in effect, someone will say: I thought when I had a child who had cancer and we went to our HMO, we would get the guarantee of accessing a specialist. And now that is overridden. I thought we would get the protections we needed. I listened to the debate in Washington that said we could get specialty care.

No, no, no, that is not so, because they passed the Collins amendment. The Collins amendment says, only if the States provide it do they get access to specialists.

We have 20 States that do not ban financial incentives for providers to delay or deny care. What is happening in HMOs is, as we heard in the numerous committee hearings we have held, there are financial incentives and disincentives for doctors on the procedures they recommend in terms of treating patients. Do we do anything about that? No, no, we are not going to do anything about that, not in 20 States, not if you live in one of those 20 States. They will have incentives and disincentives for the doctors.

Tell me what consumer knows about that. Ask any Member of the Senate, if they didn't have a briefing sheet before them, whether their State does or does not ban financial incentives. They will not have to worry because we have good Federal employee health insurance. We will not have to worry. But I doubt whether any Member knows whether their State prohibits it or not.

There is nothing under the Collins amendment that will make sure states ban inappropriate financial incentives. Under the underlying bill, there is a prohibition on their use. No HMO ought to provide incentives or disincentives to doctors in terms of providing or recommending necessary treatment. What do we have to learn from this? We have hearings, we find out, we see the affected families, and then do we say, no, Washington does not know best, in this case, ensuring we do not have inappropriate financial incentives? We ought to be able to agree on that. Is that a vast intrusion on States rights?

The list goes on. We have seven States that have not adopted a prudent layperson standard for emergency care. If you live in one of those seven States and you think you are having a heart attack and go to the emergency room, you may end up without that care covered. We have seen a number of States take action. It is important to do that.

The Breaux alternative says, when the States have taken action in these various areas, there will be respect for that action being taken in the State to protect their citizens and deference will be given to them. That is the way it ought to be. In areas where there is no protection, we are trying to establish a federal floor. If the States want to go beyond that, they can, but at least establish a floor of protections.

I listened with interest to both the Senator from Maine and the Senator

from Wyoming about two previous pieces of legislation, CHIP and HIPAA. When we passed the CHIP program we provided incentives and money. That is not the issue. The issue is, we gave the States the certain criteria that had to be met, and if they met those criteria the Federal provisions did not apply. Mr. President, 49 of 50 States have done that.

I monitored that program closely in our HELP committee. Even when I was not chairman, we had meetings with the previous administration to find out what was happening with that program. I am familiar with it. We don't have complaints from the States. We are not hearing from the States about the heavy hand of the Federal Government for establishing CHIP. They can say they were getting money for that, fine; they were also ensuring that children would have the range of services that would meet needs—not the complete range of services I would like to see. We still don't provide the comprehensive care—eyeglasses or hearing that we ought to provide for children. Dental work was left out, along with many other services that children need, but we find States conforming to the package that was developed.

The other reference was with regard to HIPAA. I have heard that speech from the Senator from Oklahoma now eight times. He gets better at it each time he talks about HIPAA and HCFA. I point out, when the GAO recommended $11 million so HCFA would be able to implement HIPAA, he was the one who led the fight against the $11 million, and he was successful. They put in $2 million. And he led the fight to strike out that $2 million so that HCFA could not implement it because they wanted greater flexibility in the States so the insurance companies—that is my conclusion—would be less interfered with. I have had that argument and I will not spend time on it now.

The fact is, tonight there are only five States which are not in complete compliance with HIPAA. It has taken time. Many of the criteria placed upon the States are similar to what is in the Breaux proposal. I personally would like to see a stronger provision. At the time we pass this bill, I would like to see all Americans have protections. We have taken those steps in the past on other issues.

We decided as a pattern of national policy we were going to pass Federal laws to outlaw child labor in this country. We didn't say: You can go ahead and have that up in Massachusetts if you want to. We passed laws. Anyone can visit now in Lawrence and Lowell, go through the mill, look at the museums and read the poems and letters of 9- and 10-year-old children trapped in factories for 10 or 12 hours a day who wrote as they looked outside and saw other children play. We went through that as a nation and passed federal laws to prohibit that.

We also said, we will pass a minimum wage law. We know there are many here who resented it. We passed laws in order to protect our environment because we recognize that environmental issues go through various States and the environmental issues know no borders. I make the same case with regard to workers today, as well. It was not that way in the old days, but it is that way today.

We made the same judgment with regard to civil rights. You can say, well, these patient protections are not of the dimension of the issues on civil rights. I think there is a lot you can say about that. But if you listen to the HMO victims whom many of us have heard, if you see the failure of the recommendations of doctors and nurses and medical professionals—the failure of their recommendations because of an HMO bureaucrat many miles away, and you see how lives have been destroyed and how families have been absolutely destroyed—we can ask ourselves, why shouldn't we give that kind of protection to families in this country?

Americans, I think, are under a lot of pressures today. Working families are under a lot of pressure. They are not asking for much. They are asking for good jobs with a good future. They are asking for schools where their children can learn. They are asking for health insurance that is going to cover them. They want clean water, they want clean air, they want safety and security in their communities, they want to own their own home, they want a national security and defense that are going to protect our interests, and they want human rights policies abroad that are going to represent our fundamental values.

They are not asking for much. But one of the things we can do is protect them when they do get that health insurance. We will be back. We give the other side the assurance we will be back. All those speeches we have heard over these past days asking why are we doing this when we have so many people uninsured—we will be back with legislation on the uninsured. We hope for support from so many of those who have been speaking recently about how we ought to make sure people are going to be covered. We will be back to try to make sure we deal with those individuals.

But when you have an opportunity to relieve families of the anxiety so every time they go to a doctor they are going to get the best the doctor can prescribe and the best the nurse can give —when you give that guarantee to every family in America, you are going to ease their anxiety when they have a sick one.

Why are we going to play roulette? Let's say you live in Massachusetts today, or Florida, or New Mexico tomorrow. You shouldn't have to worry, which one is going to give strong patient protections?

That is what this is about. I do not know what we need as a record. The reasons for this are so powerful, so compelling, so real. We have had statements from every Member in this body about the damage that has taken place and the disruptions to families. We have the opportunity to do something about it. It seems scope is a key issue, a key question. I hope the Senate will come down on the side of the proposal of the Senator from Louisiana.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I first want to say I very much enjoyed working with my colleague from New England. He is a passionate advocate for children on health care and education issues. He did, however, make a misstatement about the implications of my amendment and has invited me to correct the record if it was wrong. I want to take the opportunity to do so.

In fact, my approach does provide new consumer protections. Let me expand on that because I must not have been clear in explaining it earlier.

Under current law, there are federally regulated insurance plans and there are State-regulated insurance plans. The Federal plans, under ERISA, are beyond the reach of Federal regulators. So all those laws we have talked about, those 1,100 or more State laws and regulations, do not apply to consumers who are enrolled and covered by ERISA plans, the federally regulated plans, because State governments are prohibited from applying regulations to ERISA plans. They are preempted in that way.

All of these great consumer protections that the States have enacted over the last decade do not apply to patients who are covered by ERISA plans. This legislation—and it is one of the reasons I strongly support patient protection legislation at the Federal level—would close that gap. It would ensure that consumers who are part of ERISA plans receive the kinds of consumer protections that are available to patients whose health care coverage is provided by plans that are regulated by State governments.

So it is not accurate to say my approach will not result in any new consumer protections. Rather, the approach my colleague from Nebraska, Senator NELSON, and I have proposed is intended to make sure we can provide the same kinds of protections for consumers in Federal plans that the States have done for consumers who are covered by State-regulated plans.

In addition, there is a requirement under the Collins-Nelson amendment for States that have not enacted consumer protection laws—there are many that have in many areas, but there are some holes here and there. There is a requirement that those States either enact a law that is consistent with the purposes of those patient protections in the McCain-Kennedy bill by the date of enactment—we are not even giving them very long. They have to do it by October 1 of next year. That is going to be difficult for some States that have biennial legislatures. But we require

them to either enact a law that is consistent with the purposes of the consumer protections in the McCain-Kennedy law or, if they decline to do so, they have to certify their reasons for not doing so to the Secretary.

It is just not true to say our approach, the Collins-Nelson approach, does not result in any new consumer protections. In fact, what it does is preserve the good work that the States have done, rather than requiring the States to adopt a one-size-fits-all, made-in-Washington approach that may not work in their particular States. We preserve the State laws, but then we close the gap by requiring federally regulated insurance plans to have similar consumer protections. That is very important. That does result in new patient protections for millions of Americans whose insurance is under federally regulated plans.

In addition, States cannot ignore this issue. They haven't ignored it; they have been very active, but, as I said, there are some holes. What they would have to do as a State is consider this issue and No. 1, enact a law consistent with the purposes of McCain-Kennedy or, No. 2, certify to the Secretary that they did not enact a law because either there is no managed care in their State—such as Alaska or Wyoming, where it is irrelevant—or they believed the costs were such that they would drive people out of the insurance market and cause people to lose access to health insurance altogether.

Let us remember the best consumer protection is having health insurance coverage. That is the best patient protection we can apply and provide. So our amendment, the amendment I have crafted with my colleague, Senator NELSON, which is supported by so many of our colleagues who have spoken eloquently tonight, is an important one. It will advance consumer protections. But it will respect the good work that has been done by the States, the States that have been far ahead of the Federal Government.

Finally, let's remember the important point. States have been regulating insurance for more than 50 years. They have done a good job. They have acted without any prod or mandate from Washington to provide patient protections. They are way ahead of us in this area. Why do we want to second guess their work? Why do we want to supersede their laws? Why do we want to wipe out the good work done by the States? I submit we should grandfather in those good State laws and concentrate on the gaps.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I thank the Senator for her correction. The figures are, of the 195 million Americans with private health insurance, the 56 million who are the self-insured would have coverage. This would leave out the 139 million who are not in self-insured plans, as I understand it. These include state and local public service employees. These include firemen. These would be the police officers. These would be the self-employed. There are 139 million who would not have a federal floor of protections. I have read through this, so I appreciate what the Senator has said.

Listen to this. Under this proposal, there is going to be some $500 million that is going to be out there. A State can make a proposal for a new program, and they can receive grants for the new program.

They say the States can pass laws which are consistent with the purposes of the Federal standard. But they can keep the money and decline to enact a law because of the adverse impact of a law on premiums which would lead to a decline in coverage. So they could get the money to pass it. But, if there is a judgment that there might be a decline in coverage, they could, I guess, keep the money. They do not have to do anything further to enact a law if the managed care market in the State is negligible. There is no additional responsibility for them to take action for additional protections. They still get money from their fund.

I make the point that during the course of this debate there have been a lot of different ways of trying to cut the protections. We heard in our Health, Education, Labor and Pensions Committee about the kinds of abuses that are taking place across the country. The President of the United States recognized that. He indicated that he wanted every person covered. We want to have every person covered. We don't want to carve out a third and say they will be covered, but we will leave out two-thirds who will not be covered with a great many of these protections.

I continue to believe in the power of this issue and its impact on families. Why are we going to draw a distinction between neighbors on the same street? One works for a fire department, their family goes to a doctor, and the kind of medical advice their doctor gives to them for their child is overridden by an HMO, and they don't have protections, but his neighbor is protected because his employer self-insures? What possible fairness is there in that? What is the possible justice in that?

We should be interested in protecting all families. The President understands that. Hopefully the Senate will understand that tomorrow.

If it were left up to me, I would make sure that all of these protections were guaranteed. But we have the Breaux amendment which says: Wait. We are going to say if States have taken action in these areas, there is going to be deference given to the State. There is going to be enforcement and supervision by the State in protecting these areas.

I would have liked to see it stronger. But what is very important is guaranteeing some floor of protections.

Finally, we are talking about commonsense protections. We are talking about access to the emergency room, specialty care, OB/GYN, and continuity of care. If a woman is pregnant, and the HMO and her employer end their relationship, at least she can see her obstetrician until after the baby is born.

We are talking about prescription drug formularies. If the doctor recommends a certain medically necessary drug and it is not included in the formulary, the patient can still get the needed drug. There is going to be a shared expense by the patient as well as the HMO. That has been worked out. We use the same cost sharing that is used in the various formularies.

Point of service: There is a closed panel, and a need for outside expertise. Clinical trials are so important. Every one of the protections that is guaranteed are in existence today either in Medicare and Medicaid, or they have been recommended by the insurance commissioners, or they were unanimously recommended under President Clinton's panel, which was bipartisan and included distinguished representatives of all aspects of the health delivery system. Those are the only ones.

Finally, as we are hopefully coming fairly close to the end of this debate. We have the support of almost every health organization, every professional medical organization, every patients' organization, every children's organization, every women's organization, every disability group, and every cancer organization for this kind of protection.

The reason is very simple. They are out there on the firing line day in and day out. They understand what is happening to families. These are trained men and women who have given their lives for the protection of good health care for families in this country. They have seen what is happening and how many times they are being overruled. They have stated that is what is necessary.

The scope and protections that Senator BREAUX has included are what they strongly support.

We will have a chance to say another word about this tomorrow.

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

Mr. KENNEDY. I thank my friend from Maine.

I am glad to yield.

Mr. EDWARDS. Let me ask the Senator, as somebody who has been involved in this issue for so long, as the Senator knows, we have been working very closely with Senator BREAUX on his amendment in an effort to make sure that all Americans are covered. One of the guiding principles of our efforts in this area is to make sure that families have protections provided in this legislation so that all families in this country can make their own health care decisions. We have worked with Senator BREAUX very closely on his amendment to make sure there is a floor for every family in America.

Will the Senator comment on whether, under the amendment of the Senator from Maine, every family in America will in fact get the minimum protections as provided in our bill as opposed to the language we worked out with Senator BREAUX?

Mr. KENNEDY. As the language is constructed, they will only provide the protections to these self-insured and not to everyone else who has received their health insurance through other means—the self-employed, those who are getting it through state and local employment, those working for employers who purchase health insurance plans. There are 139 million Americans who will not have those protections.

As I mentioned earlier, they will have to rely on protections from the States. There are States that do not require access to clinical trials. There are States that do not require timely access to appropriate, accessible specialists.

I mentioned earlier the ban on inappropriate financial incentives. Twenty States don't ban plans from giving financial incentives and disincentives to doctors to delay or deny care. They won't have those protections.

The point I mentioned earlier was that we are a society in movement. We find so many families are moving from State to State. Members of families are moving with jobs and going back and forth.

We have to ask ourselves ultimately and finally—as the Senator pointed out, this is a federal floor of protections—if you are in a State with clinical trials, why should you have to make sure they have a similar protection requiring access to the clinical trials which your wife might need, but you move to another State and find there is no access to clinical trials?

That is strictly because of the protections that you might have in a particular State.

It makes absolutely no sense. We ought to have that basic federal floor. I know the Senator agrees with me.

The way the Breaux amendment has been devised, it gives the maximum deference to the States if they provide protections in these areas. I mentioned just a half dozen different protections. We could go into others this evening. I will not take the time to do so, but they are illustrative of the protections. These are pretty commonsense protections.

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

Mr. EDWARDS. Mr. President, the debate on these two amendments is critical to the issue of whether all Americans—all families in this country—will have access to the protections provided for in this Bipartisan Patient Protection Act. That is the reason this vote tomorrow morning is critical to the vitality of this bill.

We have worked very closely with Senators on both sides of the aisle to ensure that two things are accomplished with respect to coverage: No. 1, that every American is covered by this legislation and, No. 2, we give deference to States that, through their own work, have established good systems for patient protection. We honor those State legislatures and that State legislation.

So that is the purpose of this amendment, the Breaux amendment. It strikes the right balance between making sure every American is covered—every family is covered—on the one hand, and, secondly, giving deference to the States that have already done good work in this area.

We need to ensure that we do not take away the protections we are providing for all Americans by exempting a huge chunk of Americans, which, unfortunately, the Collins amendment would do.

The Breaux amendment, though, is one in a series of consensus agreements that have been reached on this legislation. Starting with the issue of scope, which the Breaux amendment addresses, we now have an agreement which I think a great majority of the Senate will be able to support and be comfortable with.

On the issue of the independence of the appeals, we have an amendment that will be supported, I believe, by virtually all of the Senate, establishing the principle that we believe the HMOs should not have direct control over who is on the independent appeal panel.

On the issue of exhaustion of remedies—exhaustion of the appeals process before a case can go to court—we are working very closely with the Senator from Tennessee to reach a bipartisan consensus on that issue. We have made great progress, and I am optimistic about it.

On the issue of employer liability, from the outset we had—the sponsors of the legislation, along with the Presiding Officer—as a principle that it was important that employers be protected, period. We have worked very hard with Senator SNOWE and Senator NELSON from Nebraska, and other Senators on both sides of the aisle, to ensure that that is being done. Tomorrow morning we will offer an amendment on that issue.

We have worked our way through a series of hurdles, going from the issue of scope, to the issue of exhaustion of remedies, to the issue of clinical trials, to the issue of medical necessity, on which we have worked with Senators BAYH and CARPER to make sure we have a consensus on what is covered, giving proper deference to the contract and the contractual language but making sure the independent reviewers have the ability to make sure that if particular treatments are needed, they can be provided.

So we started 2 weeks ago with a series of obstacles in front of us, starting with scope and running throughout the legislation. What has happened during the course of this debate, and the work that has been done, is that one by one those obstacles, those barriers, have fallen, and we have been able to reach consensus agreement.

There is great momentum to do something that really matters to the American people. The winners in this debate are not politicians. The winners of this debate are not the people within this Chamber. The winners are the American people and the families all over this country.

We have in this body an opportunity to do an extraordinary thing, which is to give people more control over their lives and more control, specifically, over their health care decisions, the things that affect their families and members of their families.

All of us have worked very hard—Republicans and Democrats—to try to get to the place where we have consensus on this legislation, and one by one by one the barriers to passing real patient protection have fallen to the floor.

We have more work to do. We will have issues of liability that remain to be resolved. But the reality is, we are a long way down the road. We have tremendous momentum for doing what there is a consensus in this country to do. Not just in the Senate, not just in the House of Representatives, but all across America, all of us who have spent time in our States have heard over and over that the American people expect us to do something about this issue.

The time has come. It is time to quit talking about it. It is time for the political debate to stop. It is time to do something that can really affect people's lives. We have an extraordinary opportunity to do something important. We have made extraordinary progress toward that goal, but we are not quite there. We need to keep our nose to the grindstone, keep working, keep debating, and finish this legislation, get it through the House, and get it on the President's desk, with great hope and optimism that the President, when confronted with legislation that during his campaign he vowed to support, will stand by his vow and do what he has told us he would do. We are optimistic about that. We believe the President will do what is right for the American people.

So I thank my colleagues for all their work on this issue.

I ask my colleagues to vote, tomorrow morning, against the Collins amendment and for the Breaux amendment, which is a bipartisan consensus that has been reached. And we will continue our work toward providing the American people the protection they need and they deserve.

Thank you, Mr. President. I yield the floor.

EXPLANATION OF VOTE

Mr. HELMS. Mr. President, I regret I was not present to cast my vote on the motion to table the amendment offered by the Senator from Arizona (Mr. KYL) and the Senator from Nebraska (Mr. NELSON). I wish the RECORD to reflect that had I been present, I would have voted ''nay.''

The PRESIDING OFFICER. The Senator from Nevada.

SUPPLEMENTAL APPROPRIATIONS

Mr. REID. Mr. President, Majority Leader DASCHLE was asked earlier today, on several occasions by Senator BYRD and Senator STEVENS, if he would bring to the floor a unanimous consent request that there be a time set on the supplemental appropriations bill that is now with the Appropriations Committee that would set a time certain for filing of amendments on this most important legislation.

Such a request has been cleared by Senator DASCHLE and the majority, but objection has been raised by the minority. So the request by Senators BYRD and STEVENS cannot be met tonight. Hopefully, this request will be cleared by the minority tomorrow so that there can be a time certain set for the amendments on this, as I said, most important piece of legislation, the supplemental appropriations bill.

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. 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 now be a period for morning business, with Senators permitted to speak for up to 5 minutes each.

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

OFFSHORE OIL

Mr. NELSON of Florida. Mr. President, I want to take a moment while the leadership of the Senate is, at this very moment, deciding which course the rest of the day will take with regard to this important legislation, the Patients' Bill of Rights. While we have a moment in which we might reflect on other items, I want to draw to the attention of the Senate the considerable concern of 16 million Floridians that the Bush administration is trying to drill for oil and gas off the shores of the State of Florida.

It is most instructive, if one looks at a map of the Gulf of Mexico, where colored in on the gulf waters are the active drilling leases. One will see clearly that, from the central Gulf of Mexico all the way to the western Gulf of Mexico, almost all of the waters of the gulf are shaded in, indicating active oil and gas drilling leases. Indeed, there is a reason for that. It is because the reserves were there, the oil and gas deposits are there, the future reserves are expected to be there. As a matter of fact, I believe it is 80 percent of all economically recoverable, undiscovered gas reserves on the Outer Continental Shelf—which not only includes the gulf but also the Atlantic and Pacitic—80 percent of the Nation's known, recoverable gas reserves in the central and western gulf and 60 percent of the future recoverable oil reserves are in that area too. They are no in the area off the State of Florida.

The State of Florida has consistently taken the position that we should not have oil and gas drilling because of the high cost and potential damage to our environment and to our economy. One of our primary industries is the tourism industry, which so often is dependent upon those pure, sugary white beaches being unspoiled so millions of visitors who come to Florida to enjoy the sunshine and the waters and the beaches can do so without having to worry about having oil spread across the beach.

I can tell you that 16 million Floridians, in unison, do not want oil lapping up on our beaches. The cost to our environment and the cost to our economy would be simply too high.

Why, you would ask, other than that the oil and gas reserves are in the central and western gulf, is there not any drilling off the coast of Florida? It goes back to the early 1980s, under the Reagan administration and a Secretary of the Interior, James Watt. He offered tracts for lease from as far north as Cape Hatteras, NC, in the Atlantic, south all the way as far as Fort Pierce, FL.

I had the privilege of being a Member of the House of Representatives at the time. So I went to work, knowing the people of my congressional district, in the early 1980s, didn't want oil lapping up onto their beaches. We were able to persuade the appropriations subcommittee on the Department of the Interior appropriations bill to insert language that said no money appropriated under this act shall be used for offering for lease tracts such and such, and then listed the tracts all the way from North Carolina south to Fort Pierce, FL. And we prevailed in the appropriations.

The administration left Floridians alone on offshore oil drilling for a couple of years but came back under a new Secretary of the Interior and tried again. This time it was harder to stop. This time it escalated all the way to the full House Appropriations Committee. But we finally prevailed, interestingly, not on the threat to the economy or to the environment of Florida, and indeed the United States eastern coastline, but prevailed by getting NASA and the Defense Department to own up to the fact that you cannot have oil rigs down there in the footprint of where you are dropping solid rocket boosters off the space shuttle and where you are dropping first stages off the expendable booster rockets that are being launched out of the Cape Canaveral Air Force station. And we have not been bothered since the early 1980s, in Florida, about offshore oil drilling—until now.

The bush administration is pressing a 6-million-acre lease off the northwest coast of Florida in a strange configuration called lease-sale 181, of which the bulk of the 6 million acres is 100 miles offshore but a stovepipe runs northward to within about 20 miles of the Alabama coastline, which is about 20 miles, then, from the white sands of Perdido Key, State of Florida.

In a meeting of the Vice President with a Florida congressional members delegation, the Vice President suggested a compromise, which was to knock off that stovepipe coming off the bulk of the 6 million acres. That is no compromise. That is unacceptable because that is still oil drilling off the State of Florida where the future reserves are shown to be not as abundant. The tradeoff to 16 million Floridians is simply not worth what potentially could be discovered in oil and gas—the despoiling of our environment and the killing of our economy.

Thus, it was such welcome news when we learned last week that the other side of the Capitol, the House of Representatives, added to the Interior appropriations bill an amendment that would prohibit such drilling. The vehicle was the Interior appropriations bill. It prohibits it for only 6 months. It will be my intention, and certainly the intention of my wonderful colleague, the distinguished senior Senator from the State of Florida, Mr. GRAHAM, that we in the future will offer amendments either to the Interior appropriations bill, to bring it in conformity with the House-passed bill, or more likely amendments that would cause a prohibition of lease-sale 181 as well as offering similar amendments to the authorizing bill that will come out of Chairman BINGAMAN's committee.

I want our colleagues to be clear. This is an issue of enormous magnitude to 16 million Floridians. It happens to be of enormous magnitude to New Jersey, the State of the Senator who sits as Presiding Officer, as well as all the States in New England which value so much the pristine waters and the waters particularly as you get on north of New Hampshire and Maine—those waters that produce such delicacies as the Maine lobsters. This is a matter of grave concern to many of us.

It is time to draw the line in the sand—hopefully, not a line that will be washed over by oil on our beaches' sands but, rather, a line that will indicate the unanimity of 16 million Floridians, joined by their sister States along the eastern seaboard, of opposition to offshore oil drilling.

LOCAL LAW ENFORCEMENT ACT OF 2001

Mr. SMITH of Oregon. Mr. President, I rise today to speak about hate crimes legislation I introduced with Senator KENNEDY in March of this year. The