For years, the CARP system has been criticized for rendering unpredictable and inconsistent decisions, employing arbitrators lacking the expertise to render sound decisions, and for being unnecessarily expensive.

H.R. 1417 is a reasonable bill to cure these concerns and is based on the input and recommendations of government and industry experts.

H.R. 1417 addresses the problem of lack of arbitrator expertise by appointing a ''Copyright Judge'' to preside over the new process. The Copyright Judge will be appointed by the Librarian of Congress, have full adjudicatory responsibility, and have the authority to make rulings on both the law and rates. The Copyright Judge will select two professional staff members with knowledge of economics, business, and finance. These staff qualifications will also improve the quality of the decisions rendered.

H.R. 1417 redefines the role of the Copyright Office. Presently, acts as an intake agency answering initial case intake questions, as well as an appellate court for CARP decisions by advising the Librarian on cases. This dual role forces the Copyright Office to often decline to answer threshold intake questions for fear of having to review its own decisions at the appellate stage. Under H.R. 1417, the Copyright Office's appellate responsibilities will be removed and the Office will only act in an administrative and advisory capacity by counseling the Copyright Judge on substantive issues as requested.

For small claimants who participate in the CARP process, the substantial expenses are practically preclusive. H.R. 1417 contains provisions to make the process more accessible. First, claimants must declare an ''amount in controversy'' during a distribution determination phase of the proceedings. If the dollar figure is $500 or less, the claimant will be assigned to the small claims process which is an less expensive, ''all-paper'' claim resolution method.

Another provision of H.R. 1417, that benefits both large and small claimants requires the filing of a ''notice of intent to participate'' in either a rate-making or distribution proceeding. This not requirement will discourage entities from disrupting the process by participating at the last minute. If a party failure to file in a timely manner or fails to pay the required fee, they will be an exclusion of either written or oral participation in that determination. Those exempted as small claimants would not be affected by this requirement.

H.R. 1417 contains several procedural changes to make the claim resolution process more convenient for the parties. H.R. 1417 expands the duration of the discovery phase from 45 to 60 days to give parties more time to file their claims. Additionally, the 180–day time-frame for completing the CARP hearing process is amended to require parties complete the hearing phase of a rate-making or distribution determination in 6 months. The Copyright Judge, at their discretion, could extend this period up to a maximum of 6 additional months.

Mr. Speaker, after the corrections made by S. Con. Res. 145, H.R. 1417 will make changes to the CARP system that will benefit the parties as well as the agents of the copyright adjudication system. I support H. Con. Res. 145 and H.R. 1417, and I urge my colleagues to join me.

STEVE LOHR'S NEW YORK TIMES ARTICLE: ''IS KAISER THE FUTURE OF AMERICAN HEALTH CARE?''

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 18, 2004

Mr. STARK. Mr. Speaker, I rise today to recognize an excellent article recently published in the New York Times. For years I have talked about the benefits of real managed care, not the managed cost model Republicans in Congress and the Bush Administration blindly push at the expense of patients.

In his article, Steve Lohr presents the facts about Kaiser Permanente and its non-profit staff model health maintenance organization. For thousands of people in my district and millions across the country Kaiser provides quality, cost effective care, while still finding the resources necessary to be a leader in the development of health information technology. At the same time, Kaiser keeps costs down by effectively managing chronic conditions and educating healthy members to avoid chronic conditions down the road.

Tax credits and personal responsibility will do little or nothing to ameliorate the crisis of 45 million uninsured Americans. The Kaiser model is the most reasonable approach to creating a single-payer universal health care system. Obstacles to reaching the goal of universal coverage are many, but this article presents the hard fact that Kaiser is the future of American health care.

It is with pleasure that I submit the attached article, ''Is Kaiser the Future of American Health Care?'' for inclusion in the CONGRESSIONAL RECORD. The article originally appeared in the October 31, 2004 edition of The New York Times.

[From the New York Times, Oct. 31, 2004]

IS KAISER THE FUTURE OF AMERICAN HEALTH CARE?

(By Steve Lohr)

OAKLAND, CA—After 18 years in private practice, Dr. Victor Silvestre was exhausted from his lonely battle, day after day, with a health care system that seemed to be working against him. A general practitioner, Dr. Silvestre found it increasingly difficult to get his patients appointments with specialists, who tended to focus on lucrative procedures instead of routine care. Paperwork and haggling with insurance companies, he said, took more and more time. ''There just had to be a better way,'' he recalled.

For Dr. Silvestre, the better way was not across the border in Canada, or in some affluent nearby suburb, but in his own backyard, in Oakland. Two years ago, he joined Kaiser Permanente, the huge health maintenance organization based here. ''So many of the solutions, the ingredients of a more rational system for delivering health care, were there,'' he said.

It may seem unlikely, given Kaiser's past image as a ham-handed H.M.O., but plenty of others are reaching the same conclusion. High-level visitors from across the political spectrum—the Bush administration and National Health Service of Britain, for example—are coming to California these days to look at Kaiser as an institution that is actually doing some of the things needed to improve health care.

Obviously, there is no single model for revamping the nation's costly, disjointed health care system, and Kaiser certainly has its share of problems. But according to economists and medical experts, Kaiser is a leader in the drive both to increase the quality of care and to spend health dollars more wisely, using technology and incentives tailored to those goals. ''Quality health care in America will never be cheap, but Kaiser probably does it better than anywhere else,'' said Uwe E. Reinhardt, an economist at Princeton who specializes in health issues.

HEALTH care systems in most industrialized countries are in crises of one form or another. But the American system is characterized by both feast and famine: it leads the world in delivering high-tech medical miracles but leaves 45 million people uninsured. The United States spends more on health care than any other country—$6,167 a person a year—yet it is a laggard among wealthy nations under basic health measures like life expectancy. In a nutshell, America's health care system, according to many experts, is a nonsystem. ''It's like the worst market system you could devise, just a mess,'' said Neelam Sekhri, a health policy specialist at the World Health Organization in Geneva.

In this political season, the health care debate has been mostly about who will pay the bill. President Bush talks about tax credits and health savings accounts that are intended to give people more control over their care but would also mean that they would pay more out of their own pockets. Senator John Kerry wants the government to pay more, and he has proposed a major, and costly, program to cover the uninsured.

The favored solution of many liberals—and of no small number of health care experts—is a single-payer system of health insurance, covering the entire population and underwritten by the government. For the foreseeable future, that is considered politically off-limits, which was the message Washington absorbed from the abandoned effort to fashion a national health program in the Clinton administration.

How to finance health care is only one side of the problem. The other is how to deliver the care more intelligently, and that is where the Kaiser experience holds lessons. Given the demands of an aging population and steady advances in medical technology, national health spending will continue to climb. Yet by all accounts, there is plenty of waste—estimates range up to 30 percent or more of total spending—from unnecessary clinical tests, hospital stays and prescriptions, and the bedeviling sea of paper used to handle bills, claims and patient records.

''We're not going to spend less, but figuring out how to get the most value out of our health spending is going to be the big issue of the future,'' said David Cutler, a health care economist at Harvard.

But Kaiser as a model? Wasn't Kaiser, an H.M.O., part of the ''managed care'' movement that faltered in the 1990's amid protests from doctors and patients? In fact, Kaiser, with its origins in the 1930's and 1940's, when the industrialist Henry J. Kaiser provided health care for his construction and shipyard workers, has always been a hybrid. The managed care concept of the 1990's was about having an outside bean counter, usually an insurance company, looking over the shoulder of the doctor—managing costs instead of managing care.

Kaiser has a different setup with different incentives. It emphasizes preventive care and managing chronic diseases like heart disease and diabetes to keep people healthier. And that saves money because healthier people require less costly care like hospitalization.

The country's largest private-sector provider of health care, Kaiser employs more than 11,000 physicians and 135,000 other workers, owns 30 hospitals and hundreds of clinics

and serves more than eight million members in nine states and the District of Columbia. Seventy percent are in California. Kaiser is both insurer and provider; employers typically pay fixed yearly fees for each member, no matter how much care is provided.

Clearly, Kaiser has its limits as a model for others. It is unlike many mainstream health plans in that it is a not-for-profit company—though one with annual revenue of more than $25 billion and operating margins of 5 percent. Its facilities tend to be large, and it has a lingering reputation for practicing an impersonal, regimented style of medicine that limits patient choice, despite recent efforts like the creation of physicians' personal Web pages and e-mail communication with patients.

Still, most health care experts who have studied Kaiser are impressed. ''Kaiser has a model that consciously manages both quality and costs in a way that has been very effective,'' said Margaret O'Kane, president of the National Committee for Quality Assurance, an independent group that monitors health plans.

Kaiser's approach is best illustrated in two ways: its management of chronic illnesses like heart disease and diabetes, and its $3 billion initiative to use information technology to improve clinical care and streamline operations.

Across the country, health costs are skewed. In any given year, 90 percent of spending provides care for 30 percent of the population, and more than half of total spending goes to 5 percent of the population. Much of it is spent on people with chronic illnesses like heart disease and diabetes. So helping people with those ailments stay as healthy as possible offers much opportunity for cutting costs—and for improving lives.

In Northern California, Kaiser has sharply reduced the death rate for its three million members there in recent years by monitoring and controlling blood pressure and cholesterol levels and by promoting the use of aspirin and beta blockers (to reduce the risk of heart attacks) and statins (to lower cholesterol). The death rate from heart disease among the Kaiser members is 30 percent lower than it is in the rest of the Northern California population, adjusted for age and gender.

Four months ago, Jose Flores, 44, a postal worker in San Francisco, had double-bypass heart surgery. While still in the hospital, he was enrolled in a program of education and treatment, which is run by nurses and lasts a year. Patients receive instruction on diet, exercise and cholesterol management; smokers are placed in a course to help them quit.

Mr. Flores says he is on a drug regimen that includes beta blockers and Lovastatin, a generic cholesterol-lowering statin. He takes large doses of niacin, a vitamin that raises the level of high-density lipoprotein, the ''good'' cholesterol that protects against heart attacks. He walks for an hour, five days a week. His eating habits have been transformed, too: fried foods were once a staple of his diet, but no more. Blacklisted, too, are sour cream, cheese and corn chips. ''Now, I try to avoid all that,'' Mr. Flores said.

In Northern California alone, Kaiser spends $55 million a year on chronic-care management programs. ''But what's really expensive is if we don't take care of these people and manage their chronic conditions,'' said Dr. Robert Mithun, chief of internal medicine at Kaiser's medical center in San Francisco.

Dr. Mithun's comment may seem like no more than common sense, but it does not reflect the typical logic of the dominant fee-for-service model of health care. Most doctors and hospitals get a fee from insurers for each patient visit, clinical test, surgical procedure or day a patient spends in a hospital. In practice, the fee-for-service system is often an invitation to do more of everything—more visits, more tests, more surgery. What gets done is what gets paid for, and insurers usually do not pay for preventive care or chronic care management provided by nurses or in group classes, like the ones at Kaiser.

In the fee-for-service medical economy, doctors and hospitals routinely strike different deals at different fees with many different insurers. The results are complexity, inefficiency and a constant bureaucratic tug-of-war between health care providers and insurers over claims.

The Kaiser economy seems a world apart. ''What works at Kaiser is the integration of the financing and delivery of care, and the aligned incentives that allow you to make more rational decisions about health care for members,'' said Ms. Sekhri, the policy expert at the World Health Organization, who has studied Kaiser.

Ms. Sekhri was a co-author of a 2002 report that compared Kaiser in California with the National Health Service of Britain. The report found that for comparable spending, the Kaiser system in California did a better job of keeping people with chronic conditions out of hospitals. And when Kaiser patients were admitted to hospitals, their stays were generally shorter. Recently, Britain sent groups of primary care physicians and hospital administrators to California to learn from Kaiser.

The Labor government in Britain may look to Kaiser as an efficient model for its health service, which is run by the government. But the Bush administration is more interested in Kaiser as a model for the efficiencies and integration that can be achieved through information technology.

In May, the Bush administration appointed Dr. David J. Brailer to the new post of national coordinator of health information technology. His mandate is to prod the nation's health care system into the computer age. Bringing patient records and prescriptions out of the pen-and-ink era promises to save both dollars and lives. The automation of an electronic system could sharply reduce medical errors, which are estimated to be responsible for 45,000 to 98,000 deaths a year, according to the Institute of Medicine of the National Academy of Sciences.

Kaiser has been investing heavily in information technology for years. Its clinical information system includes electronic records with a patient's history, prescriptions and preventive health recommendations. A doctor can call up a patient's X-ray or magnetic resonance image on a desktop personal computer. Electronic prescribing—a goal in the government plan—is routine at Kaiser.

Yet Kaiser is in the midst of a several-year, $3 billion program, called KP HealthConnect, to drastically improve and integrate its clinical and administrative systems and Web-based services for members. Once it is in place, Kaiser clinicians will be able to tap into a vast but flexible storehouse of data that uses intelligent software to automatically flag potentially harmful drug combinations for a patient or to suggest what treatments have been most effective for other people who are of the same sex, age group and—eventually—genetic profile.

Dr. Brailer, for one, checks in regularly on the progress of HealthConnect. George Halvorson, Kaiser's chief executive, said, ''Policy makers are looking to us as the cutting edge of how health care can be supported electronically.''

Kaiser has had setbacks in the program. Last year, it abandoned I.B.M. as its main partner on the project and chose to go with specialized health care software provided by Epic Systems, a private company in Madison, Wis. Despite the switch, HealthConnect is scheduled to be rolled out during the next couple of years across Kaiser's operations.

The conversion of inefficient paperwork to a digital network also opens the door to fostering more efficient markets in health care. Markets rely on information, yet the health care economy is one in which information on patients, treatments and outcomes is trapped on paper and isolated in clinics, hospitals and insurance offices—instead of being shared, analyzed and compared, while still insuring privacy.

The fee-for-service model exists because patient visits, clinical tests and surgical procedures can be measured. They are inputs, in economic terms. Whether those inputs are effective is another matter.

In recent years, there have been efforts to focus on the quality of health care. The National Committee for Quality Assurance conducts annual reports based on a health plan's use of practices shown to improve patients' health, from timely prenatal care to cholesterol management. Kaiser plans consistently earn excellent ratings in the group's reports, and, this year, it had four of the five top-rated plans in the Pacific region, its stronghold.

Dr. Francis J. Crosson, the executive director of the physicians' side of Kaiser, said, ''Our future has to be to compete on quality, offering people demonstrably better care and better value.''

And the Kaiser system delivers quality while controlling total costs. A recent survey of health care costs in 15 metropolitan areas by Hewitt Associates, the human resources consulting firm, found that the cost for care per employee last year was lowest in the San Francisco area, where Kaiser members were about 35 percent of the insured population, at $5,515, and was highest in regions where Kaiser did not operate—led by New York, at $6,818 a worker.

Quality yardsticks are helpful, but they still measure inputs—ones associated with better health—instead of tracking how patients fare. The longer-term goal is for health plans to use technology more, as leading companies in the rest of the economy do. For the health plans, that may mean constantly tracking patients, treatments and results. ''To have a real market for quality in health care, you need a product,'' Mr. Halvorson said. ''And that means reliable, timely information about outcomes, clinical-trial sorts of databases that show things like, for example, 50-year-olds in our system have fewer heart attacks.

''With the right information and the right incentives,'' he added, ''capitalism creates very good solutions.''

A TRIBUTE TO DAVID J. MANNING

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 18, 2004

Mr. TOWNS. Mr. Speaker, I rise in honor of David J. Manning for his dedication to Interfaith Medical Center and continued community efforts.

David was elected Senior Vice President of Corporate Affairs of KeySpan Energy in April 1999. He is the Senior Officer reporting to the Chairman, with responsibility for public affairs, government relations, internal and external communications, community development and altruism, corporate brand strategy, and environmental policy and operations.

Before joining KeySpan Energy, Mr. Manning had been President of the Canadian Association of Petroleum Producers (CAPP)