United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 105th CONGRESS, SECOND SESSION

Vol. 144 WASHINGTON, THURSDAY, SEPTEMBER 3, 1998 No. 115

House of Representatives

The House was not in session today. Its next meeting will be held on Wednesday, September 9, 1998, at 12 noon.

Senate

THURSDAY, SEPTEMBER 3, 1998

(Legislative day of Monday, August 31, 1998)

The Senate met at 9:30 a.m., on the expiration of the recess, and was called to order by the President pro tempore [Mr. THURMOND].

PRAYER

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

Almighty God, we begin this day with the words of the psalmist when he prayed, ''I cried out, You answered me and made me bold with strength in my soul.''—Psalm 138:3. We, too, cry out, asking You to make us bold because of Your strength surging in our souls. We yield our souls to be ports of entry and dwelling places for Your Spirit in us. You form our character in us and give us convictions we cannot deny. Your artesian strength makes us resolute in living the truth. We feel a boldness to speak the truth and to follow Your guidance. Exorcise any fear, timidity, or equivocation.

Father, as the Nation looks to our Senators for moral integrity and inspiration, give them a special measure of Your power, so that, from the depth of their souls, they will have Your supernatural strength to lead with courage. We have a great need for You; and You are a great God to meet our needs. Through our Lord and Savior. Amen.

RECOGNITION OF THE ACTING MAJORITY LEADER

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

SCHEDULE

Mr. DEWINE. Mr. President, on behalf of the majority leader, this morning the Senate will be in a period of morning business until 11:30 a.m. Following morning business, the Senate may consider any available appropriations bills or other legislative or executive items cleared for action. Rollcall votes are expected throughout Thursday's session as the Senate continues work on appropriations bills.

The majority leader would like to remind all Members that there are four remaining appropriations bills that the Senate must act on in the next several weeks. Continued cooperation of all Members will be necessary for the Senate to successfully complete the appropriations process.

I thank my colleagues for their attention.

MORNING BUSINESS

The PRESIDENT pro tempore. Under the previous order, there will now be a period for the transaction of morning business not to extend beyond the hour of 11:30 a.m.

Under the previous order, the Senator from Louisiana, Mr. BREAUX, is recognized to speak for up to 15 minutes.

Mr. BREAUX. Mr. President, I thank the Chair for recognizing me.

PATIENTS' BILL OF RIGHTS

Mr. BREAUX. Mr. President, I wish to make some comments this morning on the issue of the Patients' Bill of Rights which we have had so much discussion and dialogue about in recent months.

As we all know in this body, the House of Representatives has actually passed a Patients' Bill of Rights. The fact that one chamber has passed legislation is the encouraging news. That is the good news. The bad news is that the Senate may not do anything about it. I think that would be unfortunate for all Americans who are concerned about making sure that their families, their children, have adequate access to quality health care in this country.

The Patients' Bill of Rights, as I said, is now pending in the Senate. The battle now becomes: Do we bring it up? How do we bring it up? What happens to it? Are we going to let election year politics determine the fate of this very important piece of health care legislation?

All of this reminds me of something we just went through not too long ago. For 4 or 5 weeks the Senate debated a tobacco bill. Do we all remember that? Do we all remember what happened to it? It never passed. It never passed because both sides were not able to get together and bridge the gap between what I consider to be relatively minor differences between the various pieces of legislation and we started blaming each other for its failure. So now we are arguing about whose fault it is that it failed instead of debating the issue of who should get credit for getting it passed.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

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I think it is incredibly more important politically and for the good of this country to be able to argue about success and argue about who should get the credit for accomplishing something rather than arguing about failure and whose fault it is that nothing got done. I have a feeling that we are moving in that same direction when it comes to the Patients' Bill of Rights. Are we all going to go home and blame each other for failure? Or are we going to be able to go back home and say we got together and got something accomplished? I think the latter course of action is much better.

I was disturbed reading the Washington Post yesterday. There was a short article entitled ''Plans to Regulate HMOs Unlikely to Reach a Vote in the Senate.'' That is very disturbing, I think, for all Members who come here in order to pass legislation and do what is appropriate and proper for their constituents.

Even with the little time remaining this session, I think there is a way out of this logjam. I think that many of the issues in the various Patients' Bill of Rights are things that we can reach an agreement on if we are serious about getting a bill passed this year. We need to talk about the information that patients should have and the disclosures health plan should make. We can work that out. We need to talk about access to specialists and pediatricians and direct access for women to their ob/gyn. We can work that out. There are differences in those areas but we should be able to find some common ground on them.

We need to talk about a prudent layperson standard for patients who seek care in emergency rooms: When a person goes to the emergency room thinking they're having a heart attack and they find out it is not that bad, should the insurance company be allowed to deny payment? We can work that out by discussing a prudent layperson standard that ensures that managed companies have to pay for that treatment. If the patient thought their health was in serious jeopardy, the health insurance plan should, in fact, have to pay for that treatment.

We need to talk about an end to gag rules which prohibit doctors from telling their patients all of the treatment options that are available to them. We should put an end to gag rules once and for all. We can work that out.

It seems to me that the most controversial obstacle right now is the issue of whether to expand the right of patients to sue their health plan in state court. One side says we don't want to open up the courts to more litigation. Most of our Republican colleagues have taken a position that patients in ERISA plans should not have a right to sue their managed care plans for damages in state court.

On the other hand, there are others who say, no, you have to have access to a state court, you have to have the right to litigate if a patient is denied coverage or is otherwise harmed by a decision their plan makes. Principally people on my side of the aisle have taken that position.

While there are differences on many provisions in the various Patients' Bill of Rights, the liability issue seems to be the biggest bottleneck that is preventing this bill from even being considered after it already passed the House. That is unfortunate. If we don't break that logjam, we will go home arguing about whose fault it is that nothing was passed. We can argue about whose fault it was tobacco didn't pass. We can argue about whose fault it was the Patients' Bill of Rights didn't pass. We can argue about whose fault it was appropriations bills weren't passed. We will go home arguing about who should be blamed for failure and not getting anything done for the people who sent us here.

I suggest that there is a way of bridging the gap with a realistic compromise that gets the job done for people concerned about patients' rights. I think the approach I suggest makes a great deal of sense.

There are some managed care plans now, such as Ochsner Health Plan in Louisiana, the largest HMO in the state, that have an external review process for patients who disagree with a plan's decision. There are some plans around the country that do that already for their managed care patients. They have voluntarily established—there is no law that requires it, but they have voluntarily established a procedure where you have an external review if the patient is denied coverage by a health plan. It works very well. But private health plans are not required to have an internal and external appeals process available to their enrollees and most don't.

However, when you talk about the right to sue as being the solution, I really question that. Suppose you are a patient and your health plan says we will not pay for a bone marrow transplant, so someone says, all right, you have the right to sue. The patient will be dead and gone and buried before the litigation is completed, in many cases. That right to sue does not help a person who is in an emergency situation and needs a decision right away. For the vast majority of patients, having access to an internal and external appeals process would prevent the need to go to court in the first place. An external appeals process in particular would give patients the right to have their case heard by an independent, outside panel of experts who have no financial or other connection to the health plan.

I suggest that a compromise can be found by looking at the appeals process that already exists for Medicare beneficiaries in HMOs. About 6 million of the 38 million people in Medicare are in some form of managed care. There is a procedure already established by Congress for these beneficiaries when they are denied coverage by their HMO. There is a procedure in place that works. It has been called the gold standard of the appeals process. It is not perfect. Sure, there are problems with the system such as monitoring and enforcement. Even with a good appeals system in place, patients have to know that an appeals process is available to them, how it works and how to access it. I've recently asked the GAO to review Medicare's internal and external appeals processes to determine whether it needs to be improved. But the Medicare appeals process that Congress put in place works well for beneficiaries overall. I suggest that in an effort to bring this Patients' Bill of Rights to the floor and get something passed, to resolve the impasse between no right to sue and absolute right to sue, we should look for a middle ground by taking what we have in Medicare and using it as model for private health plans. We can do that very simply. In fact, I have an amendment drafted that, if a bill comes up, I would like to offer what I think could bridge the gap on this issue.

Here is generally how the Medicare appeals process works: Health plans have 14 calendar days to make an initial coverage determination for routine matters. If it is an emergency, a real emergency, the Medicare HMO has to make a determination within 72 hours. That is the first step the insurance company must take in this process. If the plan decides to pay for the treatment, that is the end of it, the patient gets the care. But if a patient is denied coverage after this initial decision made by the company, then the beneficiary or his doctor can request an internal review, and it is an internal review by the company. If it is an emergency, they have to reconsider their decision within 72 hours. If it is a nonemergency, they have 30 days to reconsider their original decision. If they reverse their original decision, that is it, no more appeal, the patient is covered. If a patient is still denied coverage after the internal review by the company, then the patient can access an external appeals process. The external appeals process is done by a panel of outside experts, not by the company. These outside experts are people who have no financial interest in the decision and who look at the case and make a decision. If it is an emergency, the external reviewers have to render a decision within 72 hours. If it is a nonemergency, they have 30 days in which to decide. This is an external review—not by the insurance company, not by the carrier, not by anybody who has a financial interest in the outcome of this decision. Outside, independent experts make that decision. If they find in favor of the patient, that is it. There is no further appeal by the health plan.

If the external reviewers find against a patient and say, no, the HMO does not have to pay for that treatment, that patient still has step 4, which is an administrative appeal. That is an appeal to an Administrative Law Judge at the Social Security Administration.

The Administrative Law Judge then can make a decision based on what they think the plan provides, whether it is covered or whether it is not covered. If the Administrative Law Judge rules against the Medicare beneficiary, the beneficiary can appeal the decision to the Departmental Appeals Board at the Social Security Administration.

Then, there is a fifth step in the process if the Administrative Law Judge or Appeals Board finds in favor of the plan and against the beneficiary. If the patient is denied coverage by the Administrative Law Judge, that patient still has the right to judicial review in U.S. district court where he can push his case and plead that the procedure be covered. He can't sue for damages; he can't sue for punitive damages, or compensatory damages, but he can sue for coverage. If it is a bone marrow transplant, he could sue for the cost of that procedure, or an MRI, or whatever the procedure would be. This is what we do for Medicare. This is what Congress has helped establish for the 15 percent of Medicare patients who are now in HMOs. It is already in existence and in statute and it works.

A good thing about this, in addition to the fact that it is already there and we know how it works, is that it prevents most of the cases from ever having to go to court in the first place. Either the first, second, or the third level of review solves the problem, and it is done in a timely fashion. Does anybody think they can go to court and get a decision within 72 hours? You could not even file the papers within 72 hours. You would have depositions, hearings, a trial, an appeal, and then it gets kicked back down, and the patient has died, and you are still litigating whether they should be covered or not. That is not necessarily a good procedure.

What I am suggesting to those who say, ''Don't allow suits'' and to those who say, ''You have to have suits in this Patients' Bill of Rights,'' is that there is a middle ground that makes sense. I ask all of my colleagues just to consider that we are so close to the end of this session and neither side is going to get everything it wants; it is just not going to happen. If we hold out for everything we want and not try to compromise, we are going to go home and argue about failure because nothing will pass. There is a better way to serve the people and that is, I suggest, to say on this question of what rights to give patients when they are denied coverage, let's take what we already do in the Medicare Program and establish that as the procedure to be used for managed care plans in the private sector. While it needs some fine-tuning, it works; it has a proven track record. It is not perfect, but it certainly is better than what patients have right now because, in most cases, patients do not have the right to any kind of internal or external appeal if coverage is denied. I suggest that this makes a great deal of sense and could help resolve part of this problem. We can bring this bill up to the floor next week, adopt this amendment, and then ultimately send this to the President, who I think would be certainly willing to sign something that may not be 100 percent what he wants, maybe not 100 percent of what anyone wants, but it is 100 percent more than we are going to get if we do nothing. This is a suggestion that I hope our colleagues will seriously consider.

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

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

The assistant legislative clerk proceeded to call the roll.

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

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

The Senator from North Dakota has 30 minutes reserved. Is it that time that the Senator would intend to use?

Mr. KENNEDY. The Chair is correct. I thank the Chair.

The PRESIDING OFFICER. The Senator is recognized.

INCREASING THE MINIMUM WAGE

Mr. KENNEDY. Mr. President, under the leadership of President Clinton, the country has enjoyed six years of economic growth. Unemployment is at its lowest level in a generation. Inflation is the lowest in 40 years. Despite this week's gymnastics by the stock market, economic indicators continue to be strong. Job growth is projected to continue throughout this year, and inflation is predicted to remain at historically low levels.

But for most Americans, it's someone else's boom. Too many citizens are just one paycheck away from bankruptcy. Facing a sudden health crisis, a divorce, or some other family emergency—these families often have no choice but to declare bankruptcy.

My Republican colleagues respond with legislation to make it easier for banks and credit card companies to squeeze these already-struggling families even harder. I say, giant corporations don't need the help as much as families do.

And the best way to provide effective help is to raise the minimum wage. The amendment I have introduced today will raise the minimum wage by 50 cents on January 1 next year and another 50 cents on January 1, 2000. As we begin the next century, the minimum wage will be $6.15 an hour.

Mr. President, as this chart illustrates, we can see where the minimum wage has gone since 1955 in terms of real dollars.

We were back here at $4.34 in 1988. We raised the minimum wage here in a two-step procedure, and then it declined in terms of real purchasing power. And now we are talking about raising it up to what would be $6.15 an hour in the year 2000. But if you look at this chart, Mr. President, you will see that the actual purchasing power in the year 2000 in today's dollars would be only $5.76. This chart is a constant, real dollar chart. And even if we raise it to this level, we will still be below where the minimum wage was for some 15 years from the 1960s through the 1970s under Republicans and Democrats alike—below that level at a time of extraordinary prosperity for millions of Americans—millions of Americans—even with that increase.

If we do not increase it, if we do not accept this amendment, we will find out that the minimum wage effectively will be not $5.15 an hour, but $4.82 an hour, which will put us close to the lowest levels in the last 35 years in terms of purchasing power for working families at the lower end of the economic ladder.

Those at the bottom of the economic ladder have not received their fair share of the nation's remarkable growth. Working 40 hours a week, 52 weeks a year, minimum wage workers earn just $10,700—$2,900 below the poverty level for a family of three.

In the midst of what many experts are calling ''the best economy ever,'' 12 million working Americans are still earning poverty-level wages.

For them, survival is the daily goal. If they work hard enough and their hours are long enough, they can make ends meet—but only barely. They don't have time for their families. They can't participate adequately in activities with their children.

They can't afford to buy birthday presents or do the countless other things that most of us take for granted.

We know who minimum wage workers are. They assist teachers in classrooms across the country. They care for the chronically ill in their homes. They are child care workers and aides in nursing homes. They sell us groceries at the supermarket, and serve us coffee at the local coffee shop. They clean corridors and empty trash in office buildings in countless communities around the nation.

They are workers like Valerie Bell, a custodian for a contractor in Baltimore, who told us what a higher minimum wage means in human terms. For workers and their families, it means far more than dollars and cents. It means dignity. As she said, ''We no longer have to receive food stamps or other social services to supplement our incomes. We can fix up our homes and invest in our neighborhoods. We can spend more at the local grocery store. We can work two low-wage jobs, rather than three low-wage jobs, and spend more time with our families. Our utilities won't be cut off. We can pay the medical bills we accumulated from not having health benefits in our jobs.''

Minimum wage workers are people like Cathy Adams, a home health aide from Viola, IL. Cathy is a high school graduate who is currently enrolled in a computer training program at the local