speed up the process for addressing import surges. It would provide for an early warning about import surges so action can be taken before the American industry is irreversibly damaged. All this is perfectly legal under the WTO.

Let me address a few remarks to the principal exporters of lamb to the United States—Australia and New Zealand. There has been a lot of misinformation coming from the industry and governments in those two countries.

This is not an attack on the lamb industry in Australia or New Zealand. Rather, it is a measure taken under U.S. trade law to provide temporary—and I underline the word ''temporary''—relief to a devastated American industry. The actions announced by the President are compatible with the WTO. Australia and New Zealand will continue to ship large quantities of lamb to the United States. Their exports would be able to grow each year.

The only difference is that the American lamb industry will stay in business and American workers will keep their jobs. Australia and New Zealand have the right to appeal to WTO. I am sure they will do that, and I am confident that the appeal will not be successful. Everyone should understand that this action was necessary to provide temporary relief to an industry that was hurting.

Let me conclude by again thanking the President and the administration officials who made possible this important action to provide remedies to the devastated lamb industry in the United States.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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 President, I ask unanimous consent that the order for the quorum call be rescinded.

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

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is now closed.

PATIENTS' BILL OF RIGHTS ACT OF 1999

The PRESIDING OFFICER. Under the previous order, the Senate will now proceed to the consideration of S. 1344, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1344) to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

The Senate proceeded to consider the bill.

Ms. COLLINS. Mr. President, I yield myself such time as I may consume from general debate on the bill under the unanimous consent agreement.

I am pleased that the Senate has begun debate on the Patients' Bill of Rights and the Patients' Bill of Rights Plus. There is a growing unease across this Nation about changes in how we receive our health care. People worry that if they or their loved ones become ill, their HMO may deny them coverage and force them to accept either inadequate care or financial ruin, or perhaps even both. They believe that vital decisions affecting their lives will be made not by a supportive family doctor but, rather, by an unfeeling bureaucracy.

Our goal this week should be to join together to work in a bipartisan way to enact legislation that accomplishes three major purposes.

First, it should protect patients' rights and hold HMOs accountable for the care they promise.

Second, it should expand, not contract, Americans' access to affordable health care.

And, third, it should improve health care quality and outcomes.

I believe all of us should be able to agree that medically necessary patient care should not be sacrificed to the bottom line and that health care decisions should be in the hands of medical professionals, not insurance accountants or trial lawyers.

We do face an extremely delicate balancing act as we attempt to respond to concerns about managed care without resorting to unduly burdensome Federal controls and mandates that will further drive up the cost of insurance and cause some people to lose their health insurance altogether.

That is the crux of the debate we are undertaking this week. The crux of this debate is how can we make sure that we address those critical concerns we all have about managed care without so driving up the cost of the health insurance people have—as the Kennedy bill would do—that we jeopardize coverage for thousands, indeed millions, of Americans.

As the President's Advisory Commission on Consumer Protection and Quality noted in its report, ''costs matter . . . the Commission has sought to balance the need for stronger consumer rights with the need to keep coverage affordable. . . Health coverage is the best consumer protection.''

I think President Clinton's quality commission hit it right. I believe they have stated exactly what the debate is before us. I, therefore, have been alarmed by recent reports that American employers everywhere, from giant multinational corporations to the tiny corner store, are facing huge hikes in medical insurance averaging 8 percent and sometimes soaring to 20 percent or more.

This is a remarkable contrast to the past few years when premiums rose less than 3 percent, if at all. I am particularly concerned about the impact these rising costs are having on small businesses and their employees.

A survey of small employers conducted by the United States Chamber of Commerce earlier this year found that, on average, small businesses were hit with a 20-percent premium hike last year. More important, of the small employers surveyed, 10 percent were forced to discontinue health care coverage for their employees because of these premium increases. Over half of the employers surveyed indicated that they switched to a lower cost plan, while an overwhelming majority indicated that they had passed the additional costs of these premium hikes on to their employees through increased deductibles, higher copays, or premium hikes.

This, too, is very troubling since it will induce many more employees, especially lower wage workers and their families, who are disproportionately affected by increased costs, to turn down coverage when it is offered to them. Indeed, in the HELP Committee, on which I serve, we saw a GAO report which indicated that an increasing number of American employees are turning down the health insurance offered by their employers because they simply cannot afford to pay their share of the costs.

It is no wonder that the ranks of uninsured Americans increased dramatically last year to 43 million people—the highest percentage in a decade. This is happening at a time when our economy is thriving. Imagine what could happen in an economic downturn.

We know that increasing health insurance premiums cause significant losses in coverage. That is the primary reason that I am so opposed to the Kennedy bill. According to the Congressional Budget Office, the Kennedy bill, that has been laid down before us, will increase health insurance premiums by an additional 6.1 percent over and above the premium increases we have already experienced or are likely to experience as a result of a resurgent increase in health care inflation.

The CBO report goes on to note that:

> Employers could respond to premium increases in a variety of ways. They could drop health insurance [coverage] entirely, reduce the generosity of the benefit package [in other words, cut back on the benefits that are provided], increase cost-sharing by [their employees], or increase the employee's share of the premium.

CBO assumed that employers would deflect about 60 percent of the increase in premiums through these strategies. In other words, 60 percent of this increased cost is going to go right to American workers. The remaining increase in premiums would be passed on to workers in the form of lower wages. In short, it is the workers of America, it is the employees, who will be paying this increased cost.

Lewin Associates, a well-respected health consulting firm, in a study for

the AFL-CIO, has estimated that for every 1 percent increase in premiums, 300,000 Americans have their health insurance jeopardized. Based on these projections, passage of the Kennedy bill would result in the loss of coverage for more than 1.8 million Americans. That is more than the entire population of my home State of Maine.

The Kennedy bill should be more aptly titled the ''Patients Bill of Costs'' because ultimately it will be the patient who will get hit with higher health care costs if the Kennedy bill is approved.

Our legislation, by contrast, provides the key protections that consumers want without causing costs to soar. It responsibly applies these protections where they are needed. The legislation does not preempt but, rather, builds upon the good work that States have done in the area of patients' rights and protections. States have had the primary responsibility for the regulation of health insurance since the 1940s.

I spent 5 years in State government as a member of the Governor's cabinet and was responsible for the Bureau of Insurance. I know State insurance regulators have done a good job in protecting the rights and needs of their consumers in their State. In fact, they have been far ahead of the Federal Government in responding to concerns about managed care.

For example, 47 States have passed laws prohibiting ''gag clauses'' that restrict communications between patients and their doctors. As a consequence, as the CBO notes in its report on the Kennedy bill, ''Several studies have shown that few plans impose such restrictions today.''

Forty States have requirements for emergency care. All 50 States have requirements for grievance procedures. And 36 States require direct access to an OB/GYN.

States have acted without any mandate from Washington, without any prod from Washington, to protect their consumers. Moreover, one size does not fit all; what might be appropriate for one State may not fit for the consumers in another.

Florida, for example, provides for direct access to a dermatologist, which is understandable given the high rate of skin cancer in that State. In the State of Maine, another kind of mandate may be more appropriate. Similarly, what may be appropriate for California, which has a high penetration of HMOs, may simply not be necessary in a rural State such as Wyoming where there is little or no managed care. In such States, a new blanket of heavyhanded Federal mandates in coverage requirements will simply drive up costs and impede, not enhance, health care. That is why the National Association of Insurance Commissioners supports the approach we have taken in our bill.

Currently, Federal law prohibits States from regulating the self-funded, employer-sponsored health plans that cover 48 million Americans. Our bill, which is intended to protect the unprotected consumer, extends many of the same rights and protections to these individuals and their families that those in State-regulated health plans already enjoy.

For the first time, people in self-funded plans will be guaranteed the right to talk freely and openly with their doctors about treatment options without being subjected to any kind of ''gag clauses'' that limit their communications. They will be guaranteed coverage for emergency room care that a ''prudent layperson'' would consider medically necessary without having to get prior authorization from their health plan. They will be able to see their OB/GYN or pediatrician without a referral from their plan's ''gatekeeper.'' They will have the option of seeing a doctor who is outside the HMO's network. They will also be guaranteed access to nonformulary drugs when it is medically necessary, and they will have an assurance of continuity of care if their health care plan terminates its contract with their doctor or hospital.

The opponents of our legislation contend that the Federal Government should preempt the States' patient protection laws unless they have already enacted identical protections. However, the States' approaches vary widely—for good reasons. Moreover, if we start adopting a Washington-knows-best approach to health care, we will have HCFA deciding whether a State has met the test of a Federal regulation. Our experience with other laws should show that is not a good idea.

Other provisions of our bill provide new protections for additional millions of other Americans. These are the procedural protections that are in our bill. A key provision of our bill builds upon the existing regulatory framework under ERISA to give all 124 million Americans in employer-sponsored plans the assurance that they will get the care they need when they need it.

The legislation will enhance and improve current ERISA information disclosure requirements and penalties and strengthen existing requirements for coverage determinations, grievances and appeals, including—and this is the most important provision of our bill—the addition of a new requirement for strong, independent, external review that is available at no cost to the patient.

All 124 million Americans in employer-sponsored plans will be entitled to clear and complete information about their health plan—about what it covers and what it does not cover, about any cost-sharing requirements, and about the plan's providers. Helping patients understand their coverage before they need to use it will help to avoid disputes about coverage later.

The goal of any patients' rights legislation should be to resolve disputes about coverage up front when the care is needed, not months or even years later in a courtroom, as the Kennedy bill proposes. Our legislation would accomplish this goal by creating a strong internal and external review process. Both appeals processes are available at no cost to the patient.

Here is how it would work. First, patients or doctors who are unhappy with an HMO's decision could appeal it internally through a review conducted by individuals with appropriate expertise who are not involved in the initial decision. Moreover, this review would have to be conducted by a physician, if the denial is based on a determination that the service is not medically necessary or that it was experimental treatment. Patients would expect results from this review within 30 days, or 72 hours, in cases where delay poses a serious risk to the patient's health.

Let's say that after this internal review process is completed, the patient or the physician is still unhappy with the decision; let's say that the internal review upheld the HMO's decision. There is still another protection in our bill. Patients turned down by this internal review would then have the right to a free, independent, external review conducted by medical experts who are completely independent of the insurance plan.

This review must be completed within 30 days, and even faster, if there is a medical emergency or a risk to the patient's life or health. Moreover, the decision of these outside reviewers is binding on the health plan. It is not binding on the patient.

If you have been denied care you think you need, you can apply for an internal review. If you are not happy with that review, you can go on to an independent external review, and the decision of the physician, who has to have expertise in the condition at issue, is binding on the health plan, but it is not binding on you, if you are still unhappy. If you are still unhappy with the decision made, the patient would still have the right, would retain the right to sue in Federal or State court for attorney's fees, for court costs, for the value of the benefit, and injunctive relief. Really, it is a three-stage appeals process: First, an internal review, an external appeal, and then you can still go to court to sue for the benefit and for your attorney's fees and court costs.

The purpose of our legislation is to place treatment decisions in the hands of doctors, not insurance company accountants, and not in the hands of trial lawyers. If your HMO denies treatment that your physician believes is medically necessary, you should not have to resort to a costly and lengthy court battle to get the care you need. You should not have to hire a lawyer. You should not have to file an expensive lawsuit to get the treatment.

Our approach contrasts with the approach taken in the Kennedy bill, which encourages patients to sue their health plans. I simply do not believe you can sue your way to quality health care. We should solve problems about

health care coverage upfront, when the care is needed, not months or even years later, after the harm has occurred.

Let's look at the experience with medical malpractice cases. According to the GAO, it takes an average of 33 months to resolve malpractice cases. This does nothing to ensure a patient's right to timely and appropriate care. Moreover, patients receive only 43 cents out of every dollar awarded in malpractice cases. Exposing health plans and employers to greater liability would force plans to cover unnecessary services that do not benefit patients in order to avoid costly litigation and to make decisions based not on the best practice protocols but, rather, on the latest jury verdicts and court decisions or out of fear of being sued.

The noted Princeton health economist Uwe Reinhardt was quoted in this Sunday's Washington Post as saying that he believes the financial impact of the Kennedy bill's liability provisions would be profound. He noted:

> In the end, we're back again to basically the open-ended deal where the individual physician makes a judgment and no one dares question it.

Mr. President, all of us treasure the relationships we have with our physicians. We are also well aware of studies that have shown there have been unnecessary hysterectomies, for example, or the use of mastectomy when removal of a lump from a breast would suffice. That is why we need to have reviews based on the best medical evidence and decisionmaking possible.

The President's Advisory Commission on Consumer Protection and Quality specifically rejected expanded lawsuits for health plans because the commission believed it would have serious consequences for the entire health care industry. I agree with that assessment. The last thing we need is to introduce more costly litigation into our health care system.

At a time when the tort system of the United States has been criticized as inefficient, expensive, and of little benefit to the injured, the Kennedy bill would be bad medicine for American families, workers, and employers, driving up the cost of health insurance and jeopardizing coverage for some who need it most.

Our concern is not just theoretical. I met with a group, a very good group of Maine employers who care deeply about their employees. They expressed to me their serious concerns about the Kennedy proposal to expand liability for health plans and employers. For example, the representative from Bowdoin College in Maine talked about how moving to a self-funded ERISA plan had enabled the college to greatly improve the coverage it provided to Bowdoin's employees and to offer affordable coverage to them.

Since the college is self-funded, it has actually been able to lower premiums for its employees while at the same time providing an enhanced benefit package with such features as well baby care, free annual physicals, and prescription drug cards with low copayments. The people at Bowdoin College told me that the Kennedy proposal to expand liability would seriously jeopardize their ability to offer affordable coverage for their employees. In fact, they told me they would probably abandon their self-funded plan and go back into the insurance market and, thus, buy a plan that would have fewer benefits for their employees in order to avoid this increased risk of liability and litigation.

Similar concerns were expressed to me by the Maine Municipal Association, which represents cities and towns throughout Maine, L.L. Bean, Bath Iron Works, and many other responsible Maine employers.

Unlike the Kennedy bill, the Republican bill contains key provisions that will help hold down the cost of health care while improving health care quality and holding HMOs accountable.

For example, I am particularly pleased that our bill contains a proposal, introduced by my colleague, the senior Senator from Maine, that prohibits insurers from discriminating on the basis of predictive genetic information. Genetic testing holds tremendous promise for individuals who have a genetic predisposition to breast cancer and other diseases and conditions with a genetic link. However, this promise is significantly threatened when insurance companies use the results of such testing to deny or limit coverage to consumers on the basis of genetic information.

Our legislation also establishes the agency for health care research and quality, an initiative of our physician in the Senate, Mr. FRIST from Tennessee. The purpose of these provisions is to foster an overall improvement in health care quality, to bridge the gap between what we know and what we do in health care today.

Most important, the Republican bill will expand access to health insurance for millions more Americans by making it more affordable. This is the key difference between the two alternatives before the Senate. Our bill would expand access to health care, a critical issue at a time when we have 43 million uninsured Americans. The Kennedy bill would constrict access and jeopardize coverage for many Americans. The biggest obstacle to health care in the United States today is simply cost. This is due, in part, to the Tax Code's inequitable treatment of people who do not receive health insurance through their employers. Some 25 million Americans are in families headed by self-employed individuals, and, of these, 5 million are uninsured. The Republican bill will make health insurance more affordable for these Americans by allowing self-employed individuals to deduct the full amount of their health care premiums.

I have never understood the policy behind our Tax Code that allows a large corporation to deduct 100 percent of the cost of the health insurance premiums that it is providing to its employees but restricts a self-employed individual to a deduction of only 45 percent. Our bill would move that to 100 percent immediately. This would help reduce the number of uninsured working Americans. It would help make health insurance more affordable to the 82,000 people in Maine who are self-employed. They include our lobster men, our hair dressers, our electricians, our plumbers, and the owners of our gift shops, which we hope all of you will visit this summer along the coast of Maine. It includes so many hard-working Mainers for whom the cost of health insurance is simply out of reach.

Mr. President, I believe that the Republican approach strikes the right balance, as we effectively address concerns about quality and choice without resorting to unduly burdensome Federal controls and expensive, bureaucratic, new Federal mandates that will further drive up costs and cause some Americans to lose their health insurance altogether.

I urge my colleagues to join in supporting the Republican health task force legislation.

I reserve the remainder of our time.

Mr. DASCHLE addressed the Chair.

The PRESIDING OFFICER. The distinguished minority leader is recognized.

Mr. DASCHLE. Mr. President, this is truly a historic day. My Democratic colleagues and I have been trying for nearly 2 years to bring this debate to the floor of the Senate.

For the past 2 years, I have listened to people and their complaints about the health care system. I have come to the conclusion that the reason the insurance companies call them HMOs is that H-M-O sums up their patient philosophy: Having Minimal Options.

I thank the majority leader. It is no secret that Senator LOTT faced considerable pressure to prevent this debate. On behalf of the 161 million Americans who need the protections in our bill, we thank him for agreeing, finally, to bring this debate to the floor.

Most of all, I want to acknowledge my Democratic colleagues. We would not be having this debate were it not for their steadfast determination and hard work. That is particularly true of the senior Senator from Massachusetts, Mr. KENNEDY. They have each taken considerable risks to demand that this Senate listen to and deal with the real problems America's families are having with their HMOs. Every one of them deserves recognition.

The general debate on this bill is supposed to last 3 hours—which, according to an HMO, is enough time for a woman to check into a hospital, deliver a baby, and be sent home. Senator KENNEDY and I and others intend to use these 3 hours to talk about the extraordinary difference in approach between the Democratic and the Republican plans.

There are no bills pending in this Congress that will have a greater impact on the lives and health of America's families than this bill. There are no decisions we will make that will have a more profound effect than the decisions we make this week.

The issues we will debate these next 4 days are literally life-and-death issues.

The insurance industry has spent tens of millions of dollars to try to prevent us from ever having this debate. Many of our Republican colleagues responded and worked with them. The Republicans seem to protect insurance companies the way Briana Scurry protects a soccer goal. The insurance industry has spent millions of dollars on ads designed to confuse and frighten the American people, and intimidate us. They hope that by repeating untruths often enough they will be able to kill this bill and keep their license to practice bad medicine.

The truth is, this whole debate comes down to one critically important question: Who should make medical decisions, doctors or insurance company accountants?

We have all heard the horror stories.

In Georgia, a 6-month-old boy was burning up with a 105-degree fever. His mother called her HMO twice and begged to be allowed to take her son to the emergency room. Both times the HMO refused. She finally decided to take him to the hospital anyway. By the time they arrived, the infection that was causing the fever had destroyed the circulation in the baby's extremities. Both his hands and feet had to be amputated.

In Washington, DC, a 12-year-old boy was diagnosed with a cancerous tumor in his leg. His oncologist recommended a treatment that could save the leg. But when the doctor's office called the boy's HMO, they were told the only treatment the HMO would pay for was amputation. Four months and several appeals later, the HMO finally agreed to pay for the treatment the doctor ordered. But by then, the cancer had spread; the leg had to be amputated.

In Kentucky, a man with prostate cancer needed one chemotherapy injection a month. The injections cost $500 each. His insurance company policy said they were fully covered. But when the HMO changed administrators, the man was told he would have to pay $180 a month out of his own pocket. He didn't have $180 a month, so he had to go with the only other treatment his doctor said could control his cancer. He was castrated. The day he returned from the hospital, he got a letter from his HMO saying they had made a mistake; the HMO would now pay the $500 after all.

Three different people, three different parts of the country, but they all have one thing in common: They were all powerless against their insurance companies.

Unfortunately, I could go on and on.

Two years ago, 130 million Americans said they or someone they knew had a problem with a health insurance company. Last year, that number had grown to 154 million Americans.

When we first introduced our bill, nearly 2 years ago, a lot of our Republican friends said we didn't need a Patients' Bill of Rights. Today, they have a bill of their own. We consider that progress. But we still have big differences of opinion about what a Patients' Bill of Rights should do.

Our bill covers 161 million Americans. Their bill covers 48 million people; it leaves out more than 100 million Americans.

Our bill lets health care professionals make medical decisions about your health. Their bill lets insurance company accountants make those decisions.

Our bill guarantees you the right to see a qualified medical specialist, including pediatric specialists for your children. The Republican bill doesn't guarantee that either you or your children will be able to see qualified medical specialists.

If your HMO refuses to pay for care your doctor says you need, our bill allows you to appeal that decision to an independent review board. Their bill contains an appeal process, too—except they let the HMO decide what decisions can be appealed. They also let HMOs handpick and pay the people who hear the cases.

Finally, our Patients' Bill of Rights is enforceable. Theirs isn't.

CBO estimates that the most our Patients' Bill of Rights would increase premiums is 4.8 percent over 5 years—less than 1 percent a year. That comes out to less than $2 per beneficiary—less than $2 a month to guarantee that your health insurance will be there when you need it.

Last month, when we offered our Patients' Bill of Rights, a Republican colleagues voted to kill it, without discussing its specific pieces. Yet, they claim they support nearly all the protections in our plan.

So this week, we intend to offer our plan again, piece by piece. Let's debate each of the protections in our plan. Maybe when our colleagues really look at our proposals, they will decide they can support some of the protections in our bill. The American people deserve to know exactly where each of us stands on each of these protections.

Let me just say a word at this point about the kind of debate we expect this week. By agreeing to this debate, we are assuming our Republican colleagues intend to allow a real, honest debate. That means debating and voting on each of the major protections in our Patients' Bill of Rights. If we have that sort of debate, then, whether we win or lose, we will certainly agree not to bring the Patients' Bill of Rights up again this year. Up or down, win or lose, if the debate this week is fair and honest, we will not offer our Patients' Bill of Rights again this year.

But, if we are not able to do that, if we don't have a real debate, if we are not permitted to offer our protections as amendments so that the Senate can discuss and vote on each of them, if there are those who try to prevent an honest debate by using parliamentary tricks, we are putting them on notice now: This debate will certainly not end on Thursday. We will continue to offer the protections in our plan as amendments for as long as we have to until we finally have that honest debate.

We know from experience that we can pass bills that protect the health of American families when we want. Together, Republicans and Democrats passed a bill allowing people to take their health care with them when they change jobs. Together, we passed a bill to help working parents purchase private, affordable health insurance for their kids. Together we can pass a real, meaningful Patients' Bill of Rights this week.

AMENDMENT NO. 1232

(Purpose: To provide the text of Senate Bill 326 (106th Congress), as reported by the Committee on Health, Education, Labor, and Pensions of the Senate, as a complete substitute)

Mr. DASCHLE. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from South Dakota (Mr. DASCHLE) proposes an amendment numbered 1232.

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

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

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. DASCHLE. Mr. President, let me explain the amendment I have just offered. This amendment is the Republican HMO reform bill. We are offering it as a substitute to the Democratic bill for one reason.

Senator LOTT has been very candid and open about his intentions. His intention, of course, is to offer at the end of this debate a Republican bill that has not been debated or amended or scrutinized in any way.

By offering as our first amendment the Republican substitute, we now lay down a dual track for the week—their bill and our bill. Both bills are subject to amendments. Both are subject to consideration. Both are subject to the debate that we had anticipated when we reached this agreement.

We will be offering amendments to the Republican bill. We would love nothing more than for our bill to pass without amendment. But certainly, if that is not to be, we will at least do what we can to make sure the Senate deals honestly with this issue.

By offering the Republican bill, we hope to make sure the Senate at least has an honest debate, and we have the opportunity to try to make the Republican bill what it should have been in

the first place—a good bill that deals with each of the issues and offers real protections.

I retain the remainder of our time both under the amendment as well as the general debate.

The PRESIDING OFFICER (Mr. VOINOVICH). The Senator from Texas.

Mr. GRAMM. Mr. President, let me begin by explaining how we came to be here. Then I want to take a little walk down memory lane, as Ronald Reagan used to say, and talk about the real Democrat health care bill—the bill offered in 1993. I then want to talk about the difference between the two bills—the Democratic Kennedy bill, and our bill—and why that difference is relevant to every working American family.

Then I would like to conclude by explaining why our bill is a good bill and why I am confident that if Senator KENNEDY and I could go into every house in America and sit down with people at their kitchen table, and if he could explain his bill and what he is trying to do, and if I could explain our bill and what we are trying to do, I am confident that 90 percent of the people in America would choose our bill.

We are going to have 4 days of debate. But the outcome of the debate, I think, is clear. We are going to win when the votes are cast, and we are going to win this debate because we have a better program. Our program benefits the people who do the work and pay the taxes and pull the wagon in America.

I think when the week is over that we will have discredited the approach of this bill as we discredited the bill in 1993. But, of greater importance, we will have passed a real bill that gives Americans real freedoms.

Our colleagues have lamented that we have waited this long to deal with this issue. I want to remind everyone that last year throughout the year the majority leader offered to bring this bill up, and he offered to bring it up in two different forms.

I thought the most reasonable offer was to let the Democrats write the best bill they could write that does the most that they can provide to help people with health insurance and to impose whatever restrictions they want to write. Then let Republicans put together the best bill they can put together, and bring the two bills to the floor of the Senate and let the Senate choose between one. We could then choose one or the other. That was rejected by the minority.

We then offered them the ability to bring the two bills up and each side have five amendments. That was rejected by the minority.

Not to waste a lot of time to get into a debate with the minority leader, or with other Democrats, I simply submit that we have been 2 years getting to this point because the Democrats have wanted it to be 2 years getting to this point. We could have brought up bills and voted under an orderly process 2 years ago. But, in reality, the Democrats thought they had a political issue. That is why we are only getting to this bill now. I think we are going to prove this week they don't have much of a political issue, and I think when the debate is over they are going to be glad it is over. And I think the American people are going to be glad it is over.

Let me remind my colleagues, and anybody who is watching this debate in America, that this is not the first time Bill Clinton and TED KENNEDY have wanted to rewrite the health care system of this country. I have here on this desk the Clinton health care bills, and the version of it that was sponsored by Senator KENNEDY.

Let me remind those who followed that debate in 1993—their memories might have gotten a little clouded—what this bill did. This bill said that the problem in America was that we had 43 million Americans who didn't have health insurance, and that in trying to deal with health insurance and make it available, we needed to get rid of the current health care system, and we needed to set up on a regional basis in America health care collectives that people would be forced to join. And these collectives would be run by the Government. The whole idea behind the Kennedy bill in 1993 was give up freedom to control cost.

Obviously, I wouldn't have enough time in the day or the week to go through all of these provisions. But let me just remind you of a couple of them.

In 1993, Senator KENNEDY, Senator DASCHLE, and President Clinton said: We are going to have the Government take over the health care system in your hometown—in Phoenix, AZ. There would be one health care collective run by the Government, and if you refused to join that collective, you would be fined $5,000.

That is what they wanted in 1993. That was their concept of freedom when they last asked us to let them run the health care system in America.

Then they said, if this plan did not provide the kind of health care you needed and you sought to get that health care through your physician and the health care was not allowed under this plan, the physician could be fined $50,000.

If you needed health care for your child, their concept of freedom, in 1993, in the Clinton-Kennedy health care bill, was: We know what kind of health care you need. They said: We are going to provide it in this bill, and, if you want health care outside this bill and a physician provides it for you, we are going to fine them $50,000.

That was their concept of freedom in 1993. In 1993 they said, What about the circumstance where your baby is really sick? So you go to a doctor and say, I need health care, and they, under the Clinton-Kennedy plan, say, We are not allowed to provide this kind of treatment. You say, forget about the plan, I'll pay for it out of my own pocket. In 1993, Senator KENNEDY and Senator DASCHLE and President Clinton thought so much of freedom that they said, If you pay the doctor out of your pocket for a treatment that we do not provide for, and the doctor takes the money, he can be sent to prison for 15 years. That was their concept of patients' rights in 1993. That is what they thought freedom consisted of in 1993.

I submit, this is what they still want. The bill that is before us, their bill, is step 1 toward government running the health care system, so when my mama needs to go see a doctor, she first has to talk to a government bureaucrat. We defeated that in 1993, and we are going to defeat it this week in the Senate.

What is the plan today? Unlike 1993, when our colleagues were very concerned about the cost of health care, now they are not concerned about health care cost, they are concerned about rights. So all of a sudden they have put together a bill that imposes a whole lot of government restrictions, that expands liability, so 60 percent of the premiums that go to provide insurance against medical liability will end up going to lawyers instead of to doctors and hospitals and clinics.

They have put together a bill that the Congressional Budget Office has said, when you take into account all the bureaucracy and all the legal liability, will drive up the cost of health care by 6.1 percent. That is equivalent to taking 6.1 percent right out of the paycheck of working Americans in order for them to be able to keep their insurance. Only a lot of Americans will not be able to keep their insurance. In fact, a study funded by the AFL–CIO has concluded, if you take the increase in health care costs under the Kennedy plan, 1.8 million Americans will lose their health insurance.

Mr. President, 1.8 million Americans will lose their health insurance if we should adopt the bill that the Democrats have proposed. For those who are lucky enough not to be one of the 1.8 million people who would lose their health insurance, they would pay $72.7 billion over a 5-year period more for health insurance and health costs than they are paying now.

This is not just about dollars, this is about real people and real health care. By 1.8 million people losing their health insurance, that means you would have 188,595 fewer breast examinations every year for Americans, because the Kennedy bill would take away their health insurance. It means 52,973 American women would not have mammograms who would have them under current law, because the increase in cost under this bill would take away their health insurance. It means that 135,122 Pap tests would not be undertaken, because people would have lost their health insurance and therefore lost access to that coverage. Mr. President, 23,135 American men, mostly elderly men, would lose their prostate

screening exam as a result of the health care cost increase that would be dictated by the Kennedy plan.

So what do they offer us in the name of health care rights? They offer us a bill that would drive up health insurance costs by 6.1 percent, costing 1.8 million Americans their health insurance, and for those who are lucky enough to be able to afford to keep their health insurance, they would pay $72.7 billion more for their health insurance over a 5-year period.

In return for all of these costs, what do people get? Rather than going into the details, I am going to reduce it down to a very simple example. I want to define the problem Senator KENNEDY sees—and we agree on the problem. Then I am going to explain what he provides in the name of rights that drives up costs by 6.1 percent, costs 1.8 million people their health insurance, and those who keep their health insurance pay $72.7 billion more for it.

Here is the problem. The innovation—which, by the way, has been championed by the people who are offering this amendment—is HMOs. They thought so much of them they wanted to force everybody in America into a government-run HMO. But, under HMO, there is a problem. The problem is that people lose the control they want and need over their health care. Let me reduce it down to a simple example.

When people with an HMO go into the examining room, too often, in addition to their doctor in the examining room, they have, either literally or figuratively, the HMO gatekeeper in the examining room. So they are going into the examining room—obviously, that often entails taking your clothes off. People are often a little nervous about that. They want privacy. They like to be in the examining room with their doctor, but with an HMO they find themselves with this gatekeeper virtually looking over the doctor's shoulder. They would like to be in the examining room alone with the doctor. We agree. We think they should have the right to make that choice.

But how does Senator KENNEDY fix the problem? How Senator KENNEDY fixes the problem—and you will be able to tell why it is so expensive when you look at it—the way Senator KENNEDY fixes the problem is demonstrated by this stethoscope. What people want is the doctor in the examining room with the stethoscope up against their heart, but right now they have an HMO listening in, double-checking their doctor. They would like to get this HMO gatekeeper out of the examining room. So what does Senator KENNEDY do? He says: We can fix your problem. It will cost 1.8 million of you your health insurance; those who keep the health insurance, it will cost $72.7 billion more. But look at what you get.

What you get under Senator KENNEDY's plan is this. He doesn't get rid of the HMO, that guy is still there listening in, but he brings a government bureaucrat into the examining room who will be there to keep an eye on the HMO, and to keep an eye on the doctor, and to regulate. Then, in addition to the bureaucrat, he brings the lawyer into the examining room who will be there keeping an eye on the bureaucrat and HMO and the doctor, so that he can be there to sue the doctor or the HMO.

The reason Senator KENNEDY's plan drives up health care costs by 6.1 percent and costs 1.8 million Americans their health insurance and drives up the cost for those who can afford to keep it by $72.7 billion is it costs a lot of money to bring all these bureaucrats and all these lawyers into the process.

But the point is, what people are unhappy about is the HMO gatekeepers being in the examining room. They wanted to get them out of the examining room. They do not want to bring the bureaucrats in and bring lawyers in. What they want is a health care system that looks like this: They want a health care system where you have two people in the examining room and one of them is you. You are on this end of the stethoscope, and your doctor is on the other end of the stethoscope, and there is nobody else in the room. That is what they want.

The difference between the Kennedy bill and our bill is, under his bill, he brings in the bureaucrat and the lawyer. So now you have four people in the examining room. What we do is we get rid of the HMO gatekeeper and give people real freedom.

This is such a critically important point. Our Democrat colleagues have gotten caught up in this deal about how they are going to give people rights. I think it is wonderful that it is so easy for somebody to see what they mean by ''rights'' and what we mean by ''freedom'' are two totally different things.

Under the Democrat bill, you are not free to fire the HMO your boss picks for you, but you are free to have the Government regulate it.

Under the Kennedy plan, you are not free to fire your doctor, but you can sue him.

Under the Kennedy plan, you are not free to control your health care cost, but you can share that control with a lawyer and with the Government.

What we do is give people freedom. It is an interesting paradox that the Kennedy bill debases the very term ''choice.'' It debases the very term of ''rights'' because it contains no rights; that is, no rights that are really meaningful to somebody who has a child who is sick or whose mama is ill.

We give people real rights. We give people the right to fire their HMO by guaranteeing them an alternative, which I will talk about in a minute.

We give people the right to fire their doctor.

We give people the right to take their health care money and spend it as they choose on their own family.

We give people the right to pick the protections they believe are important to their family, not those basic benefits the Government might decide in Washington would be useful.

And finally, we give people the right to control their own health care, something the Democrats do not do.

The Democrat plan means more Government, more lawyers, more rules, more uninsured and more Government control, but the one thing it does not mean, the one thing it does not provide is more freedom. Our bill provides more freedom. Let me explain two ways it does.

First of all, under the current tax system, we have a terrible inequity. If General Motors buys your health insurance for you as their employee, it is tax deductible. But if you buy it for yourself as either a small businessperson who does not have health insurance or a self-employed who does not have health insurance or somebody who works for a company that does not provide health insurance, or if you would rather buy your own health insurance rather than General Motors choosing for you, it is not fully tax deductible. The first thing our bill does is it treats you as well as current tax law treats General Motors. Under our bill, if you buy your own health insurance—let's say you are self-employed. You will get the right to the same tax treatment that General Motors does, so your health insurance is tax free.

The second and most important choice we give to people is a totally new program, a new choice. We do not force anybody to take it, but we give people the ability to buy, in addition to all the choices we provide with everything from an HMO to private practice of medicine through a medical savings account, we expand people's freedom. One of the choices we provide, which I am very excited about, is the right to buy a medical savings account. Here is how it would work.

A medical savings account is a device that really is aimed at helping people who want health care coverage but who often do not have a lot of money. The way it would work is, in addition to joining the health plan your company might try to impose on you, you have the right to take your money and buy a high-deductible insurance policy and then join with your company in setting aside money to pay the deductibles in what we call the medical savings account. Those medical savings accounts are fully tax free, just like conventional health insurance. Here is basically how it would work.

You might buy a health insurance policy with a $3,000 deductible. Normally, that policy would cost less than half as much as a first-dollar-coverage policy. Then you and your employer would begin to build up a savings account up to $3,000, which would belong to you, to cover the deductible.

Then how it works is you make the decision, when your child needs to see a doctor, which doctor your child needs to see. You are empowered to make the decision.

It is true that under the Kennedy plan, if your baby has a 104-degree fever, you could get out the phonebook and you could look under the blue pages for the U.S. Government and you could find the Health Care Financing Administration, or HCFA as they are called, and at 2 o'clock in the morning you could call up HCFA. You would, in all probability, get an answering machine if you were lucky. Maybe you would not. I do not think you are going to find the Director of HCFA at work at 2 o'clock in the morning. You can call up and leave a message, and then they, under the Kennedy plan, will set up a meeting. Maybe next Tuesday at 4:52 in the afternoon they might meet with you or talk to you on the phone.

You also could call up a lawyer. You could look under ''attorney'' in the phone page and you can pick—one thing about Senator KENNEDY's health care rights bill is it gives you no freedom with regard to doctors, but it gives you complete freedom with regard to attorneys.

Senator KENNEDY's bill is unlike the bill he put together in 1993 with President Clinton. Remember, their health care bill in 1993 did not let you sue. They have had a change in heart, it seems, so now he says you can pick up the Yellow Pages and you can look under ''attorney'' and you can pick any attorney. You have your car wrecks. Maybe you want another attorney. This one deals with car wrecks. You have injury. You have family law, criminal law, jail release, traffic tickets, bankruptcy, will and trust, personal injury, board-certified personal attorney. Anyway, you find the one who suits you. You hire that attorney, and you go to court. Eighteen months from now, you might be able to collect some money from some doctor or from some HMO.

Our bill does not work that way. Under our bill, if your baby has a temperature, you pick up the Yellow Pages. I have the Yellow Pages from Arlington and Mansfield, TX. This Yellow Pages lists all the physicians who practice medicine in that area.

Under our plan, you pick up the phone and you call up the physician you might pick. Let's say I pick Louis W. Adams, pediatric ophthalmologist, and I call him up. Under the Kennedy bill, I would have to ask him some questions. I would have to say: Are you a preferred provider? In fact, we did an experiment on that in Washington, DC. Let me show it to you.

In Washington, DC, we took a page out of the phonebook. It was page 1017. These are the physicians who were listed. The first one is Ginsberg, Susan M., M.D., and the last one is Robert O. Gordon.

Let's say you are in an HMO or you are in a PPO, and you call up—let's say you pick Philip W. Gold. You call him up and say: Dr. Gold, I need health care. I have a child who has a 103-degree temperature. Are you in the Kaiser HMO, or are you part of the Blue Cross PPO?

We found that out of the 28 doctors, 10 accepted the Kaiser HMO, 17 accepted the Blue Cross PPO. But let me tell you the amazing revelation we made. With a medical savings account, which any American could set up, under the Republican plan, you would get a checking account. This is from Golden Rule Insurance Company in Indiana. This is a medical savings account checking account. Then this is for a medical savings account that is operated by Mellon Bank, and this is a MasterCard. Then this is an American Health Value medical savings account, and this is operated through Visa.

Under the Republican plan, you would have the right to opt for a medical savings account where you would make the decision about health care for your family. We empower you—not some lawyer, not some bureaucrat—but we empower you as a parent.

So then we called up everybody on page 1017 of the Yellow Pages and we asked them three questions:

Do you take a check?

Yes. Every one of them took a check.

Do you take Visa?

Every one of them took Visa.

Do you take MasterCard?

Every one of them, all 28 of them, took MasterCard.

So the real freedom in the Republican bill is the right for you to choose—not to choose a lawyer to sue somebody 18 months from now, not to call up a government bureaucrat and fill out a form and register a protest. What kind of freedom is that? The freedom we give is the freedom to act, the freedom to hire, the freedom to fire, the freedom to say yes, the freedom to say no. That is what freedom is about.

Our Democrat colleagues believe freedom is about being able to talk to a bureaucrat. They think freedom is about the right to sue.

Under the Republican plan, freedom is the right to say to your HMO: You're fired. I don't like the way I'm being treated here. I'm leaving your HMO. I'm opting for another option. The example I gave is a medical savings account.

Freedom, under the Republican plan, is the freedom to pick up the phonebook and let your fingers do the walking. You pick the doctor: I want John V. Golding, Jr. I don't want anybody else. He is the doctor I want. I got his telephone number. I called him up and said: My mama is sick, Dr. Golding, and I would like her to come see you. Do you take a check or MasterCard or Visa? He says: Yes. I am in.

As this debate goes on, you are going to hear Senator KENNEDY, and others, say: The world will come to an end if you have medical savings accounts. They are going to use the interesting charge they use any time they are against something, and that is it is for rich people. If Democrats are not for something, they claim it is for rich people. Tax cuts are for rich people. Choice, freedom, is for rich people. They are going to say: Oh, the medical savings accounts, rich people will get medical savings accounts and poor people will not have them; it will just be terrible.

The facts are that even though we have a limited number of medical savings accounts that can be sold, even though in the year 2000 they lose this option and have to go back into the old system unless we change the law, the people who are buying medical savings accounts are primarily modest-income people. But we are going to repeal those limitations and we are going to do it this week. Uninsured people are buying medical savings accounts because it allows them to buy an affordable high-deductible policy that covers them against terrible things happening and then lets them build up savings accounts with their employer to pay the deductible.

So those who are going to criticize medical savings accounts are going to say it is for rich people, but they really do not like it because it is freedom. What they want is this. They want the old Clinton health care bill. They know that if we ever give people the right to choose, they will never nationalize health care. So medical savings accounts are, to our dear colleague from Massachusetts, like a crucifix is to a vampire. They cower, they are struck with fear at the idea that some parent would actually have the ability to fire an HMO and do it without having to call a bureaucrat or without having to hire a lawyer.

Why do they fear freedom? Because they are not for it. They want the Government to take over and run the health care system—always have, always will.

The basic question is, Who should manage care? Should it be an insurance company? Should it be the Government? Or should it be you? We believe it ought to be you. We believe that parents ought to be empowered to control health care. We believe that parents can make better decisions.

That is what this debate is about. This debate is about whether freedom means getting access to a bureaucrat or firing your HMO, whether freedom in health care means hiring a lawyer or being able to hire your own doctor. That is what the debate is about.

A final point I would like to make—and I think it is a significant point; some people would say it is a reach, but I do not think so—why, all of a sudden, are our same colleagues who in 1993 wanted the Government to take over and run the health care system and make everybody be in one big Government-run HMO—why, all of a sudden, do they want to drive up costs in the name of expanding bureaucracy and lawsuits?

Part of it is, they like bureaucracy and they like lawsuits. But that is not, in my opinion, the real story. The real story is, if, God forbid—and He is going to forbid, because we clearly have the votes to stop him but if, God forbid,

the Kennedy plan should be adopted, and health insurance went up by 6.1 percent and 1.8 million people lost their health insurance, does anybody doubt that next year Senator KENNEDY would be back with the Clinton health care bill saying: Now 1.8 million people have lost their health insurance, and we have no choice except to let the Government take over the health care system? I think that is what he would say. In fact, I think that is basically what we are debating here: Destroy the private health care system so the only alternative would be Government.

Our answer is: Let's make the current health care system better; let's have a meaningful, timely internal and external appeal if you want to stay in an HMO; let's empower people to fire HMOs and go to the private practice of medicine again if they choose; let's expand freedom as a solution to making our current system work better to make it more efficient and to empower families to make more choices.

The alternative the Democrats have is: Destroy the current system and then let's let Government take over and run the health care system.

Our answer is: Expand freedom and choice within the current system, empower families to decide, and let's forever and ever keep Government out of health care.

That is really the choice. Our Democrat colleagues believe that somehow they are going to benefit by Americans knowing they are unhappy about HMOs and they want to expand your access to bureaucrats and lawyers. We do not think that solves the problem. We think what solves the problem is to make HMOs give you an effective internal and external appeal; but we go one step further, and that is, we empower people to fire the HMO and to hire their own doctor.

We believe in freedom. We believe freedom works. It built America in every other era. Can you imagine if we had a Clinton-Kennedy car insurance bill or car repair bill so that if you are unhappy with your assigned repairman to fix your car, and if you are unhappy with what he does, you contact a bureaucrat and then, if you are unhappy with what he does, you contact a lawyer? I submit that the cost of repairing our cars would be astronomical.

We have a different system. It is one we would like in health care. That is, you pick where you go to get your car repaired, and if you do not like the work they are doing, you say to them, in a traditional American fashion: You are not doing a good job. You have not lived up to our trust. You have not done what you said you would do. And you're fired.

That is freedom. That is freedom. That is what we want. We want the right of people to choose. We don't want this substitute for the right to choose, the right to pile up costs in lawsuits or the right to deal with bureaucrats. What kind of right is that? How many wrongs do bureaucrats right? About one-tenth as many as they create.

We give you freedom. The Democrats give you bureaucracy. We help lower the cost of health care by expanding choices and expanding tax deductibility. They drive up the cost of health care by 6.1 percent. Their bill would deny health insurance to 1.8 million Americans. Their bill would drive up health care costs by $72.7 billion. Senator KENNEDY likes to claim, well, it is just a hamburger a day for however long. Well, with $72.7 billion, you could buy every McDonald's franchise in America for the 5-year cost that this will drive up health insurance.

Senator KENNEDY doesn't understand that if the company you are working for is paying your health insurance and the cost is driven up, you are still paying it. It is part of your wages. What is going to happen, according to estimates that were undertaken by the AFL-CIO—in support of this bill, by the way—is that 1.8 million people will lose their health insurance. We don't want that to happen, and we are going to stop it from happening.

This is going to be a very meaningful debate. I look forward to it. I think people will learn from it. I think in the end they are going to have two different choices about what freedom is.

If freedom to you is access to a bureaucrat and a lawyer, then you are with Senator KENNEDY. If freedom to you is the right to choose your own health care, your own doctor, the right to hire and the right to fire, the right to say what you want and people either do it or you get somebody else, if that is what freedom means in your hometown, if you would rather be able to pick up the Arlington-Mansfield phonebook when your baby is sick and look up ''physician'' rather than look up ''attorney'' or, rather than look in the Blue Pages for HCFA, if that is what you would like to have, you are with us. On the other hand, if you think your answer is at HCFA in the Blue Pages or with an attorney, then you want to be with Senator KENNEDY. It is about as clear a choice as you could possibly have.

When the debate is over this week, not only will we have won the vote, but I think, more importantly, we will have won the debate. We will have ended, hopefully forever, any dream of ever getting back to the Clinton health care bill, where every American is forced into a health care collective and, when your momma gets sick, she talks to a bureaucrat instead of a doctor. They tried that in 1993. Eighty-two percent of the American people thought this might be a good idea. Finally, when a few of us stood up and fought it, it was like sticking a great big inflated balloon with a pin. Suddenly, once people understood it, they were against it. They understood that what was at stake wasn't just health care, but what was at stake was freedom.

That is what this is about—the right to choose. Don't get confused about it, as we go through the debate.

I thank the Chair for its indulgence. I yield the floor and reserve the remainder of our time.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I am very hopeful we will be able to get into the substance of the differences between the approaches taken in the two bills. We heard a great deal of rhetoric, of course, earlier in the afternoon. We have had a brief presentation by the Democratic leader, Senator DASCHLE.

At the outset, one point worth highlighting, as we begin this debate, is that there isn't a single health or medical organization in the United States that supports the position being advanced by that side of the aisle—not one.

This really isn't or shouldn't be a Democratic or Republican debate. Republicans are members of HMOs as well as Democrats. Children are Republicans as well as Democrats. Women who need clinical trials are Republicans and Democrats. Those who have been in the vanguard of protecting women's health issues have been Republicans as well as Democrats. On children's issues, disabled issues, there have been Republicans as well as Democrats.

I cannot remember a single piece of legislation that has been considered on the floor of the Senate in the time that I have been here where you have such overwhelming support for one side and virtually no support for the opposition side—in this case, the Republicans—not a single instance. I made that statement during one of the brief times we had a chance to talk about the Patients' Bill of Rights debate and discussion. It has never been rebutted.

We heard earlier, in the course of the afternoon, about how the Republican proposal is really going to provide for necessary specialty care. Why is it then that every specialty organization in the country supports our bill? We heard over on the other side: Look, we are really giving the consumers a great deal of protection in our bill. Why is it that every consumer organization in the country supports our bill and opposes theirs? Every one, make no mistake about it.

We are in a situation where, as so many of us have seen, special interest groups can pay for and buy just about any statistic they want to buy, and they have done so. They have put out misrepresentations and distortions about our bill. These misrepresentations and distortions about cost are all over the airwaves. We will have a chance later in the course of this debate to address the issue of costs. We will have a chance to make a presentation about what independent studies have concluded about the cost of our particular proposal. Despite the fact that we will introduce and present

these independent studies, do you think that will than alter and change people's minds? Absolutely not. You are going to hear distortions and misrepresentations. You have already heard them over the course of this afternoon.

I was sitting here when our good friend from the State of Maine was speaking about the importance of the types of protections included in their Patients' Bill of Rights. The interesting fact is, their proposal doesn't cover any members of HMOs. Isn't that amazing? Listen to this: It doesn't cover any of the patients of HMOs. That is what brought about all of this concern. We can ask ourselves: Is there a concern today? The answer is yes, and not just because we say so.

I heard talk about the importance of the State insurance commissioners. I ask our colleagues on the other side of the aisle to call their State commissioners and hear about the complaints that we are hearing. Call them this afternoon; call them tomorrow. Call them before we finish this debate and find out: There are two and three and four times more complaints today than there were a year ago or 2 years ago. Those are the facts. You would not know these facts from the earlier debate.

This is a very interesting chart. We know there are 160 million Americans who are covered by private health insurance. On this particular chart, the ''Republican Plan Excludes More Than 100 Million People,'' there are 48 million people covered through self-funded employer plans. That is the total group that is covered by the Republican plan.

There are 75 million people whose employers provide coverage through insurance policies or an HMO—that is what I thought this debate was really all about. They are not protected in the Republican plan. We listened this afternoon to assertions about all the protections included in the Republican plan. But these 75 million people are not protected under the Republican plan. They are not phased in next year or in 2 years. They are out; the Republican bill doesn't apply to them.

State and local government workers, they are left out of the Republican bill. People buying individual policies, some 15 million, are left out. Who are they, Mr. President? They are the small shopkeepers.

They are the farmers and the mom-and-pop stores that have to go out and buy these health plans. They are the one of the most vulnerable groups in our society.

Do you know what was missing in the other side's presentation? The fact that the top 10 HMOs in this country, last year, made $1.5 billion. Isn't that interesting? We see crocodile tears coming from the other side of the aisle about the cost of protecting patients. Then we find out the profits of the major HMOs and the multimillion dollar salaries paid to their CEOs. We hear about the $100 million being spent by the insurance companies to defeat our proposal.

How much is that going to add? Why don't you address that, I say to our friends on the other side. Over $100 million. You know, generally around here—and the American people understand it—you can look at who is for a piece of legislation and who is against it in terms of who will benefit and who will lose out. It is not a bad way of looking at it. Sometimes issues are so complex that the balance is not completely clear. But on this issue, all the health care groups that favor adequate protections are in favor of our Patients' Bill of Rights. On the other side is the insurance industry—one industry, the insurance industry. That is it.

Can we have some explanation by the other side, as we start this debate, about how they justify that? That is the bottom line. It is one industry. The Republican program is the profit protection program for the insurance industry. It is a bill of goods. It is a bill of wrongs. The Democratic proposal is the Patients' Bill of Rights.

So as we start off on this issue, it is our hope, as we have mentioned before, to review for this body and the American people exactly what we intend to do. We have commonsense protections which have been developed over the last decade. What we want to ensure is that any bill passed will at least provide these commonsense protections. Perhaps legislation isn't going to be so all-inclusive as to include every commonsense protection. I hope it will.

These are commonsense protections. You can ask where they all come from? Where did these patient protections that are included in the DASCHLE proposal come from? That is a fair question. We say they come from at least one of four different evolutions. You have the insurance commissioner's recommendations; Insurance commissioners, representing Republicans and Democrats, making recommendations. The President's bipartisan commission made what they call, not majority recommendations but unanimous recommendations. Do we understand that? Unanimously, Republicans and Democrats have said: Here are five or six protections we recommend, and we have included those recommendations.

The only difference is that the bipartisan commission recommended that the protections be voluntary. Well, if every one of the companies complied with that recommendation, we would probably not be here today. They have not complied, and they will not comply. We also include protections included in Medicare and Medicaid, and protections recommendations by the health plans themselves. Those four groups have made the recommendations that are included in our proposal. That is why our bill has the unanimous support of the health professions.

I will not take further time this afternoon. But I will point out, as we start this debate, that no health care debate this year is more important to every family. Yes, Medicare is enormously important. Yes, the issue of medical records privacy is important. Yes, home health care for our elderly is enormously important. There are other important issues concerning basic medical research.

But the issue of health care quality is most important. The issue of whether your child, your wife, your loved one, your family member, receives the kind of health care that well-trained, committed medical professionals, doctors and nurses, who are trained and dedicated to try to provide the best in health care, want to provide, is most important.

This legislation belongs to the nurses of this country, the doctors of this Nation, the cancer researchers, the children's advocates, and to the disabled organizations. Every one of those organizations supports our bill. Over the course of this week we will have an opportunity to address each and every one of these items. Hopefully, the American people will speak through their representatives and the result will be sound patients' protection legislation.

Mr. WELLSTONE addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I will be very brief because we are anxious to get on with this debate. I want to add to the words of Senator KENNEDY.

This debate is a very personal debate for many of us, for both Democrats and Republicans. It is really heartbreaking to sit down with a family and talk to a father whose son was denied experimental treatment for cancer and wonders whether or not his son might have lived if he had been able to obtain that treatment. It is really disheartening to meet with a railroad worker whose wife talks to you about her husband and how he is fighting cancer but how every day she is on the phone battling these insurance companies to find out whether or not they will provide coverage for the treatment.

That is what this debate is really all about. I think that, by the end of the week, it is going to be really clear what the differences are between the two proposals. This Republican bill that is on the floor—the Daschle amendment—altogether covers 48 million people. But for those citizens who aren't working for a Fortune 500 company, who are small businesspeople, family farmers, and others, there is no patient protection. That is a huge difference. There is a huge difference between the 2 proposals of 115 million Americans. The Republican plan doesn't cover the 115 million Americans that the Democratic plan does. Quite often, I don't talk in terms of Democrat or Republican, but here it makes a difference.

Second of all, people are so desperate to make sure that if their child needs to see a pediatric oncologist, or a parent with Parkinson's needs to see a

neurologist, they will have access to that specialty care. The Republican plan does not guarantee that that will be the case. The Democratic plan makes it crystal clear to these managed care plans: Make sure you have those specialists available for people, and make sure that if it is not in your network, they will have access to whoever can provide the best care for their child or their parent.

Third is the question of consumer choice and continuity of care.

This Republican bill on the floor of the Senate, does not guarantee the continuity of care and doesn't give you the right, really even if you have to pay a little bit more in premium, to go outside the network of the managed care plan and take your child or your parents to the best expert or make sure your family members see the best specialist. This is called the point-of-service option.

I will have an amendment that deals with that.

Fourth, I heard my colleague from Maine speak about the appeals process. But, in all due respect, if people are not able to go to an independent, external appeal from these managed care plans dominated by these insurance companies and make sure that those independent panels are not picked by the companies, I don't call that independence.

The Republican plan has the external appeals process controlled and dominated by the very companies that you have a grievance against.

The Democratic plan provides for an independent appeals process backed by an ombudsman program that can help families.

I will conclude because there are other Senators who want to speak.

I think that this debate is all about representative democracy.

I think this debate goes far beyond the issues at hand, although I agree with my colleague from Massachusetts; I think this is the most important debate of our session.

This debate is all about whether or not the Senate belongs to the insurance companies of America or belongs to the people of Minnesota or Nevada or Massachusetts or North Dakota—the people around the country. That is what this debate is all about.

I look forward to debating into these specific amendments. I hope that people in the country will be engaged.

I say to all of my colleagues that I believe people will hold us accountable.

This is an opportunity to do well for people. This is an opportunity to provide families with some protection. This is an opportunity to be willing to stand up against some powerful economic interests—the insurance companies of America that dominate so many of these managed care plans—and be advocates for the people we represent back in our States.

Republicans, no matter what you call your plan—no matter what the acronym is—it is swiss cheese. You have too many loopholes in this plan. You don't provide protection for consumers. The people in Minnesota are not going to be in favor of an insurance company protection plan. They want it to be a Minnesota family protection plan.

That is what I am going to fight for all week.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I yield 5 minutes to the Senator from North Dakota on the substitute.

The PRESIDING OFFICER. The Senator from North Dakota is recognized for 5 minutes.

Mr. DORGAN. Mr. President, we are finally going to have a debate on the issue of the Patients' Bill of Rights. It will not be a debate about theory. It will not be a debate about past proposals for health care reform. It will be a debate about real protections for real people in this country.

We have two plans before us.

One is a patients' protection act that we have offered that has the support of virtually every health care organization in this country.

The other is a piece of paper with a name—just a name, just an empty vessel—that pretends that it provides protection but in fact it doesn't.

Let me describe, if I might, some of the details of these plans. I want to be very brief, but I want to do it by talking about protections for people.

This young boy's name is Ethan. Ethan was born in 1992 after a difficult birth. During his delivery, oxygen was cut off from Ethan, so he was born with significant problems that required special therapy. But the HMO denied the special therapy for Ethan because they said the probability of him being able to walk by age 5—a 50-percent potential of being able to walk by age 5—was insignificant. They called a 50-percent chance of being able to walk insignificant.

So corporate profits take precedence over patients' protection, and Ethan does not get the therapy he needs.

Or let me show you another example. Dr. GANSKE, a Republican in the U.S. House, used this chart to show a young child with a serious facial birth defect, a cleft lip. No one looking into the face of that young child could say that correcting this birth defect should not be done.

Yet Dr. GANSKE did a survey of reconstructive surgeons and found that 50 percent of the doctors who had patients like this have had the corrective surgery denied by HMOs. These HMOs said this procedure was not ''medically necessary.''

Would any parent in the world believe that this is not ''medically necessary''?

Dr. GANSKE, a Republican Congressman from the U.S. House, certainly doesn't believe that. He has been a champion for this kind of patients' protection act.

Here is an example of what a young child with that deformity can look like after reconstructive surgery.

Isn't that wonderful? Is that a ''medical necessity''? You bet it is. Of course, it is. But health insurance only works if patients get what they pay for.

Dr. GANSKE sent something around the other day that I pulled out in preparation for this debate. I want to describe this just briefly because I think it illustrates the difference between an empty vessel with the same title and a patients' protection bill that gives real protection to real people.

At 3:30 in the morning, Lamona Adams found her six-month infant boy, Jimmy, panting, sweaty, and moaning. He had a temperature of 104. So she phoned her HMO to ask for permission to go to the emergency room.

You have to do that, by the way—get permission to go.

The voice at the other end of the 1–800 number told her to go to Scottish Rite Hospital. ''Where is it?'' asked Lamona. ''I don't know—find a map,'' came the reply. It turns out that the Adams family lived south of Atlanta, Georgia, and Scottish Rite was an hour away on the other side of the Atlanta metro area.

Lamona held little Jimmy while his dad drove as fast as he could. Twenty miles into the trip while driving through Atlanta, they passed Emory University Hospital's ER, then Georgia Baptist's ER, then Grady Memorial's ER. But they pushed on to Scottish Rite Medical Center—still 22 miles away, because they knew that if they stopped at an unauthorized hospital, their HMO would deny treatment and they would be left with the bill.

They knew Jimmy was sick, but they didn't know how sick. After all, they weren't trained professionals.

They pushed on to where the HMO said they could stop.

With miles yet to go, Jimmy's eyes fell shut and wouldn't open.

Lamona frantically called out to him. But he didn't awaken. His heart had stopped.

Imagine Jimmy's dad driving as fast as he could to the ER while his mother is desperately trying to keep him alive.

They finally pulled into the emergency room entrance. Jimmy's mother leaped out of the car and raced into the ER with Jimmy in her arms calling, ''Help my baby! Help my baby!''

They gave him mouth-to-mouth resuscitation while a pediatric ''crash cart'' was rushed to the room. Doctors and nurses raced to see if the miracles of modern medicine could save his life.

He was intubated and intravenous medicines were given and he was cardiopulmonary resuscitated again. He was a tough little guy. He survived despite the delay in treatment by his HMO. But he didn't survive whole.

He ended up with gangrene in both his hands and feet, and the doctors had to amputate both of Jimmy's hands and feet.

This is a picture of little Jimmy before his illness, and then afterward. His folks drove past three hospital emergency rooms because the HMO said he had to go to the fourth one miles and miles and miles away. And this young boy has no hands and no feet now because of that.

We have two plans on the floor.

One of the plans, our bill, says that families have a right to the emergency care they need at the nearest hospital.

The other plan says they offer such a right—until you read the fine print. The other side will tell you they have a good plan, but they have an empty vessel.

On the issue of emergency care, little Jimmy, his parents, and others across this country will understand that it doesn't improve care when HMOs are allowed to determine which emergency rooms they will allow patients to stop at to get emergency treatment for these children.

My point is this: We are going to debate theory all week. But it is not theory that is important. What is important is children like Jimmy, children like Ethan, or children like this little boy who has a severe birth defect of the face and was told by an HMO that this deformity need not be fixed.

We know that is not right.

This debate is about profits, patient care, insurance companies, and the rights of patients who are sick.

I think at the end of the day and at the end of this week all of us will see that there are two plans. One is supported by virtually every medical and consumer group in the country because they know it allows real protections to allow doctors to practice medicine—not an insurance accountant thousands of miles away making decisions about patients' health care.

The PRESIDING OFFICER (Ms. COLLINS). The Senator from Oklahoma is recognized.

Mr. NICKLES. Madam President, what is the time situation on the amendment?

The PRESIDING OFFICER. On the amendment, there are 10 minutes remaining for the Senator from Oklahoma and 23 minutes for the Senator from Massachusetts.

Mr. NICKLES. What about the remaining time on the bill?

The PRESIDING OFFICER. On the underlying bill, there are 63 minutes for the Senator from Oklahoma and 80 minutes for the minority.

Mr. NICKLES. I yield to my colleague from Wyoming 10 minutes on the amendment, and if he desires additional time on the bill, I will yield that as well.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. ENZI. Madam President, during the last few months I have patiently watched the minority come to the Senate floor and threaten to hold up the legislative process until they received a full debate and amendment process on the President's Patients' Bill of Rights. On May 25, leaders of the minority put that request in writing by sending a letter to the distinguished majority leader asking for a debate on their bill. That time has arrived. No tricks, no gimmicks. This debate will allow us to determine if the President's bill is everything they say it is.

Last Friday, the President, while in Los Angeles, suggested that by debating his bill the Republicans are trying to hide their plan from the voters. This comment begs the question: Why wouldn't the Democrats want to debate their own bill? Aren't they getting exactly what they asked for?

They asked for it by holding up the agriculture bill. They asked for it by holding up appropriations. Now they have what they asked for. Perhaps they would rather have an issue to talk about—not legislation.

Our presence today and throughout this week clearly illustrates we are not hiding anything from the voters. Who is hiding? My mom can watch this on her television in Sheridan, WY—and she probably is.

We have every intention of offering our bill during this debate. Be assured, the Senate will vote on our bill. We are not interested in hiding. We are interested in showing that we have a better bill. If anyone should be nervous, it is the President. If I had to defend his bill, I would be pretty nervous too.

I am glad we are debating his legislation. Perhaps all the rhetoric we have heard during the last few weeks, and even today, will be replaced with some substance. Sound policy conquers rhetoric. We are confident of this as the debate unfolds. The bill left standing will be our Patients' Bill of Rights Plus.

I commend our leadership for the work they have done to put together our Patients' Bill of Rights. On January 13, 1998, the majority leader created the Republican health care task force, pouring the foundation for a comprehensive piece of legislation to enhance quality of care without increasing the number of uninsured Americans. During the last 18 months, the task force in the Senate Committee on Health, Education, Labor, and Pensions has worked together to make our bill live up to its title—a Patients' Bill of Rights our Nation's consumers and patients can be proud of.

Aside from the title, the scope of the President's bill and our bill is quite different. I agree it is important we explain the difference between the two measures. The amendments Senators offer this week will clearly show those differences. I am proud of our bill's scope. It respects State's jurisdiction. The President's would apply across the board—a nationalized bureaucracy, budget busting, a one-size-fits-all national approach.

I remember the last time this administration pushed a health care package of this size and scope. It was back in 1993 when the President and Mrs. Clinton launched an aggressive campaign to nationalize the delivery of health care under the guise of ''modest reform.'' The sales pitch back then wasn't any different from what it is now, backed with scores of anecdotes illustrated from Presidential podiums across the country. These stories will pull on the heart strings of all Americans and are intentionally aimed at injecting fear and paranoia into all persons covered or not covered by private health insurance.

I am in Wyoming almost every weekend. I am quick to ask my constituency interested in the President's bill to look at the fine print. It is no surprise to me that most of them already have. The American people aren't easily fooled. They haven't forgotten the last time the President and Mrs. Clinton tried to slip nationalized health care past their noses. Anyone can put lipstick on a pig, give it a Hollywood-style debate, and hope for a political slam dunk. Expecting the public to close its eye and kiss this pig, however, is an entirely different matter.

I remember the reaction Wyoming residents had to the 1993 ''Clinton Care'' plan. I was a State senator at the time. I recall how the President and Mrs. Clinton rode a bus across America, promoting their plan to federalize our Nation's health care system. The people of Wyoming also remember the detour they took when they got to the Wyoming border. Instead of entering our home State, they chose a more populated route through Colorado. That was an unfortunate choice. They missed their chance to receive an education on what rural health care is about. Had they driven all 400 miles across southern Wyoming, they would have seen for themselves why federalized national bureaucracy, one-size-fits-all legislation doesn't work in rural, underserved States.

Wyoming has 480,000 people scattered over 98,000 square miles. My hometown of Gillette has 22,000 people—fourth largest in the State. It is 145 miles to another town of equal or greater size, and it isn't even in our State. Many of the people in my State have to drive up to 125 miles one way just to receive basic health care. More important is the difficulty we face in enticing doctors and health care professionals to live and practice medicine in rural areas. I am very proud of Wyoming's health care professionals. They practice with their hearts, not with their wallets.

In a rural, underserved State such as Wyoming, only three managed care health plans are available, and that covers just six counties of our State. Once again, this is partly due to my State's small population. Managed care plans generally profit from high enrollment, and, as a result, the majority of plans in Wyoming are traditional indemnity plans commonly known as fee-for-service. In fact, the vast majority of regulated health insurance in Wyoming is handled by the State.

Some folks might wonder why I am so concerned about the scope of the President's bill if it doesn't affect Wyoming that much. I am worried because a number of Wyoming insurers offer managed care plans elsewhere. Any premium hike spurred by a federalized bureaucracy, national one-size-fits-all bill would be distributed across the board. We would get an increase when

we didn't receive a benefit, thereby causing increases in the fee-for-service premiums in Wyoming. Simply put, my constituents could easily end up paying for services they will never get.

Expecting my constituents to pay more dues to the President's national health care system poses a potential threat to exclude them from health insurance coverage altogether. That is entirely unacceptable. Moreover, it further hinders our ability to keep physicians in Wyoming. If the President's bill passes, it will actually drive down the number of health care professionals we have in our State.

Our Patients' Bill of Rights is not a federalized, national health care system. It stays within the traditional, regulatory boundaries established and already built in by the Employee Retirement Income Security Act, ERISA, of 1974. ERISA applies to self-insured plans, meaning employers who fund their own insurance plans for their own employees—all 48 million. These plans lie outside the regulatory jurisdiction of the States. Since it is the responsibility of the federal government to regulate ERISA plans, our bill stays within that scope.

The President and the Senate minority, however, argue that our bill should apply to all plans and all persons—including those already regulated by the states. Our bill's goal is to improve health care quality through better information and improved procedures as well as rights for consumers and patients, without significantly increasing the cost of health coverage and the number of uninsured Americans. By legislating within the federal jurisdiction of ERISA only—and not usurping state jurisdiction—we accomplish our goal.

Unfortunately, that hasn't silenced the claims made by the President and the Senate minority. These claims are no different than those made by the President and Mrs. Clinton back in 1993. He wants nationalized healthcare—plain and simple. Americans have been down this road before. The states, however, have been in the business of regulating the health insurance industry far longer than Congress or any President. The President wants all regulatory decisions about a person's health insurance plan to be made from Washington. The reason this won't work is that it fails to take into account the unique type of health care provided in states like Wyoming.

While serving in the Wyoming Legislature for 10 years, I gained tremendous respect for our state insurance commissioner's ability to administer quality guidelines and insurance regulations that cater to our state's consumers and patients. State regulation and respect for their jurisdiction is absolutely, unequivocally essential. I firmly believe that decisions which impact my constituents' state regulated health insurance should continue to be made in Cheyenne—not Washington.

You can call Cheyenne and talk to the same person each day, if you need to. But since you can talk to the same person, you do not have to make as many calls. Here you have to spend half of your time explaining to the person the problem that didn't get followed-up on the last time you called. The President and the Senate minority want to crate that all up and ship those decisions back here to Washington.

By advocating federalized, national one-size-fits-all health care, done through a bureaucracy, the President's bill would increase the number of uninsured. Perhaps that's something he wants. We know that the President and Mrs. Clinton prefer a national, Federal health care system in lieu of private health insurance. Their 1993 plan is evidence of that. By increasing the number of uninsured, maybe he hopes that these folks will join him in his campaign for a Washington-based health care system. I sure hope that is not the case, but as long as the President continues to dodge that issue, I am forced to assume that this is his position.

By keeping the scope of this bill in perspective, we also control that cost which directly impacts access. Affordable access to health care is an even higher priority than quality. If it is not affordable, quality does not exist. By issuing federalized, national one-size-fits-all mandates and setting the stage for endless litigation, the President's bill could dramatically raise the price of premiums—barring people from purchasing insurance. That is the bottom line for American families—the cost. We all want as much consumer and patient protection as the system can support. There is not a member in the Senate who does not support consumer and patient protection. But if Americans are expected to pay for the premium hikes spurred by the President's bill, they'll most often go without insurance. That is why we must keep the scope of this bill in perspective.

The President has repeatedly accused the Senate majority of being in the pocket of the insurance industry. I take great offense to that charge. That same blanket claim was also made during the tobacco debate last summer, even though I never took a dime from the tobacco industry. Just last Friday, the President said that we are being captive to the ''raw political interest of health insurers'' and said that our party's leaders had resorted to delaying debate on his plan for cynical political reasons. How does the President respond to claims that his plan was written on behalf of special interests like organized labor and trial lawyers? I'd sure like to get his thoughts on that.

The President's bill would allow a patient to sue their own health plan and tie up state courts with litigation for months or years. The only people that benefit from this would be trial lawyers. The patient, however, would be lucky to get a decision about their plan before their ailment advanced or even took their life. A big settlement does not do you much good if you win because you died while the trial lawyers fiddled with the facts. Folks are not interested in suing their health plan. They watch enough court-TV shows to know how expensive that process is and how long it takes to get a decision made. This is not L.A. Law—it is reality. Our Patients' Bill of Rights avoids all this by incorporating an expedited external appeals process that does not exceed 72 hours. Getting quick decisions saves lives. We insist on a decision before the patient dies!

The President apparently has no problem expanding the scope of federal jurisdiction, but he is silent when it comes to increasing access for the uninsured. Our Patients' Bill of Rights delivers on access. It would increase access to coverage by removing the 750,000 cap on medical savings accounts (MSA's). MSA's are a success and should be made available to anyone who wishes to control his or her own health care costs. Moreover, persons who pay for their own health insurance would be able to deduct 100 percent of the cost if our bill becomes law—equalizing the taxes, making coverage more affordable. This would have a dramatic impact on folks in Wyoming. These provisions would, without a doubt, pave the way for quality health care to millions of Americans without dismantling access and affordability due to federally captured state jurisdiction.

While the President's bill has been pitched as being essential to enhancing the quality of care Americans receive, I hope that my colleagues will carefully evaluate the impact that any federalized, national one-size-fits-all approach would have on our nation's health care system. As I have encouraged my constituents to read the fine print, I also ask them to listen carefully to this week's debate. I hope they'll see for themselves how the President's legislation effects their home state. Rural states deserve a voice, too. Only our Patients' Bill of Rights would provide them that podium from which they can be heard.

Madam President, I yield the floor and reserve the remainder of our time.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I yield 5 minutes to the Senator from New Mexico.

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

PRIVILEGE OF THE FLOOR

Mr. BINGAMAN. Madam President, I ask unanimous consent that Robert Mendoza, a fellow on my staff, and Matt Maddox on my staff be granted the privilege of the floor during the pendency of this bill, and also that same privilege be granted to Ellen Gadbois and Arlan Fuller, fellows from Senator KENNEDY's office.

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

Mr. BINGAMAN. Madam President, I rise to discuss managed care reform, an extremely important issue which we are finally getting to a debate this week. We have an opportunity this week to substantially improve the

quality of life for 161 million Americans, including 900,000 New Mexicans, many of whom have contacted me through letters and phone calls and faxes, telling about their desire for some reform of the managed care system.

Our goal this week seems to me very clear. The American people—and I believe every family who spends their hard-earned dollars on health insurance—need to receive nothing less than the finest of medical care available. We are trying to ensure that through this legislation. That is the task we have set, to guarantee the people of this country critical patient protections.

It is clear the reasons are valid, why we should do this. First, survey after survey reports the American people are demanding the passage of patient protections such as those contained in the Democratic bill that I supported, which Senator KENNEDY offered in the committee. In my State, there are 350,000 New Mexicans who will not have critical patient protections if the bill we pass at the end of this week leaves medical decisions up to non-medical insurance personnel. There are 200 patient groups and health care provider organizations, physicians, workers' unions, and employee groups, that stand behind the need for these patient protections. There are 30 million Americans who have had trouble seeing a specialist, women and children with special needs who either had critical care delayed or, worse, had that care denied. I heard my colleague from Wyoming just now say providing this access to specialized care will dramatically increase premiums.

The statistics are clear. The Congressional Budget Office did an analysis and determined that the increase in premium costs would be, at the most, 4.8 percent over a 10-year period. Providing this specialized care or access to specialists would be a one-tenth-of-1-percent increase in cost, less than $2 per patient per month for the entire array of patient protections about which we are talking. This is a very modest amount which Americans are willing to pay.

Americans who live in rural areas, such as my State and the Senator from Wyoming was talking about his State, have to travel an hour or more to get to a doctor when there is an appropriate health care provider just down the road. We are trying to ensure those other appropriate health care providers also be made available to those patients.

Even if you put aside all of these particular reasons for passing the bill, clearly the main reason we should pass it is that it is the fair thing to do.

There was a very good editorial in this morning's Washington Post which I believe all Members should read. Let me refer to it for a moment. It talks about the managed care debate coming up in the Senate this week. It says:

> The objective is, or ought to be, to legitimize the containment of these costs by giving the public a greater guarantee that the process will be fair. Republicans resist the increased regulation this would entail. In the past they have tried to deflect the bill; now they offer weak legislation that is mainly a shell.

My colleague from North Dakota said the Republican proposal is an empty vessel. The Washington Post says it is ''mainly a shell.''

It goes on to say:

> The stronger Democratic bill is itself fairly modest. Much of it is ordinary consumer protection. Patients would have to be fully informed about the costs and limits of coverage, including any arrangements a plan might have with physicians or other providers that might give them an economic incentive to cut costs. No gag orders could be imposed on physicians to keep them from disclosing the range of possible treatment, without regard to cost. A plan would be required to have enough doctors to meet the likely needs of the enrollees. Patients could not be unfairly denied access to emergency care or specialists. . . .

It goes on:

> The Republican bill professes to provide many of the same protections, but the fine print often belies the claim.

Madam President, the debate is going to be very constructive this week. The distinctions between the Democratic bill, which contains real protections, and the Republican bill, which the Washington Post refers to as ''mainly a shell,'' will be made clear to the American people. I hope very much we will step up to the challenge and pass something that contains some substantive protections for the people of my State. We will have other opportunities to debate specific amendments in the future.

I see the Democratic leader is ready to speak. I yield the floor, and I appreciate the chance to speak.

The PRESIDING OFFICER. Who yields time? The minority leader is recognized.

Mr. DASCHLE. Madam President, I commend the distinguished Senator from New Mexico for his excellent statement and for his leadership on this issue. He has been very much a part of the effort from the very beginning and has lent the caucus and the Senate an extraordinary amount of his expertise on this issue, and we are deeply grateful to him.

AMENDMENT NO. 1233 TO AMENDMENT NO. 1232

(Purpose: To ensure that the protections provided for in the Patient's Bill of Rights apply to all patients with private health insurance)

Mr. DASCHLE. Madam President, we yield back the remainder of the time on the substitute, and I send an amendment to the desk on behalf of the distinguished Senator from Massachusetts, Mr. KENNEDY.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

> The Senator from South Dakota [Mr. DASCHLE], for Mr. KENNEDY, for himself, Mr. REID, Mr. DURBIN, Mr. WELLSTONE, Mr. WYDEN, Mr. REED, Mrs. MURRAY, Mr. DASCHLE, and Mr. CHAFEE, proposes an amendment numbered 1233 to amendment No. 1232.

Mr. DASCHLE. 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 printed in today's RECORD under ''Amendments Submitted.'')

Mr. DASCHLE. Madam President, I yield the floor.

The PRESIDING OFFICER. Who yields time? Does the Democratic leader yield time?

Mr. DASCHLE. Madam President, I yield the remainder of the time to the distinguished Senator from Massachusetts for him to manage.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Madam President, there are several of my colleagues on the floor. As I understand, we have 50 minutes; is that correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. KENNEDY. I yield myself 7 minutes.

PRIVILEGE OF THE FLOOR

Madam President, I ask unanimous consent that David Doleski from Senator WELLSTONE's office and Steven Snortland from Senator DORGAN's office be granted the privilege of the floor.

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

Mr. KENNEDY. Madam President, as we start this debate, there are a series of issues before us. One of the most important and most significant is who is covered under the two different approaches before the Senate. One approach has been advanced by Senator DASCHLE, of which many of us are cosponsors, and the other approach on the other side has been reported out of the Health, Education, Labor, and Pensions Committee. Senator FRIST and the Republican leadership are cosponsors.

In our proposal, we provide that virtually every individual who has health insurance will have the protections included in our bill. Under the Republican proposal, we are finding out that the total numbers covered are only those in what they call ERISA plans. There are 163 million total individuals who have health insurance covered under our bill. The other side covers only 48 million, and excludes 113 million. They are only covering a third of all Americans.

We can ask ourselves: If their proposal is so solid and makes so much sense, why don't they cover all Americans? We heard the principal advocates for the Republicans go on about what good things their particular proposal is going to do. Then why not cover all the people in the country instead of only a third?

They will find out that under their proposed legislation, they do not cover anyone who receives their health care through health maintenance organizations. Isn't it extraordinary that this

whole development, the need for patient protections, is a result of insurance companies making medical decisions in the interest of the company profitability rather than the health interests of the patient? That is the basic reason this whole issue has developed.

Their solution is to advance a program that does not even cover all Americans. I am still waiting to hear why. If their program is so wonderful, as has been stated in the Senate, I still wonder why they are not covering everyone. Can they explain how they justify to people, living side by side, that one will be covered and the other one will not be covered under the Republican plan? They certainly are not covering the 15 million people who are buying individual policies. These are generally small business men and women, farmers, and individuals who are buying individual policies. They are excluded under the Republican plan. State and local government workers are excluded, and the 75 million whose employer provides fully funded coverage, the largest category, are all excluded. Only 48 million are covered under the Republican plan.

I tried to read through every explanation to understand. Then I started to read the proposals advanced in the House of Representatives.

There are five different Republican House proposals. But all the Republican proposals in the House of Representatives cover all Americans. Why is it that the Republican bills in the House of Representatives cover all Americans and over here in the Senate the Republicans only cover a third of Americans? I thought there might be some explanation.

The Democrats cover all Americans. When we say ''all,'' we mean all. When we say ''protections,'' we mean protections. That is what this legislation is all about. We want to make sure we will have the opportunity, over the course of this week, when we are talking about protections for the type of specialty care that a child might need—such as a child who has cancer—that they are guaranteed they will be covered by the protections we have included in our bill.

We want to ensure that all women are going to be guaranteed the protections we have included. We want to make sure that all of those with some type of physical or mental challenge are going to be guaranteed the protections we have included—not just a quarter, not just a third, not just a half, not just three-quarters but all of them.

So I find that on the most basic and fundamental issue, the plans differ greatly. We are all asked: Well, look, Senator, the Republican proposal has emergency protections and you have emergency protections. Can you tell us what the differences are?

The fact is that virtually two-thirds are excluded from the Republican proposal, before we even discuss the loopholes they have written so that their legislation does not provide adequate protections that have the support of the emergency room physicians.

We heard this afternoon how the Republican bill provides protections for emergency room care and specialty care. The fact is that none of those professional groups that are dealing with children every single day and none of the specialists that are dealing with the most complicated cases are supporting their plan. All are supporting our plan.

It is for this reason I would have thought we would be able to bring Republicans and Democrats together. Let's decide whether we really want to deal with the issue. Let's start off this debate on the first day, on Monday, and say: OK, let's go ahead and make sure whatever we are going to do is all inclusive in protecting the children, not only those covered by self-funded employer plans. I do not know how many children in this country know whether they are getting their health care as a result of a self-funded employer plan or whether it is the employer providing the services through insurance programs.

I say, let's deal with children. Let's deal with all the children. That is what our bill does. And that, I believe, is fundamental.

The PRESIDING OFFICER. The time has expired.

Mr. REID. I ask the Senator from Massachusetts to yield me 10 minutes from the bill.

Mr. KENNEDY. I yield that time.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I can remember the first time I went to New York as a young man. My wife and I, of course, traveled the streets of New York. We walked, and there were a lot of fascinating things. But one of the things I will never forget is the people on the streets who were involved in shell games. I did not participate in any of them, but they would try to get people to come. They would move these little markers around. You could never win. No one ever won. None of the people they got to participate in these shell games ever won. I had had enough experience from going to carnivals as a young man not to participate in those games because there are certain games you can never win.

What is happening with the majority is they have a shell game going on. They are here today pronouncing what is so good about their bill. But the fact of the matter is, it is a shell game. Because you pick it up, and what they talk about is never there. The important part of what they are talking about is never there. Pick it up, and it is gone.

What am I talking about? The Senator from Massachusetts has talked about the bill of the Republicans covering only about one-fourth, about 25 to 30 percent, of the people that our bill covers. That is part of the shell game. You pick it up and 75 percent of it is missing.

We are talking about passing a real patient protection act, a bill that covers 161 million Americans, not 25 percent of 161 million Americans who receive health care through some form of managed care.

Our bill is not a bill that omits 113 million Americans. Our bill ensures access to the closest emergency room without prior authorization and without higher costs.

There have been lots of stories told about people wanting to go to an emergency room but having to check first. I participated in an event this afternoon where an emergency room physician talked about what is happening with managed care and how an emergency room physician never has the opportunity, under managed care, to really do what they need to do because of: How did that patient get there? Did they come on their own? Did they get prior approval?

Our bill is not a shell game. As to emergency care, you pick up the shell and under it the Republicans give you nothing. Our bill ensures access to qualified specialists, including pediatric specialists, unlike the Republican bill, a bill that limits access to specialists and does not guarantee that children may see a pediatric specialist.

We live in a world of specialization. When your child is sick, you want your child to go to someone who is a pediatric specialist. Whether it is a pediatric oncologist specialist, whether it is a pediatric orthopedic specialist, you need to be able to take your child to the person who can render the best care. But when you pick up this Republican shell where they talk about ''they get everything,'' and you want a pediatric specialist, it is empty; you cannot get it.

Our bill, the minority bill, guarantees that women may designate their obstetrician/gynecologist as a primary care provider. Why is that? Because that is, in fact, the reality in America. Women go to their gynecologists. That person treats them when they have a cold, when they are sick from something dealing with whatever the cause might be. They look to their gynecologist as their primary care physician.

Under our legislation, it guarantees that women may designate their OB/GYN as a primary care provider. But what happens under the Republican bill? It makes no guarantees and limits this to only a few select women.

Again, you look up and you see this shell game and you see all these promises. You think you are going to score big. You pick up this shell, and there is nothing there for women that guarantees their OB/GYN as a primary care provider.

The junior Senator from Wyoming came to the floor and again tried to move this shell around. What was his shell game? The junior Senator from Wyoming said that this was national health insurance—those bad words: national health insurance. Of course, this

has nothing to do with national health insurance, absolutely nothing. But, of course, this is part of the shell game: We want to frighten people; we want to frighten and confuse people, as the health insurance industry is doing as we speak by spending millions of dollars with false and misleading advertisements.

The insurance industry, as the Senator from Massachusetts pointed out, opposes this legislation. Hundreds of groups support this legislation—hundreds of groups.

I ask unanimous consent to have printed in the RECORD a partial list of those organizations that support this legislation.

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

GROUPS SUPPORTING THE DEMOCRATIC PATIENTS' BILL OF RIGHTS

ABC for Health, Inc.
Access Living.
AIDS Action.
AIDS Law Project of Pennsylvania.
Alamo Breast Cancer Foundation and Coalition.
Alcohol/Drug Council of North Carolina.
Alliance for Lung Cancer Advocacy, Support, and Education (ALCASE).
Alliance for Rehabilitation Counseling.
Alzheimer's Association—Greater Richmond Chapter.
Alzheimer's Association—New York City Chapter.
American Academy of Child and Adolescent Psychiatry.
American Academy of Emergency Medicine.
American Academy of Neurology (AAN).
American Academy of Pediatrics.
American Academy of Physical Medicine and Rehabilitation.
American Association for Marriage and Family Therapy.
American Association for Psychosocial Rehabilitation.
American Association for Respiratory Care.
American Association of Children's Residential Centers.
American Association of Nurse Anesthetists.
American Association of Pastoral Counselors.
American Association of Private Practice Psychiatrists.
American Association of University Women (AAUW).
American Association on Mental Retardation (AAMR).
American Autoimmune Related Diseases Association (AARDA).
American Board of Examiners in Clinical Social Work.
American Cancer Society.
American Chiropractic Association.
American College of Emergency Physicians (ACEP).
American College of Obstetricians and Gynecologists (ACOG).
American College of Physicians (ACP).
American Counseling Association.
American Federation for Medical Research.
American Federation of Home Health Agencies.
American Federation of Labor & Congress of Industrial Organizations (AFL–CIO).
American Federation of State, County and Municipal Employees (AFSCME).
American Federation of Teachers.
American Gastroenterological Association.
American Group Psychotherapy Association.
American Heart Association.
American Lung Association.
American Medical Association (AMA).
American Medical Rehabilitation Providers Association.
American Music Therapy Association.
American Network of Community Options and Resources.
American Nurses Association (ANA).
American Occupational Therapy Association.
American Optometric Association.
American Orthopsychiatric Association.
American Physical Therapy Association.
American Podiatric Medical Association.
American Psychiatric Nurses Association.
American Psychoanalytic Association.
American Psychological Association (APA).
American Public Health Association.
American Society of Clinical Oncology.
American Speech-Language-Hearing Association.
American Therapeutic Recreation Association.
Anxiety Disorders Association of America.
The Arc.
Arc of Washington State.
Asian and Pacific Islander American Health Forum.
Association for the Advancement of Psychology.
Association for Ambulatory Behavioral Healthcare.
Association of Behavioral Healthcare Management.
Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN).
Bazelon Center for Mental Health Law.
Brain Injury Association.
California Advocates for Nursing Home Reform.
California Breast Cancer Organizations.
Cancer Care, Inc.
Candlelighters Childhood Cancer Foundation.
Catholic Charities of the Southern Tier.
Center for Patient Advocacy.
Center for Women Policy Studies.
Center on Disability and Health.
Children and Adults with Attention Deficit Disorder.
Child Welfare League of America.
Children's Defense Fund.
Clinical Social Work Federation.
Coalition of Wisconsin Aging Groups.
Colorado Ombudsman Program—The Legal Center.
Communication Workers of America—Local 1039.
Consortium for Citizens with Disabilities Health Task Force.
Consumer Federation of America (CFA).
Consumers Union.
Corporation for the Advancement of Psychiatry.
Crater District Area Agency on Aging.
Council of Vermont Elders.
Dekalb Development Disabilities Council.
Delta Center for Independent Living.
Disabled Rights Action Committee.
Eastern Shore Area Agency on Aging/Community Action Agency.
Epilepsy Foundation.
Families USA Foundation.
Family Service America.
Family Voices.
Federation for Children with Special Needs.
Florida Breast Cancer Coalition.
Friends Committee on National Legislation.
Friends of Cancer Research.
Gay Men's Health Crisis.
Gazette International Networking Institute (GINI).
General Clinical Research Center Program Directors Association.
Genzyme.
Glaucoma Research Foundation.
Goddard Riverside Community Center.
Health and Medicine Policy Research Group.
Human Rights Campaign.
Independent Chiropractic Physicians.
International Association of Psychosocial Rehabilitation Services.
League of Women Voters.
Lukemia Society of America.
Managed Care Liability Project.
Mary Mahoney Memorial Health Center.
Massachusetts Association of Older Americans.
Massachusetts Breast Cancer Coalition.
Meals on Wheels of Lexington, Inc.
Mental Health Association in Illinois.
Mental Health Net.
Minnesota Breast Cancer Coalition.
NAACP.
National Abortion and Reproductive Rights Action League.
National Alliance for the Mentally Ill (NAMI).
National Alliance of Breast Cancer Organizations.
National Association for Rural Mental Health.
National Association for the Advancement of Orthotics and Prosthetics.
National Association of Childrens Hospitals (NACH).
National Association of Developmental Disabilities Councils.
National Association of Homes and Services for Children.
National Association of Nurse Practitioners in Reproductive Health.
National Association of People With AIDS (NAPWA).
National Association of Protection and Advocacy Systems.
National Association of Psychiatric Treatment Centers for Children.
National Association of Public Hospitals.
National Association of School Psychologists.
National Association of Social Workers.
National Black Women's Health Project.
National Breast Cancer Coalition (NBCC).
National Caucus and Center on Black Aged, Inc.
National Coalition for Cancer Survivorship.
National Community Pharmacists Association.
National Consumers League.
National Council for Community Behavioral Healthcare.
National Council of Senior Citizens.
National Hispanic Council on Aging.
National Marfan Foundation (NMF).
National Mental Health Association (NMHA).
National Multiple Sclerosis Society.
National Parent Network on Disabilities.
National Partnership for Women & Families.
National Patient Advocate Foundation.
National Therapeutic Recreation Society.
NETWORK: A National Catholic Social Justice Lobby.
Nevada Council on Developmental Disabilities.
Nevada Council on Independent Living.
Nevada Forum on Disability.
Nevada Health Care Reform Project.
New York City Coalition Against Hunger.
New York Immigration Coalition.
New York State Nurses Association.
North American Brain Tumor Coalition.
North Carolina State AFL–CIO.
North Dakota Public Employees Association—AFT 4660.
Oklahomans for Improvement of Nursing Care Homes.

Older Women's League (OWL).
Ombudservice.
Opticians Association of America.
Oregon Advocacy Center.
Paralyzed Veterans of America.
Pregnancy Planning Services, Inc.
Physicians for Reproductive Choice and Health.
President Clinton.
Reform Organization of Welfare (ROWEL).
RESOLVE.
Rhode Island Breast Cancer Coalition.
Rockland County Senior Health Care Coalition.
San Diego Federation of Retired Union Members (FORUM).
San Francisco Peakers Senior Citizens.
Service Employees International Union (SEIU).
Service Employees International Union (SEIU)—Local 205.
Service Employees International Union (SEIU)—Local 585, AFL–CO CLC.
South Central Connecticut Agency on Aging.
Southern Neighborhoods Network.
Susan G. Koman Breast Cancer Foundation.
Tourette Syndrome Association, Inc.
United Automobile, Aerospace and Agricultural Implement Workers of America (UAW).
United Cerebral Palsy Association.
United Church of Christ, Office for Church in Society.
United Senior Action of Indiana.
University Health Professionals Union—Local 3837, CFEPE/AFT/AFL–CIO.
US TOO International.
Vermont Public Interest Research Group.
Voice of Seniors.
Voluntary Action Center.
Volunteer Trustees of Not-For-Profit Hospitals.
West Side Chapter NCSC.
Western Kansas Association on Concerns of the Disabled.
Women in Touch.
Y–ME National Breast Cancer Organization.

Mr. REID. This isn't national health insurance. This is something that the junior Senator from Wyoming and others would like you to think is. You can follow these shells. You pick one up, and, of course, again it is misleading. Our legislation ensures access to needed drugs and clinical trials. It is not a bill that imposes financial penalties for needed drugs. Of course, their bill does not guarantee access to clinical trials for cancer patients, among others.

What does this mean? Again, not speculation but facts. We were at an event at 2 o'clock today, and there was a man there whose 12-year-old son last August got cancer. It was a rare form of cancer. During his chemotherapy, the managed care entity suddenly said: We don't cover you. What was he going to do? He wrote numerous letters and called numerous people. In short, by the time the managed care entity finally agreed to cover it and that it was certainly something which was necessary, and by the time his family and friends gathered together to help pay for this, the boy was almost dead, and he died in February, just a few months ago.

Our bill ensures access to needed drugs and clinical trials, not this shell game where you say: Here, my 12-year-old son is sick; I have been told this will cover me. You pick up the shell. It is empty. There is nothing under there. You lose again.

Our legislation prohibits arbitrary interference of HMO bureaucrats. What does that mean? It means that insurers cannot overrule doctors' medical decisions. What we need is a bill that reestablishes the patient-doctor relationship, not one that allows clerks in Minneapolis or Baltimore or Sacramento to make decisions for my friends, relatives, and constituents in the State of Nevada. We want the doctors making those decisions. Our legislation does that. The Republican version does not do that. It is a part of the shell game that shuffles these shells around. People think they have won, but they pick up the shell and, again, they have lost.

The minority legislation prohibits gag clauses and improper financial incentives to withhold care. What does this mean? There are many organizations around the country that give incentives to keep people out of hospitals, incentives to keep people from having certain types of care rendered. Why? Because if they do that, they get bonuses.

Our legislation also prevents HMOs from prohibiting doctors and other medical care specialists from telling patients what is really wrong. They can't be fired if they do so. Again, our legislation is not a shell game. It is not a shell game, as the majority legislation is a shell game. The majority would like you to believe that under every one of those shells you have a winner, but the fact of the matter is, every shell you pick up under the Republican version is empty; you lose again.

The minority bill holds HMOs accountable when their decisions lead to injury or death. There have been people who have talked about how this bill is going to be overtaken by the lawyers. Let me give you a little statistic about medical malpractice cases. In the State of Nevada, since we have become a State, there have been fewer than 40 medical malpractice cases tried by a jury. We became a State in 1864.

I say that HMOs should be treated like everyone else. I went to dinner in Reno a couple weeks ago with a woman who is a manager of a managed care entity. She said: HARRY, I like your bill except for the lawyers. I said: Why should you be any different from anybody else in America? We all have to deal with lawyers. You should, too.

This legislation will not increase costs more than the cost of a cheeseburger and a very small order of fries every month. We can go through a list of people who have indicated that that, in fact, is the case, contrary to what the junior Senator from Wyoming and others have said today.

Madam President, I ask unanimous consent for 3 additional minutes, since the manager is not here. I will take that off the bill.

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

Mr. REID. Madam President, the fact that lawyers are involved will make managed care entities do better work. The history of this is certainly adequate. In the State of Texas, as an example, where they have a Patients' Bill of Rights, it doesn't cover enough people, but it covers some people. By the way, it is a Patients' Bill of Rights that George W. Bush vetoed. They came back and passed another one, and he refused to sign that. He is going around talking, in his Presidential run, about what a great Patients' Bill of Rights they have in Texas. Everyone should understand, he vetoed the bill and refused to sign the second one. The fact of the matter is, the Texas experience indicates that it doesn't increase cost; it just makes the health care entity, the managed care entity, do a better job.

Our bill holds HMOs accountable when the decisions lead to injury or death. This is not a bill, as the Republican bill, that maintains protections for HMOs that injure or kill patients. I was startled today to hear one of the majority talk about how their bill would reimburse costs for somebody who has been aggrieved, whatever the medical care would have been. That is what happens now under HMOs. That is why it makes it so bad.

We want a bill that takes care of patients, a bill that takes care of patients based on doctors' decisions, not clerks' decisions. We want a bill that is more concerned about patients than about profits.

I yield the floor.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. NICKLES. Madam President, I will speak in general on the bill, but I am on amendment time.

Mr. REID. Will the Senator yield for a unanimous consent request?

Mr. NICKLES. Surely.

Mr. REID. On behalf of Senator KENNEDY, the manager of the bill, I ask unanimous consent that the time I used, so there is no misunderstanding, be charged to the amendment and not the underlying bill.

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

Mr. REID. I express my appreciation to the Senator from Oklahoma.

PRIVILEGE OF THE FLOOR

Mr. NICKLES. Madam President, I ask unanimous consent that the list of staff I now send to the desk be granted the privilege of the floor during consideration of S. 1344, the Kennedy-Daschle health care bill.

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

The list is as follows:

HEALTH CARE TASK FORCE

Senate office	Staffer
Brownback	Rob Wassinger
Collins	Priscilla Hanley
DeWine	Helen Rhee
Enzi	Chris Spear
	Raissa Geary

HEALTH CARE TASK FORCE—Continued

Senate office	Staffer
Frist	Anne Phelps
	Sue Ramthun
Gramm	Don Dempsey
	Mike Solon
Gregg	Alan Gilbert
Hagel	Steve Irizarry
Hutchinson	Kate Hull
Jeffords	Paul Harrington
	Kim Monk
	Tom Valuck (fellow)
	Carole Vannier (fellow)
Lott	Sharon Soderstrom
	Keith Hennessy
Nickles	Stacey Hughes
	Meg Hauck
Mack	Mark Smith
RPC/Craig	Michael Cannon
Roth	Kathy Means
	Bill Sweetnam
	Dede Spitznagel
Santorum	Peter Stein
Sessions	Libby Rolfe

Mr. NICKLES. Madam President, I will speak in general about the bill and maybe correct some statements that I believe are factually incorrect. I think it is important to deal with facts.

I have heard a lot of opinions. I heard that the Republican bill that many of us worked together on was a shell. I am kind of offended by that, I mention to my colleague.

First, let me say, when we are considering health care, we should make sure we don't do any damage. We should do no harm. Maybe we should repeat the physicians' Hippocratic oath: Do no harm.

When I look at the proposal of Senator KENNEDY, the Democrats' bill, I see it doing a lot of harm. If that bill was enacted, a lot of people would become uninsured. That is harm. As a matter of fact, it is estimated as many as 1.8 million, almost 2 million, people would become uninsured if we passed his bill. We already have 43 million uninsured Americans. Let's not add to it. Let's not make it worse. Unfortunately, I think that is what would happen.

We shouldn't be dramatically increasing health care costs. That is not going to help solve the problem. Cost is a big problem. We had a little press conference today. We had several self-employed people who said: I can't afford health insurance. One said they didn't have it. One said they barely had it and, if the cost went way up, they would lose it. They would have to cancel it for themselves and their employees. We don't want to do that. That is doing harm. That is doing damage. That is doing damage, frankly, to the best health care system in the world. I am not saying the health care system we have in the country today is perfect. Does it make mistakes? You bet. Can we make it better? Sure we can. Let's do that.

But I don't think we make it better by coming up with a whole laundry list of Federal mandates stacked on top, duplicating State mandates, saying: The Federal Government knows best. Yes, this is going to cost you a lot of money. Oh, yes, Mr. Employer, you can be sued. The employer saying: Thank you very much, but I don't have to provide this benefit in the first place and, if you are going to sue me for it, I will just drop it. I hope my employees take care of their health care needs on their own. I will give them a little money. I hope they do it.

You and I know, in many cases they won't do it. We shouldn't do harm; we shouldn't do damage to the system.

I heard my colleagues, from Massachusetts and from Nevada, say: Well, our bill doesn't cost much. It costs about the cost of a cheeseburger, maybe a cheeseburger and fries.

Let's look at the reality. The Congressional Budget Office says the Kennedy bill would increase health care costs by 6.1 percent. I understand they may amend it to make it 4.8 percent. What people haven't caught onto is, that is in addition to health care inflation that is already in the system. The cost of health care is going up. It is estimated to go up 9 percent, by a national survey of plans by William Mercer. So health care costs are going up 8 or 9 percent. You add another 5 or 6 percent on top of it, that means if we pass the Kennedy bill, health care costs will be up by 15 percent. What if it is 14 percent? I think that is too high. I think if health care costs go up that percentage, you are going to have a lot more people uninsured.

Then what about: Well, it only costs as much as a Big Mac. I have the greatest respect for Senator KENNEDY, but I do not know how good his math is. Let me use some people who are pretty good at math, the Congressional Budget Office. They are not Democrats. They are not Republicans. They're not people who say: Let's come up with some bad information on the Kennedy bill.

They said, Senate bill 6, the Kennedy Patients' Bill of Rights, will increase health care premiums by 6.1 percent, resulting in an $8 billion reduction in Social Security payroll taxes over the next 10 years, an $8 billion reduction in Social Security payroll taxes. The total reduction in payroll over that period of time is $64 billion over the next 10 years. Now, $64 billion in lost wages is a lot more than a Big Mac. As a matter of fact, I think it equates to $355 more per family per year. That is not a Big Mac. That is about $30 a month. That is not $3 a month, or $2 a month, as Senator KENNEDY alluded to. That is about $30 a month. That is a big hit. That means that is $30 less that an employer will have to compensate his employees. Where does that money come from? That is real money. According to CBO, $64 billion over the next 10 years is the cost of the Kennedy bill. Where does that come from? From lost wages of employees. A whole lot of employees say: Thank you very much, Senator KENNEDY, but I want the money. Thank you, but I want to keep my health insurance. Don't price it out.

So I think it is funny, in a way, that I hear it will only cost $2 a month. That is not accurate. CBO says it would cost $355 per year per family. So I mention that, and I think it is important that we use facts. I think everybody is entitled to their own opinion, but they are not entitled to their own facts. The fact is that the Kennedy bill would cost families hundreds of dollars per year and would increase the number of uninsured in the millions.

Right now, there are 43 million uninsured Americans. That equals the population of 9 States—the population of the States that I have in yellow on the chart. If we pass the Kennedy bill, we can add 3 more States, North Dakota, South Dakota, and Wyoming. The entire population of those States would be uninsured. We should not be doing that. Democrats and Republicans, from the outset, should not do any harm and we should not increase the number of uninsured.

Another thing we should not do is increase the complexity of plans. My friend and colleague, Senator DASCHLE sent that to the desk for Senator KENNEDY. He said we need to expand the scope, that the Republican plan only covers 48 million Americans, and we cover 161 million Americans, and those other 100 million Americans have no protections whatsoever.

Well, this chart, compliments of Senator GREGG from New Hampshire, shows you the complexity of the Kennedy plan. Now, this is very graphic, and I am sure anybody looking at it closely would say that looks like a mess. And it is, because what it does it, it says: States, we don't care what you have done. We know better. The Federal Government knows best.

Again, I have great affection and admiration for my colleague, Senator KENNEDY. He has always thought the Federal Government knows best when it comes to health care. He has always supported national health care and thought the Federal Government should write the plan and insist on the benefits. We know best, so States get out of the way. The Federal Government will tell you how to run your health care business. We don't care if you have had experience over the last 50 years in administering insurance, health care, having insurance commissioners, and having quality inspectors. We don't care if you have that. We know better. The Federal Government, HCFA, Health Care Finance Administration, knows better and should be making these decisions.

Under the Kennedy bill, we are going to overlay on top of all the State regulations a Federal-Government-knows-best plan. We are going to dictate that you have all these things. This little chart kind of shows the complexity of it. Health care is fairly complex anyway with State administrations. But this says we are going to overlay, on top of what the States do, complex Federal mandates. States, you must do as the Federal Government decided.

What if there is competition? What if the State has an emergency room provision for their State-regulated plans? We are going to say: We are sorry, but we know better, so you have to comply

with ours. The State says: We think ours is better. But we are going to have to have a Government bureaucrat who knows best. Senator KENNEDY knows best, HCFA know best, the Government knows best.

That is the problem with the Kennedy bill. Unfortunately, in many cases, the Government doesn't know best. There are lots and lots of State mandates, and I pulled out a few on this chart. Forty-two States have a Bill of Rights. My colleague from Nevada said the Texas Governor vetoed a Bill of Rights. I see on the list that Texas has a Bill of Rights. I happen to see that Texas has a total of 42 mandates. Probably many of them—the Senator from Texas says it may be too many. It is probably increasing the cost of health care, but the State of Texas is doing it.

Maybe we are the source of all wisdom. I don't know what the State of Texas has, but is it really in our prerogative and our right to say: Texas, you don't know what you are doing; we know what is best. So whatever you have in your mandates, we are going to mandate something more, something more expensive. We are going to dictate to you. I think that is a mistake.

There is a basic difference in philosophy between Senator KENNEDY and Dr. FRIST, who will be here shortly to discuss this. I might mention, I think the plan we proposed, as far as scope is concerned—we said, let's regulate the unregulated and protect the unprotected. There were a lot of plans that aren't covered by State insurance, and we said those plans should have some basic protections, so we put them in. Those plans weren't covered by the State mandates. That is the reason we put them in there. My Democrat colleagues said they are unprotected, out of luck, as if the States have no role whatsoever. The States don't know what they are doing. HCFA knows better. HCFA is not a cure-all for health care.

Here is an example. On a bill that we passed last year, I have a couple comments. This was in a bill we passed:

> HCFA, as a regulatory authority to enforce consumer protections, stands by the Health Insurance Portability and Accounting Act of 1996. In States that failed to enact these provisions, according to the General Accounting Office, HCFA admits that it has ''pursued a Band-Aid or minimalist approach'' to enforcing these consumer protections. The General Accounting Office also found that HCFA lacks ''appropriate experience'' in regulating private health insurance.

So GAO said HCFA is not doing a very good job. The Kennedy bill says turn it all over to HCFA. We don't think the States are good enough. We are going to turn it over to HCFA and let them do it better. GAO also said that HCFA is doing a crummy job. They should not be trying to regulate insurance throughout the country. They have a big job. What about the health insurance portability bill, the Kennedy–Kassebaum bill? People have been bragging on it. It is interesting to find out that the State of Massachusetts has not yet complied. Five States have not complied. I doubt that that means the State of Massachusetts doesn't care about insurance portability. My guess is that it is probably just as portable in Massachusetts as it is in other States. But they have not met congressional criteria. Therefore, HCFA is supposed to administer their plans. Guess what? They are not doing it. They have not done it. I don't want them to do it; I will be frank. Even though that is a law we have already passed, I don't think Federal regulation of health care in Massachusetts is going to make it any better. As a matter of fact, it might make it worse. I think that might be a mistake.

Look at the number of health care mandates on this chart. My State of Oklahoma has 26. The State of Texas has 42. Florida has 44. States have an average, I think, of 30-some or 40. Again, is it really necessary for us to come in and say: States, thank you very much, we are sure you are well-intended, but we know better. We have decided this, and we have had hearings. Our emergency room provision has to be better than yours. Our access to specialists has to be better than yours. We don't know what yours is, but we know ours is better. A colleague showed pictures and said: Look at this child; he was denied the health care. The plan said it was not medically necessary; therefore, the child didn't get the health care. So we are going to change all the laws of all the States because somebody finds some horror stories.

I have said in the past that there have been mistakes. There always will be. There will be some mistakes. We have to decide what is the best way to solve the problem. Is the solution to the problem coming up with more Government mandates—a Federal Government takeover of health care, which is really, in effect, what the Kennedy Patients' Bill of Rights is. Is that the solution? Or will it make it worse? Look at other countries that have really tried socialized medicine, government-controlled medicine, government dictates from A to Z. Is their health care better or worse than in the United States? It is worse. It is much worse. All you need for evidence of that is people in their states continue to come to the United States for quality health care, including their leaders, and including their top officials. They want to have health care in the United States because we have the best quality health care system in the world.

We need to make sure that we do no harm to that system. We absolutely need to make sure that if we can make improvements on the system, let's do so, but let's not make it worse.

Let's not pass this government-knows-best, one-size-fits-all, Washington, DC, HCFA, you are going to run it, and that we have confidence in the government bureaucrats that we are going to hire, and solve all the problems.

Mr. GRAMM. Will the Senator yield before he gets off this point?

Mr. NICKLES. I am happy to yield to my friend from Texas.

Mr. GRAMM. This is very important. Senator KENNEDY keeps standing up and really setting up the straw man and knocking him down, it seems to me.

I want to pose this as a question.

He is saying this bill covers 160 million people, whereas our bill covers only 48 million people.

But isn't it true that under our bill we cover those that are in self-funded plans where the Federal Government has jurisdiction and where the States don't have the freedom to legislate patients' rights? So we deal with the Federal jurisdiction and allow the individual States to set up their own program. But Senator KENNEDY wants to do the same thing that he did in the Clinton-Kennedy health bill of 1993, and that is to have the Federal Government set mandates even though 43 States have passed their own laws.

Is that not the distinction we are talking about? Senator KENNEDY believes that only he knows anything about this and that the State legislature in Texas does not know anything about health care and doesn't care anything about Texas. But Senator KENNEDY knows about it. In fact, he helped President Clinton do the 1993 bill, which would have put everybody into a health care collective run by the Federal Government—one big HMO very much similar to and with all the compassion of the IRS. But now he says that States aren't competent, even though 43 of them have passed patients' bills of rights. He is trying to preempt those States, whereas I understand our bill simply goes to the people who can't, because of Federal law, be covered by State patients' rights.

Is that correct?

Mr. NICKLES. That is correct. I appreciate my colleague making that distinction.

I have a list of all of the mandates that the State of Texas has. I have a list that says 42 States have a State bill of rights.

I might say that those States might have a more far-reaching bill of rights than the proposal that Senator KENNEDY offers. They may; I don't know. But I happen to think they are probably a lot closer to the people in that State. I happen to think if there are complaints, they are more likely to be resolved favorably by the State regulators than they would be by bureaucrats in HCFA that have no idea of how to regulate health care plans.

That quote that I just read from GAO said that HCFA pursued a Band-Aid or minimus approach to enforcing consumer protections, and that HCFA lacks appropriate experience in regulating private health insurance.

The GAO has already studied HCFA's results, and they have failed. Yet Senator KENNEDY's bill says to States: We want HCFA to regulate their insurance.

I just disagree with that. I disagree with that very strongly.

When I see the pictures of the health care catastrophes where somebody was denied care, or somebody didn't get care, I am very sympathetic to the families. But I don't think they are going to get more protection by turning it over to the Federal Government. I think, frankly, they get less.

Mr. GRAMM. If the Senator will yield further, does the Senator believe that HCFA cares more about the people of Oklahoma than the State representatives—the State senator and the Governor—who may not know the Oklahoma needs the way Senator KENNEDY and HCFA know them?

Mr. NICKLES. I will answer the Senator's question. No, I don't. I don't think HCFA knows the State of Oklahoma. I think HCFA is an organization that has a lot of responsibilities, and most of which are not doing a very good job—most of which haven't done a very good job, frankly, regulating Medicare. They have caused a lot of problems, as the Senator from Maine can attest to, whether you are talking about home health care, or whether you are talking about information to seniors. I know for a fact they haven't given information to seniors which was mandated by law under the Medicare changes in 1997.

I am looking at HCFA. I am sure there are some very good quality people who are very concerned about health care in general. But I don't want to turn over all insurance regulation to them, because GAO says they don't have appropriate experience. Frankly, I don't think they can do it as well. I know they shouldn't be doing it. I think that is a responsibility that can and should be left to the States. The States may make mistakes. Individuals may make mistakes. I want to make sure that I point this out before we see—I am sure—dozens more charts of somebody who was denied care.

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

Mr. NICKLES. Let me finish this point. I haven't made this point just yet. It is important.

We will have countless charts showing somebody who needs a cleft pallet replaced, or somebody who has lost an arm by mistake, or somebody was not treated. Obviously, any lay person would say, Why didn't that person get health care?

If you pass our plan, we were going to see them and make sure they get health care.

The distinction that I want to make is that the bill that we have before us on the Republican proposal is that every health care plan in America has an internal appeal done by a doctor. The internal appeal is done by a doctor. It is done by a physician. If for some reason that physician still determines that it wasn't medical necessary, that physician can appeal it to an outside, independent expert to make the determination of whether or not it was medically necessary, or whether or not the treatment should go forward.

Hopefully that would solve the pictures, or the horror stores that we have seen.

It wouldn't be decided by politicians. It would be decided by an independent expert in that field who has no financial incentive whatsoever and no connection to the health insurance industry—as I heard one of my colleagues say, Oh. Yes. They are bought and paid for. That is not correct.

What we are offering instead of a lot of litigation and the probability that people will be dropping plans like crazy is the chance for people who need health care to get. If they are denied health care coverage, they get an appeal. If their life is threatened, or if it is dangerous, they can get it immediately, and they can get it done by an independent review board. So they get the health care they need—not get a lot of litigation, and not in the process uninsured millions of Americans.

Ms. COLLINS. Will the Senator yield for a question?

Mr. NICKLES. Sure.

Ms. COLLINS. Will the Senator agree that it is absolutely irresponsible to be proposing a vast expansion of HCFA's authority in regulating the private insurance market given HCFA's record, which includes missing 25 percent of the implementation deadlines in the balanced budget amendment of 1997; of taking 10 years to implement a 1987 law establishing nursing home standards; of yet to have updated 1985 fire safety standards for hospitals; when it is utilizing 1976 health and safety standards for the treatment of end-stage kidney disease; when it is shown that it has been unable to handle the responsibilities that Congress gave it under the Health Insurance Portability and Accountability Act?

Is that part of the Senator's concern about taking away the authority from State governments that are doing an excellent job in providing patient protections, and instead relying on the Federal Government and the agency of HCFA to do that job?

Mr. NICKLES. I certain concur with my colleague from Maine that turning the responsibility over to HCFA won't make any improvement. It will make it worse.

I might qualify part of the Senator's statement. I am not sure that States are doing an excellent job in every area. I think they will do a much better job than they would be if it is turned it over to the Federal Government. I think they would be much closer to fixing the problem, and they could fix the problem of the absence of quality. I think they can fix that much, much better than we can by dictating it from Washington, DC.

Ms. COLLINS. If the Senator will yield on one further point for a question, would the Senator agree that the health committee legislation is an attempt to protect the unprotected consumers, to reach out to those health care consumers that the States are prohibited from protecting, and that, indeed, the assertions we are hearing from Senator KENNEDY, our colleague, and others, and that we are leaving more than 100 million Americans completely unprotected is absolutely false because they are protected under State laws that the States enacted without any prompt from Washington, without any encouragement from Washington, and in fact the States are far ahead of Washington in this debate?

Mr. NICKLES. To answer my colleague from Maine, the Senator is exactly right—although I say we protect the unprotected. Even in the State-regulated plans, we make sure all those plans have an appeals process.

ERISA, which is a national law that does deal with fiduciary standards, deals with reporting standards. We make sure there is also an appeals process that covers 124 million people. Maybe our colleagues on the other side forget that. That is a basic process which we think is much better than saying, let's go to court; you were denied coverage, let's go to court and sue. It may be 3 or 4 years and the plaintiff may eventually get something—or the trial lawyer may get most of the money. We say, instead of going that way, let's go through an appeals process. We formulate an excellent internal and external appeals process for 124 million Americans, broad based, for any employer-based plan.

That is a fundamental asset in our plan that will improve quality health care throughout the country.

Ms. COLLINS. I thank the Senator. I certainly agree with his analysis.

Mr. NICKLES. I yield the floor.

Mr. KENNEDY. Mr. President, how much time do we have?

The PRESIDING OFFICER (Mr. HUTCHINSON). The Democrats have half an hour on the amendment.

Mr. KENNEDY. I yield 10 minutes to the Senator from Illinois.

Mr. DURBIN. There was a historic event that just occurred on the floor of the Senate. Those who look through the CONGRESSIONAL RECORD are going to find something truly amazing has just occurred. This debate on health insurance reform started at 1:10 p.m. It wasn't until 3:59 p.m., almost 3 hours later, that the first Republican Senator referred to our amendment as ''socialized'' medicine. Almost 3 hours passed on the Senate floor before the Republicans turned to that old, beat up shibboleth—socialized medicine. That may show there has been some progress. In years gone by, that would have been raised in the first 5 minutes.

However, I think it is important my friends on the Republican side of the aisle, who were supporting the approach favored by the insurance industry, stop and consider for a moment that the world has changed dramatically since we used to simplify debate into terms of socialized medicine and the medical practice that most Americans want.

I say to Senators on the floor for the Republican side, do the Senators not consider it odd, if State regulation—which you are lauding—is so effective, that the American Medical Association is suggesting they may have to unionize across America to deal with these health insurance companies? Isn't it strange, if State regulation and State bills of right for patients are so effective, that over 200 medical organizations and others support the Democratic approach for a national standard of protection for all American citizens? If the States are doing such a great job protecting so many people, why are so many medical professionals unhappy? Why are so many families across America calling our office, writing letters, telling these horror stories which we have recounted on the floor of the Senate and will recount during the course of this week?

There may not be a more important debate on the floor of the Senate this year for America's families. We are going to decide this week whether or not you can count on your health insurance. A lot of people across America can't count on it. When it comes down to the tough time, a 12-year-old boy with cancer, as Mr. and Mrs. Ray Cerniglia discussed this afternoon, they had to fight their HMO. A couple, facing the tragedy of a 12-year-old with a rare, dangerous cancer, summons the courage to deal with it. They go for the best medical help they can find. That isn't enough. Now they have to worry about fighting the insurance company.

The Republican approach is: So what. That's business. That is the way things are.

We on this side of the aisle disagree. We believe, along with the medical professionals in America, that American families deserve better. The Republican approach is an approach supported by one group: the insurance industry. The insurance industry is spending millions of dollars on television ads distorting what this debate is all about.

I heard my Republican colleagues talk about States rights; we should leave it to the States to decide whether or not America's families should have good health insurance protection.

Take a look at what the States have already done:

Twelve States haven't done a thing about access to emergency services. If you have a serious accident in your backyard, you can take that little boy who fell out of the tree and broke his arm to the nearest emergency room and not fumble around looking at your insurance policy, wondering if you will be covered.

Thirty-one States have not enacted laws for independent appeals. If an insurance company denies coverage, you have an opportunity for an independent appeal. The Republican approach is an in-house appeal by the insurance company.

Thirty-eight States have not protected families that want to make certain they have access to the right medical specialists. But the Republican bill is one that doesn't guarantee that right to literally over 100 million Americans.

The list goes on and on.

Many of the Republicans who oppose this plan to protect America's families and their health insurance argue ''States rights.'' It is an old argument.

Senator KENNEDY, Senator DASCHLE, and others have said: Yes, if you bring these new protections into law, as we would like to have for every American regardless of where they live, the cost of health insurance will go up—$2 a month.

I see crocodile tears on the floor of the Senate as they bemoan the increased costs of health insurance policies if we pass our bill—$2 a month. Isn't it worth $2 a month to have access to a specialist when you need it? Isn't it worth $2 a month to know your doctor is giving you the best medical advice and his decision is not being overridden by some health insurance clerk? I think it is worth that and more.

They on the other side argue that our approach is too much government. It isn't empowering government. We are empowering families across America to have negotiable rights with the insurance companies, that they can stand up and say these are our rights, this is for what we stand.

This isn't a right for government. It is a right for families—families in the most precarious situations in their lives, facing the most serious illnesses. That is what we are doing here. We are empowering families and individuals to stand up to these health insurance companies.

We have seen from the letters—I have seen them from Illinois; every Senator has—how helpless people feel when they have someone in their family who is near death and they are sitting there fighting with some faceless clerk at an insurance company, begging for the care their doctor says their little boy or their little girl needs.

We give these families power with this Patients' Bill of Rights. Why the Republicans oppose this, I don't know. I can understand why the insurance industry opposes it. They have a pretty good thing going on. They make the decisions and they can't even be sued when they are wrong. You can't even take them to court.

I had an interview the other day in Chicago. One of the reporters afterwards said: Let me get this straight. We can't sue these health insurance companies when they make the wrong decision? I said: That is right. It is the only business in America that can't be held accountable for its wrongdoing.

Think about their wrongdoing. It is a matter of life and death. A health insurance company denies a basic treatment and someone can die as a result and they wouldn't be held accountable.

The thing that troubles me, too, is the Republicans leave so many people behind. What they call ''our Patients' Bill of Rights'' is an empty promise. Mr. President, 113 million Americans without health insurance—no protection in the Republican bill; no protection in a bill supported by the insurance industry.

Look what it means in some of the States of the Senators who have been on the floor today. I say to the Senator from Oklahoma, 1,574,000 people in Oklahoma are not protected by the Republican bill; 79 percent of privately insured are not protected under the Republican plan. Who are these people? They are farmers. They are self-employed people, wheat growers in Oklahoma.

Look at the State of Maine, the potato growers. Farmers there, 557,000 of them, are not protected by the Republican bill; 70 percent of the privately insured are not protected by the Republican bill. State of Texas: We have heard a lot about big government there, haven't we? Over 6 million residents of Texas are not protected by the Republican bill, 59 percent of them.

Yes, it is true. There is a State Bill of Rights in Texas. Governor George W. Bush vetoed it, and it was overridden by the State legislature. It is on the books. But basically we say everybody in America—Texas, Illinois, you name it—deserves the same kind of protection. If the Republicans had their way, in my home State of Illinois, almost 5 million people would not be protected, would not receive the benefit of the reforms we are talking about in health insurance; 59 percent of those privately insured not protected by the Republican plan.

Who are those folks? Let me show you a picture of some of them. This is my home State, farmers left unprotected by the Republican ''Patients' Bill of Wrongs.'' This is a gentleman I know by the name of Tom Logsdon. His 24-year-old daughter was diagnosed with breast cancer. She has gone through a lot. The Republicans would not protect her, would not protect her family because they are self-employed people. They are farmers. They do not believe there should be this kind of protection for those folks. I disagree. I think these families and families across America deserve the same continuity of care, the same protection. I think, frankly, when you look at the choice in this bill, you can understand why the insurance companies support the Republican bill and oppose the Democratic bill.

Here is the only way we are going to get this bill passed. We have to hope that five or six Republican Senators will break ranks and decide to join us in a bipartisan effort to really provide coverage and protection for people across America. If that does not happen, if this breaks down along partisan lines, we will spend a week in debate and the American people will say: What happened? Nothing will have happened. I hope before this debate is concluded we have that bipartisan support.

I yield the remainder of my time.

The PRESIDING OFFICER. Who yields time?

The Senator from Nevada.

Mr. REID. On behalf of Senator KENNEDY, I yield the Senator from North Dakota 5 minutes.

The PRESIDING OFFICER. The Senator from North Dakota is recognized for 5 minutes.

Mr. DORGAN. Mr. President, I have sat and listened quietly and patiently to the debate over this amendment. I was thinking to myself that, if ever there were an Olympic sport for sidestepping, I surely have seen some gold medal winners this afternoon. The issue in this amendment is, whom does this piece of legislation protect? Whom does the Patients' Bill of Rights protect?

Some people view this debate as a debate between a bunch of wind generators in blue suits, and they do not know whom to believe. So here is an editorial from USA Today—not from Republicans, not from Democrats. The headline of this USA Today editorial reads: ''100 Million Reasons GOP's Health Plan Fails. That's How Many People Proposal Will Leave Unprotected.'' Let me read what it says:

> Judging from the health insurance reform package announced this week by Senate Republicans, at least the title is correct. The proposal is called the Patients' Bill of Rights. If you are waiting for this perfunctory plan to protect you, you'll need to be patient indeed, many of the plan's key protections are restricted to the 51 million Americans who get their insurance through self-insured employer-sponsored plans subject to direct Federal regulation. But another 100 million or so whose health plans are subject to state regulation are excluded.

Again, USA Today says this plan is an empty shell. This plan does not match the needs the American people ought to expect will be met.

I have heard debate this afternoon I would have expected 100 years ago in this Chamber. Back in the years when suspenders and spittoons adorned this Chamber, you would have heard exactly the same debate on every issue. Meat inspection? Let the States do it. The Federal Government should not be involved. Pollution control? Let the States do it. Nursing home regulation? Let the States do it. Minimum wage? The Federal Government should not be involved. That is a debate a century old, and it is old and tired.

The question here is, What kind of legislation are we going to pass that protects American families? Are we going to pass a bill that includes the 100 million people their side leaves out? You were told to be careful of stories about children who tug at your heart because somehow that is not reflective of the whole issue. Jimmy, here, is never going to stroke his mother's face, may never be able to shoot a basket. He has no arms and no legs. Why? Because in the middle of the night when 6-month-old Jimmy was desperately ill, his dad had to drive past the first hospital, drive past the second hospital, drive past the third hospital, in order to get to the hospital they approved for this little boy to get emergency treatment. As a result, he lost his hands and his feet. Our opponents bill does not provide a guarantee that this young boy would have gotten emergency treatment at the first, second, or third hospital. No such guarantee exists in their plan. If it did, it would not apply to 100 million Americans.

They say don't let these stories affect you. That is what this is about. It is about patient care. It is about real people. It is about Jimmy, it is about Ethan, it is about the people I have talked about on the floor of the Senate.

Let me conclude just by pointing out the differences in titles. They brought a bill to the floor of the Senate with the title the Patients' Bill of Rights. That is the same name as the piece of legislation we authored. Ours contains real protections; theirs does not.

Abe Lincoln was debating Douglas, and he could not get Douglas to understand his point. Finally he said to Douglas: Let me ask it this way. He said:

> Tell me, how many legs does a horse have?

And Douglas said,

> Four, of course.

Abe said,

> Now if a horse's tail were called a leg, how many legs would a horse have?

And Douglas said,

> Five.

And Abe Lincoln said,

> No, that's where you are wrong. Simply calling a tail a leg doesn't make it a leg at all.

You can call this proposal that has been offered by the majority party whatever you like, but it does not make it a patients' protection act. As USA Today says in its editorial, if you think you are going to get protection from the Republican patient protection plan, you had better be patient, because it leaves out 100 million Americans. There is a lot of misinformation that has been given on the floor of the Senate today and a lot of sidestepping on the important issues. But I say when this debate is over, do not, as the Senator from Oklahoma suggests, dismiss the concerns and stories that are raised about individual people. After all, the only question really important in this debate is how it affects the individual patients, the men, women, and children who seek treatment in our health care system.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Several Senators addressed the Chair.

Mr. NICKLES. I yield to the Senator from Maine such time as she desires.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, we have heard it again. Once again we have heard the myth that is being perpetrated on the other side of the aisle that the bill approved by the health committee leaves millions of Americans unprotected, completely unprotected. You heard it again. That is simply not true. These Americans live in States that have enacted patient protections very similar to the ones included in the health committee bill to apply to those plans where people truly are unprotected. Those are the ERISA plans, the self-funded plans that the States cannot regulate because of a Federal preemption.

According to the CBO, 80 percent of the U.S. population lives in States with laws guaranteeing access to emergency care; 77 percent of Americans work in organizations offering employee health plans with a point-of-service option. The Kennedy mandates, with direct access to OB/GYN, already exist in States containing almost 70 percent of the population. We know that 47 States have enacted laws to prohibit gag clauses, something we all agree need to be prohibited. Why do we need to duplicate and preempt the good work of the States? Why not build on the good work of the States?

The State of Maine has enacted 35 mandates—35 patient protections. Now, who is to say the emergency access protection of the State of Maine is somehow inferior to the one in Senator KENNEDY's bill, just because it differs from Senator KENNEDY's bill? Who is going to make these determinations? Are they going to end up in court? Is HCFA, by the Federal Government, by fiat, going to decide that Maine's was not quite right, that it should be knocked out, replaced by the Kennedy standard, because Washington knows best? Washington is the source of all wisdom in this?

The opponents of our legislation contend that the Federal Government should preempt the States' patient protection laws unless they are identical to the ones in Senator KENNEDY's legislation. However, the States' approaches to the same types of patient protection can vary widely.

States may have emergency requirements but not the exact same standards as in the Kennedy bill. That is the case with the State of Maine.

Moreover, what if the State has made an affirmative decision not to act in one of these areas because the market in their State does not require it and they are concerned about costs? What if the bill has failed in the legislature or has been vetoed by the Governor? Let me give a recent example from my home State of Maine.

Maine law requires insurance plans to allow direct access to OB/GYN care without a referral from a primary care physician but only for an annual visit. Maine's law also requires plans to allow OB/GYNs to serve as the primary care provider.

Our State legislature recently decided that those current laws, which Maine was the head of the Nation in enacting, provided sufficient access, that they corrected a problem in the

marketplace. The legislature rejected a bill that would have expanded the direct access provision primarily out of concern that it would drive up premium costs.

I note for my colleague from Massachusetts, this decision was made by a legislature controlled by the Democratic Party. This was not some Republican legislature that made this decision, but rather the legislators in Maine were satisfied with the current law and decided not to expand it because they were concerned about the additional costs that would be incurred.

In cases such as this, the Kennedy proposal for a one-size-fits-all model would just simply preempt the decision made by the State legislature. That is why the National Association of Insurance Commissioners supports the approach that was taken in the legislation reported by the Health Committee.

In a March letter to the committee, the NAIC pointed out:

> The states have already adopted statutory and regulatory protections for consumers in fully insured plans and have tailored these protections to fit the needs of their states' consumers and health care marketplaces. In addition, many states are supplementing their existing protections during the current legislative session based upon particular circumstances within their own states. We do not want states to be preempted by Congressional . . . actions.

The letter continues:

> It is our belief that states should and will continue the efforts to develop creative, flexible, market-sensitive protections for health care consumers in fully insured plans, and Congress should focus attention on those consumers who have no protections in self-funded ERISA plans.

That is exactly what our plan would do. I ask unanimous consent that the letter from the National Association of Insurance Commissioners be printed in the RECORD at the conclusion of my remarks.

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

(See Exhibit 1.)

Ms. COLLINS. Mr. President, current Federal law prohibits the States from regulating the self-funded, employer-sponsored health plans that cover 48 million Americans. Our legislation, which is intended to protect the unprotected, to reach those consumers in self-funded plans that the States are prohibited from regulating, would extend many of the same rights and protections to the Americans covered by these plans that are already enjoyed by Americans who are under the State-regulated plans.

The States have been ahead of the Federal Government in this area. They have acted over the past 10 years to correct problems in the managed care marketplace by enacting specific consumer protections. Our bill extends those kinds of protections to those plans that the States cannot reach. We go beyond that, though, when it comes to the procedural protections, the all-important internal and external appeal procedures that are in our legislation. We provide that to all plans across the board. Again, another myth perpetuated by those on the other side of the aisle that somehow our appeals process does not cover these Americans.

We have produced a good bill. It builds on, but does not preempt, the good work of the States. It provides protections to those 48 million Americans whom the States cannot protect. It balances carefully the need to have reforms that ensure that essential care is provided, that no one is denied care that an HMO has promised. It holds HMOs accountable for their decisions. It puts decisions in the hands of physicians, not insurance company executives or accountants and not trial lawyers. It carefully strikes a balance of providing important consumer protections without driving up the costs, as the Kennedy bill would do, in a way that would jeopardize, that would undermine health insurance coverage for millions of Americans.

Mr. President, I reserve the remainder of our time.

EXHIBIT 1

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS,
Washington, DC, March 16, 1999.

Hon. JAMES JEFFORDS,
Chair, Senate Health, Education, Labor, and Pensions Committee, Washington, DC.

DEAR SENATOR JEFFORDS: We are writing this letter in response to some concerns raised by your office regarding the testimony of the National Association of Insurance Commissioners (NAIC) Special Committee on Health Insurance (''Special Committee'') before the Senate Health, Education, Labor, and Pensions (HELP) Committee on March 11, 1999. The hearing focused on the rule of the states and the federal government in enacting patient protections for consumers in group health plans. Specifically, concerns have been raised over the Special Committee's testimony and whether the Special Committee now supports a federal floor.

We understand why the members of the Senate HELP Committee would get the impression from our oral testimony that the members of the Special Committee are supportive of a federal floor. During our testimony we may have implied that the members of the Special Committee would accept a federal floor in any federal patient protection legislation. The members of the Special Committee have not made a determination that a federal floor is acceptable. It is our belief that states should and will continue the efforts to develop creative, flexible, market-sensitive protections for health consumers in fully insured plans, and Congress should focus attention on those consumers who have no protections in self-funded ERISA plans.

Rather, the members of the Special Committee are interested in strengthening the distinction between self-funded ERISA plans, which are clearly outside the purview of state law, and fully insured plans. State insurance departments want to ensure that citizens in their states who are covered by fully insured ERISA plans can still rely on the state to address their questions, complaints and grievances and can still expect the same level of protections already established by the states. The states have already adopted statutory and regulatory protections for consumers in fully insured plans and have tailored these protections to fit the needs of their states' consumers and health care marketplaces. In addition, many states are supplementing their existing protections during the current legislative session based upon particular circumstances within their own states. We do not want states to be preempted by Congressional or administrative actions.

During our testimony, we highlighted our Statement of Principles on Patient Protections (''Statement of Principles''), which were created to assist Congress in developing patient protection legislation. The Statement of Principles highlights the elements that we believe must be included in any patient protection legislation and reflects the NAIC's commitment to consumer protection. We suggested that these principles be used as guidelines in drafting any federal legislation.

The principles are as follows:

Principle 1: Federal legislation establishing patient protection laws should reinforce the ERISA saving clause and not preempt existing state health care consumer protection laws, particularly as these protections apply to fully insured health plans.

Principle 2: Federal legislation establishing patient protection laws should ensure a basic level of protections for all health care consumers, focusing particular attention on those consumers in self-funded ERISA plans who do not currently have such protections.

Principle 3: Federal legislation establishing patient protection laws should preserve the state infrastructure already in place.

Principle 4: Federal legislation establishing patient protection laws should ensure that all health care consumers, whether under fully insured or self-funded plans, have access to an appropriate regulatory body for answers to their questions, complaints and grievances.

Principle 5: Federal legislation establishing patient protection laws should establish an appeals process to resolve disputes and enforce decisions for those consumers, such as those in self-funded plans, without access to such a process.

The members of the Special Committee appreciate the efforts of Congress to provide patient protections to all consumers, and we offer the above principles as guidelines in developing such legislation. In doing so, we urge Congress to focus its legislative activity on consumers in self-funded ERISA plans, which are under the federal government's exclusive jurisdiction, and to preserve the state protections that already exist for consumers in fully insured ERISA plans. Again, we have not endorsed the concept of a federal floor with regard to patient protections.

On behalf of the members of the Special Committee, we would like to thank you for the opportunity to testify before the Senate HELP Committee and for the opportunity to clarify our position. If any members of the NAIC can be of further assistance, please feel free to contact Jon Lawniczak at (202) 624–7790.

Sincerely,

GEORGE REIDER, Jr.
President, NAIC.

KATHLEEN SEBELIUS,
Secretary-Treasurer, NAIC.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, we have 15 minutes left; is that true?

The PRESIDING OFFICER. The Senator is correct.

Mr. REID. I yield 7½ minutes to the junior Senator from North Carolina and 7½ minutes to the senior Senator from Rhode Island.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. I thank the Chair.

Mr. President, I will briefly respond to the remarks by Senator COLLINS from Maine, for whom I have tremendous respect. She and I have worked together on a number of issues. I know she believes deeply in the cause she advocates this afternoon. I have great professional and personal respect for her. This is an issue on which I happen to disagree with her for a number of reasons.

First, she suggests their plan—the plan she is referring to I assume is the Republican plan—is one that adequately protects patients' rights because of laws enacted in States across the country. If that is so, why is there such an enormous public outcry for reform? The American people believe deeply that patient protection legislation is desperately needed across this country. If these laws already exist and are already in place and are working, why in the world does anybody need to do anything? The reality is that these laws are not in place and they are not working. Let me give a few examples.

For example, access to clinical trials, which is a critical component of our bill: 47 States of the 50 have no provision for access to clinical trials.

External appeals, which are absolutely essential: 32 States have no provision for independent external appeals.

Access to specialists: 39 States have no provision allowing people to designate a specialist as their primary care provider, and 36 States have no provision for standing referrals to specialists.

Continuity of care: 30 States have no continuity of care provisions.

This list goes on and on.

The reality is, No. 1, that the majority of States have none of the protections we are talking about in the Democratic Patients' Bill of Rights. That is the reason there is an enormous public outcry. That is the reason we have a health care crisis in this country today, and it is the reason I respectfully disagree with my colleague, the Senator from Maine.

The second reason is, to the extent a State has passed any kind of patient protection legislation and that legislation conflicts in any way with ERISA, it is preempted. It is absolutely preempted, under existing law, if we never pass anything. Even the laws that have been passed, to the extent those laws conflict in any way with the existing ERISA statutes, are preempted by ERISA.

The bottom line is this: No. 1, if State laws adequately dealt with this problem, we would not have the public outcry, the horror stories which we have heard and will continue to hear in this Senate over the course of the next week.

No. 2, the fact of the matter is, to the extent those laws exist—and they do not exist in the majority of States on the critical issues—to the extent they do exist, they are preempted by ERISA.

I do want to mention one other thing on the issue of cost because there has been a lot of discussion about cost from the Senator from Oklahoma and the Senator from Maine.

First of all, it is critically important to recognize that to the extent we get a patient to a specialist soon, and we do that in our bill, to the extent we allow women to go directly to an OB/GYN as their primary care provider, to the extent we allow patients who are in a critical emergency to go the nearest hospital and be seen by an emergency room department or physician and thereby save that patient's life or reduce the amount of long-term care that patient receives—in every one of those instances we are reducing long-term health care costs in this country.

So I want us to recognize, first, that to the extent we are talking about increased costs, they are only talking about short-term costs, not long-term costs. The truth of the matter is that long-term costs will be reduced by passage of the Patients' Bill of Rights for the very same reason that preventive medicine reduces health care costs in this country, because we are going to get folks to the doctor they need to see sooner; they are going to get the care they need quicker.

The net result of that is that they do not need the ongoing, chronic, long-term care that many patients, unfortunately, have to get because they do not see the physician they need to see as quickly as they need to see them. That is what the external review process does. That is what the internal review process does.

I might add, those two things work in concert with the fact that, under our bill, an HMO can be held accountable in court for what they do. I want the American people to recognize what happens when an HMO cannot be held accountable, when they are treated as a privileged entity. And under existing law they are a privileged entity. They, among all the businesses and corporations and individuals in this country, get special treatment, treatment that none of our families or our children or our small businesses get. They are all held completely responsible. But HMOs, for some reason, are above the rest of us. They are a cut above the rest of us. They get special treatment. They cannot be held accountable in court.

So what happens when an HMO makes an arbitrary and capricious decision and a child suffers a serious injury as a result and has a lifetime of medical care in front of them—for example, a 7-year-old child? If the HMO can be held responsible, the HMO bears that cost, as well they should bear that cost because they are responsible for it.

But what happens if the HMO does not bear the cost? We know where the cost goes. It goes to us. It goes to the American taxpayer. Because those kids do not have the money to pay for chronic, long-term care over the course of their lives. They are paid out of Medicaid. They are paid with taxpayer dollars. The net result of that is that the cost an HMO or a health insurance company would bear has been shifted to the American taxpayer. That is wrong. We know it is wrong. That is one of the things we are trying to do something about in this bill.

I have to add one other thing. The Senator from Oklahoma said over and over during the course of his argument that what our bill proposes is that the Government knows the answer, that the Government has the solution. My response to that, with all due respect, is existing law and the bill of the other side would say the HMO has the answer, the health insurance company has the answer.

I say to the American people, and to my colleagues, we have tried that. We have tried leaving this in the hands of the HMO. We have tried leaving it in the hands of the health insurance industry. And it has not worked.

With that, I conclude by saying I think it is critically important that we cover all Americans, that all Americans are covered by health insurance plans. That is done under the Democratic bill.

The PRESIDING OFFICER. The time has expired.

Mr. EDWARDS. Thank you, Mr. President.

Mr. CHAFEE addressed the Chair.

The PRESIDING OFFICER. The Senator from Rhode Island is recognized.

Mr. CHAFEE. Mr. President, one of the key issues in this debate is the scope of the provisions; that is, should patient protections we are debating apply solely to those 48 million Americans enrolled in the self-insured ERISA plans or should they apply to all privately insured Americans? Obviously, there can be varied views on this subject, as we heard from the Senator from Maine, the Senator from Oklahoma, and otherwise on the floor today.

In 1996, through the Kassebaum-Kennedy law, Congress passed reforms to the private health insurance marketplace with respect to portability. In my opinion, we should use the same framework used then with respect to scope and effect on State law. Thus, we should establish, I believe, a minimum floor of Federal protection for all 164 million privately insured Americans, not just those 48 million enrolled in self-insured ERISA plans.

I see no reason for narrowing the scope of the patient protections in this next and far more consequential area of reform. Protections as critical to patients as the right to a specialist when needed should apply to all Americans, I believe.

Some of my colleagues argue that it is the individuals only in the self-insured plans—those completely out of State reach—who should benefit from these Federal protections. While it is true that States do have the authority

to legislate patient protections for these other plans, that alone, I believe, is insufficient reason to deny these basic quality improvements and safeguards to all 164 million Americans in privately insured plans. Such a system would, in my judgment, create many unnecessary and inequitable circumstances for consumers and exacerbate the already unlevel playing field which exists in the health insurance marketplace.

Congress has recognized the need for minimal Federal guarantees regarding health insurance in several instances. I think this is very important to note. For example, in addition to the portability protections included in the Kassebaum-Kennedy bill, all Americans have been granted protections for continuation of care under the so-called COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985. They have been given this protection in mental health parity. They have been given this protection in maternity lengths of stay. They have been given this protection just last fall when we passed the breast reconstructive surgery protections. And we extended that to all Americans; we did not restrict it just to the self-insured under the ERISA plans.

Republicans and Democrats alike continue to recognize the need for Federal protections that apply to the entire health insurance market. The generic nondiscrimination provisions of S. 326 would apply to plans beyond the self-insured ERISA plans.

Where is the logic in creating Federal protections applying to the entire health insurance market regarding these aspects of health insurance but not patient protections as fundamental as access to external appeal or emergency services?

Furthermore, as with many other limited preemption laws on the books, this approach would not preempt equal or stronger patient protections which have been adopted by the States.

Look at this list. These are not health matters. These are environmental matters. They are consumer and other statutes. They start with the Clean Air Act. All of these statutes provide a floor of Federal protections that the States can and, in some instances, do go beyond.

The Federal Government has come in, in all these instances, and said: This is a floor—Toxic Substances Control Act, Safe Drinking Water Act. If you in the State want to go further, fine, go ahead, but these are the minimals you have to do. That is what we are suggesting presents a real problem in the legislation that has been reported and then discussed by the Senator from Maine and the Senator from Oklahoma.

It is critical that the protections we adopt this week in the Senate apply to all Americans, including those with plans regulated by the States because State protection is extremely spotty. One justification for applying privacy protections to the entire health insurance market is that there is not a complete body of State law on privacy. For example, it is likewise true with respect to patient protections. Considering only a few of the most important patient protections, only 15 States have adopted an external review procedure and only 13 States have adopted standing referrals to specialists.

It is important to note that by not covering all Americans, many of the most vulnerable insurance customers will be left with no protection. You go out to buy a policy. You do not have employee benefit managers; you do not have somebody to look after you like that; and you are at the mercy of the insurers making decisions based solely or primarily on cost considerations.

To summarize, all Americans, I believe, should have these basic protections regardless of whether the plan they are in is regulated at the State or Federal level. In fact, most Americans probably do not know who is responsible for regulating their plan and should not have to worry when they are sick as to who is the regulator and what protections they have as a result. They should have the assurance that however their plan is regulated, it will provide them the care they need according to the most basic and commonsense principles.

I thank the Chair.

Mr. FRIST addressed the Chair.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Mr. President, how much time do we have on this side?

The PRESIDING OFFICER. Fifteen and a half minutes.

Mr. FRIST. Mr. President, I yield myself 10 minutes.

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

Mr. FRIST. Let me just say at the outset that I, for one, am very glad that we are on this bill, the Patients' Bill of Rights. It is a bill that is terribly important to the American people. All of us know, as we conduct our town meetings around our various States, that we have a real problem today in that today's problem is reflected in the feeling of helplessness by patients, helplessness by physicians, helplessness by other providers when it comes to managed care. There are reasons for that.

As my colleagues know, I am a physician and was involved in the practice of medicine and training for about 20 years where every day—before coming to this body—I took care of many patients, thousands of patients, well over 10,000 patients, and the changes have been tremendous over the last 20 years as we look at how health care is delivered and the reasons for it.

Right now our society, our country is caught up in a rapidly changing health care system. In all those changes and in that evolution, many challenges have been introduced. Part of our responsibility as Senators, as trustees to the American people, is to make sure that we very gently, but in many ways very firmly, make sure these challenges are faced in a systematic way, such that a patient—again, I come back to patients. We are going to hear about cost and about managed care companies and health maintenance organizations and trial lawyers and costs going up and big budgets. I hope throughout this week we will come back again and again to patients. Patients have to be at the center of this debate.

When we talk about patients, we are talking about a Patients' Bill of Rights, a bill of rights that patients can expect when they are dealing with the health care system and with managed care and with HMOs. We also need to be talking about the quality of care that is delivered. We need to be talking about access and not ever forget about the 43 million people who don't have health insurance.

For the most part, people say: Well, let's deal with the people who have insurance, group health insurance with managed care plans. Let's make sure their rights are protected. In doing that, let's not forget that there is a whole group of people over here, 43 million people—too many people, inexcusable, I feel—who don't have any health insurance at all, making sure that when we fight for the rights of the people who do have health insurance, we don't want to drive more people to the ranks of the uninsured, who don't even have insurance in the first place.

When we talk about the Patients' Bill of Rights, whether it is the gag clause or access to specialists or scope of the plan, let's not forget that we are talking about individual patients. In trying to get rights to one segment, let's not go so far or too far in all the anger that we feel against managed care that it drives up the ranks of the uninsured.

Why is this access issue important? We know—studies document it again and again—that in America, if you have some health care insurance, the health care system does open up to you broadly. If you have no health care insurance at all, it is less likely that that health care system will open up to you broadly. So the last thing I think we want to do in this body is take rights to such an extreme that we drive up the number of uninsured, recognizing that access is a huge problem, a huge challenge for our country.

When I first started 20 years ago in the field of medicine, it was very different. The practice of medicine was basically straight out fee for service. Very few physicians were in groups. They were practicing by themselves. They had full autonomy. They were making a very good living, basically went to medical school and worked very hard. They had professional ethics of ''do no harm,'' all of which continues today, except the system around them has changed dramatically. Managed care 20 years ago was tiny. Today, managed care, coordinated care, health maintenance organizations, if you look

at the overall, nongovernment coverage is the majority of care that we give. And as a product of that, we have this pendulum which has swung back and forth over time. It is true—that is why we are debating this bill today—there is no question that that pendulum has swung way over towards managed care and away from individual patients, individual people who need that care, who will go to bed tonight worried that if they have a heart attack tomorrow, will they be taken care of appropriately, will they have access to the emergency room, will they have access to the appropriate specialist. That is where this whole Patients' Bill of Rights comes in because over the last 5 years or 10 years that pendulum has swung way in the favor of managed care.

Now, I believe we are going to hear a discussion over the next week of how we can best get that pendulum back to the middle and have that balance between patients and physicians on the one hand and managed care on the other.

One of the objectives I would like to see as we go forward in a very rational way, after we cut away all the rhetoric, going at each other and the hot debate, is to come back and say: Let's keep our eye on the ball. The ball is the patient who is in this system of managed care, and not physicians and trial lawyers and lawsuits, and make sure we say that they are going to get the very best care. If anything is going to happen to them, they know they will have certain rights in this evolving, changing world.

It has gotten to the point that it is not just anecdotal, but some managed care, some health maintenance organizations have garnered so much power, so much control that they have abused the system. The whole accusation that some HMOs are in the business of practicing medicine is hard to argue against. I think one of our objectives needs to be to make sure that we don't have insurance companies or managed care companies or HMOs practicing medicine. In other words, get that pendulum back to that patient, to that decisionmaking through that doctor-patient relationship.

On the other hand, I think it is irrational to assume that we will go back 20 years and not have managed care, not have coordinated care, not have health maintenance organizations. That being the reality, we want to have a strong Patients' Bill of Rights that looks to those patient protections that empower the patient, empower the American citizen, empower the physician and bring that pendulum back over to that doctor-patient relationship, to keep the patient in charge.

We have on the floor now a Democratic bill, a Republican leadership bill, and we have one amendment talking about the scope. We will need to come back to talk a little bit more about scope because it is one of the important issues where there is a sharp dividing line. We will hear words like ''medical necessity,'' the issue of scope, of medical specialists, but amidst all of that, let's come back to the patient.

Let me speak to what is in the Bill of Rights Plus Act, which is the Republican bill which is now on the floor, in terms of scope. Scope really means who is being covered. Does this bill cover just a targeted population, the whole population, a part of the population? You can almost look at it as a pie chart in your mind.

There are a number of provisions in each of these bills. You have to go through each of the provisions when you are talking about scope.

When we talk about the issue of comparative information in the Republican leadership bill, all group health plans would be required to provide a wide range of comparative information about health insurance coverage so that the individual patient knows what is covered and what is not covered, what that relationship is, what they have actually signed, what that contract is about, what the network descriptions are, what the cost-sharing information is. The scope is complete, all 124 million people in the Republican bill are covered by that particular provision, the information.

When we look at what I think is fundamentally the most important mechanism by which we are fixing the system, getting that pendulum back over in the middle between managed care and the patients and the physicians, it is the whole process of accountability, the grievance and appeals process, the internal review process, the external review process. Over the next 4 days, we will be talking a lot about how these appeal processes work.

If you look at the way health care is delivered, I do believe this is one of most important provisions in the Patients' Bill of Rights. Both bills address grievance and appeals, but I want to make it very clear, in terms of the Republican bill, that the scope is complete, with all 124 million Americans covered. The scope is complete. All group health plans would be required to have written grievance procedures and have an internal review process. So if you have a patient who disagrees with the coverage from the plan, or a doctor and a patient who disagree with a plan, they will have someplace to go in an internal review process. If they don't like what the internal review process says, if there is disagreement on coverage between the doctor, the patient, and the plan, they can go outside the system to an external review process.

Now, what I like very much about our plan, which I think is very important, is that our external review process has a physician in charge. It is not an insurance company; it is not a trial lawyer; it is not a bureaucrat. It is a medical—I will use the word—''specialist,'' if necessary, in that field who is independent of the doctor, the patient, and the plan.

Remember, that external appeals process all started with a disagreement on coverage; you have gone through the internal appeals process, and now you are outside. You go through an external appeals process and that person also is independent.

So we have an internal appeals process, and then we have an external appeals process, where you have an independent physician reviewing the coverage and making the decision. In addition, that independent medical expert makes the final decision on coverage—not a trial lawyer somewhere, not a court, not a lawsuit, but an independent medical specialist makes the final decision on coverage. That decision is binding; it is binding on the plan.

Therefore, we aim at the heart of what I think is broken today; that is, if there is some sort of disagreement, if the managed care is taking advantage in some shape or form of an individual patient or individual physician, we have an independent medical expert making the final decision, not some statute written here in the Congress, not some definition that we try to give it if we try to define ''medical necessity'' in statute, but somebody who is independent and outside of the system.

I mention that because when we are talking about scope, all 124 million people in plans are covered, not a segment. It has nothing to do with ERISA, and non-ERISA, and State-regulated, and Federal-regulated. All 124 million Americans are covered by both self-insured and fully insured group health plans. All 124 million Americans are in there.

Again, when we talk of scope and about the information components of our bill, everybody is covered. What I think is much of the heart and guts of this bill is the accountability provisions, the accountability of managed care, the accountability of coordinated care. Everybody is covered, all 124 million people.

Now, in our bill, we also have an important component on genetic information. As we all know, the human genome project has been tremendously successful. We have 2 billion bits of information coming out in the next several years and, with that, we raise the potential for insurance companies, or managed care companies, to use that information to discriminate against a patient. In other words, if a patient had a test, and there was an 80-percent chance that a patient would develop cancer, and that information were to get out, an insurance company might say: We are not going to insure you. That is interesting information so we are going to raise your rates.

We are not going to let that happen. That provision in our bill—which is not in the Democrats' bill—basically covers everybody. Scope is complete.

Now, the one area where scope is targeted in a particular area is what we call the consumer protections, patient protections. That is the gag clause, the access to specialists, the prudent layperson access to emergency rooms, and the continuity of care.

Mr. President, do we have 1 minute remaining?

The PRESIDING OFFICER (Mr. BROWNBACK). That is correct.

Mr. FRIST. Mr. President, I will yield 30 seconds to my colleague, Senator ENZI. Let me notify my colleague that he will have more time than that. Instead of yielding now, I will yield to him in about a minute.

Mr. President, do we have 30 seconds left on the amendment?

The PRESIDING OFFICER. The chairman will be recognized for 30 seconds.

Mr. FRIST. Mr. President, the last area, in terms of focus, where the scope narrows down, is that for the specific patient protections we cover the 48 million people. Why? Because they are not covered. They are not regulated by the States, and that is why we target that population.

The PRESIDING OFFICER. The Senator from Tennessee has 30 seconds remaining.

Mr. FRIST. Mr. President, I yield the floor.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, I yield myself 3 minutes on the bill.

The PRESIDING OFFICER. The Senator is recognized for 3 minutes on the bill.

Mr. KENNEDY. Mr. President, I am not going to take the time right now. I was waiting for my good friend, Dr. FRIST, to be able to get into the questions of scope. I was waiting for Dr. FRIST to and answer why the protections included in our legislation—for example, the guarantees for emergency room care, the access to specialists who might be necessary to care for a sick child, the formulary protections that were included in our legislation, should not apply to all Americans. I was waiting to ask Dr. FRIST why the Republican House of Representatives bills protect 124 million Americans, while the Senate Republican legislation falls woefully short on those particular protections.

I hope in these next few days we come back to what this whole debate is about, the commonsense protections that are included in this bill. That is what is important. Are we really going to have the protections necessary to guarantee the prudent layperson's judgment is used in determining whether emergency room treatment is covered? Are we going to have that? Are there going to be real protections, or are we going to have in the fine print something that effectively creates a loophole? Let's get to addressing that issue.

Let's start talking about guaranteeing access to clinical trials, which are so important to women who have cancer. Clinical trials may be the only option for saving their lives—yet their medical doctor says this is in your best interest but the HMO says no. That is what this legislation is about.

The information that the Senator talked about is all very valuable, but what this is about is clinical trials. Their particular proposal requires a study of this particular provision. There isn't a clinical researcher out there, or I daresay a member of the National Cancer Institute at the NIH, who does not support the importance of clinical trials. That is what is at the heart of this. Those are the kinds of protections we are talking about here. Are we going to make sure we will finally have the accountability that is so important to assure that plans are really going to be serious in guaranteeing good quality health care?

Mr. President, on behalf of my colleagues, Senators GRAHAM and others, is it in order for me to send an amendment to the desk?

The PRESIDING OFFICER. Until the time has been used or yielded back on the first-degree amendment, a second-degree amendment is not in order.

Mr. KENNEDY. Mr. President, how much time remains on the first-degree amendment?

The PRESIDING OFFICER. There are 30 seconds on the Republican side and a minute and a half on the Democrat side.

Mr. KENNEDY. Mr. President, I yield our time.

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

The PRESIDING OFFICER. There is not sufficient time to suggest the absence of a quorum.

Mr. FRIST. Mr. President, I yield 10 minutes to Senator ENZI to speak on the general debate time.

The PRESIDING OFFICER. The Senator from Wyoming is recognized for 10 minutes on the general debate time.

Mr. ENZI. Mr. President, I am sorry that in my absence from the floor for a few minutes there was some exception taken to the comments that I made about the Democrats' proposal for this one-size-fits-all, budget-busting Federal bureaucracy bill.

I am pleased now to return to be able to talk a little bit more about States rights and to support the scope of the Republican amendment.

Among the handful of principles that are fundamental to any true protection for health care consumers, probably the most important one is allowing States to continue in their role as the primary regulator of health insurance—not a Federal bureaucracy.

This is a principle which 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. And, as if we need to re-learn this lesson yet again, it is usually for the best when we let each state respond to the needs of its own consumers.

As recently as this year, this matter of 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. But, 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's about a mandate that I voted for and still support today. You see, unlike in 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. So, we passed an any willing provider law that requires health plans to contract with any provider in Wyoming who's willing to do so. While that idea may sound strange to my ears in any other context, it was the right thing to do for Wyoming. But I know it's not the right thing to do for Massachusetts or California, so I wouldn't dream of asking them to shoulder that kind of mandate for our sake when we can simply, responsibly, apply it within our borders.

An extra, unnecessary layer of mandates, whether they be for certain kinds of coverage or for a protection that not everybody needs or wants, are so-called ''protections'' we simply shouldn't force people to pay for. If we were all paying for skin cancer screenings that only a few of us need or want, or if we were all paying for any willing provider mandates that only some of us need to assure access, then we'd all be one of two things—either over-charged, not-so-savvy consumers, or we'd be uninsured.

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. It is being suggested that all of our local needs will be magically met by stomping on the good work of the states through the imposition of an expanded, unenforceable federal bureaucracy. It is being suggested that the American consumer would prefer to dial a 1–800–number to nowhere versus calling their State Insurance Commissioner, a real person whom they're likely to see in the grocery store after church on Sundays.

As for the uninsured population in this country, carelessly slapping down a massive new bureaucracy on our states does nothing more than squelch their efforts to create innovative and flexible ways to get more people insured. We should be doing everything

we can to encourage and support these efforts by states. We certainly shouldn't be throwing up roadblocks.

And how about enforcement of the minority's proposal?

One of the findings of the amendment reads as follows, ''It would be inappropriate to set federal health insurance standards that not only duplicate the responsibility of the 50 State insurance departments but that also would have to be enforced by the Health Care Financing Administration (HCFA) if a State fails to enact the standard.'' In other words, not only is it being suggested that we trample the traditional, overwhelmingly appropriate authority of the states with a three-fold expansion of the federal reach into our nation's health care, they want HCFA to be in charge. HCFA, the agency that leaves patients screaming, has doctors quitting Medicare, and, lest we not forget, is the agency in charge as the Medicare program plunges towards bankruptcy.

I could go on at length about the very real dangers of empowering HCFA to swoop into the private market with its embarrassing record of patient protection and enforcement of quality standards. For example, it took ten years for HCFA to implement a 1987 law establishing new nursing home standards intended to improve the quality of care for some of our most vulnerable patients. According to the General Accounting Office, HCFA missed 25 percent of its implementation deadlines for the consumer and quality improvements to the Medicare program which were required under the Balanced Budget Act of 1977—10 years.

Even more alarming is that HCFA is still using health and safety standards for the treatment of end-stage kidney disease that are 23 years old! Equally astonishing is that HCFA has yet to update its 1985 fire safety standards for hospitals. HCFA is a federal bureaucracy at its worst, making it the last place to which we want our consumer protection responsibilities to revert.

The message is pretty clear to me. Expanding the role of the federal government well beyond its lawful authority would be a big mistake. The scope of federal authority under the Employee Retirement Income Security Act (ERISA) with regard to the regulation of health care is well understood. Duplicating, complicating and ultimately unraveling 50 years of state experience and subsequent action makes no sense. For those of my colleagues who think no one is bothered by that, I, and the 117 million Americans currently protected by State health insurance standards, beg to differ.

Our federal responsibility lies with the 48 million consumers who fall outside the jurisdiction of state regulation. That's our scope; that's our charge. That's what the states are politely reminding us of right now.

In March of this year, the National Association of Insurance Commissioners implored us not to make a mess of what they've done for health care consumers, saying, ''The states have already adopted statutory and regulatory protections for consumers in fully insured plans and have tailored these protections to fit the needs of their states' consumers and health care marketplaces. In addition, many states are supplementing their existing protections during the current legislative session based upon particular circumstances with their own states. We do not want states to be preempted by Congressional or administrative actions.'' I'm stunned that their plea is so easy for some to ignore.

I will not undo what's good in Wyoming only to offer my constituents what's good for Washington. That's my mandate from them.

When we balk at the minority's ''one-size-fits-all'' proposal, it sounds like such a cliche, but the health care needs and wants in this country are a living, breathing example of why a singular approach is a bad prescription for American consumers. No one should be forced to swallow this poison pill.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

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

The PRESIDING OFFICER. On whose time?

Mr. NICKLES. On my time equally divided.

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

The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. NICKLES. 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. NICKLES. Mr. President, I ask unanimous consent to yield back the remainder of our time on the last amendment.

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

AMENDMENT NO. 1234 TO AMENDMENT NO. 1233

(Purpose: To do no harm to Americans' Health Care Coverage and expand health care coverage in America)

Mr. NICKLES. I send an amendment to 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 Oklahoma [Mr. NICKLES], for Mr. SANTORUM for himself, Mr. BOND, Mr. NICKLES, Mr. HUTCHINSON, and Mr. CRAIG, proposes an amendment numbered 1234 to Amendment No. 1233.

Mr. NICKLES. 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:

Strike all after the first word in line three and insert the following:

SENSE OF THE SENATE CONCERNING THE SCOPE OF A PATIENTS' BILL OF RIGHTS.

(a) FINDINGS.—The Senate makes the following findings:

(1) Congress agreed that States should have primary responsibility for the regulation of health insurance when it passed the McCarran-Ferguson Act in 1945.

(2) The States have done a good job in responding to the consumer concerns associated with a rapidly evolving health care delivery system and have already adopted statutory and regulatory protections for consumers in fully-insured health plans and have tailored these protections to fit the needs of their States' consumers and health care marketplaces.

(3) 117,000,000 Americans who are enrolled in fully insured plans, governmental plans and individual policies are protected by State patient protections.

(4) Forty-two States have already enacted a Patient's Bill of Rights.

(5) Forty-seven States already enforce consumer protections regarding gag clauses on doctor-patient communications.

(6) Forty States already enforce consumer protections for access to emergency care services.

(7) Thirty-one States already enforce consumer protections requiring a prudent layperson standard for emergency care.

(8) The Employee Retirement Income Security Act of 1974 (referred to in this section as ''ERISA'') expressly prohibits States from regulating the self-funded employer sponsored plans that currently cover 48,000,000 Americans.

(9) The National Association of Insurance Commissioners has recommended that Congress should focus its legislative activities on consumers in self-funded ERISA plans, which are under the Federal Government's exclusive jurisdiction, and preserve the State protections that already exist for consumers in fully insured ERISA plans.

(10) The National Association of Insurance Commissioners has expressly stated that they do not endorse the concept of a Federal floor with regard to patient protections.

(11) Senate bill 6 (106th Congress) would greatly expand the Federal regulatory role over private health insurance.

(12) It would be inappropriate to set Federal health insurance standards that not only duplicate the responsibility of the 50 State insurance departments but that also would have to be enforced by the Health Care Financing Administration if a State fails to enact the standard.

(13) One size does not fit all, and what may be appropriate for one State may not be necessary in another.

(14) It is irresponsible to propose vastly expanding the Federal Government's role in regulating private health insurance at a time when the Health Care Financing Administration is having such a difficult time fulfilling its current and primary responsibilities for Medicare.

(15) In August, 1998, the United States Court of Appeals affirmed a district court ruling that the Health Care Financing Administration failed to enforce due process requirements and monitor health maintenance organization denials of medical service to medicare beneficiaries.

(16) On April 13, 1999, the General Accounting Office testified that the Health Care Financing Administration failed to use its authority to ensure that medicare beneficiaries were informed of their appeals rights under managed care plans.

(17) The General Accounting Office testified at a July, 1998 hearing in the Ways and Means Committee of the House of Representatives that the Health Care Financing Administration missed 25 percent of the implementation deadlines for the consumer and quality improvements to the Medicare program under the Balanced Budget Act of 1997.

(18) The Health Care Financing Administration should not be given new, broad regulatory authority as they have not adequately met their current responsibilities.

(19) The Health Care Financing Administration took 10 years to implement a 1987 law establishing new nursing home standards.

(20) The Health Care Financing Administration has yet to update its 1985 fire safety standards for hospitals.

(21) The Health Care Financing Administration is utilizing 1976 health and safety standards for the treatment of end-stage kidney disease.

(22) ERISA preempts State requirements relating to coverage determinations, grievances and appeals, and requirements relating to independent external review.

(23) In a recent judicial decision in Texas (*Corporate Health Insurance, Inc. V. The Texas Department of Insurance*), the lower court held that ERISA does preempt the State's external review law as it relates to group health plans.

(b) DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS INCREASED.—IN GENERAL.—Section 162(l)(1) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, the taxpayer's spouse, and dependents.''

(c) CLARIFICATION OF LIMITATIONS ON OTHER COVERAGE.—The first sentence of section 162(l)(2)(B) of the Internal Revenue Code of 1986 is amended to read as follows: ''Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any subsidized health plan maintained by any employer (other than an employer described in section 401(c)(4)) of the taxpayer or the spouse of the taxpayer.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

Mr. NICKLES. Mr. President, for the information of our colleagues, let me outline where we are procedurally. We notified Members under the unanimous consent request that we would lay down S. 6, the so-called Kennedy bill, to mark up. The Democrats offered a substitute to that, the Republican bill that passed out of the Labor Committee, S. 326.

The Democrats then offered a first-degree perfecting amendment to the substitute, to the Republican bill. Their amendment dealt with scope. Their amendment says: We want the Federal Government to have far-ranging scope to overrule all State plans. All State plans must do such and such under their first-degree amendment.

I am offering a second-degree amendment on behalf of my colleagues. The amendment would do two things. One, it is the sense of the Senate that the States are the primary providers of health care, for good reasons. States have hundreds of mandates. We don't think the Federal Government should come in and say: We know best; Senator KENNEDY knows what is best; HCFA knows what is best; the Health Care Financing Administration should regulate all health care plans.

We think that would be a mistake. We don't think that, many times, the Federal Government knows best. That doesn't mean all State plans are administered perfectly. It doesn't mean that they are not without problems. We just don't think HCFA—the Health Care Financing Administration—overruling States, dictating to the States, or this Congress, or Senator KENNEDY, should be saying: States, here is what we know should be in your plan.

We state that in the sense of the Senate.

We also state some other things that come not just from Republicans but from the GAO. The Health Care Financing Administration has, in paragraph 16, stated:

On April 13, 1999, the GAO office testified the Health Care Financing Administration failed to use its authority to ensure that Medicare beneficiaries were informed of their appeals rights under managed care plans.

HCFA failed, according to the GAO. Yet Senator KENNEDY's bill says: We want to give HCFA more power.

Section 17 says the GAO testified in a July 1998 hearing in the Ways and Means Committee, House of Representatives, that the Health Care Financing Administration missed 25 percent of the implementation deadlines for consumer and quality improvements to the Medicare Program under the Balanced Budget Amendment of 1997.

Senator COLLINS alluded to that earlier.

Section 18 states the Health Care Financing Administration should not be given new, broad authority as they have not adequately met their current responsibilities.

I could go on.

Section 1 of this amendment states the States should maintain primary regulatory authority over health care.

Section 2 states that self-employed individuals should be able to deduct 100 percent of their health care premiums.

It is ironic that when we talk about health care we have such inadequate, inequitable treatment under the present Tax Code. Corporations deduct 100 percent of their health care costs; self-employed individuals deduct 45 percent. I personally am offended by that provision. I used to be self-employed, and I used to run a corporation. I wanted health care for my family in both circumstances. When I was self-employed, you could deduct almost nothing. Any person self-employed today can deduct 45 percent. Under the present Tax Code, in another 8 years they finally get to deduct 100 percent. That is a mistake. It needs to be remedied. We remedy it in this amendment. We provide 100 percent deductibility, beginning December 31, 1998—it would be effective immediately—100 percent deductibility for the self-employed.

I want my colleagues to understand that under this provision we are correcting the fact that the self-employed can only deduct 45 percent of their health care costs. We are expanding access. We are making it possible for more people to buy health insurance. I hope we will have strong bipartisan support for this provision.

This amendment is a second-degree amendment to the underlying amendment offered by Senator KENNEDY and Senator DASCHLE that tries to expand the scope that says the Federal Government knows best. We say no, the States should be the primary regulator over health insurance, and self-employed individuals should be entitled to deduct 100 percent of their health care premium.

I yield to my colleague from Arkansas such time as he desires.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, I rise in very strong support of the second-degree amendment of the Senator from Oklahoma, the sense of the Senate regarding the State being the primary regulator of health insurance plans, as well as the provision supporting 100 percent deductibility for the self-employed.

We talk about scope. We talk about increasing the number of people in this country who have health insurance. This is one of the most important steps we could possibly take.

Over the next 3 days, the Senate will debate legislation that will impact the lives of every American in terms of health care benefits they receive. The Kennedy bill that we will talk a lot about in the next few days, while called the Patients' Bill of Rights, is certainly not as simple as it sounds. It involves decreased access; it involves higher costs; and it involves the quality of our Nation's health care.

In 1997, the percentage of uninsured individuals under the age of 65 in my home State of Arkansas was 28.2 percent. Arkansas ranks the lowest in the country in terms of the percentage of individuals covered by private insurance and is second to dead last in terms of the percentage of workers covered by employment-based health insurance.

An even more alarming figure is that Arkansas has the highest rate of uninsured children in the Nation. I applaud the efforts of our Governor in Arkansas and the State legislature in trying to change that, but still it is a very alarming figure.

Any legislation this body passes will have a direct impact on Arkansas workers and families. The bill introduced by Senator KENNEDY and his colleagues would increase premiums by as much as 6.1 percent according to the Congressional Budget Office. If we pass the Kennedy bill and were it signed into law, over 1.8 million people would lose their health insurance coverage.

We see heartrending portrayals of those who have been denied care under managed care plans, and we ought to be concerned about that. That is why we have a bill that is going to provide protections for 48 million Americans

under self-insured ERISA plans. But as Senator FRIST from Tennessee well pointed out, let's not forget the millions, over 40 million Americans, who are without any health insurance at all and whose numbers are going up by the day.

The Kennedy bill, by increasing premiums over 6 percent, will result in over 1 million, nearly 2 million more Americans being added to the ranks of the uninsured. Let's not forget those. Those are the ones who are most vulnerable. If we could only put up their portraits, portrayals of those millions of Americans who, day in and day out, are living without the protection that most Americans take for granted in their health insurance plans, I think we would see the Kennedy bill, the so-called Bill of Rights, in a different light altogether.

If we pass the Kennedy bill, 1.8 million people will lose health insurance coverage they now have. That is demonstrated by a Lewin study commissioned by the AFL–CIO which shows that for every 1 percent increase in premiums an additional 300,000 people will become uninsured.

My colleague, Senator KENNEDY, during the markup of the Republicans' Patients' Bill of Rights Plus Act, stated that this premium increase would be spread out over several years; therefore somehow that made it acceptable. I suspect that the 6-plus percent increase in premiums being spread out over several years and the additional 1.8 million people added to the ranks of the uninsured which occurs over several years is of little comfort to those who will lose their insurance as a result of this bill. No matter how you slice it, the total number of people impacted, the 1.8 million people impacted, remains the same. That is simply unacceptable.

Last year, 98 Members of the Senate voted for an amendment expressing their belief that Congress should not increase the number of uninsured. Clearly, the Kennedy health care bill violates this statement of belief. The uninsured population in the United States grew from 32 million to, most recently, 43 million in 1997. It is certain the Kennedy legislation will only make this growing problem even worse.

The result of passing the Kennedy health care bill is more hard-working Arkansas families, more American families will go without health care insurance. The Kennedy bill gives quality health care only to those who can afford it. On average, the Kennedy bill would cost employees an additional $183 per year according to the Congressional Budget Office, and the cost for families under the Kennedy bill is estimated to be an additional $275 per year. Whether it is $183 or $275 per year, the Kennedy bill places a huge additional expense on American families which many simply cannot afford. What the Democrats give with one hand, they take away with the other. How can you say you are protecting people when you are taking their insurance away from them?

By contrast, the Republican Patients' Bill of Rights Plus Act, I believe, is both rational and responsible. It protects those who are not covered by State regulations. It ensures that health insurance premiums will not rise more than a fraction of a percent according to CBO. It also provides important tax incentives to increase access to health insurance for the current uninsured population, including the 100 percent deductibility of health insurance premiums for the self-employed and the expansion of medical savings accounts.

There are few more effective things we could do in the area of patients' rights to expand access than to include the self-employed and give them that 100-percent deductibility that they so deserve. According to one recent poll by Public Opinion Strategies, 82 percent of the public want Congress to make health care more affordable. The Republican Patients' Bill of Rights Plus Act responds to that need and that overwhelming desire of the American people.

Does the Kennedy bill do anything for the 43 million uninsured Americans in this country? The answer to that is very simple, it is very plain, and I think it is absolutely undisputed. The Kennedy bill does nothing to assist 43 million Americans who do not currently have health insurance get that insurance they so desperately need. It does nothing. So while we hear from bleeding hearts, while we hear emotional stories, I ask my colleagues to remember, I ask the American people to remember, the 43 million who currently do not have insurance need to have it more accessible. The Republican bill does that while providing greatly enhanced protections for the 43 million Americans who are in self-insured plans under ERISA. Not only does the Kennedy bill increase cost and decrease access, it creates a whole new system of Government-run health care. The Kennedy bill would create 359 new Federal mandates, 59 new sets of Federal regulations, and would require 3,828 new Federal bureaucrats to enforce the legislation at a cost to taxpayers of $155 million per year. The question begs to be asked: Who will benefit from this new bureaucracy and maze of Government regulation? Patients? Or the bureaucrats? I think we know the answer.

It is illustrated by a chart we have already seen today. The bottom of this chart, a summary of the effects of the Kennedy bill, are all of the new mandates that would be imposed as a result of the Kennedy legislation. Flowing from these mandates are the arrows and all of the various bureaucratic agencies required to enforce the Kennedy health care bill.

It is simply a one-size-fits-all approach to regulating health care in this country. It disregards the good work that has already been done by the States in this area, as opposed to what the Republican bill does, building upon the good works the States have already done in patient protections.

Mr. President, 42 States have already enacted a Patients' Bill of Rights; 47 States already enforce consumer protections regarding gag clauses on doctor-patient communications; 40 States already enforce consumer protections for access to emergency care services; 50 States, every State already has requirements for grievance procedures; and 36 States already require direct access to an OB/GYN.

The Kennedy bill imposes a blanket of heavy-handed Federal mandates on States and throws away the States' hard work to tailor patient protections for their populations' specific needs. One size does not fit all. What may be appropriate for California may not be appropriate for a rural State such as Arkansas.

When the Congress passed the McCarran-Ferguson Act in 1945, it agreed that States should have primary responsibility for the regulation of insurance. The National Association of Insurance Commissioners has also spoken on this issue. We have heard about this on the floor of the Senate today. In a March 16, 1999, letter to members of the Health and Education Committee, the commissioners stated their concern. They said:

> It is our belief that states should and will continue the efforts to develop creative, flexible, market-sensitive protections for health consumers in fully insured plans, and Congress should focus attention on those consumers who have no protections in self-funded ERISA plans.

That is precisely what the Republican bill does. Congress needs to act to protect the 48 million Americans covered by self-insured ERISA plans. It should not override the States in the area that they have primary responsibility.

My colleague, Mr. KENNEDY, says the Republican bill leaves millions of Americans without any protection. That is false. If you are not covered by an ERISA self-insured plan, you fall under the protections enacted by your State legislature, a group in which most Americans have greater confidence, I daresay, than in their Federal officials hundreds of miles away. This is why the Republican bill applies patient protections to the 48 million Americans who currently do not have any protections. It is sound policy and it makes good sense.

The Republican bill also creates new rights for millions more Americans. For instance, all 124 million Americans in employer-sponsored health plans will have an improved internal appeals process available to them as well as a new, independent, external review process. These 124 million Americans will also be entitled to clear and complete information about their health plan, about what their health plan does

and what it does not cover, about copayments, and about other plan procedures and policies. Our bill also improves existing Federal law on insurance underwriting with regard to preexisting conditions by ensuring that all 140 million Americans' group and individual plans will not be discriminated against by health insurers on the basis of predicted genetic information. Ironically, Senator KENNEDY's bill includes several provisions that were specifically rejected by the President's Advisory Commission on health care quality.

For example, State-run ombudsman programs were rejected by the Commission. Yet they are included in the Kennedy bill. This is the President's Advisory Commission on health care quality.

The Kennedy bill also includes 12 other Federal mandates that were not specifically recommended by the President's Advisory Commission.

In its report, the Commission states that it sought to ''balance the need for stronger consumer rights with the need to keep coverage affordable.''

That is the balance we have sought to maintain in our Republican bill. It is rejected by the Democrats in the Kennedy bill; it is embodied in the Republican Patients' Bill of Rights Plus Act.

The bottom line is that cost does matter because cost is directly related to access and the number of uninsured in our country. If cost was not such a factor, why have the Democrats tried to reduce CBO's scoring of their own bill? It is a factor. It is a big factor. It is an important factor because it affects who can buy insurance and how many millions of Americans are going to go without insurance protection.

Guess how the Democrats thought about trying to reduce that CBO scoring. They sought to reduce the CBO scoring by taking away legal remedies currently available to those in ERISA health plans.

A Patients' Bill of Rights should not be about taking away existing rights. The fact of the matter is, the Kennedy bill would put health care out of reach for close to 2 million Americans. It is not in this country's best interest to pass the kind of legislation that will make insurance less affordable and less accessible to those who need it most.

I thank the Chair, and I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I rise to address the amendment.

Mr. REID. Mr. President, if the Senator will yield, I yield the Senator 3 minutes on the amendment.

Mr. DURBIN. Mr. President, the amendment proposed in the second-degree amendment by the Republican side states a principle which is universally popular in the Senate. It is this: If you are a self-employed person buying health insurance, you should be able to deduct the cost of that health insurance from your taxes like other Americans do.

I introduced legislation along these lines more than 10 years ago in the House. I introduced it in the Senate with Senator BOND of Missouri and Senator COLLINS of Maine. It is bipartisan. It is universal. It will easily pass. And it is a diversion from the debate. It is a diversion.

The Republicans want to talk about access to health insurance, which is important; the Democrats believe it is equally important to talk about the quality of the health insurance that you are buying.

It is ironic as well that the Republicans offer this amendment so that the self-employed people in America can buy insurance. When I take a look at their underlying bill, which you might find surprising, it says those same people who will now be able to buy insurance will enjoy none of the protections of the Republican bill. On the one hand they say: Buy the insurance. But on the other hand they say: We can't guarantee that it is worth buying.

The Democratic approach is consistent: Help families buy insurance, make sure the insurance policy is worth owning, make sure that in time of family crisis you are protected.

The Republican approach is: We will help you buy it, but we cannot tell you whether it is worth buying or not.

They argue it is a matter of States rights. This is such a weak argument when you consider the 200 different organizations—the American Nurses Association, the American Medical Association, all of the different groups for medical professionals—have said that State regulation is not enough; we do not have a consistent national standard of protection for American families. That is what the Democratic side is offering: a consistent national standard.

It bothers those on the Republican side. They do not want to see this consistency. They think people who live in Oklahoma deserve perhaps more rights than those who live in Maine. They think people who live in Nevada should be treated differently than people in Illinois. I disagree. Wherever you live in America, if you buy health insurance, you ought to know that it protects your family. To leave it to State legislatures and to leave over 113 million Americans behind, as the Republicans have done with their approach, is not fair.

This second-degree amendment, which allows self-employed people like farmers and businesspeople to buy health insurance, is so universally popular we can accept it with a voice vote. But let it not divert us from our mission at hand: to make sure the insurance that every American buys is worth owning.

I yield back the remainder of my time.

The PRESIDING OFFICER. Who yields time? The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I was a little disappointed when I heard my colleague say the Republican amendment is a diversion. The Republican amendment is an effort to increase access to quality health care for the self-employed. We have 43 million Americans who are uninsured today. We want to help them get insurance.

A large number of the people who are uninsured are self-employed. They are in small businesses. Small businesspeople who are just starting their businesses sometimes have a hard time getting quality fringe benefit packages. Almost all of the larger corporations have health insurance and pension benefits. But most job growth is in small businesses, and a lot of small businesses have not had time yet to develop and expand a fringe benefit program, including access to quality health care.

When they find out they can deduct 100 percent of their wages but they cannot deduct but 45 percent of their health insurance cost, what do you think most self-employed people are going to do? They might tell their employees: I will just give you the money and you buy the insurance yourself; I cannot deduct it so why spend it? I want to spend my money in my business operations. Everything I spend should be deductible.

It is not. We are trying to remedy that.

I am glad my colleague from Illinois says we have bipartisan support. I know we passed a provision a year or two ago that phased it in gradually, but that is too long. We want to make it effective now. We want to make it where the self-employed get to deduct 100 percent of their health care costs just like corporations. Why not do it now? That is not a diversion.

When we promote our bill, we say Patients' Bill of Rights Plus. What is the plus? We want to increase access. That is in stark contrast to the Kennedy bill which will decrease access. Their bill dramatically increases health care costs, and when you increase health care costs, you are going to be driving a lot of people into the ranks of the uninsured. We do not want to do that. That is not a diversion. It just happens to be a fact.

We want to make health insurance more affordable. The people who cannot afford it, in many cases, are self-employed, and they get the short end of the stick in the Tax Code. They are not treated fairly in the Tax Code. We are trying to remedy that. That is what we have in our amendment.

Also, we have in our amendment a finding of the Senate that, frankly, HCFA does not do a very good job in many cases. Despite what our colleagues say—we want all these people to have assurances and we want them to have all these guarantees. They are basically saying: We want the Health Care Financing Administration of the Federal Government to regulate insurance—we are saying no, that really

should not be the prerogative of the Federal Government to duplicate, override, overrule State regulation of insurance plans.

There is a difference. I am amazed that people keep making the comment: The Republican plan leaves all these people unprotected, as if the States are not doing anything. Every State has a regulatory regimen set up to regulate health insurance under their plans, and our colleagues evidently on Senator KENNEDY's side seem to think whatever the States are doing is not good enough; we know better, in spite of the fact, if you look at HIPAA, the Health Insurance Portability and Accountability Act that Congress passed in 1996, there are five States that are not complying. HCFA is supposed to be regulating those plans, and they are not. They are not complying with the law that we passed 3 years ago. The State of Massachusetts is one of the States that is not complying. Maybe I have too much faith in the States, but I cannot help but think the State of Massachusetts is still interested in making sure employees have portability and continuity of coverage, so I am not really faulting the State. I just find it ironic that some people seem to think: Whatever the States are doing, it's not good enough. We know better. And HCFA, this grand almighty bureaucracy of the Federal Government, can do better than the States. I disagree with that.

So the second-degree amendment that we have states two things: One, findings that the primary regulatory authority of insurance should be done and handled by the States, not the Federal Government; and, two, we should help the self-insured be able to have equitable tax treatment comparable to corporations; they should be able to deduct 100 percent of their health care costs.

I just hope that our colleagues, if they agree in the primacy of States, if they believe in State regulation, if they believe in the 10th amendment to the Constitution that says all other rights and powers are reserved to the States and to the people, respectively, will adopt this amendment. I hope we will when we vote on this. For the information of our colleagues, I expect the vote will occur sometime tomorrow, most likely after the policy lunches.

Mr. President, I yield the floor.

Mr. GRAHAM addressed the Chair.

The PRESIDING OFFICER. The Senator from Florida.

Who yields time?

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. GRAHAM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded for purposes of a parliamentary inquiry.

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

Mr. GRAHAM. Mr. President, I had thought that the Senator from Oklahoma was yielding back the remainder of the time on that amendment.

Mr. NICKLES. No.

Mr. GRAHAM. Therefore, I was going to offer the next in order second-degree amendment.

Mr. NICKLES. To clarify, I did not yield back the remainder of the time. I yielded the floor, just for the information of my colleagues.

Mr. GRAHAM. Mr. President, parliamentary inquiry. How much time is remaining on this amendment?

The PRESIDING OFFICER. The Democrat side controls 47 minutes; the Republican side controls 26 minutes.

Mr. GRAHAM. Is the time running during the quorum call?

The PRESIDING OFFICER. It was.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

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

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

Ms. COLLINS. Mr. President, I yield myself such time as I may consume on the amendment.

The PRESIDING OFFICER. The Senator from Maine is recognized for such time as she may consume.

Ms. COLLINS. Mr. President, I regret that my colleague and friend from Illinois, Senator DURBIN, has temporarily left the floor because I wanted him to hear my comments.

I want to start by commending the Senator from Illinois who has, indeed, been a leader in the effort to provide 100 percent tax-deductibility for health insurance purchased by self-employed individuals. I have been proud to be a cosponsor of the legislation he has introduced, as well as an identical bill introduced by Senator BOND, the chairman of the Senate Small Business Committee.

This issue has been an important one to me. I believe it will help many of our small business men and women throughout this Nation, including the 82,000 Mainers who are self-employed. They include, as you might suspect, many of our farmers, our fishermen, our lobstermen, our hairdressers, our electricians, our plumbers, our small shop owners. They are the ones who find it very difficult to afford the costs of health insurance.

Indeed, the part of Maine's population that has the most difficulty in affording health insurance is our self-employed individuals. By providing 100 percent deductibility for health insurance, we can assist these individuals in affording health insurance coverage. We thus will be taking a very important step toward reducing the number, the growing number, of uninsured Americans.

But this provision is important for another reason. It is important as a matter of equity. Right now a multinational corporation can deduct 100 percent of the cost of health insurance premiums for its employees, and yet the Tax Code discriminates against self-employed individuals. It allows self-employed individuals to deduct only 45 percent of the cost of the health insurance they purchase. That is simply unfair. So this corrects an inequity in our Tax Code, and it is important in terms of expanding access to health insurance.

I disagree with those on the other side of the aisle who contend, however, that somehow this very important provision does not belong on this bill, that it is a diversion of some sort. That statement tells me that my friends on the other side of the aisle still do not understand the crux of this debate. The crux of this debate is, are we going to pass legislation which will drive up the cost of health insurance to the point where we jeopardize coverage for 1.8 million Americans? That is the crux of this debate.

This debate is not only about holding HMOs accountable for the care that they promise; it is not only about improving the quality of care; it is not only about ensuring that people who are denied care that they need have the remedies to give them that care to ensure that care is provided before harm is done, but also this debate is about ensuring access to health insurance.

The single most important determining factor about whether or not people have health insurance is its cost. We face a growing problem with uninsured Americans in this country. It has gone to a record high 43 million Americans who lack health insurance. That is a terrible situation.

We should not be passing any legislation that is going to exacerbate that problem. Yet that is exactly what the Kennedy bill would do, by driving up the cost of health insurance to the point where it would jeopardize coverage for 1.8 million Americans. That is more than the population of the entire State of Maine. The last thing we need to do is to increase the pressure to drive up the cost and jeopardize insurance for working Americans.

The second part of Senator NICKLES' amendment is also important. It affirms the Federal policy that was passed back in the 1940s when Congress passed the McCarran-Ferguson Act giving the States primary responsibility for insurance regulation. Some on this side of the aisle apparently believe that we need a debate on the McCarran-Ferguson Act. Fine. Let's have a debate on that. But we should recognize that until we repeal or change the McCarran-Ferguson Act, it is the policy of this country and the law of the land that the States, not the Federal Government, have the primary responsibility for the regulation of insurance. It is a system that has worked well for more than 50 years.

As someone who was responsible for the Bureau of Insurance in the State of

Maine for 5 years, I know firsthand what a good job our State regulators do and how seriously they take their responsibility of protecting consumers. Indeed, in my capacity as commissioner of the Department of Professional and Financial Regulation, I worked hard to strengthen the consumer division of our Bureau of Insurance. We took enforcement actions against insurance companies that did not live up to the letter and the spirit of Maine's law. I can tell you that I know the people of Maine would much rather make a phone call to Augusta to the Bureau of Insurance and to ask for help—it has actually moved to Gardiner now—but to ask for help from the Bureau of Insurance's Consumer Division than to try to figure out the maze of Federal regulation and call the ERISA office in Boston for assistance. I don't think that is serving our consumers well.

I urge my colleagues to support Senator NICKLES' amendment. It is an important amendment that will help expand access to health care while reaffirming the wisdom of the policy adopted more than 50 years ago when the Federal Government gave responsibility to the States to be the primary regulator of insurance.

Mr. President, I yield the floor and reserve the remainder of the time on our side.

The PRESIDING OFFICER. The Senator from Florida.

PRIVILEGE OF THE FLOOR

Mr. GRAHAM. Mr. President, I ask unanimous consent that two members of my staff, Mr. Matt Barry and Ms. Melanie Nathanson, be granted the privilege of the floor for the balance of consideration of this legislation.

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

Mr. NICKLES. Mr. President, will the Senator mind repeating the request?

The PRESIDING OFFICER. It was floor privileges.

Mr. NICKLES. No objection.

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

Mr. NICKLES. Mr. President, how much time remains on both sides on the amendment?

The PRESIDING OFFICER. The Republican side holds 19 minutes, and the Democrat side controls 47 minutes.

Mr. NICKLES. I yield 5 minutes to our colleague from Alabama, Senator SESSIONS.

The PRESIDING OFFICER. The Senator from Alabama is recognized for 5 minutes on the amendment.

Mr. SESSIONS. I thank the Chair.

Mr. President, I appreciate very much the outstanding remarks of the distinguished Senator from Maine on her experiences dealing with insurance issues in that State.

I served as attorney general of the State of Alabama until a little over 2 years ago. I worked with the State insurance commissioner on a number of important issues. Each State in our Nation has an insurance commissioner. They have for many years worked to develop specific regulations of insurance plans within their own States.

The reason we are here—and, in my opinion, it is for a legitimate reason—is because under the Federal law known as ERISA, certain state policies are preempted. That is what this Congress should concern itself with: the kind of health care plans that cannot be regulated by the States. States have set up policies regarding health care. They have passed regulations. The insurance departments have promulgated their own regulations to address managed care concerns in their own states, and I think it is healthy that that happens.

Therefore, it is appropriate that we in Congress focus only on the policies and insurance programs that fall under the federal law ERISA.

Many have attempted to create an aura of fear by saying that health care in America is failing and in great danger, and that people can't count on their health care anymore. That is not what the people of America are saying. I am not hearing them say that to me when I travel my State. When I have town hall meetings, they are not lining up and complaining about that issue. They are, in most instances, well satisfied. We can, and we will, help and improve health care in certain areas, but I am just not hearing really outrageous cries of widespread abuse.

In fact, in March of this year, March 14 to be exact, the Mobile Press Register-University of South Alabama reported a poll of Alabamians concerning their views of health care. This is the question that was asked:

> I would like to ask you a few questions about health care. Which of the following statements best describes your family's health insurance coverage?

A number of potential answers was listed. The one that received the highest vote: We have sufficient health insurance coverage. Sixty-nine percent of the people in Alabama said: We have sufficient health insurance coverage for our family.

The second answer, which was the second highest vote getter at 7 percent, was: We probably have more coverage than we need: We have insurance, but we don't have sufficient coverage: 16 percent. We do not have health insurance at all: 6 percent.

Therefore, I suggest that what we in Congress need to do is recognize the fact that we have a good health care system in the United States. The first thing we should want to do is do no harm and not destroy it. When you have 76 percent of the people satisfied with their health care, then you have to conclude the system is doing well. In fact, we have the greatest health care system in the world.

I will make one more point. I know the Senator from Missouri would like to make some comments, and I would like to yield the floor to him.

The National Association of Insurance Commissioners has testified before our Health, Education, Labor, and Pensions Committee and on March 16, 1999, they sent a letter stating the official position of their association on the matter as to whether or not the federal government ought to have control over every plan in America.

They said this:

> It is our belief that states should and will continue efforts to develop creative, flexible, market-sensitive protections for health consumers in fully-insured plans. Those are the plans that the States can regulate and do regulate data.
>
> Congress should focus attention on those consumers who have no protections under the self-funded ERISA plans.

Now, that is exactly what this bill does. It focuses on those plans.

My time is up, and I yield the floor. I believe the legislation as proposed is precisely the course we should take.

The PRESIDING OFFICER. Who yields time?

Mr. NICKLES. Mr. President, I yield to the Senator from Missouri, who has been one of the principal sponsors of deductibility for the self-employed in the Senate. How much time do we have remaining?

The PRESIDING OFFICER. The majority side controls 14 minutes.

Mr. NICKLES. I yield the Senator 13 minutes and 30 seconds, reserving 30 seconds for myself.

The PRESIDING OFFICER. The Senator from Missouri is recognized for 13 minutes 30 seconds.

Mr. BOND. Mr. President, I thank the Chair and I thank my distinguished colleague from Oklahoma. In a gesture of goodwill, I ask that the Chair notify me when 13 minutes is up because I would like to hear a full minute from the Senator from Oklahoma. I very much appreciate the opportunity to discuss the amendment that the Senator from Oklahoma has addressed and sent to the floor.

First, let me put into context some of my views about the competing Patients' Bill of Rights. I happen to be very proud to be a supporter of the majority or Republican Patients' Bill of Rights Plus. I am proud to be one of 50 Senators who cosponsored the majority bill, and I will be proud to vote for the legislation.

As with anything we do up here, there are probably some ways you could say it is not perfect. But I believe it is the best approach we have before us that places reasonable controls on managed care companies, while also helping rather than hurting access and coverage problems.

That is something that is extremely important to many Americans—having access and getting the coverage they need.

When we look at the competing proposals, I think it is good to drop back to the first rule of medicine, which is do no harm. I am stunned that with the bill offered on the other side, described as helping patients, we are faced with the fact, according to the Congressional Budget Office and others, that

over a million people who have health insurance today probably can't afford it tomorrow, and that thousands more who were thinking they would be able to get insurance would see that opportunity snatched away if their bill, which would drive up costs, were to pass.

I wonder how anyone can support such a backwards proposition that we are willing to price people out of health care in the name of helping them. That is a fatal flaw, as I see it, in the Kennedy plan: too much cost; too little gain.

In contrast, our Patients' Bill of Rights Plus contains basic, reasonable, commonsense patient protections; access to emergency room care for which their health plan will pay. Americans shouldn't have to worry that their insurance won't pay for necessary emergency room care. Our bill guarantees that patients have information on treatment options. Doctors and patients need to be able to discuss openly all possible treatment options without gag rules.

Our bill provides access to a quick, independent, expert appeals process. Patients should get the care they need when they need it. There has been a lot of talk on the other side about how we need to open up the courts for more costly litigation. Well, frankly, we don't want to see widows or orphans having to sue because their breadwinner did not get the health care he or she needed. We want to make sure they get that care promptly, efficiently, and effectively.

I am very pleased that the Patients' Bill of Rights Plus contains important pediatric and maternal health care protections, which I introduced earlier this year in what we call the Healthy Kids 2000 legislation, which had broad support from major health care supporters, including children's hospitals and pediatricians, who are concerned about care for children.

The Patients' Bill of Rights Plus gives the right for a child to go see a pediatrician without going through a gatekeeper. It gives the right for a child to see a specialist with pediatric expertise, including going to children's hospitals when necessary. It gives the right to a woman to have direct access to an obstetrician or gynecologist without having to go through some gatekeeper. It gives the right to have a pediatric expert review a child's case when appealing an HMO decision. In other words, somebody who treats kids will be the one who will oversee the decision and be able to participate in the external review as to whether the kind of care the HMO proposes for a child is appropriate for that child.

But just as important as what is in our Republican bill, the Patients' Bill of Rights Plus, is what isn't in it. It doesn't contain the same costly bureaucratic provisions the Democratic bill has. One would have thought they would have learned something when we had the health care debates of 1993 and 1994, the Clinton plan, which had the Federal Government and its bureaucracy controlling health care. When people took a look at that dog and found out how mangy it was, it failed, not because the Republicans beat it, but because nobody was willing to get out and support it—and with good reason. The more people looked at it, the worse it looked.

Well, the Congressional Budget Office has given estimates that the Democratic bill could raise health care premiums anywhere from 5 to 6 percent, depending on which version of the bill we are discussing. I have heard people on talk shows saying that is one Big Mac a month. Five percent of basic family health insurance at $3,600 a year—my math suggests that is a whole lot more than a Big Mac a month. We are talking in the neighborhood of $180 a year.

CBO and others have told us that for every 1 percent increase in costs, a couple hundred thousand people will lose health care insurance. Under this bill, that means, under the Democratic version, over a million Americans or more could lose their health care coverage.

I speak as chairman of the Committee on Small Business because cost increases for small businesses and small business employees is a No. 1 concern. We have listened to small businesses, and we have heard from small businesses. They say: Please don't do us any more favors. Don't burden us with more costly health care plans. Small businesses are fighting to try to get economical, caring, compassionate, effective health care for their employees and for the business owners themselves. Small business owners are particularly sensitive to the issue of cost. Small businesses—the owners and their families, the employees and their families—would be the ones who would pay for an extravagant bill.

Nearly 40 years ago, President Kennedy told the Nation that a rising tide would lift all boats. Unfortunately, the bill before us turns that concept on its head, and perhaps a new doctrine is that rising costs will sink health care hopes. To me, that is a major concern.

As an alternative to this heavy-handed bureaucratic approach, the Patients' Bill of Rights Plus, offered by the Republicans, tries to increase access and coverage. Now, it is extraordinary and unconscionable that the bill we are debating, the Democratic bill, doesn't do anything to improve access to health care. It seems that the only thing our colleagues on the other side of the aisle can think of to improve access is to have Government-run care, like the Clinton health care plan of 1993 and 1994. Since that fell on its face a few years ago, they seem not to have had any good ideas about how to get more people health insurance.

We need to increase access. Perhaps the most important part of our bill is the acceleration of the full deduction of insurance costs for the self-employed. I am very pleased that our distinguished majority whip, the Senator from Oklahoma, has introduced an amendment that achieves, for this year, full deductibility of health care costs. That means there is hope that the health care premiums paid this year will be fully deductible.

Now, my colleagues, the Senator from Maine and the Senator from Alabama, have already discussed the importance of keeping insurance regulation at the State level. As a former Governor, I can tell you that government insurance regulation, run at the State level, is readily accessible, it is more professional, and it is more responsive to the needs of the citizens. That is why I agree with the portion of the amendment introduced by Senator NICKLES which talks about moving away from Federal Government takeover of health care regulation.

But I am particularly pleased that Senator NICKLES has introduced full deductibility based on the Self-Employed Health Insurance Fairness Act of 1999, which I introduced on February 3 of this year. I am very proud to have 30 bipartisan cosponsors. We are making progress when we work on a bipartisan basis to assure full deductibility of health care costs for the self-employed. I am proud to work with my colleagues on both sides of the aisle.

According to the Employment Benefit Research Institute's estimates of the March 1998 current population survey, there are 21.3 million Americans in families headed by a self-employed entrepreneur. Nearly a quarter—23.9 percent—of them have no health insurance. That is 5.1 million uninsured Americans. Even more troubling, that means that the 21.1 percent of the children in self-employed American families are uninsured; 1.3 million children have no coverage for annual checkups, let alone any major health care needs.

This amendment would address these alarming statistics by providing an immediate—I mean right now, in real time—100 percent deductibility in order to make health insurance more affordable and accessible to hard-working entrepreneurs and their families.

Let me add an additional perspective on the importance of this amendment. Today, one of the fastest growing segments of the small business community is the woman-owned business. Women are opening businesses at a very rapid rate. They are the ones with the entrepreneurial spirit. They may be operating out of their homes, they may be moving from another full-time job, or they may just have a good idea. But women are now seeing an opportunity to start up their own businesses, and we are very proud of the significant contributions they are making to our economy.

According to statistics from the National Foundation for Women Businessowners, there are now 9.1 million women-owned businesses in the United States, which compromise almost 38 percent of all U.S. businesses.

In addition, between 1987 and 1999, the number of women-owned firms increased by 103 percent nationwide—more than double. The reasons for this explosive growth are manifold. Topping the list is greater flexibility in meeting the demands of family life, and the ability to spend more time with children.

Even more impressive, the National Foundation for Women Business Owners reports that women-owned businesses employ more than 27½ million people, and that employment rate has increased by 320 percent over the past 12 years.

Today, while self-employed woman business owners can deduct 60 percent of their health care costs thanks to the strides that we made in previous years, that is still not on a level playing field with a large business which can deduct 100 percent. While the self-employed are slated to have full deductibility in 2003, what woman business owner or her family members can wait 4 more years to get sick?

By making health-care insurance fully deductible now, the added tax savings will enable many women business owners to cover their health-care needs and those of their children. In addition, it will encourage these women entrepreneurs to provide health insurance for their employees and their families.

And we're not talking about a tax break for ''the rich'' when it comes to the health-insurance deduction for the self-employed. Recent estimates based on the March 1998 Current Population Survey indicate that 68.7 percent of families headed by a self-employed individual with no health insurance earn less than $50,000 per year.

These are the people who we are trying to get health coverage. These are the people who need the benefit of full deductibility.

Coverage of these entrepreneurs and their children through the self-employed health-insurance deduction will enable the private sector to address the health-care needs of these individuals rather an expensive and intrusive government program.

Currently, S. 343, from which my amendment is derived, has the bipartisan support of 30 cosponsors. It also enjoys overwhelming support of small business organizations including the National Association for the Self-Employed, the National Federation of Independent Business, the Small Business Legislative Council, the National Small Business United, and the Health Tax Deduction Alliance, to name just a few.

I have also added a provision to the amendment to correct a disparity under current law that bars a self-employed individual from deducting any of her health-insurance costs if she is eligible to participate in another health-insurance plan. This provision unfairly affects entrepreneurs who are eligible for, but do not participate in, a health-insurance plan offered through a second job or through a spouse's employer. The bill ends this disparity by clarifying that a self-employed person loses the deduction only if she actually participates in another health-insurance plan.

It has long been my goal that the self-employed have immediate 100 percent deductibility of health-insurance costs. I have sought every opportunity to achieve that goal, and I will keep coming back until we get this job done. I commend the Senator from Oklahoma for pushing for this amendment on the bill so that we can have bipartisan, unanimous support for the effort to ensure that all Americans who are self-employed will have the same kind of benefits in terms of taxes that a large corporation or its employees do; and that is 100 percent deductibility.

I am very proud to be a cosponsor of this amendment. I ask all of my colleagues to join in supporting a very forward-looking amendment which deals with some of the significant problems in the underlying bill offered by our colleagues on the other side and makes significant changes to assure access to fair and equitable health care insurance for all Americans.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I thank Senator BOND for cosponsoring this amendment, in addition to Senator SANTORUM, who is also a principal sponsor of this amendment, and Senators HUTCHINSON, CRAIG, and myself who are original sponsors.

Mr. President, I inquire of my colleague from Nevada, is he prepared to yield the remainder of time on this amendment?

Mr. REID. Yes. We are.

Mr. NICKLES. Mr. President, if my colleague from Nevada is yielding back the remainder of time on the amendment, we likewise yield the remainder of time on the amendment.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. NICKLES. 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. NICKLES. Mr. President, I ask unanimous consent that the Republican manager of the bill be allotted an additional 40 minutes on the bill itself.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Reserving the right to object, on second thought, I tell my friend, the majority whip, we also want 40 minutes.

Mr. NICKLES. Mr. President, I ask unanimous consent that both sides be allotted an additional 40 minutes on the underlying bill.

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

Mr. NICKLES. Mr. President, I ask unanimous consent that the second-degree amendment proposed by myself and Senator BOND and others be temporarily set aside.

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

The PRESIDING OFFICER. The Senator from Florida.

AMENDMENT NO. 1235 TO AMENDMENT NO. 1233

(Purpose: To provide for coverage of emergency medical care)

Mr. GRAHAM. I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Florida (Mr. GRAHAM), for himself, Mr. REID, Mr. CHAFEE, Mrs. MURRAY, Mr. DURBIN, Ms. MIKULSKI, Mr. SCHUMER, Mr. KENNEDY, Mr. DASCHLE, Mr. BAUCUS, Mr. FEINGOLD, and Mr. DORGAN, proposes an amendment numbered 1235.

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

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

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. GRAHAM. Mr. President, on behalf of the Senators listed, I offer an amendment relative to emergency care services.

This is a particularly critical issue because so many of the conflicts between beneficiaries and their health maintenance organizations occur in an emergency room setting.

When the Senate in 1997 adopted provisions that extended to Medicare and Medicaid beneficiaries—the same rights that this amendment will now provide to all Americans—we discussed the fact that 40 percent—40 percent—of the conflicts between Medicare beneficiaries and HMOs occurred in an emergency room setting.

Questions of coverage, type of coverage, and what would happen after the patient was stabilized was the cauldron in which many of the disagreements between HMOs and beneficiaries were fought out.

Just as the Medicare and Medicaid provisions which were adopted by the Congress and signed into law by the President have helped to relieve that tension for 70 million Americans, this amendment will attempt to do the same for the rest of Americans.

This amendment also raises a couple of other important issues.

One of those is what I call the ''big monster argument''—that anything that we do is going to inevitably lead to an escalation of cost and an escalation of Federal regulation and bureaucracy and an overwhelming of the patients' ability to get affordable health care.

I would like to point out the first sentence of this amendment. The first sentence is essentially, if the health care plan offers emergency services, then these are the standards that will have to be met.

The clear implication of that is that no HMO under this amendment is required to offer emergency room services. If the HMO wishes to go to its beneficiaries and say, Now, look, you are not covered if you go to the emergency room—you understand that—and the fee that you are going to pay for your HMO contract is predicated on the fact that emergency room services are not covered, the HMO has the prerogative of so doing. If the HMO gives the appearance that it is offering emergency room services, then it is required to offer credible emergency room services that comport to what the average American thinks they are going to get in an emergency room.

So the ''big monster argument'' that this is going to have all of these adverse effects is irrelevant as long as the HMO plays by the rules. It cannot offer emergency room services at all. But once it purports to do so, it can't bait and switch and say, Yes, you thought you were getting comprehensive emergency room coverage, but in fact you are getting something much, much less.

The second argument is what I call the ''checking off the boxes'' argument. We have heard it already. We will say, well, the plan of the Republicans offers an external appeal provision, and the Democratic plan offers an external appeal provision. So we check both of them with an equally large mark. We have an emergency room provision. You have an emergency room provision. Check, check—both get the same large mark.

The problem is that it is not just a matter of checking off the boxes. It is a matter of seeing what inside the box. What are the actual words? What is the detail? Words make a difference. Details matter. We are not talking about semantics or legalisms. We are talking about whether in the final analysis the beneficiary—the American family—gets the kind of protection that they think they paid for.

There will be other colleagues who will discuss important distinctions between the two bills. I want to focus on two of those differences.

I look forward to a debate with my Republican colleagues on these two differences, whether they are meaningful, and whether they have properly stated what the Republican provisions are. The first of those distinctions is hidden in the Republican bill in language which effectively eviscerates the ''prudent layperson standard'' that is at the heart of the emergency care provision.

What is the prudent layperson standard? This is a standard which is now in the Medicare law and the Medicaid law by action of Congress. It essentially says if a prudent layperson—a layperson of normal intelligence and knowledge of health and medical matters—thinks symptoms occurring require urgent attention, that prudent layperson can then seek the attention of the most available emergency room, and the HMO will be responsible for paying the costs of that emergency room service.

How does the Republican bill eviscerate that basic principle, which now protects 70 million Americans on Medicare and Medicaid? The Republican bill allows for the imposition of ''any form of cost-sharing applicable to any participant or beneficiary (including copayments, deductibles, and any other [form of] charges . . . if such form of cost-sharing is uniformly applied under such plan with respect to similarly situated beneficiaries.''

Now, what does that mean? It means that a patient who goes to a hospital that is not part of the network of the HMO will have to pay, according to the HMO's plans, for additional deductibles, coinsurance, and other charges, while a person who is in the same position of an emergency medical crisis, who goes to the in-network hospital will not be required to pay those additional out-of-network charges.

The practical effect of that distinction is to create a strong economic incentive for the prudent layperson who thinks they have symptoms requiring emergency attention. If they understand they could go to the emergency room which is 5 minutes away but which is not part of their HMO's network or they could go to the emergency room that is 30 minutes away and be within the network of the HMO, and that there will be a significant economic differential as to what that choice is, then you have a prudent layperson making a critical decision. Will I go to the emergency room that offers the most immediate attention to my condition, or will I go to the emergency room where the cost will be less?

How do we know this is what was meant in the Republican version of the emergency room provisions in the Patients' Bill of Rights? Because they said it in very clear language in the committee's report of this section, which appears on page 29. I will read from that report:

> The Committee believes that it would be acceptable to have a differential cost-sharing for in-network emergency coverage and out-of-network emergency coverage, so long as such cost-sharing is uniformly applied across a category (i.e. [across all] in-network, out-of-network). . .[beneficiaries and providers.]

I suggest there goes the prudent layperson definition, or the rationale for the prudent layperson definition, right out the window.

The Democratic plan provides explicitly that there will be parity payment between in-network and out-of-network emergency room services; that is, the prudent layperson would have the right to go to what is the most prudently accessible emergency room to get that service.

I suggest what is good for 70 million Medicare and Medicaid beneficiaries should be good for all Americans. Patients should not be required to call an insurance bureaucrat to see if they can get emergency room care approved before they go to the emergency room. They shouldn't have to call their HMO before they call 911. That is the very thing we are trying to prevent. Patients should be able to seek the treatment wherever it can be provided—inside or outside the network—and not be subject to economic compulsion.

That is one important differential between the Republican and the Democratic bill. That little devil was in the details.

Another provision called poststabilization is a crucial component of emergency room care. This provision relates to what happens after a person has gone to the emergency room, had that immediate treatment, and their condition is now stabilized; what happens next?

Let me give an example. A person goes to an emergency room on a Friday night with shortness of breath, high fever, pain in the left side of their chest. They are diagnosed by the emergency room as having not a heart attack but acute pneumonia. The emergency room treats the patient with intravenous antibiotics and oxygen. The emergency department then calls the HMO to request one of two things be done: that the plan take responsibility for the patient by having the patient transferred to one of their in-network hospitals, or the plan authorize the admission of the patient to the treating hospital.

Unfortunately, this is a Friday night, about 10 or 11 o'clock, and no one picks up the phone at the other end of the line. The hospital is stuck; the party is stuck. The hospital cannot transfer the patient to another facility but it can't get authorization to admit the patient to its own facility. As a result, the emergency room does admit the individual for treatment. On Monday, the patient goes home.

The health care plan has not authorized the treatment. It now denies the claim, retroactively, after the hospital services have been provided. Under the Republican bill, the patient is responsible for the noncovered hospital bill, potentially for several thousand dollars for that weekend institutionalization.

Under our amendment, the nonresponsive HMO would be financially responsible for that bill. Better yet, we see a different scenario. Under our amendment, we see the health plan with a positive incentive to coordinate the patient's care with the emergency department. The patient was transferred to a network facility, which in turn has saved all overall health costs both for the patient and the health plan—a win-win scenario.

Let me give an example of this coordination. A parent brings their young child into an emergency room with a high fever. The emergency physician rules out a life-threatening illness. She brings the fever under control, thereby stabilizing the patient. However, follow-up care is necessary to determine the cause of the high fever and the extent and nature of the illness. The emergency room calls the

plan to get the plan to refer the child to a primary care doctor. The plan doesn't call back. What is the result? The child is admitted to the hospital overnight, potentially costing the family thousands of dollars of unnecessary hospitalization and emotionally traumatizing the child.

Under the Republican proposal, the plan gets a double windfall. First, the plan saves the money of having to staff ''response capability,'' particularly on the weekend, and by not having personnel to respond to that emergency room call and to make treatment decisions. That is not all. The HMO also saves; when the emergency room treats the patient without prior authorization, the health plan can then go back and claim the care was unnecessary and refuse to pay.

What the Democratic poststabilization provision is all about is simply requiring the health plan to take responsibility for the patient by answering the phone when the emergency room calls, and then either authorizing treatment, referring followup primary care, or transferring the individual.

There are those who say this provision places an unwarranted burden on the HMO. But let's give an example of one of the Nation's oldest and largest health maintenance organizations, Kaiser-Permanente. Kaiser-Permanente endorses this position and has implemented the poststabilization requirement voluntarily. Guess what. After all the discussion about cost and the desire to maintain affordable and accessible health care, this provision has saved Kaiser-Permanente money. How could it do that? Because Kaiser has found that by coordinating care with the emergency room, it has been able to avoid unnecessary admissions through providing followup care at an outpatient facility.

I will quote from a letter signed by Mr. Don Parsons, the associate executive director for health policy development for Kaiser-Permanente. I ask unanimous consent the entire letter be printed in the RECORD immediately after my remarks.

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

(See Exhibit 1.)

Mr. GRAHAM. Mr. Parsons states:

By assuring immediate response to telephone inquiries from non-participating emergency facilities, we have been able to provide substantial assistance to the emergency doctor who otherwise is practicing in an isolated environment without access to the patient's medical record.

Our own emergency physicians on the telephone have offered peer consultations, personally approved coverage for urgently needed tests and treatment, arranged for the coordination of follow up care, and implemented critical care transportation of patients back to our own facilities. Of over 2,000 patients transported in this fashion, one third have been discharged to their homes. Without this coordination of care, these patients would have been hospitalized at needless expense.

For example, to go back to my hypothetical of the child with the high fever without signs of a bacterial infection, they could have been sent home if there were arrangements made for the child to see a doctor the next day. But absent the communication between the plan and the emergency room, the emergency room admits the child. If the insurance company plays by the rules, as Kaiser-Permanente, it will now be only out the $50 for a routine primary care visit rather than the $1,000 or more that it might be out if the child is admitted to the hospital.

So why are companies such as Kaiser coordinating poststabilization care with emergency departments? They are doing it because it is good health care and it is good business. I point out again, this is the same provision that the Congress passed in 1997 as it relates to Medicare and Medicaid beneficiaries who currently have this poststabilization coordination of care coverage.

So how the amendment is drafted, what the amendment says, what the details are, makes all the difference. This is not just a matter of checking off the box. It is a matter of looking inside that box to see if the prudent layperson provision, which both versions purport to offer—is it meaningful? The person who exercises prudence by going to the nearest emergency room, not necessarily the nearest emergency room that happens to be part of the network of the HMO, will they be financially protected?

The person who has been stabilized—and now the question is what needs to be done to deal with the underlying cause of their symptoms—will they be financially protected when the HMO fails to respond to the request for specific authorization? Those are the types of real differences that make the difference between the two alternative versions of emergency room care that are before the Senate.

I urge my colleagues to study these differences and to be mindful of the other differences that will be articulated by the other cosponsors of this amendment. I urge their support for this amendment that makes emergency room care real for the families of America.

I ask unanimous consent that two letters be printed in the RECORD: One from the American College of Emergency Physicians supporting the amendment that has been offered, and the letter from the American Heart Association supporting the emergency room provision that I and colleagues have offered.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

AMERICAN COLLEGE
OF EMERGENCY PHYSICIANS,
Washington, DC, July 12, 1999.

Hon. BOB GRAHAM,
Hon. JOHN H. CHAFEE,
U.S. Senate,
Washington, DC.

DEAR SENATORS GRAHAM AND CHAFEE: The American College of Emergency Physicians (ACEP), on behalf of its more than 20,000 physicians and the patients we serve, is pleased to support your amendment, which will protect people with health insurance who make reasonable decisions to seek emergency care from claims denials by managed care plans. Today's health care market warrants establishment of basic consumer protections to ensure coverage for emergency services, and ACEP believes that your amendment would provide such safeguards.

As emergency physicians, we applaud your efforts to prevent health plans from denying patients coverage for emergency services. Prior authorizations requirement for emergency care and ''after-the-fact'' claims denials create barriers that can place a patient's health at serious risk. Your amendment provides those covered by private managed care plans with the same ''prudent layperson'' standard that Congress provided Medicare and Medicaid patients as a part of the ''Balanced Budget Act of 1997.''

Again, ACEP is pleased to offer its support of your amendment, and we commend your leadership in proposing a bipartisan solution.

Sincerely,

JOHN C. MOORHEAD, MD, FACEP,
President.

AMERICAN HEART ASSOCIATION, OFFICE OF COMMUNICATIONS AND ADVOCACY,
Washington, DC, July 13, 1999.

Hon. BOB GRAHAM,
Washington, DC.

DEAR SENATOR GRAHAM: The American Heart Association strongly supports your amendment, to be offered today to the patient protection legislation, which will ensure prompt emergency room access. This important amendment is essential to our mission of reducing death and disability from cardiovascular diseases, the leading cause of death in America.

To reduce the devastation caused by cardiovascular diseases, the American Heart Association is committed to educating the public about the warning signs and the symptoms of heart attack and stroke. Acting on this knowledge is often the key to survival. In fact, every minute that passes before returning the heart to a normal rhythm after a cardiac arrest causes the chance of survival to fall by as much as 10 percent. Our consistent message to the public, therefore, is both to know the signs and symptoms of heart attack and stroke and to get emergency care as quickly as possible.

However, unnecessary and burdensome obstacles often stand between the patient and the emergency room door. Insurer ''pre-approval'' processes for emergency care can impede prompt treatment of heart attack and stroke. Delays in treatment can significantly increase mortality and morbidity. Our efforts to educate the public about the importance of getting prompt treatment are severely hindered by these ''pre-approval'' barriers.

The American Heart Association applauds your efforts to address these obstacles by ensuring the ''prudent layperson'' definition of emergency. Any managed care reform proposal that seeks to protect patients' rights must include this prudent layperson standard.

Thank you for your leadership on this important issue.

Sincerely,

DIANE CANOVA, ESQ.,
Vice President, Advocacy.

Mr. GRAHAM. And so, Mr. President, as I stated early in my remarks, how the amendment is drafted, and what the amendment says, makes all the difference.

It's not good enough just to check off the boxes. That's why I urge the adoption of our amendment.

EXHIBIT 1

KAISER PERMANENTE,
Washington, DC, July 7, 1999.

Hon. BOB GRAHAM,
U.S. Senate,
Washington, DC.

DEAR SENATOR GRAHAM: Since 1996, Kaiser Permanente has supported the passage of federal legislation embracing the Prudent Lay Person concept, which requires insurance coverage of emergency services provided to people who reasonably expect they have a life or limb threatening emergency. In connection with this, we support a requirement that the emergency physician or provider communicate with the health plan at the point where the patient becomes stabilized. This will allow for coordination of post-stabilization care for the patient, including further tests and necessary follow-up care. These concepts are contained in several bills currently pending before Congress. I should note, however, that our favoring of this language should not imply endorsement in its entirety of any specific bill that deals with other issues.

As a result of the Balanced Budget Act of 1997 with its ensuing regulations applicable to Medicare + Choice and Medicaid enrollees and the Executive Order applying the President's Advisory Commission's Bill of Rights to all federal employees, approximately 30 million Americans are now the beneficiaries of a financial incentive to emergency departments to communicate with the patient's health plan after the patient is stabilized. This helps to ensure that the patient's care is appropriate, coordinated and continuous. It is important that emergency departments have the same incentive to coordinate post-stabilization and follow up care for patients who are not federal employees or beneficiaries of Medicare or Medicaid. We have heard of minimal problems implementing this standard in those health plans participating in FEHBP and Medicare + Choice programs. Since a federal standard is in place and working, it is good policy to extend that standard to the general population.

For the past ten years, we have implemented on a voluntary basis a program that embraces these concepts of honoring payment for the care our members receive in non-participating hospital emergency departments up to the point of stabilization. Our Emergency Prospective Review Program has encouraged the treating physicians in such settings to contact our physicians at the earliest opportunity to discuss the need for further care. This has allowed us to make available elements of the patient's medical record pertinent to the problem at hand and to coordinate on-going care as well as the transfer of the patient back to his/her own medical team at one of our facilities. We have found this program to be considerate of the patients' needs, emphasizing both the urgency of treatment for the immediate problem as well as the continuity of high quality care.

This has been a cost-effective practice, affording the patient the highest quality of care in the most appropriate setting. By assuring immediate response to telephone inquiries from non-participating emergency facilities, we have been able to provide substantial assistance to the emergency doctor who otherwise is practicing in an isolated environment without access to the patient's medical record. Our own emergency physicians on the telephone have offered peer consultations, provisionally approved coverage for urgently needed tests and treatment, arranged for the coordination of follow up care, and implemented critical care transport of patients back to our own facilities. Of over two thousand patients transported in this fashion, one third have been discharged to their homes. Without this coordination of care, these patients would have been hospitalized at needless expense.

In summary, this program has served the needs of our patients, the treating emergency physicians, and our own medical care teams, while providing substantial savings in both clinical expense and in administrative hassle over retrospective approval of payment for services provisionally approved through the telephone call. We are strongly in favor of the post-stabilization coordination provision as an essential element of the emergency access provision of the Patients Bill of Rights.

Sincerely,

DONALD W. PARSONS, MD,
Associate Executive Director.

The PRESIDING OFFICER. Who yields time?

Mr. REID. Mr. President, I yield myself such time as I may consume on the amendment.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, just briefly, the Senator from Alabama stated the State of Alabama had this great health insurance by some poll that he had conducted by, I think, South Alabama University.

First of all, regarding coverage of emergency care, the State of Alabama is one of 12 States that does not use the prudent layperson or similar standard for emergency room treatment. In addition to that, with drug formularies, 36 States have no procedures for obtaining nonformulary drugs; Alabama is one of those. Access to clinical trials, 47 States have no access to clinical trials; Alabama is one of those. Continuity of care, 29 States have no continuity of care provisions; Alabama is one of those. Bans on financial incentives, 28 States have no ban on financial incentives to providers; Alabama is one of those. Provider protections, 21 States have no protections for providers who are terminated; Alabama is one of those. Point-of-service options, 30 States do not require that point-of-service plans be offered; Alabama is one of those. Coverage of emergency care, I have already stated 12 States do not use a prudent layperson or similar standard; Alabama is one of those.

The State of Alabama has 1,617,000 State residents who are not protected under the Republican plan; 62 percent of privately insured in Alabama are not protected under the Republican plan. So I do not know about the poll in South Alabama, but I know what the facts are. The facts are that State is similar to many States. That is why groups support our Democratic Patients' Bill of Rights.

Why do I say groups? Hundreds of groups. They are already on the record, the groups that support us, a listing of some of the groups that support us. Alliance for Lung Cancer Advocacy, Alzheimer Association, American Academy of Child and Adolescent Psychiatry, American Academy of Emergency Medicine, American Academy of Neurologists, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation—over 200 groups support this legislation, over 200.

In addition to that, we have a unique situation. The doctors and the nurses have joined with the lawyers to support this legislation. It is a unique day in American legislation when we can say not only do the doctors support this—the American Medical Association does, all the specialty groups—but in addition to that the lawyers support it.

I suggest people coming in, bragging about the other bill, the majority's bill, they are talking about—the junior Senator from Maine said all we want to do is ensure access. I respectfully submit they want to ensure the insurance companies continue to rip off the American public. That is what that legislation is about. That is what they are trying to ensure, and this legislation is meant to stop that.

The PRESIDING OFFICER. Who yields time? The Senator from Tennessee.

Mr. FRIST. Mr. President, I yield myself 10 minutes on the amendment.

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

Mr. FRIST. Mr. President, we have a number of issues on the floor today—the underlying bill that has been introduced and a substitute bill. We have talked some about scope today. Now we are talking about emergency services. I think it is important that people understand that both of the underlying bills do have parts which address this access to emergency medical care. It is absolutely critical that over the course of today and on future amendments on emergency care we appropriately address a bill of rights that does have a real impact because there is no way we can responsibly leave this debate without addressing the fear, the fear which is supported by anecdote—I do not know how big of a problem it is, but it is a fear and that means we have to deal with it and we should deal with it—of having a heart attack or chest pain or laceration or broken arm or a sick child and going to an emergency room, and in some way, for some reason, having that care denied or be channeled to emergency rooms that are across town, all of the sorts of things that are truly frightening and are really unconscionable. Therefore, it needs to be addressed and needs to be addressed well.

The amendment today brings up an issue of poststabilization, which I think needs to be addressed, and I will carefully look at the amendment.

Poststabilization is a point after which you have gone to the emergency room, gone through screening, and gone through treatment. Then what happens? Again, it looks at a more complete picture, and we need to make sure what we ultimately pass several days from now addresses that adequately and appropriately, given the

realities of the managed care, coordinated care, and fee-for-service system.

Let me briefly comment on what is in our Republican bill. This was discussed in the Health, Education, Labor, and Pensions Committee. We talked about emergency access, and we talked about some of the other issues as it went through the committee.

What passed out of committee, and is before this body, is as follows: We require group health plans that are covered by the scope of the bill—and the issue of scope has come forward—to pay, without any sort of prior authorization, for an emergency medical screening exam. If you go to the emergency room, that exam, using a prudent layperson standard, which has just been discussed—meaning, if you are at a restaurant and you have chest pain, you think it might be a heart attack, you know it is an emergency or you feel it is an emergency, and you go to the emergency room. They say it is indigestion, not a heart attack; therefore, they are not going to cover it. The prudent layperson —that is, the average person in terms of medical knowledge in America today—says there is no way I am going to know if it is an emergency or not, if it is serious or not. We reach out, using the prudent layperson standard, and cover that individual.

You would not have to have prior authorization. That would be for an emergency medical screening exam and any additional emergency care that is required to stabilize that condition.

Stabilization is difficult. As a physician, when I think of stabilization, because I am a heart surgeon, I think of heart failure and blood pressure, going into shock, and all sorts of bad things happening overall. Stabilization might also mean if you have a broken arm or if you have a laceration. The definitions are important as we go forward.

Mr. GRAHAM. Mr. President, will the Senator from Tennessee yield for a question?

Mr. FRIST. Let me finish walking through what is in the Republican proposal first.

The stabilization end of it is important. I mention that because we are talking about a period of poststabilization—after you are stabilized. Again, the Republican bill covers, through the screening and stabilization process, using that prudent layperson standard.

We define in our bill what a prudent layperson is, and that is an individual who possesses an average knowledge of health and medicine. I think that is as good a definition as one can generate, and the concept of prudent layperson I believe is accepted by both sides.

As to the cost-sharing aspect, again looking at what is in the Republican bill which was introduced earlier today, plans may impose cost sharing on emergency services, but the cost-sharing requirement cannot be greater for out-of-network or out-of-plan emergency services than for in-network services. That is very important, because I have heard several people allege, no, you can charge anything, you can charge much higher than what in-network cost sharing is, and that is simply not true in the Republican bill.

An individual who has sought emergency services from a nonparticipating provider or nonparticipating hospital or nonparticipating emergency physician cannot be held liable for charges beyond that which the individual would have had to pay if that physician were a member of that particular coordinated care plan or managed care plan or health maintenance organization.

The important points are basically that you do not need prior authorization. It does not matter whether or not that facility is part of that plan or that HMO's network itself. So you can go to the nearest hospital if, using that prudent layperson standard, you have a concern that you have something that does need to be treated and treated very quickly.

The prudent layperson would expect the absence of immediate medical attention to result in some sort of jeopardy to the individual's health or serious impairment—again referring back to that standard—or serious dysfunction of their body. Again, it is very difficult in terms of covering the overall realm.

The poststabilization period: What happens after you go to the nearest emergency room, using that prudent layperson standard, not having to pay anything beyond what you would have to pay if you had gone to a facility in that network, you have had the screening exam and you have had that stabilization or that initial treatment.

Poststabilization introduces: What if you are there and you had this chest pain and you found out it was just indigestion, but while you were there in that poststabilization period, the physicians find a spot on the chest x-ray that you need to rule out as lung cancer, or you have cholecystitis or right quadrant pain, and with a quick exam it is pretty clear another medical problem has been picked up. Does that fall into that poststabilization period? And, if so, does that treatment continue over time?

Those are the questions we need to debate, we need to look at. We need to make sure we do not open the door so broadly that somebody basically goes to an emergency room with a complaint and it is taken care of, but 10 other complaints are found and that is an excuse to get all your care outside of that network simply because that might potentially circumvent the whole point of having care coordinated and to have a management aspect of coordinated care.

Over the debate, as it continues tonight and in the morning, the poststabilization period is an important period we need to address. We do not want to create any huge loopholes through which people can slide. I am going to keep coming back to again and again that we have to do what is best for the individual patient, and we have to keep our focus on the patient, and we do not want to do anything that exorbitantly increases cost if it is unnecessary, if it is wasteful, because if we do that, we increasingly, by an increase in premiums—somebody is going to have to pay for it—drive people to the ranks of the uninsured.

I reserve the remainder of my time.

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

Mr. FRIST. I will be happy to yield.

Mr. GRAHAM. First, on the question of prudent layperson, you are correct; both bills have essentially the same language on a prudent layperson, but there is a very sharp difference in terms of the economic exposure of that prudent layperson, whether they are in a hospital as part of the HMO's network or in a hospital that is not part of the network.

The Democratic plan clearly states there must be parity of treatment; that is, if you are in an out-of-network hospital, you cannot be charged more than if you are in an in-network hospital.

The Republican bill—and I will quote from the committee report, which is on our desks, on page 29. This is the committee that reported the Republican bill, the Labor Committee. The first full paragraph states:

> The committee believes that it would be acceptable to have a differential cost-sharing for in-network emergency coverage and out-of-network emergency coverage, so long as such cost-sharing is applied consistently across a category (i.e., in-network, out-of-network) and uniformly to similarly situated individuals and communicated in advance to participants and beneficiaries. . . .

What that language seems to say to me is that under the Republican proposal, if you have a standard copay, let's say, of 20 percent if you are inside the HMO network but it is a 50-percent copay if you are out of the network, and you end up in the emergency room that is out of the network because it was the one closest to where you were when you had that chest pain, you may end up having to pay 50 percent of the emergency room bill rather than 20 percent that you would have had to pay in your in-network emergency room, which is what the Democratic bill would provide, that you would pay whatever emergency room from which you ended up receiving that emergency service.

Mr. FRIST. The question is, in essence, what I said earlier about the differential cost sharing; if you go back and look at the committee report, if you go to an emergency room, you can be charged out-of-network rates instead of in-network cost sharing. I do not have that report language before me right now, but if that is what is in the committee report, that is unacceptable to me. That is something that I am willing to work on in terms of the amendment process over the next several days because there is no question

in my mind as to the cost-sharing requirement, when you go into an emergency room, that you have to remove all barriers, that you can go to the closest emergency room, and that that cost-sharing requirement cannot be exaggerated or elevated to an out-of-network rate as we go forward.

I will work with you in terms of this whole issue that the cost-sharing requirement cannot be greater for out-of-network emergency services than for in-network services. That is a barrier that should not be there.

Mr. GRAHAM. Mr. President, that response was so satisfactory and indicated the kind of spirit which I hope this debate over the next 3½ days will sustain; that we are all trying to do what is best for patients and that we will work together to get to that end.

I have no further questions.

Mr. FRIST. Mr. President, let me just respond that I hope in my earlier comments in what I was saying about poststa-bilization—although I have not seen the wording of the amendment, but I know from committee that the Senator is committed to this—in the poststabilization end of things, in terms of how far in the process of prudent layperson recognition, the presentation to the emergency room of your choice, the cost-sharing arrangement we talked about, the medical screening, the stabilization, the poststabilization period, I, again, want to work with the Senator as we go forward.

I have to say it is a very complex issue as to how you trade back into the network, how you do that notification process. I worked in emergency rooms. I have been there. I worked for years in emergency rooms.

When somebody comes in, the last thing you want to be thinking about is a lot of phone calls and calling networks—should we or should we not take care of that individual patient? On the other hand, after things settle down and you take care of the emergency in the emergency room, you have the heart going, you have resuscitated them, then at some point in time they have to make their entrance back into the coordinated care plan.

So we have to be careful about poststabilization—at an appropriate time—but, again, doing what is right for the patient. So those two issues—the cost sharing and the poststabilization—I am committed to working with the Senator over the next several days.

I reserve the remainder of my time and yield the floor.

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I say to my friend from Florida that was an excellent question. It does appear the Senator from Tennessee has indicated that the Republican version of the emergency care aspect of that bill is lacking and that he would support the provisions you have indicated, having parity in charging from one emergency room to the other. It was an excellent question.

Mr. President, I yield 5 minutes to the Senator from Montana.

Mr. BAUCUS addressed the Chair.

The PRESIDING OFFICER. The Senator from Montana.

PRIVILEGE OF THE FLOOR

Mr. BAUCUS. I first ask unanimous consent that my assistant, Brent Asplin, be allowed floor privileges during the remainder of this bill.

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

Mr. BAUCUS. Mr. President, I want to follow up on the dialogue we had between Senator GRAHAM from Florida and Senator FRIST from Tennessee. I think we are finally getting to the heart of the matter as to on why the amendment offered by the Senator from Florida really does make sense and why it saves money and at the same time helps the patients.

I point out that this amendment contains identical language that this Senate has already passed 2 years ago with respect to Medicare and Medicaid—the same language. I frankly think it would not be wise—in fact, I think it would be a mistake—if the Senate were now to turn around and adopt a lower standard of care for Americans with private health insurance plans. It just does not make any sense.

I must also say that both bills appear to provide coverage for emergency services using the prudent layperson standard. At least that is how it appears on the surface. The prudent layperson standard is the standard that guarantees emergency care without prior authorization in any case that a prudent layperson would regard as an emergency. Both bills appear to have that same standard.

The question here is something that is a little bit different. The difference comes down to poststabilization services. The amendment before us today does offer coverage for poststabilization services. The Republican bill does not.

What are poststabilization services? They are those services needed when a patient has been stabilized after a medical emergency. That is afterwards.

Really, the debate about poststabilization comes down to two basic questions: First, is poststabilization care going to be coordinated with the patient's health plan or is it going to be uncoordinated and therefore inefficient?

The second question is: Are decisions about poststabilization care going to be made in a timely fashion; that is, when they are needed, or are we going to allow delays in the decisionmaking process that will compromise patient care and also lead to overcrowding in our Nation's emergency rooms?

Those are the two basic questions. Again, are the poststabilization services going to be coordinated with the health care plan or not; and, second, are these decisions going to be made in a timely fashion?

We have heard a lot of rhetoric about how poststabilization services amount to nothing more than a ''blank check'' for providers. That is the major argument against this amendment. Is it going to provide for a ''blank check'' for doctors, for hospitals, and for emergency care providers? If these provisions are a ''blank check,'' I might ask, then, why did one of the oldest, largest, and most successful managed care organizations in the country, Kaiser-Permanente, help create them in the first place?

Kaiser-Permanente likes this because it knows it makes sense. It helps patient care and it helps reduce costs. Kaiser-Permanente is a strong supporter of the poststabilization provisions in our bill; that is, the provisions offered by the Senator from Florida.

Why does Kaiser-Permanente support this? One simple reason. They realize that coordinating care after a patient is stabilized not only leads to better patient care but—guess what—it also saves money.

Let me give you an example of how the poststabilization services in this amendment can actually save money.

Just last week, while the Senate was in recess, I learned of a 40-year-old woman who went to an emergency room complaining of numbness on the right side of her body. The symptoms began to improve in the emergency room, and she was diagnosed with what her physicians referred to as a ''mini-stroke'' or a ''TIA.'' This condition is a warning sign for the possibility of a more serious, debilitating stroke.

The patient was stabilized in the emergency room, and the emergency physician attempted to contact the patient's physician but was unable to do so. The emergency doc tried to contact the patient's physician but could not. If the poststabilization provisions in our bill had been in place, it may have been possible to send this woman home to continue her tests as an outpatient. It would have been possible. It would have been probable because of the way she was stabilized.

But because the plan and the private physician were not available to provide coordinated and timely followup care, the emergency physician had to admit the patient to the hospital. Now, I am confused. Why don't some of my colleagues support this provision? Why don't they support a provision that provides a pathway to more efficient medical care?

Mr. President, I ask consent to speak for an additional 3 minutes.

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

Mr. BAUCUS. In this case, the outcome is very simple. A patient could have been discharged to home with follow-up care as an outpatient. Instead, she was admitted to the hospital because timely follow-up care couldn't be guaranteed through the health plan. Her hospitalization costs were much higher than the care she would have received as an outpatient.

Now, I must say, too, we have heard many stories about the retrospective denial of coverage for poststabilization services. These services are not optional medical care. That is not what we are talking about. That is a red herring. We are not talking about optional medical care. We are talking about the situation where the emergency doc has time only to make sure the patient is taken care of, either admitted to a hospital poststabilization or coordinate a plan with the patient's doctor, some similar thing, not unrelated or just tangentially related optional medical care. That is a red herring. That is not what we are talking about.

If my colleagues support the Graham-Chafee amendment, it is clear they will be voting for more efficient and more timely medical care. I hope the Republicans will join us to pass the real prudent layperson standard for emergencies. This standard has bipartisan support. It is endorsed by many professional organizations and consumer groups throughout the country.

For example, just this afternoon I received an endorsement by the American Heart Association of the prudent layperson amendment offered by Senators GRAHAM and CHAFEE. The American Heart Association states that the prudent layperson standard is ''essential to their mission of reducing death and disability from cardiovascular disease, the leading cause of death in America.''

The American Heart Association wants this amendment because they know it is right. Kaiser-Permanente wants this amendment because they know it is right. There is no reason why this amendment should not pass, particularly when the same standard applies today because of a law passed by this Congress 2 years ago, to Medicare and Medicaid.

I think it is common sense. I can't believe the objections to this amendment. I hope that after the other side thinks about it a little bit, they will realize that it does make sense and support it.

Mr. President, I ask unanimous consent to have printed in the RECORD a letter to me from the American Heart Association endorsing this amendment.

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

AMERICAN HEART ASSOCIATION,
Washington, DC, July 13, 1999.

Hon. MAX BAUCUS,
U.S. Senate,
Washington, DC.

DEAR SENATOR BAUCUS: On behalf of the 4.2 million volunteers of the American Heart Association, I urge you to support Senator Bob Graham's amendment, to be offered today to the patient protection legislation, which will ensure prompt emergency room access. This amendment is essential to our mission of reducing death and disability from cardiovascular diseases, the leading cause of death in America.

To reduce the devastation caused by cardiovascular diseases, the American Heart Association is committed to educating the public about the warning signs and the symptoms of heart attack and stroke. Acting on this knowledge is often the key to survival. In fact, every minute that passes before returning the heart to a normal rhythm after a cardiac arrest causes the chance of survival to fall by as much as 10 percent. Our consistent message to the public, therefore, is both to know the signs and symptoms of heart attack and stroke and to get emergency care as quickly as possible.

However, unnecessary and burdensome obstacles often stand between the patient and the emergency room door. Insurer ''pre-approval'' processes for emergency care can impede prompt treatment of heart attack and stroke. Delays in treatment can significantly increase mortality and morbidity. Our efforts to educate the public about the importance of getting prompt treatment are severely hindered by these ''pre-approval'' barriers.

The American Heart Association strongly supports Senator Graham's efforts to address these obstacles by ensuring the ''prudent layperson'' definition of emergency.

Thank you for your consideration of this issue. We look forward to your strong support for the Graham amendment.

Sincerely,

DIANE CANOVA, Esq.,
Vice President, Advocacy.

Mr. KENNEDY. Mr. President, HMO's across the country are denying coverage for emergency care, and patients are suffering.

A child has a severe fever, but his parents are forced to drive past the nearest emergency room to a distant facility that participates in the HMO's network. The child's hands and feet are amputated as a result of the delay in getting care.

A middle-aged man has severe chest pain and believes he is having a heart attack, but finds out at the emergency room that it was merely indigestion. His HMO denies payment for the visit, leaving him with an expensive bill for tests to rule out his symptoms.

A woman fractures her skull and is knocked out during a 40-foot fall while hiking. She is airlifted to a local hospital, but her HMO later denies coverage because she did not seek ''pre-authorization'' for emergency treatment.

A teenager dislocates his shoulder in an after-school sports program in Massachusetts. Another student's mother—who happens to be a physician—saves his arm by performing an emergency procedure while waiting for his HMO to send an ambulance to take him to the hospital.

Each case is unique, but all share a common theme. Patients are injured or stuck with the bill because their HMO tries to avoid responsibility for care that should be covered. According to a September, 1998, survey by Harvard University and the Kaiser Family Foundation, one in seven HMO patients report that their plan refused to pay for an emergency room visit, and one in ten say they have difficulty getting emergency care.

Two years ago, Congress passed legislation with strong bipartisan support in the Balanced Budget Act that put a stop to these abuses for Medicare and Medicaid patients. As a result, America's elderly, disabled and low-income citizens can seek care at the nearest hospital—without financial penalty—when they believe they are facing a medical emergency.

The Graham amendment and the Democratic Patients' Bill of Rights, which are strongly supported by the American College of Emergency Physicians, would extend those protections to all 161 million Americans with private health insurance.

The Republican leadership claims to do the same in their proposal, but their so-called protections are missing key parts or are riddled with loopholes. They apply to fewer than one-third of privately insured Americans. According to the American College of Emergency Physicians in a letter dated June 22, 1999, S. 326, as reported out of Committee, ''fails to achieve the promise of its section name. As drafted, [it] calls into serious question the underlying intent of the provision.''

First, the prudent layperson standard applies only if the HMO happens to define emergency medical care exactly as the act does. Thus, plans may be able to avoid the standard simply by changing their definition of emergency care.

Second, even if the prudent layperson standard were to apply, the Republican bill allows plans to charge patients more for going to the nearest emergency department, instead of the HMO's hospital. An amendment was offered in the committee to try to limit cost-sharing for patients who seek care at an out-of-network provider, but conflicting language in the legislation and accompanying Committee Report calls into question the true effect and intent of the amendment. The American College of Emergency Physicians calls the situation ''vague and confusing.'' Clearly, without this assurance, the protections offered by using a prudent layperson standard and removing prior authorization restrictions are moot. Patients will still feel pressured to seek care only at network hospitals—even if it means risking life or limb to get there—because they will fear the financial repercussions that may occur if they go to the nearest emergency room.

Third, the Republican leadership bill does not ensure coverage and coordination of the care that is provided after a patient is stabilized in the emergency room. This is a critically important gap, and an area in which coverage can be confusing and disputes frequent. That is why Congress included coverage for post-stabilization care in the Balanced Budget Act's protections for Medicare patients. Senator HUTCHINSON included it in the legislation he cosponsored with Senator GRAHAM last year. This year, however, Republican support for this important protection has disappeared, leaving millions of patients out in the cold.

Coverage of post-stabilization care will not significally undermine an

HMO's relationships with particular facilities or become a vehicle for a hospital or patient to manipulate the system after care is provided at a non-participating hospital. It simply ensures that patients receive all necessary care before being transferred or discharged, and that they are not left with the bill simply because the HMO turns off its phones at 5 p.m. or refuses to coordinate with the hospital.

Our plan would create a system to ensure that the treating provider and the plan begin a conversation to coordinate care as soon as practical once the patient arrives at the emergency room.

I have heard my Republican colleagues argue that this protection is unnecessary because no hospital will discharge a patient until that patient is sufficiently stabilized. That may be true, but the problem we seek to address here deals with coverage, not treatment. Thanks to the anti-dumping Emergency Medical Treatment and Labor Act, under current law patients should received the care they need when they present with symptoms in an emergency room.

But HMOs do not need to abide by this act—hospitals and doctors do. So, when the hospitals and doctors do their job and provide the care they think is necessary, the insurance company can later deny coverage for the care and patients are stuck with the bill.

The Graham amendment, which I strongly support, would put a stop to this abuse by ensuring that all parties begin discussing proper treatment and coverage options at the earliest possible moment. This amendment is based on Medicare's provisions. It says that insurance companies must use a prudent layperson standard if they cover emergency services. It says patients should not be charged more for going to the closest, but non-participating hospital. And it says that coverage should extend for necessary post-stabilization care, too. Millions of families deserve this protection, and they are waiting for its passage.

Mr. CHAFEE. Mr. President, today I urge my colleagues to join me in supporting meaningful emergency services protection for patients in managed care plans. I am happy to cosponsor this amendment with my good friend, Senator BOB GRAHAM.

This is one area where we should have little difficulty in coming to agreement—we have already extended this critical protection to Medicare and Medicaid beneficiaries as part of the Balanced Budget Act of 1997. Now it is time for the federal government to finish the job and provide all Americans with a single and consistent standard for emergency room coverage. What's good for our Medicare and Medicaid patients should be good for patients in private plans; there is no earthly justification for not extending this basic protection to all Americans. If a plan says it covers emergency medical services, then it ought to do just that—cover legitimate emergencies.

Simply put, this provision establishes reasonable standards to guarantee that patients will have their emergency services covered by their insurance company—regardless of when or where they happen to be faced with the emergency. This question of where the emergency occurs is an important one—the very nature of an emergency situation suggests that the patient will not always have the luxury of going to an emergency room that is part of the plan's network. It is important for patients who reasonably believe they need emergency medical care to receive it without delay.

There are several aspects to this provision that must be included to make it a meaningful protection for patients. I will quickly run through just a few of the most important:

First, protection from higher cost-sharing must apply to emergency services received without prior authorization. When time is of the essence, the patient should not be held to prior authorization requirements.

Second, if the patient is faced with an emergency, he or she should not be charged higher cost-sharing for going to an out-of-network hospital.

Third, the patient must have the assurance that his or her plan will arrange for necessary post-stabilization care—either at the facility where the patient is being treated for the emergency, or at an in-network facility—in a timely fashion. The best way to achieve this is through a reference to the post-stabilization guidelines already established in the Social Security Act.

This so-called ''post-stabilization'' requirement has been widely mischaracterized as requiring plans to pay for a whole host of services unrelated to the emergency condition at hand. However, I want to make clear that the requirement is really one for coordination—that is, the plan must simply communicate with the emergency facility in order to coordinate the patient's post-stabilization care. If the plan fails to communicate with the treating emergency facility, then, and only then, could the plan be held responsible for payment of post-stabilization services. Furthermore, the services must be related to the emergency condition.

Lest anyone doubt the importance of this coordination requirement—for patients and plans alike—all we have to do is look at the experience of Kaiser-Permanente, one of our nation's largest and oldest health insurers. They have found the provision easy to implement, and a money-saver. In a letter to Senator BAUCUS dated June 24, 1999 they write ''Of over two thousand patients transported in this fashion, one third have been discharged to their homes. Without this coordination of care, these patients would have been hospitalized at needless expense.''

All of these features are a part of the current law for Medicare and Medicaid beneficiaries, and have been extended to Federal employees by Executive Order. Patients in private health insurance plans deserve no less protection.

In sum, with passage of this provision, patients will no longer be in the unreasonable position of fearing that payment for emergency room visits will be denied even when these emergency conditions appear to both the patient and emergency room personnel to require urgent treatment. Patients will be assured prompt access to emergency care regardless of whether the emergency happens to occur out of range of an in-network provider.

I thank the Chair.

Mr. GRAHAM. Mr. President, how much time remains on this amendment?

The PRESIDING OFFICER. The Senator from Florida has 17 minutes 11 seconds.

Mr. GRAHAM. Mr. President, I yield myself such time as is necessary and ask to be notified when there are 5 minutes remaining for the proponents of the amendment.

When I spoke earlier, I said the devil was in the details, and I took some time to talk about two of those details, which were the question of cost sharing, whether you went to an emergency room that was inside the HMO's network or outside the network and, therefore, created an economic incentive under the Republican plan to not go to the emergency room that might be closest and most appropriate and, in instances, the life-saving emergency room. Then we talked about poststabilization care, whether the HMO could, by just not answering the telephone, not giving authorization, put the hospital and the patient in the situation where they had to take either a medical risk or an economic risk.

Let me mention two other specific areas which I think deserve the attention of the Senate where there are differences between the Republican and the Democratic proposal.

First is the issue of what is the kind of initial care that one will receive when they go into the emergency room as a prudent layperson. That is, they have exercised common sense as a layperson, that they have a symptom that could be emergent in character and, therefore, they should go to an emergency room.

In the Democratic plan, the definition of the services that will be provided are: A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition. That is the definition of the services to which you are entitled.

In the Republican bill, here is the definition: The plan shall provide coverage for benefits without requiring prior preauthorization for appropriate emergency medical screening examinations.

Now, are we going to get into the situation a week, a month, a year after

the emergency services have been provided that there will be a raging debate between the emergency room physician and the HMO as to whether the services that were provided were appropriate? Or should we not use the language that is in the Democratic provision which clearly states that it will be those services that are within the capability of the emergency department of the hospital?

The second concern is: What is the responsibility of the prudent layperson while you are lying there on the gurney having emergency diagnosis? Under the Republican plan, it states that to the extent that a prudent layperson who possesses an average knowledge of health and medicine would determine such examinations to be necessary to determine whether emergency medical care is necessary.

Do they really mean to say that here is this person who is having symptoms of a heart attack, is stretched out, is attached to all kinds of medical equipment, is obviously in a very distressed physical condition and probably in a very distressed emotional condition, that now this prudent layperson has to be so prudent as to second-guess whether the examinations that the emergency room physician is providing are the kind of examinations that should be provided? Presumably, if the prudent layperson in that almost comatose state doesn't make the right judgment as to what examination the emergency room physician should be rendering, those services won't be covered by the HMO.

That provision is so extreme as to shock the conscience of a prudent layperson who is just reading the language in the Republican bill. I am hopeful that the kind of spirit of common sense that our colleague, Dr. FRIST, the Senator from Tennessee, expressed would apply to focusing on these provisions.

The fortunate aspect of this proposal is that we don't have to totally operate in an environment of hope and guess. As the Senator from Montana stated, it has now been almost 3 years since this Senate and our colleagues in the House of Representatives, and the President of the United States, joined hands to adopt an emergency room provision for Medicare and for Medicaid covering almost 70 million Americans. We have had 3 years of experience under virtually the identical language that is now in the amendment before us.

My exploration with emergency room physicians, who strongly support this amendment, with HCFA, the Federal agency with the responsibility for the administration of the Medicare program in conjunction with the States, of the Medicaid program, have not pointed out that there have been this parade of horribles as a result of that legislation. If someone has other evidence they would like to offer, I urge them to do so.

I do not believe such testimony was given before the Labor Committee, when it considered this legislation, that indicated there had been a cratering of health care services in the emergency room for Medicare or Medicaid beneficiaries, or an escalation of cost as a result of the actions of the Congress and the President just some 3 years ago.

So I suggest that the prudent senatorial course of action on this matter would be to adopt the amendment that is before us. It is an amendment that we have already voted on in previous years as it relates to Medicare and Medicaid. We have a positive track record. We don't need to take chances with the emergency room treatment of the other almost 190 million Americans who are not under Medicare or Medicaid.

So in the spirit of the good will expressed by our colleague from Tennessee, I look forward to a close examination, and I hope that at the conclusion of that examination we will support and reaffirm the wisdom and judgment that we made in 1997.

The PRESIDING OFFICER. Who yields time?

Mr. GRAHAM. Mr. President, I suggest the absence of a quorum and ask unanimous consent that the time be charged to the opponents of the amendment.

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

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.

Mr. REID. Mr. President, I ask unanimous consent that the time during the quorum call run against both sides.

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

Mr. REID. 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.

Mr. REID. Mr. President, I ask unanimous consent that the time not be charged against either side on this quorum call that I am going to suggest.

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

Mr. REID. 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. NICKLES. 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. HARKIN. Mr. President, today I stand in support of a strong Patients' Bill of Rights. S. 6, the Democratic leadership bill, is of immense importance to the American people.

Some may ask, is such a bill necessary? Without question, it is. Currently, over 160 million of our family, friends, neighbors and children, are paying good money for health care with no guarantee of proper and appropriate treatment.

We don't have to look too hard to see that there are too many cases where appropriate care is not being provided. We have all heard horror stories of individuals unable to see their doctor in a timely manner * * * of patients unable to access the specialist they need * * * of individuals unable to get coverage for the type of care they believed and expected was covered under their plan.

It's very simple. Insurance either fulfills its promises or it doesn't. And we've heard enough to know that in too many cases it doesn't. Employers and patients pay good money for health care coverage, only to find that they're not getting the coverage they expected. In too many cases, the coverage they expected disappears when the need arises. I didn't have to look very hard to find such situations in my own state of Iowa.

Let me tell you a story about Eric, from Cedar Falls, Iowa, who has health insurance through his employer. Eric is 28 years old, with a wife and two children. He suffered cardiac arrest while helping out at a wrestling clinic. He was rushed to the hospital, where he was resuscitated.

Tragically, while in cardiac arrest, Eric's brain was deprived of oxygen. He fell into a coma and was placed on life support. The neurosurgeon on call recommended that Eric's parents get Eric into rehab.

It was then the problems began. Although Eric's policy covered rehabilitation, his insurance company refused to cover his care at a facility that specialized in patients with brain injury.

Thankfully, Eric's parents were able to find another rehab facility in Iowa. And Eric began to improve. His heart pump was removed, his respirator was removed, and his lungs are now working fine.

But, even with this progress, Eric's family received a call from his insurance company saying they would no longer cover the cost of his rehab, because he is not progressing fast enough.

Eric's mother wrote to me, saying, ''This is when we found out we had absolutely no recourse. They can deny any treatment and even cause death, and they are not responsible.''

This week, here on the Senate floor, we have a critical choice before us. A choice for Eric and his family. A choice between real or illusionary protections. A choice between ensuring care for millions of Americans or for perpetuating the already burgeoning profit margins of the Managed Care industry.

The Republicans have offered a bill that leaves out 115 million people because most of the patient protections in the plan apply only to self-funded employer plans. This would protect only 48 million of the 161 million with private insurance.

Our bill establishes a minimum level of patient protections by which managed care plans must abide. States can—and it's my hope that states will—provide even greater protections, as necessary, for the individuals in such plans in their states. As a starting point, however, we need to pass a strong and substantive managed care reform bill.

The American people want real patient protections.

Our bill, the real Patients' Bill of Rights Act, delivers on what Americans want and need, real protection against insurance company abuse. The bill provides basic protections for Americans, such as:

Access to needed specialists, including access to pediatric specialists;

the guarantee that a patient can see a doctor who is not on their HMO's list if the list does not include a provider qualified to treat their illness;

access to the closest emergency room and coverage of needed emergency care;

the guarantee that patients with ongoing serious conditions like cancer, arthritis, or heart disease can see their oncologist, rheumatologist, or cardiologist without asking permission from their HMO or primary care doctor each time;

the guarantee that patients can continue to see their doctor through a course of treatment or a pregnancy, even if their HMO drops their doctor from its list or their employer changes HMOs;

the guarantee that patients can get the prescription drug their doctor says they need, not an inferior substitute the HMO chooses because it's cheaper;

access to quality clinical trials for those with no other hope;

the ability to appeal an HMO's decision to deny or delay care to an independent entity and receive timely, binding decisions;

and, finally, the right to hold HMOs accountable when their decisions to deny or delay care lead to injury or death. Most situations will be resolved through our appeals mechanism. However, I believe that HMOs and insurers should not have special immunity when they harm patients.

No one can argue with the need to ensure access and quality of care for Americans. Over 200 organizations representing patients, consumers, doctors, nurses, women, children, people with disabilities, small businesses, and people of faith support the Democrats' Patients' Bill of Rights.

The Majority pretends that their bill offers real patient protections, but when you read everything below the title, it reads more like an insurers' bill of rights.

We have a chance to pass real and responsible legislation. The time for real reform is now. The American people have been in the waiting room for too long.

TRIBUTE TO JEANMARIE HICKS

Mr. DASCHLE. Mr. President, today I would like to take a moment to acknowledge a remarkable young woman from Rapid City, South Dakota, Jeanmarie Hicks, who was recently selected as the National Winner in the 1999 National Peace Essay Contest sponsored by the United States Institute of Peace.

This year more than 2,500 high school students from all 50 states were asked to express their thoughts on the topic of preventing international violent conflict. Winners from each state were awarded a $1,000 college scholarship and invited to participate in a week of special activities here in Washington. The National Winner receives an additional $10,000 college scholarship.

Jeanmarie Hicks, who recently graduated as valedictorian from St. Thomas More High School in Rapid City, wrote an eloquent essay entitled ''Preventive Diplomacy in the Iraq-Kuwait Dispute and in the Venezuela Border Dispute.'' In addition to her writing skills, Jeanmarie recently took first place in South Dakota in both the National French Contest and the National Spanish Contest, and will attend the College of St. Benedict in Minnesota this fall.

I know my colleagues join me in congratulating Jeanmarie on all of her accomplishments, and I ask unanimous consent that her essay be printed in the RECORD.

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

PREVENTIVE DIPLOMACY IN THE IRAQ-KUWAIT DISPUTE AND IN THE VENEZUELAN BORDER DISPUTE

(By Jeanmarie Hicks, St. Thomas More High School, January 22, 1999)

''Too little, too late'' often in the prevention of violent conflicts holds true (Peck). When the roots of the problem are not identified in time, violence becomes the solution. Preventive diplomacy, one way of avoiding conflicts, can be defined as ''action to prevent disputes from arising among parties to prevent existing disputes from escalating into conflicts, and to limit the spread of the latter when they occur'' (Boutros-Ghali 45).

Preventive diplomacy protects peace and ultimately people, who suffer greatly in armed conflicts. Preventive diplomacy has been used in many disputes, including the border dispute in Venezuela with Great Britain in the 1890s and in this decade's Iraq-Kuwait dispute. Conflict was prevented in Venezuela. However, preventive action was not effective in Kuwait; and civilians suffered as a result.

The United States' intervention in the border dispute in Venezuela is one example of preventive diplomacy. Unfortunately, the border between Guyana and Venezuela was never clearly defined; and colonial maps were inaccurate (Lombardi 29). From the 1840s until the 1880s, Britain pushed into Venezuela over Guyana's western border by claiming the area's gold (Lombardi 29), and by asserting that the land from the Rio Essequibo to the Orinoco was part of Guyana (Schomburgk Line) according to colonial maps (Daly 2). Britain was vehement about its right to the land, and Venezuela appealed to the U.S. for aid. Under the Monroe Doctrine, the U.S. states that it will act as a police force to protect Latin America from European influence. The U.S. viewed Britain's occupation of a portion of Venezuela as a breech of the doctrine (Cleveland 93).

Conflict was imminent, as Britain began to prepare its navy for war (Boutwell 4). A solution appeared in 1895 in the person of Secretary of State Richard Olney, Enthusiastic to attempt preventive diplomacy, Olney sent a dispatch to Britain stressing the importance of the Monroe Doctrine. Lord Salisbury of Britain responded, saying that the Monroe Doctrine was not applicable in the Venezuela situation, as no system of government was being forced upon the country (Cleveland 100–101). In addition, Salisbury pointed out that the conflict was not the result of the acquisition of new territory: Guyana owned the territory in question (Boutwell 10).

Olney stressed that the issue was pertinent to American stability, and remained steadfast in his demands (Cleveland 109). When Britain refused to submit, Congress authorized the president's appointment of an investigative committee. Meanwhile, Salisbury and Olney organized a meeting for November 10, 1896. At the meeting, a treaty was written; and the U.S. threatened to use its military to remove Britain from Venezuela's border if necessary. Britain and Venezuela signed the treaty on February 2, 1897, giving Venezuela control of the Rio Orinocco and much of the land behind the Schomburgk Line (Cleveland 117–118). Thus preventive diplomacy on the part of the U.S. was successful, and war was avoided.

The use of preventive diplomacy in the recent Iraq-Kuwait dispute was less successful. Iraq had been part of the Ottoman Empire from the 1700s until 1899, when Britain granted it autonomy (Darwish and Alexander 6). When in 1961, Britain gave Kuwait independence, Iraq claimed that, historically, Kuwait was part of Iraq (Sasson 9). Iraq begrudgingly recognized Kuwait's independence in 1963.

For awhile, relations between the two countries improved as Kuwait aided Iraq monetarily in the Iran-Iraq War (1980 until 1988) (Sasson 11). After the war, however, Iraq demanded money from Kuwait for reconstruction. Then Iraq accused Kuwait of drilling oil from the border without sharing and of taking more oil than the Organization of Petroleum Exporting Countries (OPEC) quota permitted (Sasson 12). Iraq began to threaten Kuwait borders, beginning a conflict that would take thousands of soldiers away from their homes, harm civilians, and detrimentally affect the environment.

In 1990, Iraq began to mobilize near the Kuwait border (Darwish and Alexander 6). Arab nations made unsuccessful attempts at preventive diplomacy (U.S. News & World Report 99). Surrounding nations attempted unsuccessfully to meet with Saddam Hussein. Iraq invaded Kuwait, took control of its capital on August 2, 1990, and installed a puppet government under Hussein's command. Iraqi soldiers brutally raped Kuwaiti women, and killed any civilian who was considered an obstruction (Sasson 76). At this point, the United Nations Security Council and the Arab League placed an embargo on Iraqi oil as punishment. Iraq, in response, annexed Kuwait (U.S. News & World Report 95–96).

War was imminent. On November 29, 1990, Iraq showed no signs that it would retreat. The United Nations Security Council declared that the coalition should use all