United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 106th CONGRESS, FIRST SESSION

Vol. 145 WASHINGTON, THURSDAY, JULY 15, 1999 No. 100

Senate

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

The PRESIDENT pro tempore. Today's prayer will be offered by our guest Chaplain, Reverend J. Blaine Blubaugh, Graham Road United Methodist Church, Falls Church, VA.

We are pleased to have you with us.

PRAYER

Almighty God, as we gather here to execute the function of our responsible positions, we are reminded of Your generosity in blessing us with this great Nation of vast human and natural resources and count it a privilege to live and serve here.

We lift before You today these women and men who lead our Senate and express gratitude for their labors. We pray for our President, the President of this Senate, Members of this Senate, and all who serve with them. May they serve with compassion and hope. Empower them to realize their potential in this service.

May all who serve here carry both the privileges and burdens of authority with well-founded responsibility and duty. May they use their influence with honor and dignity and serve to be examples to citizenry wherever they travel so that all with whom they come in contact may realize that service to our Creator and humanity is an honorable work of life. May concrete and effective help be delivered from the votes on various issues and encouragement for those who are attempting to provide a better life for all.

We pray for wisdom, sensitivity, clarity of vision, and a correct perspective which avoids superficial or temporary solutions. We express gratitude for all who make a positive impact in our world, those who lead, build, and contribute to make a difference.

We pray for the families of those who serve in this Senate and ask for a measure of strength and grace for them to cope during their separation and a sense of joy when they are reunited. May all who serve here temper their toil with periods of rest, refreshment, and recreation, and may the spirit of peace and goodwill be the order of the day for this U.S. Senate session. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore. Senator CRAPO of Idaho is designated to lead the Senate in the Pledge of Allegiance to the flag.

The PRESIDING OFFICER (Mr. CRAPO) led the Pledge of Allegiance, as follows:

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

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

SCHEDULE

Mr. SPECTER. Mr. President, I would like to make opening remarks on behalf of the distinguished majority leader to the following effect, that today the Senate will immediately proceed to a period of morning business until 10 a.m. Following morning business, the Senate will resume consideration of the Patients' Bill of Rights, with Senator NICKLES or his designee to be recognized to offer an amendment. Under the previous agreement, there will be 100 minutes of debate on that amendment. Further amendments will be offered and debated in anticipation of completing the bill today. Senators can expect votes throughout the day.

As a reminder, a cloture vote on the Social Security lockbox legislation will take place during tomorrow's session of the Senate.

I thank my colleagues for their attention.

Now, Mr. President, a parliamentary inquiry. May I proceed with the 15-minute order which has been allotted to me?

MORNING BUSINESS

The PRESIDING OFFICER. The Senate is in morning business. The Senator is recognized for 15 minutes.

Mr. SPECTER. I thank the Chair.

Mr. President, I had requested this time on behalf of myself and Senator BIDEN. We had originally requested 30 minutes, but because of the crowded schedule today, the time was set at 15 minutes. But I will be delighted to share the 15 minutes with Senator BIDEN if he arrives before the expiration of the time.

ELECTRONIC FILING OF SHIPPERS' EXPORT DECLARATIONS

Mr. SPECTER. Mr. President, I have sought recognition in this special order to introduce legislation, on behalf of Senator HELMS, the Chairman of the Foreign Relations Committee; Senator BIDEN, the ranking Democrat; Senator DORGAN and Senator SCHUMER, which would provide for electronic filing of Shippers' Export Declarations. This legislation takes up a recommendation of the Commission on Weapons of Mass Destruction and is directed to assist in our export control to stop those who would acquire the material for weapons of mass destruction from accumulating those weapons. At the present time, there are very sophisticated ways of ordering the component parts of weapons of mass destruction which are not known and cannot be readily ascertained because of the voluminous paper filings.

This legislation would call for electronic filing and would enable our Government to be able to regulate in a desirable fashion, without undue burden on exporters, materials which can be used for nuclear, biological, or chemical weapons. This is a recommendation of the Commission on Weapons of

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

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Mass Destruction which filed its report yesterday with copies to the President and to the legislative leaders.

This Commission was established by legislation under the Intelligence Authorization Act signed into law in October of 1996 when I chaired the Senate Intelligence Committee. This legislation was designed to deal with the enormous threat posed to the United States by weapons of mass destruction.

When I chaired the Intelligence Committee in 1995 and 1996, I was aghast at the kinds of problems which I saw with respect to rogue nations having ballistic capabilities for the delivery of nuclear weapons. Since that time, it has been publicly commented that North Korea has nuclear capability; that they have trajectory and ballistic capability to reach parts of the United States; that they pose an enormous threat. It is well known that other rogue nations seek ballistic capability as well. We now find that a nuclear device can be carried across national borders in a suitcase. We have seen in the experience of the Tokyo subway catastrophe the potential for biological and chemical warfare.

Those capabilities are so important that there needs to be preventive action to deal with them in advance of a catastrophe. Regrettably, our Government customarily reacts, instead of acting in anticipation.

The Commission was formed because there are now some 96 separate agencies dealing with weapons of mass destruction, and the Commission filed in its report a recommendation urging Presidential action with the suggestion that the authority be concentrated in the hands of the Vice President. There have been jurisdictional disputes, turf battles, but the Vice President would have the clout to adjudicate disputes and to coordinate the efforts on this matter of such enormous national and international importance.

The Commission recommended providing staffing, with a director to the National Security Council, a top level position, to preside over a council of representatives from the various Departments—State, Energy, Defense, Commerce, et cetera—with ranking officials who have been confirmed by the Senate.

One of the key recommendations of the Commission on Weapons of Mass Destruction was to mandate electronic filing on export items which are in the category that they could provide component parts for weapons of mass destruction.

My staff, Dobie McArthur, has already taken the lead in circulating this legislation among a number of Senators. We have had a favorable response from Senator HELMS and Senator BIDEN, chairman and ranking member of the Foreign Relations Committee. There is an excellent opportunity that this provision could be included in a markup of Foreign Relations this month. As noted earlier, Senator DORGAN and Senator SCHUMER have also joined as cosponsors.

What this legislation does is to provide for the electronic filing of what is known and currently required as a shipper's export declaration. In 1995, the Customs Service and the Census Bureau created the automated export system, but that system has been utilized by only about 10 percent of the filers.

This legislation provides that the electronic filing requirement would come into operation 180 days after the Secretary of Commerce and the Secretary of Treasury certify that a secure Internet-based filing system is up and running. The requirements would be directed toward components which could be used in the manufacture of weapons of mass destruction.

The problem is illustrated by action taken by Iraq in the acquisition of weapons of mass destruction. In a very sophisticated way, when Iraq was purchasing its component parts, instead of buying them all at one time and all from a single supplier, or quite a number of items from a single supplier a few times, the Iraqis would buy an item here, an item there, an item somewhere else, from a wide variety of suppliers, so it was impossible, without some tracking system, to find out exactly what Iraq was doing as they were acquiring these components for weapons of mass destruction.

As we all know, there is dual use on many of these items; that is to say, they can be used for peaceful purposes or they can be used for putting together weapons of mass destruction. In this way, with a sophisticated system, a purchaser may acquire the ingredients to produce weapons of mass destruction.

Electronic filing will put the matter all under one umbrella. Without undue burden on shippers, there can be a determination as to what is being purchased which has the potential for being turned into a nuclear weapon, a biological weapon, or a chemical weapon of mass destruction.

Mr. President, how much time remains on my allotment of 15 minutes?

The PRESIDING OFFICER. Six minutes 14 seconds.

Mr. SPECTER. Mr. President, I will use that time on another subject of currency and importance.

GATHERING EVIDENCE FOR THE WAR CRIMES TRIBUNAL

Mr. SPECTER. Mr. President, the War Crimes Tribunal, which was created by United Nations resolution for prosecuting crimes against humanity arising in the former Yugoslavia, has brought very significant indictments out of the events in Bosnia. There have been indictments; there have been some convictions. The work of the War Crimes Tribunal has taken on even greater significance as a result of what has happened in the war with Kosovo, with the very noteworthy and important indictment against President Milosevic of Yugoslavia.

The Tribunal is now in the process of gathering evidence in Kosovo. Justice Louise Arbour, who is head of the War Crimes Tribunal and has given notice of her intention to leave to become a justice in the Canadian judicial system, visited the Senate back on April 30, 1999. She met with a group of Senators, including myself, and pointed out the need for the acquisition of evidence.

There had been a preliminary allocation of some $5 million. That was supplemented in the emergency appropriations bill with the direction for an additional $13 million, for a total of $18 million to go towards the Tribunal.

The FBI dispatched a group of investigators to acquire evidence in Kosovo, but they have run out of money. Those funds, I believe, are available in the Department of State. I have discussed this matter with the FBI Director Louis Freeh. I compliment the FBI and Director Freeh for their very prompt action in going to Kosovo to gather evidence.

From my own experience as district attorney of Philadelphia, I can personally attest to the fact that evidence has to be acquired when it is fresh. If you do not get it with immediacy, it disappears.

A part of the evidence acquisition has been to question women who were subjected to rape. In conversations with officials of the State Department yesterday, I found that the $50 million which has been appropriated for the United Nations High Commissioner on Refugees has not been released. So there is an urgency in making those funds available for a variety of purposes, including a substantial part of the $50 million to give attention to the women who have been rape victims—in part to counsel them for their own mental health and in significant part to acquire their testimony in the prosecution of those violent perpetrators of the rapes.

So I make these comments and urge that we move ahead with this funding which has been authorized by the Congress, $50 million to the U.N. High Commissioner on Refugees, and also urge that funding be provided in accordance with the direction of the Emergency Supplemental Appropriations Bill so the FBI can have the funding to proceed immediately to Kosovo to gather this very important evidence.

Ms. MIKULSKI. Will the Senator from Pennsylvania yield for a question?

Mr. SPECTER. I will.

Ms. MIKULSKI. First, I congratulate the Senator from Pennsylvania on his leadership in this area. As he knows, we have worked together, but he has certainly been in the forefront on the war crimes issue in particular, the issue of rape as a war crime. We thank him for that.

Does the Senator from Pennsylvania know why the money is not being released?

Mr. SPECTER. I thank my distinguished colleague from Maryland for those kind remarks.

In response, I am advised by officials of the State Department that early on were some problems in the United Nations agency. There is chaos, as one might expect, in Kosovo. The Kosovars are returning to their homes. Some have raised a point that the money was not being officially utilized. I have been advised by the State Department that the issue has now been corrected; so when I made inquiries of the State Department yesterday to liberate $2 million for the FBI, I was told that they had this collateral problem and have begun discussions on the matter with our appropriate colleagues to get the funds released.

Ms. MIKULSKI. Just for a point of information and clarification back to the Senator from Pennsylvania, in a meeting yesterday with the women of the Senate—a bipartisan meeting, I might add—I believe we were told there is a hold on this among our colleagues. Perhaps we can work together to lift that hold to ensure that the bureaucracy concerns are dealt with so we can go on with the mutual humanitarian concerns that I know we share on both sides of the aisle.

Again, I thank the Senator for his leadership on this in the most sincere, kind way.

Mr. SPECTER. If I may respond, that is consistent with what I was told. I did not want to use the expression ''hold'' because of the pejorative connotation in this Chamber. I made the same point by saying that there were obstacles to getting the funds released. But I think it is a matter of enormous importance. I am glad to hear the bipartisan group of women were meeting yesterday to exercise their leadership. This business about crimes against humanity and rape is just horrendous. We have to act, and act promptly.

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

Under the previous order, the Senator from West Virginia is now recognized for 15 minutes.

THE STEEL IMPORT CRISIS: ANOTHER 1,800 U.S. JOBS AT RISK

Mr. BYRD. Mr. President, I thank the Chair.

For months now, I and many of my colleagues, including the very distinguished senior Senator from Pennsylvania, Mr. SPECTER, have been alerting this Congress to the devastating nature of the steel import crisis that has plagued this Nation since the end of 1997.

A year and a half later, in yesterday's Wheeling Intelligencer headlines, we see the statement: ''Sixth Steelmaker Claims Bankruptcy.'' Let me repeat that headline from the Wheeling, WV, newspaper: a sixth U.S. steel mill has declared bankruptcy.

With that announcement, U.S. steelworkers in West Virginia, and elsewhere, are wondering when the Clinton administration and this Congress will realize that enough is enough. I have no doubt that the 1,800 people who are employed at Gulf States Steel, Inc., in Gadsden, AL—the sixth U.S. steel mill to declare bankruptcy since the steel import crisis began—are also wondering why no one is acting on a long-term basis to prevent the illegal steel dumping that has jeopardized their jobs.

I say enough is enough. Six companies declare bankruptcy, more than 6,200 jobs are jeopardized, and this Administration and this Congress still fail to act:

1,800 jobs in Gadsden, Alabama;
200 jobs in Alton, Illinois;
140 jobs in Holsapple, Pennsylvania;
2,400 jobs in Vineyard, Utah; and
540 jobs in Washington, Pennsylvania, and Massillon, Ohio.

For those who believe that the steel industry is not in difficulty, tell it to these families. Tell it to those workers who have lost their jobs. These men and women and their families are the human faces of the steel crisis. They are not just numbers. They are not just statistics. These are real faces. These are real men and women. These are real children of the steel crisis.

While we do nothing, the list of the victims of the steel import crisis grows ever longer. I hear from U.S. steelworkers. They want to know how many more bankruptcies it will take to make the President of the United States and the Congress understand that immediate action must be taken against the tide of cheap and illegal steel imports into this country. How many more U.S. jobs must be lost before we tell our trading partners that enough is enough?

We already know that there will be no quota bill passed by this Congress. The House passed a quota bill. The Senate has not passed a quota bill and will not pass a quota bill. Penalties are not likely against Brazil and Russia, even though the Commerce Department and the International Trade Commission found them to be guilty of dumping steel illegally on American shores. Instead of finding a long-term, global solution, this administration chooses to promote piecemeal solutions and negotiate suspension agreements with those two countries. Changes in U.S. trade laws to strengthen enforcement seem even more unlikely.

According to the Wheeling, WV, Intelligencer, the U.S. steel industry is still holding on to the thin hope that the steel loan guarantee program, which the Senate has already approved twice, will quickly, hopefully, be approved in the House of Representatives. While this is only a short-term program to help U.S. steel mills that have been hurt by the steel import crisis, I thank my colleagues for passing the Emergency Steel Loan Guarantee Program, authored by me, and a similar program, the Emergency Oil and Gas Guaranteed Loan Program, authored by Senator DOMENICI.

On June 21, the Senate requested a conference with the House on H.R. 1664, which contains the steel loan guarantee and the oil and gas loan guarantee, and conferees have been appointed by the Senate. I am hopeful that this conference will take place soon, and we have every right to expect that that conference will take place soon.

There was a commitment entered into not too long ago, at the time the emergency supplemental appropriations bill was in conference between the two Houses. A commitment was entered into by the leadership of both the House and Senate to call up the bill in the Senate. That was done. The majority leader of the Senate and the minority leader kept their commitments. The bill was called up in the Senate, and the steel loan guarantee program and the oil and gas loan guarantee program were passed by the Senate for the second time and sent to the House. It is to be expected that a conference will take place, as the Senate has requested. Hopefully, that conference will then meet and act, and act quickly, and hopefully, further, both Houses will quickly adopt a conference report and send it on to the President for his signature.

Illegal steel dumping has created exigent circumstances for the U.S. steel industry, and the loan guarantees will provide help to companies, small and middle-sized steel companies that employ thousands of hard-working Americans. These loan guarantees would work through the private market, help to sustain good-paying jobs, support our national security, and save taxpayers millions of dollars from lost tax revenues and increased public assistance payments for things such as unemployment compensation, food stamps, and worker retraining.

The fate of the loan programs rests today in the hands of the U.S. House of Representatives. With great respect, I urge the House to act quickly. On behalf of U.S. steel mills and U.S. steelworkers, for those 1,800 steelworkers at great risk with Gulf States Steel in Alabama, for the thousands of other steelworkers and their families across the country who cry out for help, I urge the other body to take action and to support the Emergency Steel Loan Guarantee Program.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator has 5 minutes 28 seconds remaining.

Mr. BYRD. Does the distinguished Senator from Alabama wish time?

Mr. REID. Mr. President, if I could interrupt my friend from West Virginia, the Senator from Maine has requested 5 minutes and there isn't time left for that unless he would yield to the Senator. Otherwise, she would—

Mr. BYRD. I would be very happy to yield to the Senator. First, I would like

to inquire of the distinguished Senator from Alabama if he wishes some of my time.

Mr. SESSIONS. I thank the Senator from West Virginia. I do not. I expect to follow the Senator from New Hampshire. I do not seek the floor now.

Mr. BYRD. I thank the Senator.

Mr. SESSIONS. I do appreciate the leadership of the Senator from West Virginia on the steel question. It is important; a company in critical condition, with 1,800 employees in Alabama and a 30-year record of business success, which has, in just the last week, gone into bankruptcy.

And I do believe the loan guarantee could help save that historic company. I thank the Senator for his leadership.

Mr. BYRD. I thank the distinguished Senator. With my remaining time, I am very glad to yield to the Senator from Maine, Ms. SNOWE, if she wishes to have my remaining minutes.

Ms. SNOWE. I thank the Senator from West Virginia. I appreciate that. How much time remains?

The PRESIDING OFFICER. Four minutes 4 seconds.

Mr. GREGG. Mr. President, I ask unanimous consent that in addition to the 4 minutes she would be receiving from the Senator from West Virginia, the Senator from Maine receive 5 additional minutes in morning business.

Mr. REID. Mr. President, I don't want to be obstreperous, but we have to get to the bill. That is why I urged the Senator from West Virginia to give his time to the Senator from Maine. I have no problem with that. But as far as extending time, it would have to come off the bill.

The PRESIDING OFFICER. There is objection. Does the Senator from Maine desire to have the remaining time?

Ms. SNOWE. Yes, I do. I thank the Senator from West Virginia for yielding.

Mr. BYRD. Mr. President, my time is rapidly dwindling. I would like to know whether or not she wishes my remaining time.

Ms. SNOWE. Yes.

Mr. BYRD. I ask unanimous consent that my remaining time may be allotted to the Senator from Maine.

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

The Senator from Maine is recognized.

CONGRATULATING THE U.S. WOMEN'S SOCCER TEAM

Ms. SNOWE. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 141, a resolution submitted earlier by Senator SNOWE, Senator REID, and others.

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

The clerk will report.

The assistant legislative clerk read as follows:

A resolution (S. Res. 141) to congratulate the United States Women's Soccer Team on winning the 1999 Women's World Cup Championship.

There being no objection, the Senate proceeded to consider the resolution.

Ms. SNOWE. Mr. President, I rise today to introduce a resolution along with Senators REID, MURRAY, MIKULSKI, COLLINS, LANDRIEU, FEINSTEIN, BOXER, HUTCHISON, and LINCOLN honoring the U.S. Women's National Soccer Team for their outstanding performance and dramatic victory in winning the 1999 Women's World Cup. This is a resolution that I've worked on with Senator Reid, who spoke eloquently earlier in the week on the World Cup victory, and I want to thank him for his strong support for the team and its accomplishments.

The U.S. Womens' National Soccer Team has got to be the single greatest sports story this year, and certainly of this decade. Capturing the hearts and the imagination of America with remarkable play and even higher levels of teamwork and good sportsmanship, the U.S. Women's Soccer Team has ushered in a new era in women's athletics.

We are not just talking about talented athletes here—we're talking about role models who are driven to play by the thrill of victory and the excitement of competition. And perhaps therein lies the true appeal of this team—in a time when money and commercialism often seem to overwhelm the true spirit of sport, along comes these extraordinary women who restore our faith in the virtues of athletic competition and truly give us something to cheer about.

Is it any wonder, then, that these women—as well as women from other nations who have come to the United States in search of World Cup glory—have been ''packing them in'' wherever they have played. Indeed, The Boston Globe reported that only the Pope has drawn more people to Giants Stadium in New Jersey, and all 65,080 seats at Soldier Field in Chicago were sold-out for the United States-Nigeria game—the largest crowd ever to see a soccer game at that venue.

For the final, over 90,000 fans were on hand to see the national team's dramatic victory over China—a record for an all-women sporting event. Not only has women's soccer arrived, it's taken the nation by storm.

From coast to coast, Americans tuned in to watch our team play world-class soccer—and they weren't disappointed. In fact, it's estimated that about 40 million viewers watched all or part of that nail-biting final match. That's nearly double the rating for the men's World Cup final last year between Brazil and Italy, and bests even the average national ratings for the recent NBA finals between the New York Knicks and the San Antonio Spurs.

Those of us who viewed the tournament were rewarded with victory after victory, as well as the joy of watching athletes who truly love to play. And if Saturday's real-life finale had instead been the ending to a Hollywood movie, it would have been panned for being utterly unbelievable. Who would have thought that after 120 minutes of regulation play, the score would still be tied at zero-zero, with penalty kicks the only thing standing between defeat and victory?

Throughout all that time—with the nation watching, waiting, hoping, and anticipating, with 90,000 chanting fans hanging on every kick, every header, every pass, and every breakaway—our team never gave up or gave in. Goalkeeper Briana Scurry was nothing short of remarkable, robbing the Chinese team of a critical penalty kick. And at the end, when Brandi Chastain's shot came to rest at the back of the opposing team's net, it all paid off in one of those incredible sporting moments that will go down not only in the history of sports, but in the history of womens' struggles for recognition and equality.

There is no question, Mr. President, that sports are just as important an activity for girls and women as they are for boys and men. Through sports, girls and women can experience a positive competitive spirit applicable to any aspect of life.

They can truly learn how to ''take the ball and run with it'', not only on the playing fields, but in classrooms, boardrooms, and, yes, even the Committee rooms of Congress. Through athletics, girls and women can achieve a healthy body and a healthy mind. They gain the self-esteem to say ''give me the ball'' with the clock running out and the game on the line.

You know, when I was growing up, girls and women did not have much opportunity to participate in competitive athletics. But the enactment of Title IX of the Education Amendments of 1972 changed all that for good. Finally, with the passage of this landmark legislation, women would be afforded equitable opportunities to participate in high school and college athletics.

And the results are indisputable. Since Title IX's enactment, women and girls across the nation have met the challenge of participating in competitive sports in record numbers. In the past 28 years, the number of college women participating in competitive athletics has gone from fewer than 32,000 to over 128,000 in 1997. Before Title IX, fewer than 300,000 high school girls played competitive sports. As of 2 years ago, that number had climbed to almost 2.6 million.

The U.S. Women's Soccer Team has not only underscored the achievements of Title IX, but has encouraged even more young women to get into the arena and onto the playing fields. You know, it used to be said that girls were made of ''sugar and spice and everything nice.'' Well, the U.S. Women's Soccer Team proved that there is room for being both ''nice'' and determined. There is room for being both a woman and a competitor.

Indeed, it astounds me when I think of how far we have come since I introduced the original joint resolution of Congress establishing the very first National Girls and Women in Sports Day back in 1986. Where dreams of athletic glory were once almost the exclusive domain of boys, today—thanks in large part to out Women's National Soccer Team—girls now have aspirations of their own.

Watching this team has inspired a whole generation of girls to believe that they can go as high and as far as their talent—and their drive—will take them. Indeed, I have no doubt that girls across America will be running around the soccer fields this summer pretending to be Briana Scurry, Michelle Akers, Mia Hamm, or whoever their particular heroine may be. Certainly, on this team, there are plenty from which to choose.

The U.S. Women's National Soccer Team is but one more example of how, when it comes to athletics, women are ''coming off the bench,'' as it were, and taking their rightful place on the fields, on the courts, in the schoolyards and in our stadiums. They prove, once again, that women are just as sure-footed in cleats as they are in heels or whatever other shoes they decide to fill.

In addition to commending the team for all they've done, I would like to take this opportunity to thank the organizers and sponsors of the entire event for the extraordinary job they did in making this tournament a success beyond anyone's wildest dreams. I have no doubt these past few weeks will have an impact on sports in America that will resonate for years.

Again, let me just express my most sincere appreciation to each and every member of the U.S. Women's World Cup Team for making us so proud. They have honored their nation with their sportsmanship, and they have honored themselves with their commitment to each other and their dedication to excellence. Now it is our turn to honor them, and I am pleased to have my colleagues' support for this resolution.

The PRESIDING OFFICER. Without objection, the resolution is agreed to, and the preamble is agreed to.

The resolution (S. Res. 141) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 141

Whereas the Americans blanked Germany in the second half of the quarter finals, before winning 3 to 2, shut out Brazil in the semifinals, 2 to 0, and then stymied China for 120 minutes Saturday, July 10, 1999;

Whereas the Americans, after playing the final match through heat, exhaustion, and tension throughout regulation play and two sudden-death 15-minute overtime periods, out-shot China 5–4 on penalty kicks;

Whereas the Team has brought excitement and pride to the United States with its outstanding play and selfless teamwork throughout the entire World Cup tournament;

Whereas the Americans inspired young women throughout the country to participate in soccer and other competitive sports that can enhance self-esteem and physical fitness;

Whereas the Team has helped to highlight the importance and positive results of title IX of the Education Amendments of 1972 (20 U.S.C. 1681), a law enacted to eliminate sex discrimination in education in the United States and to expand sports participation by girls and women;

Whereas the Team became the first team representing a country hosting the Women's World Cup tournament to win the tournament;

Whereas the popularity of the Team is evidenced by the facts that more fans watched the United States defeat Denmark in the World Cup opener held at Giants Stadium in New Jersey on June 19, 1999, than have ever watched a Giants or Jets National Football League game at that stadium, and over 90,000 people attended the final match in Pasadena, California, the largest attendance ever for a sporting event in which the only competitors were women;

Whereas the United States becomes the first women's team to simultaneously reign as both Olympic and World Cup champions;

Whereas five Americans, forward Mia Hamm, midfielder Michelle Akers, goalkeeper Briana Scurry, and defenders Brandi Chastain and Carla Overbeck, were chosen for the elite 1999 Women's World Cup All-Star team;

Whereas all the members of the 1999 U.S. women's World Cup team—defenders Brandi Chastain, Christie Pearce, Lorrie Fair, Joy Fawcett, Carla Overbeck, and Kate Sobrero; forwards Danielle Fotopoulos, Mia Hamm, Shannon MacMillian, Cindy Parlow, Kristine Lilly, and Tiffeny Milbrett; goalkeepers Tracy Ducar, Briana Scurry, and Saskia Webber; and midfielders Michelle Akers, Julie Foudy, Tiffany Roberts, Tisha Venturini, and Sara Whalen; and coach Tony DiCicco—both on the playing field and on the practice field, demonstrated their devotion to the team and played an important part in the team's success;

Whereas the Americans will now set their sights in defending their Olympic title in Sydney 2000;

Resolved, That the Senate congratulates the United States Women's Soccer Team on winning the 1999 Women's World Cup Championship.

PATIENTS' BILL OF RIGHTS ACT OF 1999—Resumed

The PRESIDING OFFICER. The clerk will report the pending bill.

The assistant 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.

Pending:

Daschle amendment No. 1232, in the nature of a substitute.

Collins amendment No. 1243 (to the language proposed to be stricken by amendment No. 1232), to expand deductibility of long-term care to individuals; expand direct access to obstetric and gynecological care; provide timely access to specialists; and expand patient access to emergency medical care.

The PRESIDING OFFICER. Under the previous order, the Senator from Oklahoma is recognized.

Mr. NICKLES. Mr. President, I ask the Senator from New Hampshire to manage this portion of the bill.

The PRESIDING OFFICER. The Senator from New Hampshire, Mr. GREGG, is recognized.

AMENDMENT NO. 1250 TO AMENDMENT NO. 1243

(Purpose: To protect patients and accelerate their treatment and care)

Mr. GREGG. Mr. President, 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 New Hampshire [Mr. GREGG] proposes an amendment numbered 1250 to amendment No. 1243.

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

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

The amendment is as follows:

At the end of the amendment add the following:

SEC. . PROTECTING PATIENTS AND ACCELERATING THEIR TREATMENT AND CARE.

(a) FINDINGS.—The Senate makes the following findings with respect to the expansion of medical malpractice liability lawsuits in Senate bill 6 (106th Congress):

(1) The expansion of liability in S. 6 (106th Congress) would not benefit patients and will not improve health care quality.

(2) Expanding the scope of medical malpractice liability to health plans and employers will force higher costs on American families and their employers as a result of increased litigation, attorneys' fees, administrative costs, the costs of defensive coverage determinations, liability insurance premium increases, and unlimited jury verdicts.

(3) Legal liability for health plans and employers is the largest expansion of medical malpractice in history and the most expensive provision of S. 6 (106th Congress), and would increase costs ''on average, about 1.4 percent of the premiums of all employer-sponsored plans,'' according to the Congressional Budget Office.

(4) The expansion of medical malpractice lawsuits would force employers to drop health coverage altogether, rather than take the risk of jeopardizing the solvency of their companies over lawsuits involving health claims.

(5) Seven out of 10 employers in the United States have less than 10 employees, and only 26 percent of employees in these small businesses have health insurance. Such businesses already struggle to provide this coverage, and would be devastated by one lawsuit, and thus, would be discouraged from offering health insurance altogether.

(6) According to a Chamber of Commerce survey in July of 1998, 57 percent of small employers would be likely to drop coverage if exposed to increased lawsuits. Other studies have indicated that for every 1 percent real increase in premiums, small business sponsorship of health insurance drops by 2.6 percent.

(7) There are currently 43,000,000 Americans who are uninsured, and the expansion of medical malpractice lawsuits for health plans and employers would result in millions of additional Americans losing their health insurance coverage and being unable to provide health insurance for their families.

(8) Exposing health plans and employers to greater liability would increase defensive

medicine and the delivery of unnecessary services that do not benefit patients, and result in decisions being based not on best practice protocols but on the latest jury verdicts and court decisions.

(9) In order to minimize their liability risk and the liability risk for the actions of providers, health plans and employers would constrict their provider networks, and micro manage hospitals and doctors. This result is the opposite of the very goal sought by S. 6 (106th Congress).

(10) The expansion of medical malpractice liability also would reduce consumer choice because it would drive from the marketplace many of the innovative and hybrid care delivery systems that are popular today with American families.

(11) The provisions of S. 6 (106th Congress) that greatly increase medical malpractice lawsuits against private health programs and employers are an ineffective means of compensating for injury or loss given that patients ultimately receive less than one-half of the total award and the rest goes to trial lawyers and court costs.

(12) Medical malpractice claims will not help patients get timely access to the care that they need because such claims take years to resolve and the payout is usually made over multiple years. Trial lawyers usually receive their fees up front and which can be between one-third and one-half of any total award.

(13) Expanding liability lawsuits is inconsistent with the recommendations of President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which specifically rejected expanded lawsuits for health plans and employers because they believed it would have serious consequences on the entire health industry.

(14) At the State level, legislatures in 24 States have rejected the expansion of medical malpractice lawsuits against health plans and employers, and instead 26 States have adopted external grievance and appeals laws to protect patients.

(15) At a time when the tort system of the United States has been criticized as inefficient, expensive and of little benefit to the injured, S. 6 (106th Congress) would be bad medicine for American families, workers and employers, driving up premiums and rewarding more lawyers than patients.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that—

(1) Americans families want and deserve quality health care;

(2) patients need health care before they are harmed rather than compensation provided long after an injury has occurred;

(3) the expansion of medical malpractice liability lawsuits would divert precious resources away from patient care and into the pockets of trial lawyers;

(4) health care reform should not result in higher costs for health insurance and fewer insured Americans; and

(5) providing a fast, fair, efficient, and independent grievances and appeals process will improve quality of care, patient access to care, and is the key to an efficient and innovative health care system in the 21st Century.

(c) NULLIFICATION OF PROVISION.—Section 302 of this Act shall be null and void and the amendments made by such section shall have no effect.

Mr. GREGG. Mr. President, this amendment goes to one of the critical issues in the Kennedy health care bill that we have been debating for the last few days, which is the fact that the bill dramatically expands lawsuits in this country.

Our Nation is already far too litigious; 2.2 percent of our gross national product goes into lawsuits every year. That is literally hundreds of billions of dollars every year absorbed in our legal system—dollars that could be used much more productively.

Compared to other nations in the world, we are the most litigious by far. For example, Japan only uses about .8 percent of its gross national product for lawsuits. Canada, our neighbor, uses about .5 percent of its gross national product for lawsuits. These lawsuits that have, for years, been used against individuals and manufacturers accomplish some good, but in many instances they end up chilling events, creating greater costs for consumers and causing such things as research to be retarded, especially in the area of health care. This is a sensitive issue because things such as the development of new devices and the need for doctors to practice defensive medicine are issues that are highlighted and aggressively expanded by the expensive use of lawsuits.

Just this week, for example, we saw a $4 billion judgment—$4 billion—against one manufacturer in this country. That type of judgment against a medical manufacturer, for example, would end up being passed on to the consumers through an increase in premiums and an increase in the cost of insurance.

We are as a society simply too litigious. In many areas we as a society—as a government—have decided that lawsuits should be not cut off but at least curtailed to some degree.

However, the other side of the aisle has come forward with a bill which would dramatically expand the number of lawsuits available in this country. It would essentially be the ''Kennedy Annuity for Attorneys Act'' rather than a health care bill. This bill, as proposed by the other side, would create the opportunity for 48 million more incidents of lawsuits involving 48 million more individuals, which could then be multiplied in a geometric progression.

Let's just take one situation. Right here, we have the example of how 137 different doctors might treat one simple type of medical problem, ''uncomplicated urinary tract infection.'' There are 82 different treatments from 137 different treating physicians. If one of these doctors picked a treatment which didn't work, under the Kennedy bill that would immediately open a brand new lawsuit against a variety of different individuals, including the employer, the HMO, and the insurer. That lawsuit could be multiplied literally by hundreds of different treatments and hundreds of different opportunities, because this bill dramatically expands the opportunity for lawsuits.

Another example of the expansion of lawsuit opportunity under this bill is this chart. All these different blue lines are new regulatory actions which are available under the Kennedy bill. Fifty-six new causes of action are created under this bill. It is truly an explosion of opportunity for attorneys to bring lawsuits.

There would be a whole new business enterprise created in this country, and it would be a massive enterprise, the purpose of which would be to bring lawsuits under the Kennedy bill. And the practical implications of this are that the cost of health care in this country would go up dramatically.

The Congressional Budget Office has estimated that this bill, the Kennedy bill, because of the lawsuit language which allows attorneys to go out and sue in a variety of different areas—which right now they do not have the opportunity to sue in—would increase the cost of premiums by 1.4 percent.

What does that mean? That means that approximately 600,000 Americans would be thrown off the insurance rolls. The practical effect of this expansion in lawsuits is that you would see a dramatic expansion in the cost of health care in this country and an equally dramatic expansion in the number of uninsured in this country.

In addition, the cost of insurance for doctors would go up dramatically. Under a study done by the doctors' insurance agents—not necessarily the HMO insurance agents or the health plan insurance agents but, rather, the doctors—it is estimated that the premiums on the errors and omissions policies of doctors would go up somewhere between 8 and 20 percent relative to the ERISA part of their insurance.

This means we would see a massive expansion of defensive medicine being practiced. We already know that defensive medicine is practiced excessively in this country, which means procedures undertaken not because the doctor believes they have to be undertaken but they are undertaken to protect a doctor from a lawyer. We would see a massive expansion of this defensive medicine by doctors.

What does that do? That drives up the cost of medicine, and it does very little to improve the quality of care.

Equally important, what we would see is a deterioration in the availability of doctors to practice specialties, which are unique and needed in rural areas—especially OB/GYN—which we have already seen driven out of many rural areas in this country because of the cost of the error and omissions policies. An 8 to 20 percent increase in the cost of those policies would have a devastating impact on an area of medicine which is already underrepresented in the rural parts of this country.

Six-hundred thousand fewer insured people, and what do we get for this expansion in lawsuits? What does the consumer get for this huge expansion in lawsuits? They get a lot more attorneys. There is no question about that. They get a lot more wealthy attorneys. There is no question about that. They will get a lot more attorneys who will be able to contribute to the Democratic National Committee. There is no question about that. The trial lawyers

love this Kennedy bill. They are enthusiastic for this bill. If there is a basic beneficiary for the Kennedy bill, it is the trial lawyers in this country. That is what I call this bill. It is the ''attorneys' annuity bill'' rather than the Patients' Bill of Rights.

What do the consumers get when they get involved in these lawsuits? They will get very little. Will they get greater care? No. They will have to go to court to get care under this bill. A lawsuit has to be brought. Do they get better results? Absolutely not. The attorneys get 54 percent of the recovery. That leaves the litigants with a combined 46 percent after this, one-half being an economic loss and one-half being compensation for pain and suffering.

It makes very little sense when you realize that the only winners under the Kennedy bill are actually the attorneys in the expansion of lawsuits that will occur as a result of the bill.

So where does that bring us? We have come up with a better idea in our bill. We say that rather than creating a brand new opportunity to create all sorts of new lawsuits and add a lot of new attorneys to the American culture, who really add very little in the way of productivity—or better medicine, for that matter—let's let doctors take a look at what doctors are deciding for patients.

Under our bill, a patient, rather than having to go to court to have their concerns addressed, gets to have their concerns addressed by, first, a doctor in the specialty dealing with the type of problem the patient has within the clinic or the group by which the person is being served. That doctor is independent. That doctor makes a decision: Did that patient have the right care or did that patient have the wrong care? Or should that patient get more care? If the patient isn't comfortable with that decision, then the patient can go outside the clinic, outside the insurance group, and have another doctor, who is appointed after having been prequalified by a certified either State or Federal agency, and have another doctor review that patient's care.

If that doctor decides that the patient needs some other type of care—something that the clinic or the interests group did not decide that the patient should have—then that is binding. It is binding on the insurance group. There is an independent review at two different points, one inside and one outside, done by doctors who have a binding decision on the patient. If the patient again is uncomfortable with that decision, then the patient can bring a suit. But it is limited as to amount of damages, and it is limited to the cost of the event.

The practical approach they have put forward is to try to get the patient care, and get the patient good care and efficient care quickly, and make sure they have gotten fair treatment and they have had a review by the appropriate doctors.

As a result, we reduce the cost of health care. As a result, we keep more people insured. As a result, we allow more people to participate in health insurance in this country. As a result, I admit that we do not create as many opportunities for attorneys to bring lawsuits. That is absolutely right. We do not create a bill that basically underwrites the legal profession in this country. That is absolutely right. We assist patients in getting care.

That is a big difference between these two bills. The Democratic bill, the ''Attorneys' Annuity Act,'' the ''Kennedy Patients' Bill of Rights,'' is essentially a bill to promote attorneys. Our bill is a bill to promote health care.

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

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, the fact of the matter is, in the United States of America, this great country we live in, there are basically two groups of people who cannot be sued: foreign diplomats and HMOs. That is not the way it should be. We are saying HMOs should be treated like every other entity in the United States.

Today, even an HMO involved directly in dictating, denying, or delaying care for a patient can use a loophole in what we call ERISA to avoid any responsibility for the consequences of its actions. The American people simply do not support that. ERISA was designed to protect employees when they lose pension benefits to fraud, mismanagement, and employer bankruptcies, which occurred so often during the 1960s.

The law now has the effect of allowing an HMO to deny or delay care, with no effective remedy for patients. What they are trying to do is strike a provision from our bill which simply ensures HMOs can be held accountable for their actions, a responsibility of every other industry to consumers. They talk about this in vague abstract, as if this is some big cabal to change the law. All we want to do is make the law apply to HMOs.

Let's talk about a real person. Florence Corcoran is an example of the need to hold HMOs accountable. She lost a baby because the HMO refused the doctor's request for hospitalization in the last days of her pregnancy. The HMO would pay for only 10 hours of at-home care. During the final months of pregnancy, when no one was on duty, her baby went into distress and died. Because Florence received health care coverage through an employer, they had no recourse or remedy for the death of this baby. The HMO was not responsible under the law for any cost because the Corcorans never incurred any medical expenses for the loss of their baby.

The court of appeals—the court that is highest except for the Supreme Court in this country—said, and I quote from a Fifth Circuit Court of Appeals:

> The result ERISA compels us to reach means that the Corcorans have no remedy, State or Federal, for what may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is . . . less deterrence of substandard medical decisionmaking.

In another case, another Federal judge, Judge William Young, said:

> ERISA has evolved into a shield of immunity that protects health insurers . . . from potential liability for the consequences of the wrongful denial of health benefits.

That is from the case of Andrews-Clarke v. Travelers Insurance Company, decided last year.

All we want to do is be able to hold the HMOs accountable.

What about the cost of this? We have an independent study by Coopers & Lybrand that found the cost to be as little as 3 cents per person per month. We can handle that. That is fairness.

This is not going to touch off a flood of lawsuits. In fact, it will make people feel better about their health care and, in fact, make health care providers be more diligent in rendering adequate, complete care to their patients. It is not going to create massive lawsuits, as Coopers & Lybrand said.

The Republican provision leaves patients with no recourse if benefits are denied. That is wrong.

I yield 10 minutes to the Senator from North Dakota.

Mr. DORGAN. Mr. President, it is Thursday and most of the week we have seen amendments and offerings from the majority party that do little or nothing for the vast majority of Americans.

The Gregg amendment before us, however, is an amendment that would do something. It would prevent accountability. It would say that patients have no right to expect accountability on the part of HMOs and the insurance companies.

USA Today, in an editorial, says there are ''100 Million Reasons that the GOP's Health Plan Fails.'' That is the number of people not covered by our opponent's health plan. The majority of the American people with private insurance are not helped by their proposal.

Now, some of my colleagues say that doesn't matter because the States cover these folks. Mr. President, 38 States don't guarantee access to specialists; 48 States don't hold plans accountable; 29 States don't provide for continuity of care; 39 States don't provide for omsbudsmen; 27 States don't provide a ban on financial incentives to limit care. The fact is, the argument that the States do this is a specious argument.

Let me go back to a couple of cases I have described in the past to illustrate my point. I know some here in the Senate say this debate is not about individual cases, but I disagree. Ethan Bedrick was born in circumstances that were devastating, the umbilical

cord wrapped around his neck causing partial asphyxiation. Consequently, he was born with cerebral palsy and was a spastic quadriplegic. He began to get therapy.

At age 14 months, the HMO said: We are going to cut back on Ethan's therapy.

The doctor said: You shouldn't cut back on the therapy. Ethan has a chance to be able to walk by age 5.

The HMO says: A 50 percent chance of being able to walk by age 5 is minimal or insignificant. Therefore, we won't pay for it.

Now, is somebody going to protect Ethan? Does anything proposed by anyone on the other side of the aisle in the last 3 days solve this problem? The answer is no. In nothing they proposed can they say they will have solved this problem—not just for Ethan but for all the other little Ethans in our country. They will deny him the rights that he ought to have.

What about Jimmy Adams? We had a big debate yesterday about emergency care. One of my colleagues stood up and said little Jimmy would be covered under their amendment. That is not the case. Jimmy Adams got sick with a 104 degree fever in the middle of the night. His mother and father called the HMO. They were told to go to the Scottish Rite Hospital way across the city of Atlanta.

Where is it? the mother asked.

Find a map, she was told.

So they got in the car at 2 in the morning and headed for Scottish Rite Hospital. They passed the first hospital, they passed the second and third hospitals—because they were not authorized to go to these emergency rooms by their HMO. An hour into the trip, they pulled into Scottish Rite Hospital, having passed three emergency rooms because the HMO wouldn't have paid for Jimmy's care there. At that point, Jimmy Adam's heart had stopped. They were able to get his heart restarted. They intubated him. He was a very sick young man. He survived. However, gangrene from that episode caused Jimmy to lose both of his hands and his feet.

This is young Jimmy without hands or feet. He passed three emergency rooms because the HMO said: You have to be in a car an hour to go to the emergency room we will pay for.

Is there anything offered by anybody on the other side yesterday that would have solved this problem? The answer is no because Jimmy's family is enrolled in an HMO that would not be covered under our opponent's proposal. No emergency room proposition offered by anyone over there, even though it was described in wonderful terms, would have done anything to help the Jimmy Adamses in a good many States in this country.

If you think that is wrong, I challenge anyone to tell me how you will receive this protection if you are among the 100 million not covered under the majority's bill and live in a State that doesn't have this coverage. That is the problem with the proposal by the majority party.

Let me give another example. This case deals with the issue of who determines what care is medically necessary, doctors or insurance company bureaucrats. This example was used by Dr. GREG GANSKE, a Republican Congressman from Iowa, who happens to be a reconstructive surgeon. This is a picture of a child with a very serious medical problem, a cleft lip. Dr. GANSKE contacted his colleagues in reconstructive surgery, and Mr. President, he found that 50 percent of them had cases such as this denied. In cases dealing with reconstructive surgery, 50 percent had cases denied because they were not medically necessary.

Think of that. Think of being the mother or father of this young child and being told reconstructive surgery is not medically necessary. Ask yourself whether you think that is reasonable. Yet it happens in this country and will happen again under the Republican bill because they do not allow a patient's doctor to determine what is medically necessary.

Let me show you another picture of a child with the same cleft lip problem. Now let me show Members what happens when reconstructive surgery gives this young child a chance, an opportunity. Here is the same child. Take a look at what someone decides is ''medically necessary'' and what it will mean to this young child's life. This picture demonstrates what reconstructive surgery can do for this wonderful child.

As these real cases illustrate, this debate is not about theory. It is not about arguing the terminology in some half-baked plan that doesn't do much. It is about providing assurance and guarantees to people in this country. Help this young child. Provide protection for Jacqueline Lee who fell off a cliff 40 feet, fractured her body in three places, and unconscious, is helicoptered to an emergency room. She is unconscious, out cold on a gurney. She survives and then is told by her HMO that she did not get prior approval for her emergency room visit and therefore they will not pay it.

Or Ray, the father who, with tears in his eyes, told about Matthew, his 12-year-old son, who lost his battle with cancer because they were forced to fight both the cancer and the insurance company to provide for the treatment necessary to try to save him. Ray says, ''We could not fight cancer and the insurance company at the same time, and it is not fair to ask us to do it.''

I say this to you, those who say you are providing wonderful protection —you are not. This editorial says you are not and we know you are not and you know you are not. Mr. President, 100 million people are left out of your plan and you say: Yes, they are left out of our plan but the States cover them. They do not and you know they do not. Medical necessity? Emergency room? OB/GYN? Go down the list and then tell the American people, tell these children, tell the women, tell the families why you do not think they ought to be covered.

This last amendment says to patients, we do not think you ought to be protected, but we certainly think we ought to provide protection to the insurance companies. We certainly think insurance companies ought to be given protection and patients should be denied the right to hold them accountable.

My colleague talks about lawsuits. It is interesting. Texas passed a statute allowing consumers to hold HMOs accountable a couple of years ago. There has been one lawsuit, I understand—perhaps by now two or three. Where is the blizzard of lawsuits our opponents predict when you make health care providers accountable?

Every Medicare patient in this country has the basic protections we are proposing in our Patients' Bill of Rights. Every Medicaid patient in this country has the same protections, and every Federal employee and every Senator sitting on this floor has these protections.

But we have folks in this Chamber who decide it might be good enough for Senators, they voted for it for Medicare, but it is not good enough for the rest of the American people. And the result is too many cases, too many children, too many Jimmy Adamses whose parents decide they have to comply with the rules because they do not have the money.

I remember the first time I saw an entertainer use the moon walk. It made him look as if he was moving forward when instead he was moving backwards. I see that on the floor of the Senate in this debate. People offer proposals when they want people to believe they are making progress, but in reality, they are not doing anything or maybe even moving backwards. That is not going to work in this debate. This debate is not about theory. It is about people's lives, about their medical treatment. It is about providing protection for hardworking Americans who have insurance and think they are protected with decent health coverage—only to discover at 2 a.m. that they do not have access to an emergency room.

The PRESIDING OFFICER (Mr. SANTORUM). The Senator's time has expired.

Mr. DORGAN. I thank the Senator from Nevada for the time and yield the remainder of my time.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Mr. President, I will yield to the Senator from Alabama in a second. I do want to point out the Senator from North Dakota, although well informed in most instances, on the issue of suing health care plans of Senators he is not informed. The fact is, under our plan we cannot sue the insurer. We are limited in our rights to sue, and our ability to recover is also

significantly limited—in fact, about the same way it is limited in our bill. I would point that out as a point of clarification.

The Senator from Alabama.

Mr. SESSIONS. I thank the Senator from New Hampshire. I will delay my general remarks.

The PRESIDING OFFICER. Who yields time?

Mr. GREGG. I yield the Senator from Alabama 10 minutes.

The PRESIDING OFFICER. The Senator is recognized for 10 minutes.

Mr. SESSIONS. Mr. President, I will delay my overall remarks on this matter to deal precisely with some of the examples that have been cited.

There are a number of provisions in the law that allow the containment of lawsuits. Workman's comp—if a person is injured on the job, there are very limited matters for which they can sue. They do not have to prove negligence. They get compensation. They have a lot of advantages. They also are not able to sue their employer under those circumstances. Federal employees, including Senators, are not able to sue.

But let me say this, first and foremost, this is not a step backwards. Right now we have this limitation on lawsuits—not a banning of lawsuits, but a limitation on lawsuits under Federal law. This legislation will increase significantly the power of individual patients to protect their rights against HMOs. It does change existing law. It does move the bar much lower for patients, in a way that makes sense, that keeps costs to a minimum, but improves their access. Now we talk about offering a 2- or 4-year lawsuit in exchange for the plan we have proposed that would allow immediate access to a panel of medical experts to review your claim.

Let me mention some of the special cases that were discussed previously. There was a case in which the HMO had denied therapy. Under our bill, you would have the existing rights we have today to go to court, but in addition to that, you would have an internal review process by the insurance provider. In addition to that, you would be able to have an independent external review of your claim that this therapy is needed. It would require, and provide for, a person with expertise in that medical specialty who is independent of the plan. That is a major step forward for the rights of patients. We do not need to foster a jackpot justice mentality when we can get prompt, professional care.

With regard to the Jimmy Evans situation, what will our bill do for that? Obviously, this matter has been discussed over and over again. It hurts me to see the emotional arguments made that ignore what this bill provides. This bill says you could use a ''prudent layperson'' standard on emergency care. That means, if you believe your child needs to stop at the first hospital, you can stop there. A prudent layperson means the parent, using normal good judgment, is allowed to use that judgment about where to go in an emergency.

With regard to problem of cleft palate and medical necessity—we have, and have provided for, new requirements on HMOs. Ultimately, there would be an independent, medical expert to review that claim. Surgery for cleft palate is not going to be denied. That is pure scare tactics, and it is offensive to me to suggest that. You can still go to court, at any rate, for the cost of the benefit denied and still get coverage for the medical care you need. So I would say that really is discouraging.

With regard to the fundamentals of the appeals process, you do have to have a decisionmaking process in any complex contractual relationship. How are we going to do it? There is a clear choice. As a matter of fact, many have already discussed this. Friends on the other side of the aisle have said from the beginning that the biggest difference between our parties bills is the question of how to handle the liability issue. They want to add new lawsuits not provided for under current law to allow increased lawsuits. We want to increase the ability of patients to get prompt, cost-free, independent medical reviews for benefits denied when they need it.

I have heard doctors express to me they do not like dealing with bureaucrats when they need to talk about what kind of treatment their patient needs. They are frustrated about that. So this bill says: That is not good enough, HMO; if you cannot respond promptly to a physician's request that the patient receive a certain type of treatment, you are going to have to provide an independent, external expert, with a specialty related to that patient's particular medical problem, who can make a decision that is binding on the HMOs but not on the patient. Let me emphasize, it is binding on the HMO. If that expert says this treatment is needed, then it must be provided immediately.

I think these are the protections we want to provide.

This appeals process is a good plan. Basically, if a patient is denied a benefit, he or she can call the HMO for an internal review. If that is not satisfactory, he or she can demand an external review by an independent medical expert. Even after that, they still maintain the right to sue—a right which exists today.

I think this is a very good policy. As a matter of fact, the Senator from Massachusetts who was here in 1973 pointed out the obvious when he supported the establishment of HMOs. He said in his remarks on the Senate floor at that time these words:

> Medical malpractice litigation has become an onerous and protracted means to resolve medical malpractice disputes. The costs are escalating with less of the medical insurance premium dollar going to compensate the injured party. The delays in resolving such disputes average up to 4½ years from filing of a lawsuit. Litigation has failed to provide an efficient means to achieve a fair result for all concerned.

And I say amen to Senator KENNEDY. He was correct about that. This is not working. It is not the way we can assure prompt care and responses to patients, doctors and injured parties when they need help.

Senator KENNEDY went on to say:

> Litigation of medical malpractice claims have not been an effective method to monitor quality health care standards.

I agree with that also.

I believe the plan proposed by the Republicans provides for a prompt, professional, low-cost, independent determination of disputes. Make no mistake about it, lawsuits are expensive. It takes 25 months—4 years, as Senator KENNEDY says—to bring one to a conclusion. Lawyers charge $200 plus an hour. The plaintiffs' lawyers charge a 40- to 50-percent contingent fee. That means if the plaintiff receives $100,000, the lawyer gets $50,000. If the plaintiff gets $1 million, the lawyer gets $500,000. The lawyers have junior partner lawyers, paralegals, law clerks, and secretaries who work with them. They take deposition after deposition after deposition. Medical experts are called. Testimonies, reports, and legal research have to be prepared. Court appearances, pretrial hearings, discovery conferences have to be arranged and briefs have to be filed.

There is a burden on the courts when you have lawsuits. We pay the judges salaries. The more these cases are given to them to handle, the more judges we need to handle them. The judge has law clerks. Federal judges have at least two law clerks each, bailiffs, U.S. marshals, and court clerks to handle the cases—all of whom are paid for by the taxpayers. This does not include jurors and witnesses. Let's not forget the cost of the courtroom. Go to your courthouse and find out how much a courtroom costs to build. Figure it out on a weekly basis.

These cases go on for 1 year, 2 years, or even 4 years before they ever reach a conclusion.

That is not the way to help patients who need help. Some will win millions of dollars and some will win nothing. I will tell you what else will happen. It will be routine for plaintiff lawyers, to sue a doctor or hospital—which they can already do, make no mistake. Currently, if a physician treats you improperly or the hospital commits an act of negligence or a willful act of wrongdoing, you can sue them. Now we are questioning whether you can sue the insurance company for these kinds of problems.

We have made progress in allowing a good review, a tough new review process. The Kennedy plan is fatally flawed. We must not allow his plan to happen. President Clinton's own hand-picked 34-member Advisory Commission on Consumer Protection and Quality in the Health Care Industry refused to put

liability reform or the Democratic liability plan in their bill when they did their report for the President. They did that for a reason. They considered the issue and decided it was not wise.

Meanwhile, for some reason the President and the Democratic Members have changed their minds. I suspect they have talked with their trial lawyer friends in the meantime and have been convinced they ought to go along with this new proposal.

It is not just the President's own review commission that has rejected liability expansion and more lawsuits, but major newspapers in this country as well.

The Los Angeles Times:

> Bad medicine for both employees and employers driving up premiums.

The New York Times:

> Jury awards in State courts for malpractice are——

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

Mr. SESSIONS. I ask unanimous consent for 1 additional minute.

Mr. GREGG. I yield 1 minute.

Mr. SESSIONS. The New York Times:

> Jury awards in State courts for malpractice are notoriously capricious and do more to reward lawyers than patients.

The Washington Post:

> The threat of litigation is the wrong way to enforce rational decisionmaking.

This is a terrible idea. It is the wrong direction to go. It will add expense throughout the system and will not benefit patients by getting them care when they need it. This bill, as proposed, which I support, will do that. It will give patients immediate relief and expert evaluation of their claims.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

PRIVILEGE OF THE FLOOR

Mr. REID. Mr. President, I ask unanimous consent that the privilege of the floor be granted to the following individuals: Kathryn Vosburgh and Jennifer Barker who are interns with Senator BYRON DORGAN of North Dakota.

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

Mr. REID. On behalf of the minority, I extend 10 minutes to the Senator from Illinois, Mr. DURBIN.

The PRESIDING OFFICER. The Senator from Illinois is recognized for 10 minutes.

Mr. DURBIN. I thank the Senator from Nevada.

Mr. President, this is the heart of the debate. This is what the Patients' Bill of Rights is all about. The insurance companies hate the idea of being sued in court as the devil hates holy water. They do not want to be held accountable for their actions. They want to be protected so they can make the wrong decision when it comes to medical care for American families and never be held accountable.

The amendment being offered on the Republican side is an effort to take away from 123 million Americans the right to hold health insurance companies accountable. That is the bottom line: 123 million Americans will be denied an opportunity to go to court when a health insurance company makes a decision which costs them their health or their life.

Most people are stunned to know that you cannot take a health insurance company to court. Since 1974, a Federal law has protected health insurance companies from being sued.

What does that mean? When your doctor wants a certain procedure, a certain medicine, a certain specialist for your good or the good of your family, and that doctor is overruled by a health insurance company bureaucrat, the doctor is the only one who will be taken to court, not the health insurance company.

If we pass nothing else in this Patients' Bill of Rights but this section which says health insurance companies will be held accountable in court, it would be a major victory for America. I trust the judgment of 12 citizens of this country in a jury box to decide the fairness and legality of an issue. Obviously, the Republican side does not. They do not want the health insurance companies to go to court. They do not want them to face a jury. They do not want them to be held accountable.

This party, which parades and triumphs values and responsibility does not want to hold the health insurance companies responsible in the most basic form of adjudication in our country: a jury of your peers.

Oh, they make a lot of arguments about, oh, we are just gilding the lily and feathering the nests of all these trial lawyers. That is not what it is all about. You know it and all America knows it.

The health insurance companies, with the Republican majority, are determined to stop 123 million Americans from ever having a day in court. Ever.

For the last 2 days, Senator KENNEDY, Senator REID, and all of my colleagues have brought stories to the floor—chilling, heartbreaking stories. Here is one. Florence Corcoran. Let me quote Florence Corcoran:

> They let a clerk thousands of miles away make a life threatening decision about my life and my baby's life without even seeing me and overruled five of my doctors. They don't get held accountable. And that's what appalls me. I relive that all the time. Insurance companies don't answer to nobody.

That is what Florence Corcoran says: ''Nobody knows about ERISA,'' this Federal law that protects health insurance companies.

If you are listening to the debate, you would think: Well, surely there must be a long roster of companies in America that receive the same kind of immunity from liability that cannot be brought to court. No. This is it, folks. This is the only sector of the American economy—maybe the only sector in America—that is going to be allowed to be held above the law.

The Republican majority and the health insurance industry are determined to protect their immunity from a lawsuit so that Florence Corcoran, when her life and the life of her baby were threatened by the decision of a health insurance company, can't even take that health insurance company to court.

The Senator from Alabama gets up and talks about: Oh, this legal system, it is so expensive. It takes so long. Let me tell you, when it is your life or the life of your baby, and this is the only place to turn, this is where you will turn. Yes, you will go to a lawyer because you are not wealthy, who will charge a contingency fee, meaning if he wins he gets paid; if he loses, he does not. That is part of the American system.

How many times, day in and day out, do we hear about these cases—simple, ordinary Americans, living their life, doing what they are suppose to do, paying their taxes, going to work every day. They get caught up in a situation where someone's negligence or wrongdoing hurts them. It could be an accident; it could be medical malpractice; it could be a decision by a company that was just plain doing wrong.

Where do you turn? You write a letter to your Senator. That isn't worth much, I will tell you. We will read it. We will write a reply. But if you want justice in America, then you have a chance to go in the court system. But the Republican majority says, no, close the door to America's families so that they cannot hold health insurance companies accountable in court.

For the last 2 days, we argued about all the outrages in these health insurance policies, that you can't go to the nearest emergency room when someone in your family is hurt, that you can't go to the specialist your doctor wants you to go to—the cases go on and on and on—and we try, item by item, to make these health insurance plans more responsive to the reality of life and more responsive to the medical needs of Americans.

But let me tell you this. All of those amendments, all of those votes notwithstanding, this is the bottom line. This will change the mentality of these health insurance companies that say no, because they are driven by the ambition for greed and profit, say no over and over, regardless of the outcome.

The Cortes family from Elk Grove Village, IL, their tiny little baby, Rob, who is now 1 year old, has spinal muscular atrophy. For a year they tried to keep their family together with this little boy on a ventilator at home—on a ventilator at home. They have been fighting this disease, and every week they fight the insurance companies. Will they cover this care? Will they cover this drug? The battle goes on and on.

Mark my words—and I say this to my Republican colleagues—if that health insurance company knew their decisions would be judged by 12 of their

peers, 12 American citizens, sitting in a jury box, I bet the Cortes family would get a lot better treatment. You know they would. They know they would be held accountable.

But the health insurance industry and the Republican majority does not want the 123 million Americans to ever have a day in court when it comes to these health insurance decisions. Their arguments are as weak as they can be.

The State of Texas passed a patients' bill of rights. They said you could take the health insurance company to court for certain insured people in Texas. You would think, from the arguments on the Republican side, that the sky fell on Texas 2 years ago. It did not happen. You know how many lawsuits have been filed since this law was enacted, a law which Governor Bush vetoed, but the legislature overrode his veto? Three lawsuits—three lawsuits in 2 years. Does that sound as if we are flooding the courts?

But I will tell you something. In that State, for those who are protected by that law, I will bet you there has been a change in the way they do business.

Let me give you a quote from a health insurance executive. This is from the Washington Post.

> . . . currently, ''We would charge the same premium to a customer with the ability to sue as we do to those who do not have the ability to sue.''. . .

This is from Aetna. Have you picked up the Washington Post lately? Two-page ads every day begging us not to vote for the Patients' Bill of Rights—Aetna sponsors them, full-page ads. But their spokesman said:

> Why? Those judgments to date have been a very small component of overall health care costs.

That is what Mr. Walter Cherniak, Jr. of Aetna said.

So the argument that this was going to flood the courts did not happen. It did not happen in Texas. As to the argument that it is going to raise premiums, according to a man who does this for a living, it makes no difference in the premium charged for those insured who have the right to sue and those who do not.

Take a look at some of the numbers that have come out in terms of the estimated costs of increases in premiums if there is a right to sue. How much is it going to go up? The Republicans argue it is going to skyrocket. The Congressional Budget Office estimated the impact on premiums to be 1.4 percent; Multinational Business Services, less than 1 percent; Muse and Associates, a private firm, they say .2 percent.

Is it worth a quarter a month to you as an American with a health insurance policy to have the right to go to court when it is your baby's life?

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

Mr. DURBIN. I say to my colleagues, this is the key vote on the Patients' Bill of Rights. This is a vote about whether 123 million Americans will be precluded from court by the Republican majority and the health insurance industry.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. I simply note ERISA does not cover 123 million Americans, so the Senator from Illinois is incorrect.

I yield to the Senator from Iowa 10 minutes.

The PRESIDING OFFICER. The Senator from Iowa is recognized for 10 minutes.

Mr. GRASSLEY. Mr. President, this is a Democratic leadership war on health insurance coverage. This is their proposal to subject employer-sponsored health plans, and thus employers, to lawsuits. As a member of the Judiciary Committee, I have worked for tort reform throughout my tenure in Washington. I believe our tort system is badly broken, so it will come as no surprise that I have grave reservations about sending more disputes into it.

First, the big picture: The proliferation of lawsuits has damaged the efficiency, effectiveness and integrity of America's civil justice system. Almost as bad, it is injuring the nation's economy. Now, our Democratic colleagues propose to declare a ''new gold rush'' for the legal industry, this time in the area of health insurer liability. And the harm that results from doing so will not be limited to our judiciary or our economy—it will harm our health. It's downright unhealthy for America. Is that an overstatement, Mr. President? Well, people with health insurance are likely to have better health than those without it. If the Democrats are now saying that insurance coverage doesn't affect health status, then they'll have to explain why they keep coming up with all kinds of ideas on how to insure people. Five years ago, they thought insurance coverage was important—so much so that they wanted the government to insure everyone. Of course, even with a Democratic President and Democratic control of both Houses of Congress, they didn't manage to do it. It's funny how we don't hear about that effort anymore, but it's certainly not because we solved the problem.

The President acknowledged the problem of the uninsured again when he proposed to allow people under age 65 to buy their way into the Medicare program. By the way, with a hefty subsidy from other Americans under age 65 who pay payroll taxes. Why does the President propose this unless he thinks insurance coverage will improve peoples' health status. Health insurance coverage is not an end unto itself, but a means to an end, and the end is better health. So when the Democrats propose things that will lessen health insurance coverage, and thus harm the health of the American people, we need to ask why.

Some argue that liability laws are a good way to guarantee quality of care. We're certainly not hearing much from the other side in this debate about quality, but objective people think that ensuring quality of care should be the point of patient protection. I care a great deal about health care quality, let me tell you about research that has been done in the context of medical malpractice. These studies, particularly the well-known Harvard study, tell us that the medical liability system is simply not an effective way to ensure quality. There is a tremendous mismatch between incidents of malpractice, on one hand, and the lawsuits that are brought, on the other. For many reasons, instances of substandard medical care often do not give rise to lawsuits, while many lawsuits that are brought are groundless. In the malpractice context, it is not feasible to have immediate appeals of physicians' decisions when they make them, so we're stuck with the tort system.

But when we talk about insurance coverage decisions, we do have an alternative to lawsuits. We can have immediate, independent, external reviews of these decisions. We can do better than lawsuits after-the-fact. That's what our Republican Patients' Bill of Rights will do. It will get patients' claims decided when the patient needs the care. Isn't that the best thing for the patient? Yes—but it's not the best thing for the lawyers, and that's why we're here today.

Mr. President, the other day, I heard a Senator note that only a handful of medical malpractice cases have ever been tried to a jury in his state. His point, apparently, was the lawyers don't really bring lawsuits: just a myth. Well, I am certain that the former trial lawyers in this body understand that defendants in cases sometimes pay out money in settlement of a claim, whether the claim was well-founded or not. Where do my colleagues believe that the money comes from? It comes out of the pockets of the people who buy tht good or service, obviously.

In medical malpractice cases, the cost of medical settlements, just like the cost of jury verdicts, is paid for by you and me. We pay in two ways: higher prices for medical services, and higher insurance premiums. When my friends on the other side say that creating a right to sue health plans somehow will not bring about more lawsuits, they should pay more attention to what their trial lawyer allies are up to. Who knows, maybe if they took a look at what trial lawyers are doing to our economy, they'd have second thoughts about supporting them all the time.

Let's see what an objective source says. The Congressional Budget Office has noted that the lawsuit provision of the Democrat proposal is, by far, the most expensive single item in their bill. More than anything else they are proposing, this liability piece is what will drive people out of their insurance

coverage into the ranks of the uninsured. That's a high price to pay to keep the lawyers happy.

Employers are not required by law to offer health insurance coverage to their employees. There are tax advantages for employers to do so, but we're finding that those aren't enough. More and more employees are dropping coverage for their employees. That's not an opinion, that's a fact. My friends across the aisle have repeatedly noted that many liberal advocacy groups support their version of patient protections. Those groups have every right to get involved in this debate, and I'm glad that they are. But my point is that most Americans don't work for liberal advocacy groups. In fact, very few do. I'll also note that most Americans don't work for plaintiffs' law firms.

Even if you're anti-business, you have to admit that businesses provide health insurance coverage to most Americans, and businesses are in a position to discontinue that coverage. The businesses that most Americans do work for, both large and small, are telling us that the Democratic bill will force many of them to drop coverage for employees; hence adopt the Republican Patients' Bill of Rights instead.

Let's keep our eye on the ball. There are two goals that we should be trying to achieve. One is to ensure that people get the appropriate health care to which they are entitled under their insurance coverage. But the 2nd goal is to avoid taking that very insurance coverage away. There are many times in politics when it's impossible to achieve two goals at the same time, but we can this time. We have a Republican approach that achieves both goals. I call on my colleagues to support this approach, and to resist the temptation to join the other side's war on health insurance coverage.

Mr. KENNEDY. Mr. President, I yield 3 minutes to the Senator from New Jersey.

The PRESIDING OFFICER (Mr. VOINOVICH). The Senator from New Jersey.

Mr. TORRICELLI. Mr. President, in the last few days, the Senate has revealed a lot about itself and where it stands.

Members of the Senate have had a chance to respond to the needs of American women in allowing OB/GYNs to be their primary health care provider, and they failed. Members of the Senate have had a chance to protect traveling Americans across the country, allowing access to emergency rooms, and they declined. Americans have asked that doctors make final medical judgments. That issue was brought to the Senate. The Senate declined.

Senator DURBIN now brings to the floor of the Senate one last chance for the Senate to do something fair and decent for the American people in this plan to protect people in Health Maintenance Organizations—to give them the right afforded every other American with every other industry to bring their grievance to a court of law.

It is ultimately the choice between a Patients' Bill of Rights or an insurance protection plan. If we fail, make no mistake about it, this debate and this vote will be noted for the fact that the Senate balanced the interests of 120 million Americans against several dozen insurance companies and made the wrong choice.

In a nation in which we pride ourselves on access to the system of justice and equal rights for all people in this land, there are two privileged classes. By international treaty, foreign diplomats cannot be sued; and by ERISA, insurance companies in the health insurance industry cannot be sued. Here is a chance to reduce that list and make insurance companies and those responsible for our health accountable like everybody else.

Every small business in America is responsible if they do damage to a customer, every dry cleaner, every trucking company, every mom and pop store. This industry, and this industry alone, is treated differently.

Under the Republican proposal, that status quo is protected.

Under Mr. DURBIN's amendment, they will be held accountable. As other Members of the Senate, I have heard constituents come forward where an HMO has failed to diagnose cancer in a small child and months later, because they could not get access to an oncologist, a leg or an arm is lost. Tell that parent they cannot go to court.

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

Mr. TORRICELLI. This is a great opportunity to provide fairness and access. It is the last chance to do something decent in this debate for the American people.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, I yield myself 8 minutes.

The longer this debate goes on, the stranger I find those who are supporting the Republican proposal. Their basic proposal started out costing $1 billion. They will have the agreement later this morning, with the acceptance of the long-term care credit, that will end up costing $13.1 billion—$1 billion for patient protections; 100-percent deductibility, $2.9 billion; liberalized MSAs, $1.5 billion; flexible spending accounts, $2.3 billion. That adds to $7.7 billion. And the deductibility of long-term care is $5.4 billion, according to the Senator from Oklahoma. That is $13.1 billion, and not a cent of it is paid for.

Their proposal has gone from $1 billion to $13 billion. Our proposal, according to CBO, is approximately $7 billion, which represents the 4.8 percent figure from CBO. I certainly hope we won't hear any more about the cost of our proposal from our good friends. That was a hot button item. It didn't have anything to do with protecting patients, but it was a hot button item.

Secondly, I hope we won't hear any more about one-size-fits-all. We listened to that line for 3 days. We will probably hear it later in the course of debate on many different measures. ''We don't want a solution of one-size-fits-all.'' Our good friend, Senator COLLINS from Maine, used that 10 times in her presentation. We are having a one-size-fits-all with the Republican proposal because, effectively, they are excluding the States from making their own determination as to what actions the state might take in holding people accountable. The Republican proposal can be labelled ''one-size-fits-all'' if they are successful on this measure.

They are saying to every State in the country: No, you cannot provide the remedies you would like for malpractice by those making health care decisions. We have one industry in this country that is going to be sacred, one industry that will not be held responsible. You can continue to sue doctors, but we will not permit any State in this country to determine whether you can sue your HMO.

That is an extraordinary position for our good friends, the Republicans, who are always talking about one-size-fits-all, who are always saying that Washington doesn't always know best. I hope we are not going to continue to hear, ''Washington doesn't know best. The people in the hinterlands know what is going on. They can make up their minds in the States. The States are the great laboratories for innovation and creativity.''

I can give those speeches, but they are wiping that out with this particular amendment. As the Senator from Illinois pointed out, this amendment is so basic and fundamental in protecting American citizens.

Even my good friend from New Hampshire has addressed this issue—I am sure he expected to hear this, but he ought to hear it as one of the principals, and now as acting manager. Last year, when we had the issue of liability of tobacco companies, this is what he said, and we will include the statement in the RECORD:

> When you eliminate that right of redress issue—

Which is effectively what the Republican proposal would do—

> which this bill does, when you take away the ability of the consumer, of the person who has been damaged, of John and Mary Jones, of Epping, NH, to get a recovery for an injury they have received, you have artificially preserved the marketplace, but, more importantly, you have given a unique historic and totally inappropriate protection to an industry.

The Senate accepted that position overwhelmingly. I think there were 20-odd votes in opposition on that issue. But here we have the insurance industry. Evidently, the message is that the insurance industry is more powerful than the tobacco industry. Apparently, the insurance industry has the votes to get their way on this issue.

Why is this issue important? This issue is important for two very basic and fundamental reasons. First, by making the right to sue available, there is an additional incentive—a powerful incentive—to HMOs and others in the health delivery system. There is an incentive to make sure they do what is medically appropriate because they know they may be held liable if they do not.

You may say: That is good in theory, but is it so? Look at Medicaid. Under the Medicaid system, a plan may be held liable, the health delivery system may be held accountable. Do we have people abusing the liability provisions? The answer is no. The answer is no.

As the Senator from Illinois pointed out, the State that allowed for liability most recently was Texas. Has there been a resulting proliferation of lawsuits, as the Senator from Alabama has suggested? The answer is no. There is one legal case that was brought and possibly one or two more pending.

City and State officials have the right to sue. You can take the example of CalPERS, one of the largest health delivery systems in the country, with 1.2 million members. They have had the right to sue for a number of years. You can look at CalPERS premiums over the last 5 years. The cost increase of the premium for CalPERS—whose members have the right to sue—has actually been below the national average for HMOs over the last 5 years. The Senator from Illinois has indicated, as well, the findings of the various studies which support this.

Most important, the answer we get from the other side is we don't need accountability because we have a good internal and external review system under the Republican proposal. That is a phony argument. Over the past 3 days we have shown why this argument is phony. The Republican appeals proposal is a fixed system. There is no de novo review. There are many other problems in their appeals system which we have previously addressed. Yet their best answer is that the external review program is a substitute for the right to hold plans accountable in court.

What happens when the plan drags its feet through the review process until it is too late for the patient? What happens when the plan doesn't tell the patient an external review is even available and the patient doesn't find out about its availability until the damage is done? What happens when the plan makes a practice of turning down everyone—this is reality—who applies for an expensive procedure, knowing there will be an appeal in only a fraction of the cases? Knowing that the worst penalty they could have is to pay the cost of the procedure that should have been provided in the first place?

The PRESIDING OFFICER. The time of the Senator has expired. Fourteen minutes remain.

Mr. KENNEDY. The patient never learns the procedure should have been provided until it is too late.

What happens when the plan refers the patient to an unqualified doctor for a procedure because it doesn't want to pay for a more qualified specialist outside the network? What happens when the patient trusted the plan to do the right thing?

According to the opponents of this proposal, those kinds of abusive practices should carry no penalty at all because you can't sue your way to quality. I would like to hear them say that to a widow who lost a husband—the father of her children—to a plan's greed.

I would like to hear them say that to a young man disabled for life because his health plan insisted on the cheapest therapy instead of the best therapy.

I would like to hear them say that to the parents whose child has died because the health plan mislead them about the availability of appropriate treatment.

I challenge the opponents of this provision to tell the American people why public employees in there own States should have the right to hold their health plan accountable, but the equally hard-working family just down the street employed in the local bank or grocery store shouldn't have the same right.

I challenge them to explain to the child or spouse of someone who has died or become permanently disabled due to HMO abuses, why they should have to live in poverty while a multi-billion-dollar corporation gets off scot-free.

I challenge those on the other side—who talked so much during the debate on welfare reform about the need for people to take responsibility for their actions—to explain why this standard should apply to poor, single mothers but not to HMOs.

I challenge them to explain why every other industry in America should be held responsible for its actions, but HMOs and health insurance companies should be immune from responsibility.

The time has come to say that this unique immunity should end.

The time has come to say that someone who dies or is injured because an insurance company accountant overrules the doctor is entitled to compensation.

The time has come to say that profits should no longer take priority over patients' care.

I withhold the remainder of my time.

The PRESIDING OFFICER (Mr. BURNS). Who yields time?

Mr. GREGG. Mr. President, I yield 7 minutes to the Senator from Washington.

The PRESIDING OFFICER. The Senator from Washington.

Mr. GORTON. Mr. President, nothing could more dramatically illustrate the differences in general attitudes and attitudes towards health care between the Senator from Massachusetts and the Members on this side than his statement that his bill would be preferable to ours because it would only ''cost'' the American people $7 billion, while ours would ''cost'' the American people $13 billion.

In fact, of course, overwhelmingly, the ''costs'' of his bill will be evidenced in higher taxes on the American people. His so-called ''costs'' of our bill are, in fact, the reduction of taxes on the American people so they can use their own money to take care of more of their own health care costs. But to the Senator from Massachusetts, it is the same thing—more taxes, not less taxes.

We do not think that is the same thing by any stretch of the imagination.

In addition, of course, he ignores entirely the costs imposed on the American people by paying higher health insurance premiums. Those presumably are irrelevant.

But the subject before us primarily is lawsuits.

There is widespread agreement in this body and across the United States that the medical malpractice system is simply broken, that it comes too late, that it costs so much, that less than half of the dollars that it costs ever get to victims and the rest is consumed by lawyers and by the administration of the system itself.

The problem is, of course, we have never come up with a majority for a way in which to fix that medical malpractice system. But the proposition that it is broken is very widely held.

It is into that broken system the Democrats' plan pours another element of our health care system and says: Oh, the system may be broken, but the only solution is to make it worse, is to make it more widespread.

Pouring good wine into a broken bottle with what impact? Better health care? No. We know the medical malpractice system doesn't create more and better health care.

More lawsuits? Clearly, yes. One aspect of that broken system, of course, is the costs go not into providing better health care for the people of the country but into the system itself.

But the patients—ultimately, the people who buy insurance, the people who consume health care—pay the entire bill, including all of the bills for the lawyers. With what impact? Higher costs for everyone who is insured and therefore fewer insured.

But I think that is perhaps the least of the vices of the Democratic proposal because it allows, under certain circumstances at least, the employer—the person who is providing health care to his or her or its employees—to be sued. As well, it will drive logical and thoughtful employers out of the business of providing insurance at all. And it will do that in a devastating degree.

I suspect that perhaps half of the employers, when they find they are going to be sued, will simply say: We are not interested in any more lawsuits. Sure. We will give each of our employees more money for the cost of that health insurance in cash, and the employee can do what he or she wishes with it.

Some will ignore the cost of health care insurance and will become self-insured—some very much to their pain. Others will attempt to buy individual policies, which will inevitably cost more and give them less than any kind of group policy does. So we will have less insurance under this set of circumstances in order to have more lawsuits.

Let's go back to this whole idea of medical malpractice as a broken system.

What we should be searching for is a better system, and the better system is exactly the plan that the Republican proposal has. It says instead of lawsuits after the harm has been done with the reward, if any, coming 3, 4, or 6 years later, we tell the potential patient who thinks his health care system has not done right by him that he has a right to get an answer promptly before the damage is done.

This is the system we ought to expand to other health care systems. This is the system we are asked by the Supreme Court of the United States to apply to asbestos litigation—a unanimous Supreme Court of the United States.

But instead, if the Senator from Massachusetts has his way, we will simply take a broken system and apply it in more areas than it applies to right now.

That is a perverse answer to a very serious question. We will not treat the patients. They will treat the court system.

Mr. KERRY. Mr. President, we have heard the horror stories: An HMO delays a breast cancer patient's treatment until the cancer has spread throughout her body. Parents are forced to drive their critically ill child to a hospital 50 miles away from their home because their insurer refuses to let them take the boy to a hospital 5 miles from their home. A patient complaining of chest pains is not allowed to see a cardiologist, and as a result suffers a fatal heart attack. Americans want their doctors—not managed care bureaucrats—to make their medical decisions. And when managed care wrongfully delays or denies care, Americans want the right to bring a lawsuit to hold managed care responsible for its misconduct.

And let me tell you directly—the Gregg amendment won't do a thing to help Americans who suffer from the abuse of HMOs. It will maintain the provision in ERISA that allows patients in employer self funded plans to only recover damages in court from an HMO related to the cost of the treatment delayed or denied. It denies the right of Americans to receive punitive damages that send the message to insurance companies that when they do wrong, they'll be held accountable for the wrong they do.

The Gregg amendment sets up a weak appeals process where patients could first dispute the HMO's ruling with a doctor within the insurance plan (but not the one they saw for treatment) and if they are still not satisfied then they can talk to a second doctor that is outside of the insurance plan but regulated by either a state or federal agency. Whatever each of the doctors rule would then be binding. The Gregg amendment only exacerbates a bureaucratic nightmare. It doesn't allow Americans to hold insurance companies accountable in court. It doesn't address the real impediment to accountability in health care: ERISA.

Today, even if an HMO has been directly involved in dictating, denying or delaying care for a patient, it can use a loophole in the Employee Retirement Income Security Act (ERISA) to avoid any responsibility for the consequences of its actions. ERISA was designed over 25 years ago, long before managed care companies became the powerful entity in controlling the health care of Americans that it is today. ERISA was originally designed to protect employees from losing pension benefits due to fraud, mismanagement and employer bankruptcies during the 1960's, but the law has had the affect of allowing an HMO to deny or delay care with no effective remedy for patients.

Judge William G. Young, a Reagan appointed US District Judge, in his landmark opinion in one case, laid the problems out before us in clear language. He said, and I quote, ''ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits. ERISA thwarts the legitimate claims of the very people it was designed to protect.'' Judge Young was barred by law from awarding damages for wrongful death in an HMO case—his hands were tied by ERISA—but he laid out the point we're trying to make today. We need to end the ERISA nightmare that is hurting ordinary Americans.

We have built a system that puts paperwork ahead of patients and ignores the real life and death decisions being made in our health care system. We must do better. Americans deserve better care, and deserve the right to hold insurers accountable if they do not receive that care.

Our opponents erroneously argue that ensuring that plans are held accountable will drive up premium costs and result in lost coverage. They fail to acknowledge however, that the timely appeals mechanisms in our amendment could prevent lawsuits before harm can occur. In fact, an independent study by Coopers and Lyband found that the Democratic provision to hold health plans accountable would cost a mere 3 to 13 cents a month. Ironically, the industry's cry that liability will raise costs assumes that health plans are very negligent and that patients do indeed suffer real harm.

History bears out our case: access to the court system for ordinary Americans—the right to seek redress—rescued America from Pintos that caught on fire, it gave us seatbelts, bumpers, airbags in cars, and every innovation in safety for consumers that we've witnessed over the last thirty years.

So why would we oppose access to the court system for patients injured by runaway insurance companies? Well, some have said it will clog the courts and increase costs and premiums on insurance. And all the studies that prove otherwise aren't enough for these ideologies. Well, they might want to take a look at the State of Texas, where, over Governor George Bush's objections, they gave Texans the right to sue their HMO. And what's been the result? In 2 years since an external review process was established, only 480 complaints have been filed with the Texas Independent Review Organization—about 30 times less than the 4,400 complaints that were predicted in the first year alone by the Texas Department of Insurance. Even more important, only one medical malpractice lawsuit has been filed under this law. Mr. President, the Republicans have been asking America to look towards Texas for some answers—Mr. President, this is one issue on which I think we ought to follow Texas's example. It works.

Americans overwhelmingly favor holding managed care plans accountable. A Kaiser Family Foundation/Harvard School of Public Health survey released in January of this year found that 78 percent of voters believe that patients should be able to hold managed care legally accountable for malpractice. A poll released in September of 1998 by The Wall Street Journal and NBC News revealed that 71 percent of voters favor legislation that gives patients the right to hold managed care accountable for improper care, even if that might increase premiums—which studies show it would not.

Mr. President, it is clear that accountability is the key to enforcing patients' rights. A right to emergency room care on a ''prudent layperson'' standard or a right to specialty care does little to protect patients if such care can routinely be delayed or denied. Only legal remedies provide adequate protection against managed care's biggest abuses. And it's time we embraced those legal remedies. That is something about which we should all agree.

I ask unanimous consent to have articles from the New York Times and the Wall Street Journal printed in the RECORD.

There being no objection, the articles were ordered to be printed in the RECORD, as follows:

[From the New York Times, July 11, 1998]

HANDS TIED, JUDGES RUE LAW THAT LIMITS H.M.O. LIABILITY

(By Robert Pear)

WASHINGTON, July 10—Federal judges around the country, frustrated by cases in which patients denied medical benefits have

no right to sue, are urging Congress to consider changes in a 1974 law that protects insurance companies and health maintenance organizations against legal attacks.

In their decisions, the judges do not offer detailed solutions of the type being pushed in Congress by Democrats and some Republicans. But they say their hands are tied by the 1974 law, the Employee Retirement Income Security Act. And they often lament the results, saying the law has not kept pace with changes in health care and the workplace.

The law, known as Erisa, was adopted mainly because of Congressional concern that corrupt, incompetent pension managers were looting or squandering the money entrusted to them. The law, which also governs health plans covering 125 million Americans, sets stringent standards of conduct for the people who run such plans, but severely limits the remedies available to workers.

In a lawsuit challenging the denial of benefits, a person in an employer-sponsored health plan may recover the benefits in question and can get an injunction clarifying the right to future benefits. But judges have repeatedly held that the law does not allow compensation for lost wages, death or disability, pain and suffering, emotional distress or other harm that a patient suffers as a result of the improper denial of care.

Congress wanted to encourage employers to provide benefits to workers and therefore established uniform Federal standards, so pension and health plans would not have to comply with a multitude of conflicting state laws and regulations.

The United States Court of Appeals for the Fifth Circuit, in New Orleans, reached a typical conclusion in a lawsuit by a Louisiana woman whose fetus died after an insurance company refused to approve her hospitalization for a high-risk pregnancy. The woman, Florence B. Corcoran, and her husband sought damages under state law.

In dismissing the suit, the court said, ''The Corcorans have no remedy, state or Federal, for what may have been a serious mistake.''

The court said that the harsh result ''would seem to warrant a reevaluation of Erisa so that it can continue to serve its noble purpose of safeguarding the interests of employees.''

In another case, Judge William G. Young of the Federal District Court in Boston said, ''It is deeply troubling that, in the health insurance context, Erisa has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect.''

Judge Young said he was distressed by ''the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry,'' leaving many consumers ''without any remedy'' for the wrongful denial of health benefits.

Disputes over benefits have become common as more employers provide coverage to workers through H.M.O.'s and other types of managed care, which try to rein in costs by controlling the use of services.

Here are some examples of the ways in which judges have expressed concern:

Judge John C. Porfilio of the United States Court of Appeals for the 10th Circuit, in Denver, said he was ''moved by the tragic circumstances'' of a woman with leukemia who died after her H.M.O. refused approval for a bone marrow transplant. But, he said, the 1974 law ''gives us no choice,'' and the woman's husband, who had sued for damages, is ''left without a remedy.''

The United States Court of Appeals for the Eighth Circuit, in St. Louis, said the law protected an H.M.O. against a suit by the family of a Missouri man, Buddy Kuhl, who died after being denied approval for heart surgery recommended by his doctors. ''Modification of Erisa in light of questionable modern insurance practices must be the job of Congress, not the courts,'' said Judge C. Arlen Beam.

The United States Court of Appeals for the Sixth Circuit, in Cincinnati, said that Federal law barred claims against a ''utilization review'' company that refused to approve psychiatric care for a man who later committed suicide. Because of Erisa, the court said, people who sue an H.M.O. or an insurer for wrongful death ''may be left without a meaningful remedy.''

Federal District Judge Nathaniel M. Gorton, in Worcester, Mass., said that the husband of a woman who died of breast cancer was ''left without any meaningful remedy'' against an H.M.O. that had refused to authorize treatment.

Federal District Judge Marvin J. Garbis, in Baltimore, acknowledged that a Maryland man may be left ''without an adequate remedy'' for damages caused by his H.M.O.'s refusal to pay for eye surgery and other necessary treatments. But, Judge Garbis said, whether Erisa should be ''re-examined and reformed in light of modern health care is an issue which must be addressed and resolved by the legislature rather than the courts.''

The United States Court of Appeals for the Ninth Circuit, in San Francisco, ruled last month that an insurance company did not have to surrender the money it saved by denying care to a Seattle woman, Rhonda Bast, who later died of breast cancer.

''This case presents a tragic set of facts,'' Judge David R. Thompson said. But ''without action by Congress, there is nothing we can do to help the Basts and others who may find themselves in this same unfortunate situation.''

Democrats and some Republicans in Congress are pushing legislation that would make it easier for patients to sue H.M.O.'s and insurance wrong decision, he or she can be sued, said Representative Charlie Norwood, Republican of Georgia, but ''H.M.O.'s are shielded from liability for their decisions by Erisa.''

Changes in Erisa will not come easily. The Supreme Court has described it as ''an enormously complex and detailed statute'' that carefully balances many powerful competing interests. Few members of Congress understand the intricacies of the law. Insurance companies, employers and Republican leaders strenuously oppose changes, saying that any new liability for H.M.O.'s would increase the cost of employee health benefits.

Senator TRENT LOTT of Mississippi, the Republican leader, said today that he had agreed to schedule floor debate on legislation to regulate managed care within the next two weeks. Senator TOM DASCHLE of South Dakota, the Democratic leader, who had been seeking such a debate said, Mr. LOTT's commitment could be ''a very consequential turning point'' if Democrats have a true opportunity to offer their proposals.

But Senator DON NICKLES of Oklahoma, the assistant Republican leader, said, ''Republicans believe that health resources should be used for patient care, not to pay trial lawyers.''

Proposals to regulate managed care have become an issue in this year's elections, and the hottest question of all is whether patients should be able to sue their H.M.O.'s. The denial of health benefits means something very different today from what it meant in 1974, when Erisa was passed. At that time, an insured worker would visit the doctor and then if a claim was disallowed, haggle with the insurance company over who should pay. But now, in the era of managed care, treatment itself may be delayed or denied, and this ''can lead to damages far beyond the out-of-pocket cost of the treatment at issue,'' Judge Young said.

H.M.O.'s have been successfully sued. A California lawyer, Mark O. Hiepler, won a multimillion-dollar jury verdict against an H.M.O. that denied a bone marrow transplant to his sister, Nelene Fox, who later died of breast cancer. But that case was unusual. Mrs. Fox was insured through a local school district, and such ''governmental plans'' are not generally covered by Erisa.

The primary goal of Erisa was to protect workers, and to that end the law established procedures for settling claim disputes.

Erisa supersedes any state laws that may ''relate to'' an employee benefit plan. Erisa does not allow damages for the improper denial or processing of claims, and judges have held that the Federal law, in effect, nullifies state laws that allow such damages.

[From the Wall Street Journal, July 8, 1998]

LAWSUITS HAVE LITTLE EFFECT ON PREMIUMS

(By Laurie McGinley)

WASHINGTON—Adding fuel to one of the most contentious issues before Congress, a study found that allowing patients to sue their health plans over treatment denials hardly increased premiums.

Though laced with caveats, the study could have a significant impact on the managed-care debate heating up on Capitol Hill, where a key question is whether injured patients should be permitted to sue their plans for damages. The report, by Coopers & Lybrand for the Kaiser Family Foundation, is the first attempt by an independent group to look closely at the costs associated with litigation. It undercuts assertions by the managed-care industry and employer groups that imposing legal liability on health plans for wrongly denying treatment would send insurance premiums soaring.

After examining three big health plans for state and local government employees, who already have the right to sue, the study found that the cost of litigation was between three and 13 cents a month per enrollee, or 0.03% to 0.11% of premiums.

''Coopers found that in these places where patients can sue, very few have and the costs have been rather small,'' said Kaiser Foundation President Drew Altman. He cautioned against drawing strong conclusions from the data. ''These are real-life examples, but you can't necessarily use them to generalize to the whole country.''

MORE COST ESTIMATES COMING

The study won't be the last word on the subject. The Congressional Budget Office is working on a cost estimate of a Democratic ''patients' bill of rights'' proposal that includes a managed-care liability provision. And the managed-care industry has touted its own study, by the Barents Group, which estimated that the right-to-sue provision could raise premium costs by 2.7% to 8.6%.

The report came as Senate Democrats fired the opening shot in what is likely to be a protracted struggle over managed-care reform. Last night, Minority Leader Tom Daschle of South Dakota tried to attach the Democratic bill to a funding bill for the veterans and housing departments. In response, Majority Leader Trent Lott of Mississippi pulled the bill off the floor. Meanwhile, GOP senators are working on their own, slimmer, managed-care bill.

The Kaiser report gives the Democrats and their legislative allies, including the American Medical Association, added ammunition on the right-to-sue provision. ''The study strips away the only serious argument against the right to hold health plans accountable that has been made by the opponents of change,'' Sen. Edward Kennedy (D., Mass.) said in a statement.

Richard Smith, vice president for policy at the American Association of Health Plans, which represents more than 1,000 managed-care plans, said the study was deficient because it doesn't include the cost of ''defensive medicine''—the provision of services solely to avoid lawsuits. Such practices, he said, would be the ''single largest cost driver'' resulting from the right-to-sue provision.

Larry Atkins, president of Health Policy Analysts, a Washington consulting group, said that ''it's impossible to assess the real cost'' of liability, but its passage would end managed care's success in curbing health costs.

SUITS IN FEDERAL COURT

Under the 1974 Employee Income Retirement Security Act, injured patients enrolled in employer-sponsored health plans can't sue their plans for damages under state law if they're improperly denied treatment. They are permitted to bring actions in federal court, but if they win they receive only the value of the denied benefit.

But the law doesn't apply to employees of state and local governments, so Coopers & Lybrand examined the litigation experience of the California Public Employees Retirement System, the Los Angeles Unified School District and the State of Colorado Employee Benefit Plan. Altogether, the three plans cover 1.1 million workers. ''All three programs reported very low rates of litigation ranging from 0.3 to 1.4 cases per 100,000 enrollees per year,'' the study said.

Coopers & Lybrand cautioned that public employees may be less likely to sue than their counterparts in the private sector.

The PRESIDING OFFICER. Who yields time?

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

The PRESIDING OFFICER. The Senator from Nevada is recognized for 3 minutes.

Mr. REID. Mr. President, our bill that is now being attempted to be wiped out as far as liability has not established a right to sue but simply says Federal law cannot break what the States say are appropriate remedies for patients and families who are harmed.

Our legislation protects employers against liability.

I repeat. Our legislation protects employers against liability.

It allows patients who are harmed by an insurance company's decision to deny or delay care to hold their insurance company accountable—not their employer.

There is a lot of talk about the ads that are being run that the employers are going to be held responsible. That is absolutely not true.

Under the Republican amendment, if someone dies of cancer because an insurer refuses needed tests, all the insurer is responsible for is the cost of that test. It may be $20 or $30. That will be the extent of liability. Doctors and other health providers can be sued for harm, pain, and suffering. Yet health plans that make decisions to deny or delay care will continue to be off the hook. Doctors and other health providers can be sued, and yet these HMOs continue to be left off the hook.

It is ironic that those who defend States rights so much on the floor of the Senate obviously don't follow through because they are the loudest and the first to use Federal law to protect health insurers that injure patients.

That is another way of saying the insurance industry is being protected by the majority.

Democrats believe insurance companies should be held accountable when their decisions lead to injury or death. And our opponents claim that isn't the way it should be. They say they should be protected in this separate category, as has been pointed out about the foreign diplomat.

In fact, I repeat what I said earlier this morning. An independent study by Coopers & Lybrand, the international accounting firm, found that the provision in our bill to hold health plans accountable would cost as little as 3 cents per person per month.

Our legislation is directed toward patients, not profits. Our legislation wants to maintain and reestablish the party-physician relationship, which the Republican, the majority, have attempted to destroy with their protecting of the HMOs.

The Republican, the majority, bill is an insurance protection bill; ours is one that protects patients.

Mr. GREGG. Mr. President, I note for the RECORD that the bill sponsored by the Democratic side does allow employers to be sued under subsection A(302). It says specifically ''shall not preclude any cause of action described in paragraph one against employer.''

Mr. REID. Will the Senator yield?

Mr. GREGG. Under the Senator's time.

Mr. REID. If the Senator is accurate in his statement, it would have said the only time an employer can be held responsible is when the employer is involved directly in a specific case and makes a decision that leads to injury or death.

Of course that is fair. If an employer makes a decision—not the employer's HMO, not the employer's doctor, but the doctor himself is involved in making a decision that leads to injury or death—that seems fair to me.

Mr. GREGG. Actually, the language says ''discretionary authority,'' which is a very broad term.

I yield the Senator from Oregon 7 minutes.

The PRESIDING OFFICER (Mrs. HUTCHISON). The Senator from Oregon.

Mr. SMITH of Oregon. Madam President, many of the HMOs that Senator REID identifies are self-funded insurance plans that are provided by businesses. They certainly are included.

As Senator GREGG has noted, the language reads ''discretionary authority'' which is a very broad term. The potential for liability is very great.

As I speak to my colleagues and the American people today, I simply say we have a problem. We are mortals, and no one gets out of this life alive. When people die and when they get sick, there are lots of tears. We would like to help. Often, as we reach out to help, we look also for people to blame for tragedy. There are plenty of people in the legal profession to help them find others to blame.

I stand before the Senate as a member of the bar. But I am not going to speak as a member of the bar. I am going to speak as the Senator from Oregon and as a member who holds a somewhat unique perspective in this Chamber—as a businessman, also as someone who has actually paid the health care bills.

Colleagues, as I have listened to Senator FRIST I have been impressed by his skill as a physician, his nuances and his understanding of these issues and they have been helpful to me. As I watched Senator EDWARDS of North Carolina use his great skill and ability as a trial lawyer to make the case for liability, I was also impressed.

However, there are not many people in this Chamber who have actually written the check to provide the health care coverage to their employees. My experience before coming to this Senate was as a food processor. I provided health insurance to hundreds of employees and their families. For nearly 20 years in which I managed that business, I saw health care costs rise three, four, even five times the rate of inflation. My business was not to provide health care, it was to produce food. It was—beyond all others—a cost out of control.

These people who are writing the checks, trying to live up to the promise that we all want in this country for health care, are not the enemy. They are trying to do a good job, and to meet the needs of their employees. I cannot think of a single thing that would imperil health care more in this country than removing the protections provided to employers on the issue of liability.

We are shown all of the terrible situations by the charts shown in this Chamber. But I say to you, I have a heart, too. I would like to help. But I also know that when you deal with an inflationary cost such as medicine, sometimes you don't have the ability—particularly in agriculture—to pass those costs on in the price of your product. So when you add on top of that the potential cost of liability, I fear that employers will not be able to bear it and will turn that benefit into cash for their employees and simply say to employees—you will have to buy it yourself.

But people don't have the ability to buy health care coverage as individuals as well as when they are pooled in employer groups. I support employer-provided health care. I think we are imperiling it if we remove the protections provided to employers by ERISA.

Now, employer-provided health care has an interesting origin in our country. It was very rare prior to World War II when we put on wage and price controls but did not limit the ability of businesses and labor to bargain for benefits. When the men went off to war, businesses reached out to many of the

women. They could not offer them a higher wage, so they offered them the benefit of health care. Then businesses began to do this more and more, and it became the subject of collective bargaining under Taft-Hartley and other labor provisions. By the 1970s, nearly three quarters of the American people were covered by employer-provided health care plans.

Congress wanted to go further. In fact, it was a Democratic Congress in 1974 that produced the protection called ERISA to further induce and incentivize businesses to expand in a multistate way to provide health insurance.

Folks, it has worked. Right now the frustrating thing to me is, as we try to legislate, we inevitably have to draw lines and make decisions.

We once were in the position in the State of Oregon of figuring out how best to allocate Medicaid resources. We don't like to have uninsured people in our State; we want them to be insured. Our current Governor's name is John Kitzhaber. He is a medical doctor; he is an emergency room physician. He is a Democrat. He came to the Federal Government, along with many on the Republican side, and said: Let's take this Cadillac plan for a few and essentially turn it into a Chevrolet plan for many.

So we got a waiver. Instead of rationing medicine through waiting lines and price, we did it upfront by saying: These are the health care procedures that are available.

The Vice President, AL GORE, and others referred to our Governor sometimes in very disparaging terms. He was even called ''Doctor Death'' by the media. But he had the courage, and many with him, to make decisions that were tough.

So when we see the pictures and the charts, I say to you that I have been there, I have seen and lived them before. My heart strings are pulled by those, too. But I also know that we don't help them by increasing health care costs—we uninsure them.

What we are debating, really, is where to draw the line, how to make health care more affordable to more people. The last thing in the world we should be doing is so disincentivizing the ability of small businesses to afford health care that they will simply turn it into cash.

I ask unanimous consent to have printed in the RECORD a letter on behalf of the National Grocers Association.

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

NATIONAL GROCERS ASSOCIATION
Reston, VA, July 9, 1999.

Hon. GORDON H. SMITH,
U.S. Senate,
Washington, DC.

DEAR SENATOR SMITH: On behalf of independent retail and wholesale grocers nationwide, I am writing to express our strong opposition to legislation that allows employers to be sued for health plan decisions or that modify or eliminate ERISA preemption of state regulation. The National Grocers Association (N.G.A.) is the national trade association representing retail and wholesale grocers who comprise the independent sector of the food distribution industry. This industry segment accounts for nearly half of all grocery sales in the United States.

Under current law, the Employee Retirement Income Security Act (ERISA) supersedes all state laws concerning employee benefits. This means that states cannot regulate or tax employer health and welfare plans, and beneficiaries may not sue plans or employers for violations of state law. The purpose of ERISA preemption of state law is to encourage businesses to offer health insurance to their employees by guaranteeing a uniform national regulatory system and limiting liability. It has served this purpose extremely well.

Elimination of the ERISA preemption would subject companies in the food distribution industry to a patchwork of new regulations in the states in which they operate, and expose them to a new class of possible lawsuits in each of those states. Plans would be forced to cover treatments to avoid litigation, thereby driving up the cost of offering health insurance. There is tremendous concern that the new costs associated with removing the ERISA preemption could cause many businesses to stop offering health insurance to their employees.

Again, I urge you to oppose legislation to modify or eliminate the ERISA preemption thereby increasing the cost of health care while expanding employer liability. Thank you in advance for your consideration of our concerns.

Sincerely,

THOMAS K. ZAUCHA,
President and CEO.

Mr. SMITH of Oregon. The letter talks about how many small grocers, as many in business, simply will not be in a position to bear this additional burden.

I ask Members to understand, we are talking about a very significant thing. It is not just about price; it is about the ability to participate, and to continue providing health insurance to the working men and women of this country. I ask my colleagues to vote against expanding liability and in support of the Gregg amendment.

Mr. KENNEDY. Madam President, I yield myself 5 minutes. Do we have 9 minutes left? Please let me know when 4 minutes are up.

Madam President, statements have been made here to the effect that we should not let this process go forward. Statements have been made that this is basically a Democratic initiative, a partisan issue. We have claimed it is an issue of fundamental justice.

Let me quote Frank Keating, the Republican Governor of Oklahoma, a man who was so respected in his own party that he was elected chairman of the Republican Governors' Association. According to an Oklahoma newspaper, in an interview with Keating, Keating sided with congressional Democrats. He said health maintenance organizations should be open to lawsuits if they are grossly negligent. Keating said his oldest daughter had a heart defect since birth, but that the gatekeeper at her health maintenance organization in Texas told her she did not need to see a cardiologist. Keating said he made a call to a top aide to Texas Governor George W. Bush to get some action. He said he realized other people might not be able to pull such strings.

That is what a Republican Governor has said is the reality in real America.

We see it in the Federal courts. I will have printed in the RECORD a series of statements from judges who are seeing these cases. Let me read one by Federal Judge William Young, a longtime Republican, who, incidentally, was appointed to the bench by President Ronald Reagan. He said that disturbing to this court is the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original sense. This court has no choice but to pluck the case out of State court and then, at the behest of the insurance company, slam the courthouse door in the wife's face and leave her without any remedy.

Judge Young came down here and urged us to include this particular provision in our legislation because of what he has seen occur in the Federal courts.

I could read instance after instance. Judge Spencer Letts has a long statement about this as well. He said that it is not just the parents. They are the most powerful voices, but it is the judges who are appalled at the inequity and outrageous injustice that is taking place in the Federal courts all over this country, and it is wrong.

Most Americans would be shocked to know that HMOs enjoy immunity from suits. If a doctor fails to treat a patient with cancer correctly and if the patient dies, you can sue the doctor for malpractice. But if a managed care company decides to pinch pennies and overrule the doctor's recommendations on treating the patient and the patient dies, the insurance company is immune from responsibility. No other industry in America enjoys this immunity from the consequences of its actions. The HMOs do not deserve it. On this life-and-death decision, immunity from responsibility is literally a license to kill.

Madam President, we ought to at least leave this matter up to the States, not preempt the States.

I want to say the strongest supporters of this provision are the doctors. The reason the doctors are the strongest advocates of this position is because they are sick and tired of having their medical recommendations overruled by HMOs. That is the basic justification.

Ultimately, it is basic fairness to the individual who may be harmed. The provision ultimately improves the quality of care by ensuring their accountability. Finally, we have the doctors themselves pleading, pleading, pleading for Congress to act.

The American Medical Association has indicated its strong support in a letter. I ask unanimous consent to have that printed in the RECORD as well.

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

AMERICAN MEDICAL ASSOCIATION,
Chicago, Il, July 8, 1999.

Hon. EDWARD M. KENNEDY,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR KENNEDY: On behalf of the 300,000 physician and student members of the American Medical Association (AMA), we are pleased that the Senate has agreed to begin debate on patient protection legislation. Bipartisan enactment of comprehensive legislation in this area is urgently needed.

* * * * *

This bill should remedy the inequity that results from health plans' ability to routinely make medical decisions while remaining unaccountable for the injuries they cause. Health plans duplicitously argue that they should make medical necessity decisions and control utilization review and appeals processes while stating that they want to be protected by ERISA preemption. By not removing that immunity, this bill would fail to hold those health plans accountable. Presently, 125 million enrollees participate in ERISA–covered health plans, and despite state legislative initiatives to provide adequate legal remedies, those enrollees are all without effective legal recourse against their health plans. This is an issue of fundamental fairness. The AMA firmly believes that Americans covered by ERISA plans must have the same right of redress as those who are covered by non-ERISA plans. We therefore request that S. 326 be amended to remove ERISA preemption for health plans.

* * * * *

In conclusion, the AMA appreciates the Senate's efforts to adopt legislation that would promote fairness in managed care. We urge you to join us in advancing patients' rights by strengthening the ''Patients' Bill of Rights Act,'' S. 326, to guarantee all patients these essential protections.

Respectfully,
E. RATCLIFFE ANDERSON, Jr., MD.

Madam President, I hope this amendment will be defeated and that we let the States make the final judgment. They ought to be the ones who make the decision about protecting their own citizens. On this issue, it should not be the Federal Government or the Senate preempting and denying States the opportunity to protect their citizens.

How much time do I have remaining?

The PRESIDING OFFICER. The Senator has 4 minutes and 29 seconds.

Mr. KENNEDY. I yield 2 minutes on the bill to the Senator from California.

The PRESIDING OFFICER. The Senator from California is recognized for 2 minutes.

Mrs. BOXER. Madam President, I thank Senator KENNEDY for his incredible leadership on this issue.

Last night, I said the score was 8 to 0; it was 8 for the HMOs, patients nothing. I think this amendment is worth 2 points, so it will either be 10 to nothing or 8 to 2.

Let me tell you why I think this amendment is so important. If this amendment is agreed to and the HMOs cannot be held accountable in a court of law, it means that if they kill you, if they maim you, if they hurt you or your family or your children due to callous and uncaring bureaucrats, they cannot be held accountable. We set no new Federal cause of action. We simply say if the States believe it is right—such as Texas decided it was—then they can allow these lawsuits to proceed.

Let me tell you about an emergency room physician I met. He came before the Congress. He told a harrowing tale of a man who was brought into the emergency room with uncontrollable blood pressure. The doctor tried everything. Finally, by administering drugs through an IV, he was able to control the pressure. He felt the man needed to stay in the hospital at least overnight. He called the HMO. The HMO said, ''Absolutely not. Give the man his medication and send him home.''

The doctor begged. The doctor cajoled. The HMO was unrelenting. The doctor went to the patient. He said, ''Your HMO will not allow you to stay here, sir, but I strongly advise you to stay here.''

The patient said, ''What will it cost?''

The doctor said, ''About $5,000.''

This gentleman started laughing. He said: I don't have $5,000. I have a family. I have to go home. I have a job. I am sure my HMO would never do this to me, would never put me in danger. If they say I can have the drugs, give me the drugs, and I will go home.

The doctor could not prevail with the gentleman. The gentleman went home and had a stroke. He is now paralyzed on one side of his body.

I ask for an additional 30 seconds on the bill.

Mr. KENNEDY. I yield 30 more seconds.

The PRESIDING OFFICER. The Senator is recognized for 30 seconds.

Mrs. BOXER. So now what happens? This man is paralyzed for life. Oh, he could sue the doctor, that good doctor who begged the HMO. Yes, he could sue the hospital. The hospital had nothing to do with it.

I am saying to my friends on the other side of the aisle, you are always talking about States rights. We come in here and get lectured every day. All this amendment, under the underlying bill, says is, if a State decides to allow their people the right to sue a callous, uncaring, and negligent HMO, as Texas decided to do and other States did, let them do it.

I hope this amendment will be defeated. Remember, it is worth 2 points.

Mr. NICKLES. Madam President, I ask that the Senator from New Hampshire yield me 1 minute.

Mr. GREGG. I yield the Senator from Oklahoma 1 minute.

Mr. NICKLES. Madam President, I ask unanimous consent to have printed in the RECORD a letter from the Republican Governors Association, signed by Governor Keating from Oklahoma, Ed Schafer, Governor of North Dakota, and Don Sundquist, Governor of Tennessee, all urging us to defeat the KENNEDY bill.

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

REPUBLICAN GOVERNORS ASSOCIATION,
Washington, DC, July 14, 1999.

Hon. DON NICKLES,
Assistant Majority Leader, U.S. Senate, U.S. Capitol, Washington, DC.

DEAR SENATOR NICKLES: As Congress begins debate on managed care reform legislation, we would like to emphasize our confidence in states' achievements in managed care and ask that any legislation you consider preserve state authority and innovation. We applaud the Republican Leadership's efforts to complement the states' reforms by expanding managed care protections to self-insured plans without preempting state authority.

Historically, regulating private insurance has been the responsibility of the states. Many, if not all of the ideas under consideration now in Congress, have been considered by states. Because the saturation of managed care is different throughout the nation, each state has its own unique issues relative to its market place. We have concerns about the unintended consequences of imposing one-size-fits-all standards on states which could result in increasing the number of uninsured and increasing health care costs.

As Governors, we have taken the reports of abuses in managed care seriously and have addressed specific areas of importance to our citizens. As you know, some analysts estimate that private health insurance premiums could grow from the current 6 percent to double-digit increases later this year. This does not include the costs of any new federal mandates. Health resources are limited.

We hope the Congress' well-intended efforts take into account the states' successful and historical role in regulating health insurance.

Sincerely,

FRANK KEATING,
Governor of Oklahoma, Chairman.

ED SCHAFER,
Governor of North Dakota, Vice Chairman.

DON SUNDQUIST,
Governor of Tennessee, Chairman, RGA Health Care Issue Team.

Mr. NICKLES. I want to be clear. The Governors do not want us micromanaging their health care. The Governors, frankly, do not want us driving up health care costs. The Governors do not want to have a bill that is not really for patients rights, but rather for trial lawyers' rights. It would be great for lawsuits, but it would be terrible for health care. It basically would have people dropping health care all across the country because, not only do you sue HMOs, but you sue employers as well. Maybe many people have missed that part of the debate.

The Kennedy bill says, let's sue employers. If your health care is not good enough, sue your employers. The employers say: We do not have to provide health care; we are going to drop it. Employees, I hope you take care of it on your own. If you want to increase the number of uninsured, pass the Kennedy bill. This amendment would strike the provision. I think it would be very positive for health care in America.

Mr. GREGG. I yield, off the bill, to the Senator from Pennsylvania, 3 minutes.

The PRESIDING OFFICER. The Senator from Pennsylvania has 3 minutes off the bill.

Mr. SANTORUM. Madam President, I thank the Senator from New Hampshire. Many have said that you cannot sue your HMO. There are three Federal Circuit Court cases and 12 Federal District Court cases that have said ERISA does not preempt State law when you want to sue your HMO for malpractice.

I ask unanimous consent to have this list printed in the RECORD.

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

ERISA IS NOT A BARRIER TO HMO MALPRACTICE LIABILITY

The key argument made time and again by sponsors of the Kennedy unfunded mandates bill is that we need expanded liability because managed care companies are shielded from being held accountable for malpractice by the federal ERISA (Employee Retirement Income Security Act).

The fact is that in at least 15 cases since 1995, federal circuit and district courts have ruled that ERISA does not shield an HMO from being sued for medical malpractice.

Federal circuit court

In Dukes (1995), the third circuit court held that ERISA did not preempt Pennsylvania state law on medical negligence action involving an HMO.

In Pacificare (1995), the tenth circuit court held that ERISA did not preempt Oklahoma state law, stating, ''just as ERISA does not preempt the malpractice claims against the doctor, it should not preempt the vicarious liability claim against the HMO . . .''

In Rice (1995), the seventh circuit court held that ERISA did not preempt Illinois state law medical malpractice action.

Federal district court

In Henderson (1997), the court rejected claims of ERISA preemption in a malpractice case against an HMO, its hospitals, and treating professionals and settlement for $5 million was reached shortly thereafter.

In Prihoda (1996), the court held that ERISA did not preempt vicarious liability of an HMO.

In Kampmeier (1996), the court held that ERISA did not preempt Pennsylvania state law claim for medical negligence.

In Quellette (1996), the court held that ERISA did not preempt Ohio state law claim for medical negligence.

In Roessert (1996), the court held that ERISA did not preempt California state law for negligence.

In Fritts (1996), the court held that ERISA did not preempt Michigan state law for medical negligence.

In Lancaster (1997), the court held that ERISA did not preempt Virginia state law medical negligence claim.

In Blum (1997), the court held that ERISA did not preempt Texas malpractice claim against an HMO.

In Edelen (1996), the court held that ERISA did not preempt District of Columbia law in malpractice action against an HMO.

In Prudential (1996), the court held that ERISA did not preempt Oklahoma malpractice law in an HMO case.

In Ravenell (1995), the court held that ERISA did not preempt Texas malpractice law in an HMO case.

State court decisions

In Pappas (1996), Pennsylvania Superior Court held that medical malpractice action against an HMO was not preempted by ERISA.

In Naseimento, Massachusetts Superior Court held that ERISA did not preempt liability of an HMO, and a jury awarded $1.4 million.

Mr. SANTORUM. So the issue is not whether you can sue your HMO. That is not why we are so adamantly against the provision in the Kennedy bill. It is not to be able to sue your HMO. I do not have any problem with your being able to sue your HMO. What I do have a problem with is what this bill does; it allows you to sue your employer. It allows you to sue the employer for a decision made by an HMO, by an insurance company. What will that mean?

You heard the Senator from Oregon, who is a small business owner, say—and, by the way, I have talked to dozens of employers who have said this:

If you are going to open up the books of my corporation—I make widgets or I make steel or I make desks or I make pencils—you are going to open up my books for my employees to sue me for a decision my insurance company, that I hired, made. I cannot afford it. I am not in the business of health care. I am not managing these health care decisions. I hired someone to do that, but I am going to get sued for their decisions? Sorry, as much as I would love to provide group health insurance to you, I cannot allow the corporation—our corporation, our effort—to be jeopardized by a decision made by someone outside of what I do.

I cannot let it happen. They will drop their insurance. I ask for 30 additional seconds.

Mr. GREGG. I yield the Senator 30 seconds.

Mr. SANTORUM. Who will be the first person, once these employers drop their insurance as a result of this bill, to run to the Senate floor and say: These nasty employers, look at them; they are dropping their insurance; we need the Government to take over the health care system?

Yes, the Senator from Massachusetts would be the first person on the Senate floor calling for a Government health care system.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Madam President, I ask unanimous consent that 23 cases emphasizing ERISA's limitations, Federal cases from most every circuit plus various State courts around the country, be printed in the RECORD.

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

COURT CASES EMPHASIZING ERISA'S LIMITATIONS

A. FEDERAL APPELLATE DECISIONS

1. Bedrick v. Travelers Insurance Company (4th Cir. 1996) 93 F.3d 149

Ethan Bedrick was born with severe cerebral palsy and required speech therapy and physical therapy to prevent contraction of his muscle tissues. In April of 1993, Travelers Insurance Company terminated the speech therapy and severely restricted physical therapy when Ethan was 14 months old. When Ethan's father threatened to sue, the insurance company reviewed the decision. The insurance company concluded, without updating Ethan's file or consulting with his physicians, that intensive physical therapy would not result in what the insurance company described as ''significant progress'' for Ethan.

In its ruling in 1996, the Fourth Circuit held that Travelers' decision was arbitrary and capricious because the opinions of their medical experts were unfounded and tainted by conflict. The court observed that neither the insurance plan nor the company's internal guidelines required ''significant progress'' as a precondition to providing medically necessary benefits. ''It is as important not to get worse as to get better'', the court noted. The court noted that ''the implication taht walking by age five. . . would not be 'significant progress' for this unfortunate child is simply revolting.'' (page 153)

ERISA left the Bedricks with no remedy to compensate Ethan for the developmental progress he lost during the three years and more that his parents had to litigate the benefit denial by Travelers. The Bedricks' state law causes of action were eliminated due to ERISA.

2. Corcoran v. United Healthcare, Inc. (5th Cir. 1992) 965 F.2d 1321

Mrs. Corcoran was in an employer-sponsored health plan using Blue Cross as administrator and United Health Care handling utilization review. Mrs. Corcoran was pregnant and had a history of pregnancy-related problems. Although her own doctor recommended hospitalization, United Health Care denied that hospitalization was medically necessary and did not pre-certify a hospital stay. Instead, 10 hours of daily in-home nursing care were authorized. When the nurse was not on duty, the fetus developed problems and died. The Corcorans had no remedy for damages against United under ERISA. The Corcorans' claim for state damages were eliminated due to ERISA.

The court noted: ''The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system . . . Moreover, if the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgements) need not be factored into utilization review companies' cost of doing business, bad medical judgements will end up being cost-free to the plans that rely on these companies to contain medical costs. ERISA plans, in turn will have one less incentive to seek out the companies than can deliver both high quality services and reasonable prices'' (page 1338).

3. Cannon v. Group Health Services of Oklahoma, Inc. (10th Cir. 1996) 77 F.3d 1270

Ms. Cannon was diagnosed with elobastic leukemia. She received chemotherapy treatments, and her leukemia went into remission. Subsequently, her insurer amended her policy to state that preauthorization would be denied for an autologous bone marrow treatment if sought after the first remission.

Ms. Cannon's doctor recommended an autologous bone marrow treatment and requested preauthorization from the insurer. When the insurer denied the treatment as experimental, the doctors made a second request which was also denied. Through persistence by the doctor and Ms. Cannon, the insurer reversed its decision and authorized the treatment approximately seven weeks after the first request was made. It was not until 18 days after the decision to authorize the treatment was made that Ms. Cannon

learned of the reversal. Two days after notification, she was admitted to the hospital and died the following month.

Ms. Cannon's surviving spouse brought several state law claims. The court held that the state law causes of action were preempted due to ERISA and that there was no remedy under ERISA for the delay in receiving the authorization. The court apologized for the result and wrote ''although we are moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted, we conclude the law gives us no choice but to affirm'' (page 1271).

4. Jass v. Prudential Health Care Plan, Inc. (7th Cir. 1996) 88 F.3d 1482

Ms. Jass was in an employer-sponsored health plan using Prudential Health Care Plan to administer the plan. She had complete knee replacement surgery. A utilization review administrator for Prudential determined that it was not necessary for Ms. Jass to receive a course of physical therapy following the surgery to rehabilitate the knee.

Ms. Jass claimed that her discharge from the hospital was premature since she had not received required rehabilitation and she had permanent injury to her knee.

Ms. Jass had no damages remedy against either the utilization review administrator or Prudential under ERISA. The court found that ERISA preempted any state claim against Prudential for vicarious liability for the doctor's alleged negligence in connection with the denial of rehabilitation.

5. Comer v. Kaiser Foundation Health Plan (9th Cir. 1994) 1994 U.S. App. LEXIS 27358, 1994 WL 718871

Although Ryan Comer had been diagnosed with an unusual form of pediatric cancer, Kaiser denied coverage for high-dose chemotherapy and denied authorization for an autologous bone marrow transplant. Ryan subsequently died.

Ryan's parents' state wrongful death action was preempted by ERISA. Ryan's parents had no damage remedy available to them under ERISA.

6. Kuhl v. Lincoln National Health Plan of Kansas City, Inc. (8th Cir. 1993) 999 F.2d 298

Mr. Kuhl had a heart attack. His doctor decided on June 20, 1999 that he required specialized heart surgery. Because the hospitals in his town did not have the necessary equipment for such surgery, the doctor arranged for the surgery to be performed in St. Louis at Barnes Hospital.

When Barnes Hospital requested precertification for the surgery, the utilization review coordinator at Mr. Kuhl's HMO refused to precertify the surgery because the St. Louis hospital was outside the HMO service area. Accordingly, the surgery scheduled for July 6 was canceled. The HMO instead sent Mr. Kuhl to another Kansas City doctor on July 6 to determine whether the surgery could be performed in Kansas City. That doctor agreed with the first doctor that the surgery should be performed at Barnes Hospital. Two weeks later, the HMO agreed to pay for surgery at Barnes Hospital. By then, the surgery could not be scheduled until September.

When the doctor at Barnes Hospital examined Mr. Kuhl on September 2, Mr. Kuhl's heart had deteriorated so much that surgery was no longer a possibility. Instead, he needed a heart transplant. Although the HMO refused to pay for an evaluation for a heart transplant, Mr. Kuhl managed to be placed on the transplant waiting list at Barnes. Mr. Kuhl died waiting for a transplant.

The survivors of Mr. Kuhl have no damages remedy against the HMO under ERISA. Mr. Kuhl's survivors' state law causes of action were eliminated due to ERISA.

7. Spain v. Aetna Life Insurance Co. (9th Cir. 1993) 11 F.3d 129, cert. denied (1994)

Mr. Spain was diagnosed with testicular cancer. The recommended course of treatment was three-part procedure which had to occur in a short time period. Although Aetna initially approved the treatment, Aetna withdrew its approval prior to the third part of the procedure.

While Aetna ultimately changed its position and authorized the third part of the procedure, it was not authorized until it was too late to be effective. Mr. Spain died. There are no damage remedies against Aetna under ERISA. Mr. Spain's survivors' state law causes of action were eliminated due to ERISA.

8. Settles v. Golden Rule Insurance Co. (10th Cir. 1991) 927 F.2d 505

Mr. Settles was in an employee-sponsored health plan. The employer paid a monthly premium to Golden Rule and the employer was required to give written notice to the insurer in advance of terminating Mr. Settles' coverage. On October 24, the insurer notified Mr. Settles by a letter that it had terminated his insurance unilaterally. That same day Mr. Settles suffered a heart attack and he died five days later.

The widow sued Golden Rule in state court alleging that the death of her husband was caused proximately by the insurer's unilateral decision to terminate his insurance. The court ruled that ERISA preempted her state claims. ERISA does not provide a damage remedy for her losses.

B. FEDERAL DISTRICT COURT DECISIONS

9. Wurzbacher v. Prudential Insurance Co. of America (E. Dist. Ky. January 27, 1998)

Mr. Wurzbacher received monthly injections of leupron as treatment for his prostate cancer. Under his retiree health plan, the treatment was fully covered (paid 100% of the $500 charge) and paid for. When Prudential took over as the plan administrator, it changed the coverage stating the plan would now only over 80% of $400 ($320) of the $500 charge for each injection. Since Mr. Wurzbacher could not afford to pay the additional $180, he asked his physician for alternatives. In light of the aggressiveness of the cancer, the doctor said the only alternative was castration. The request was approved by Prudential and he was castrated.

When he returned home, he found a letter from Prudential notifying him that it had made a mistake and that the plan would pay the full $500 for the monthly leupron injection.

The court held that the Wurzbachers' claims for state damages were eliminated due to ERISA. Neither Mr. Wurzbacher nor his spouse have a damage remedy under ERISA for alleged negligence by Prudential in denying the claim.

10. Andrews-Clarke v. Travelers Insurance Co. (D. Mass. Oct. 30, 1997) 21 EBC 2137, 1997 WL 677932

Richard Clarke's health plan covered at least one 30-day inpatient rehabilitation program per year when necessary. Travelers refused to approve Richard's enrollment in a 30-day inpatient alcohol rehabilitation program. Instead it approved two separate brief (five and eight days, respectively) hospital stays. Within 24 hours after the second hospital stay, Richard attempted suicide in the garage with the car engine running while he consumed a combination of alcohol, cocaine, and prescription drugs. His wife discovered him by breaking through the garage door. Mr. Clarke was taken to the hospital where he was treated for carbon monoxide poisoning.

At his mental commitment proceeding, the court ordered Mr. Clarke to participate in a 30 day detoxification and rehabilitation program following his release from the hospital. Travelers ''incredibly refused'' to authorize admission under his plan. Instead, for his detoxification and rehabilitation, Mr. Clarke was sent to a correctional center, where he was forcibly raped and sodomized by another inmate. He received little therapy or treatment at the correction center. Following his release, he went on a prolonged, three-week drinking binge. He was hospitalized overnight with respiratory failure. After his release from the hospital, he began drinking again. He was found the following morning dead in his car, with a garden hose running from the tailpipe into the passenger compartment.

Mr. Clarke's widow and four minor children sued Travelers and its utilization review provider under state law. ERISA was held to preempt all of these and to provide no remedy. The Court noted that ''the tragic events set forth in Diane Andrews-Clarke's Complaint cry out for relief'' (p. 2140) and ''Under traditional notions of justice, the harms alleged—if true—should entitle Diane Andrews-Clarke to some legal remedy on behalf of herself and her children against Travelers and Greenspring. Consider just one of her claims—breach of contract. This cause of action—that contractual promises can be enforced in the courts—pre-dates the Magna Carta'' (p. 2141).

But the Court also noted: ''Nevertheless, this Court has no choice but of pluck David Andrews-Clarke's case out of the state court in which she sought redress (and where relief to other litigants is available) and then, at the behest of Travelers and Greenspring, to slam the courthouse doors in her face and leave her without any remedy'' (p. 2141).

In discussing the need for ERISA reform the Court was quite clear:

''This case, thus, becomes yet another illustration of the glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system'' (pp. 2141-2142).

''It is therefore deeply troubling that, in the health insurance context, ERISA has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect. What went wrong?'' (p. 2144).

''The shield of near absolute immunity now provided by ERISA simply cannot be justified'' (p. 2151).

The Court, recognizing ''the perverse outcome generated by ERISA in this particular case,'' called upon Congress for reform.

11. Thomas-Wilson v. Keystone Health Plan East HMO (E.D. PA 1997) 1997 U.S. District court LEXIS 454, 1997 WL 27097

In May of 1995, Ms. Thomas-Wilson was diagnosed with Lyme disease. She began receiving intravenous antibiotic treatment on June 6, 1995, which the HMO covered. In August of that year, the HMO denied continuation of that treatment. Since she could not afford to pay herself for the treatments, she stopped receiving them and her condition worsened. She could not work or perform household duties. Her neck and back pain became so severe and persistent that she needed a full-time caregiver.

From September through December of 1995, the HMO required her to undergo extensive testing to determine if she had Lyme disease. In December of 1995, the HMO reinstated coverage for the intravenous antibiotic treatment.

Ms. Thomas-Wilson filed suit alleging that she became severely disabled and endured great pain, suffering, depression, and changes in personality as a result of the interruption of her treatment.

The court found that Ms. Thomas-Wilson's and her spouse's state tort claims against

the HMO were preempted by ERISA. There was no damage remedy available under ERISA.

12. Turner v. Fallon Community Health Plan Inc. (D. Mass. 1997) 953 F. Supp. 419

Mrs. Turner's HMO refused to authorize cancer treatment. She died. Mr. Turner sued his spouse's HMO for allegedly causing her death by refusing to authorize treatment.

The court held that, even assuming there had been a wrongful refusal to provide the treatment to Mrs. Turner, her surviving spouse's state claims were preempted by ERISA. Mr. Turner has no damage remedy available under ERISA.

13. Foster v. Blue cross and Blue Shield of Michigan (E.D. Mich. 1997) 969 F. Supp. 1020

Mrs. Foster was diagnosed with breast cancer and Blue cross refused to approve the treatment prescribed of high dose chemotherapy with peripheral cell rescue and autologous bone marrow transplantation. Because of this denial, Shelly Foster did not receive the treatment and died. The court, noting that this was a ''harsh result,'' held that the claims of her spouse for breach of contract, bad faith and infliction of emotional distress, negligent misrepresentation and fraud, and wrongful death, as well as any claim under the Michigan civil rights statute, were all preempted by ERISA. Mr. Foster had no damage remedy under ERISA.

14. Smith v. Prudential Health care Plan, Inc. (E.D. Pa. 1997) 1997 WL 587340

Mr. Smith's contract with Prudential through the PAA Trust required pre-authorization for medical treatment before insurance coverage would be provided. After Mr. Smith injured his leg in an automobile accident on January 18, 1995, he needed surgery to reduce his heelbone. When no doctor participating in the Prudential HMO was available, Mr. Smith found a qualified out-of-network doctor to perform the surgery. Prudential would not authorize the surgery since ''surgical correction is no longer possible.'' Mr. Smith filed a state action for breach of contract, negligence, and negligent performance of contract. The court ruled that plaintiff's claims were preempted by ERISA. Mr. Smith has no remedy under ERISA.

15. Udoni v. The Department Store Division of Dayton Hudson Corporation (N.D. Ill. 1996) 1996 U.S. Dist. LEXIS 8282, 1996 WL 332717

Mrs. Udoni's bone deterioration in her facial bones, caused by osteoporosis, prevented her from eating food. Her bone deterioration caused numerous other problems. Her doctors had to replace her facial bones with bones from her hip.

Under Mrs. Udoni's medical plan, medical conditions were fully covered but treatments to correct conditions of the teeth, mouth, jaw joints were excluded. The plan's administrator classified Mrs. Udoni's operation as ''dental'' and denied coverage for surgery.

The court ruled the interpretation of the plan was arbitrary and capricious. The physicians had provided evidence repeatedly explaining the medical necessity and classification of her specific surgery. Recognizing that to remand the case to the administrator would be futile in light of its ''continued refusals to consider (or even acknowledge) substantial evidence of the merits'' of Mrs. Udoni's claim, a bench trial was scheduled.

ERISA provides no remedy for complications resulting from the deterioration in Mrs. Udoni's physical condition during the coverage disputes. Mrs. Udoni's claim for damages arising from improper denial of benefits were eliminated under ERISA.

16. Bailey-Gates v. Aetna Life Insurance Co. (D. Conn. 1994) 890 F.Supp. 73

Mr. Bailey-Gates was hospitalized in May of 1991 for physical and mental disorders. A managed care nurse for Aetna ordered him released on June 18, 1991. He was released on June 25 and less than two weeks later, on July 4, 1991, he committed suicide.

His survivors sued Aetna for negligently releasing him while he was still in need of hospitalization for his disorders. The court ruled that ERISA preempted his survivors' state claims. Mr. Bailey-Gates' survivors have no damage remedy under ERISA.

17. Gardner v. Capital Blue Cross (M.D. Penn. 1994) 859 F.Supp. 145

Although Ms. Wileman's tumor from her peripheral neuroectodermal cancer was reduced by 70% from chemotherapy, only a bone marrow transplant could possibly eliminate the cancer. Blue Cross initially denied the request and refused to pre-certify the procedure. Blue Cross reconsidered and agreed to pay for the bone marrow transplant after it heard from Ms. Wileman's lawyer and the Pennsylvania Insurance Department.

Ms. Wileman's condition worsened sufficiently during the delay following the denial. Her doctors decided she was too weak to undergo the bone marrow transplant when they were preparing for the transplant in June of 1993. In September of 1993, Ms. Wileman died.

The court held that ERISA preempted her survivors' state negligence claims against the HMO. Her survivors have no damage remedy under ERISA.

18. Nealy v. U.S. Healthcare HMO (S.D. N.Y. 1994) 844 F. Supp. 966

Mr. Nealy had been treated by his doctor for an anginal condition. The HMO had assured Mr. Nealy that he could continue the care he was receiving for his pre-existing condition and be treated by the doctors he had been seeing.

After Mr. Nealy enrolled in the HMO, he was not issued an identification card. One week after first seeking an appointment, Mr. Nealy was examined on April 9, 1992, by a primary care physician who refused to refer Mr. Nealy to his former cardiologist. The HMO explained its refusal in an April 29, 1992 letter saying it had its own participating cardiologists. On May 15, 1992, the primary care physician authorized Mr. Nealy to see a cardiologist on May 19, 1992. Mr. Nealy suffered a massive heart attack on May 18, 1992 and died.

The court ruled that Mr. Nealy's surviving spouse's state claims were preempted due to ERISA. Mrs. Nealy has no claim for damages under ERISA.

19. Dearmas v. Av-Med, Inc. (S.D. Fla. 1993) 814 F. Supp. 1103

Ms. Dearmas was injured in an automobile accident, and she was transferred to four different hospitals in three days by her HMO based on the availability of providers participating in her plan at those facilities. As a result of those transfers, as well as other delays in her treatment, she alleged irreversible neurological damage.

The court held that ERISA preempted her state negligence claims against the HMO. Ms. Dearmas has no claim for damages under ERISA.

20. Pomeroy v. Johns Hopkins Medical Services, Inc. (D. Md. 1994) 868 F. Supp. 110

Mr. Pomeroy required surgery for dilopia (double vision). The HMO denied his claim. Five months later, in September of 1990, suffering from back pain and severe depression, the HMO again denied treatment. After these denials, he became addicted to a pain killer. When he sought treatment for the addiction, the HMO once again denied his claim.

Mr. Pomeroy pursued his benefits under the state Health Claims Arbitration Board and the HMO removed the case to federal court.

The court dismissed with prejudice Mr. Pomeroy's state claims for mental, physical and economic losses due to ERISA preemption. The court also dismissed without prejudice his benefit claim. Mr. Pomeroy has no claim for damages under ERISA.

21. Kohn v. Delaware Valley HMO Inc. (E.D. Penn. 1991) 14 EBC 2336

Mr. Kohn entered outpatient drug and alcohol rehabilitation in 1989. His HMO primary care physician admitted him in February of 1990 into an in-patient program. When the 15 days concluded, the therapist determined additional inpatient care was necessary. The HMO not only refused coverage for the additional inpatient care but refused to allow Mr. Kohn's family to pay for that additional care. While attempting to cross the railroad tracks in a drunken stupor, he was struck, and killed by a train two weeks after leaving the rehabilitation center.

The court found that ERISA preempted his survivors' claims based on denial of additional treatment. The court also held that a vicarious liability claim against the HMO based on ostensible agency would not be preempted if the HMO doctors committed malpractice. The survivors had no claim for damages under ERISA.

Mr. REID. I yield the final minutes we have on this amendment to the Senator from Illinois, the floor leader for the Democrats.

The PRESIDING OFFICER. Four minutes 24 seconds remain.

Mr. GREGG. Will the Senator suspend?

Mr. REID. Will the Senator withhold?

Mr. GREGG. I understand this is your last speaker. We have Senator DOMENICI, and then I will close. If Senator DOMENICI can go in between that.

Mr. REID. The Senator wants Senator DOMENICI to go now, if Senator DURBIN will withhold.

Mr. GREGG. I yield 5 minutes off the bill to Senator DOMENICI.

Mr. DOMENICI. I thank the Senator from New Hampshire.

Madam President, I want Senator KENNEDY to know that I will not get red in the face today. My wife is watching, and she tells me I do better when I do not yell.

Looking at America today, I ask this question: Is the best way to resolve the problem of somebody who is a patient and sick, and the kind of coverage and care to which they are entitled, to give it to the trial lawyers to resolve before juries in court cases?

I cannot believe the best we can do to arbitrate and settle these disputes is to say: Let the trial court do it; let the juries do it. We already know, if you are looking for an egregiously inefficient way to resolve disputes, use the trial lawyers and use the courts of America. It just does not target the problem. It resolves issues in a very arbitrary way.

I say to everybody here, I am convinced that letting the trial lawyers solve a medical problem is borderline useless. It will cost immeasurable amounts of money because every lawsuit will be worth something and because everybody will be frightened to death to try something before a jury,

not because they are guilty but because jurors and the trial system are apt to award a gigantic verdict. Then every case is worth something.

Can we not figure out a better way than that? Whatever the arguments in this Chamber, the issue is: When people are covered by managed care or private health care, to what are they entitled?

It is not an issue of whether a doctor performs malpractice. That litigation is wide open. It is, if they are not getting what they are entitled to, how do you fix that? Frankly, I believe to fix it by throwing every one of those decisions into the lap of a trial lawyer who can file a lawsuit is, for this enlightened America, borderline lunacy. For an intelligent, bright America, it is ludicrous to suggest that as a way to settle disputes about coverage and quality of care.

Think of this: You open this up to the trial lawyers, and whatever an HMO or a managed care or an employer's policy provides for people is going to be in question unless the patient turns out healthy, safe, and sound.

If it turns out that they get sick or sicker, what do you think the case is going to be? They should have provided a different kind of care; I am in court; I am going to get an expert to say it should have been different; I am going to get a contract lawyer, an expert, to read into this contract what they think I should have.

Then they are liable for wrongful death, they are liable for any kind of illness, because the patient did not get well.

Frankly, I believe that is a giant mistake, and everybody should understand we are adding billions of dollars to the cost of health care through this and maybe will not get the kind of relief the people need.

Whatever the Republicans' final package is, I hope and pray that as part of the external review process we put in something that is very tough on HMOs and managed care and other policies, that they will provide what an independent medical expert says they are supposed to do, and it will force them to do it, not in a jury trial but in the process run by the States and their policymakers and insurance carriers.

Do we want the final decision as to the kind of coverage, the propriety of what was given to patients, to be decided by jurors in a courtroom with monstrous liability attached to it, or do we want it to be done by an expert as part of a review process with short timeframes and mandatory performance when they make a decision as to what they are entitled to?

I believe an enlightened America should opt for the latter. I do not believe an enlightened America should even consider having contract disputes of this type determined by trial lawyers in courtrooms by jurors.

Which do we want? Do we want health care or do we want a jury verdict? Do we want health care as it should be or do we want a trial in the courts of this country? I choose the former, and you can do it without putting these issues into the courts of America, Federal or State.

I yield the floor.

Mr. KENNEDY. I yield the remaining time to the Senator from Illinois.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. I thank the Chair.

Let me say at the outset that the Senator from Pennsylvania misstated this amendment. This amendment says an employer can be held liable only when that employer uses his discretionary authority to make a decision on a claim. If a decision is made by an insurance company hired by the employer, the employer cannot be held liable. That is what this language says clearly.

Is there a time when an employer could be held liable? We found two cases. You decide whether they should be brought into court.

The employer collected the premiums from the employee and did not turn them in to the insurance company. When the employee had a claim, the insurance company said: You are not on the books.

In the second situation, the employee was a full-time employee and had worked 9 months at this firm. He filed a claim with the health insurance company. The insurance company said: No; we see you as a part-time employee. It is a dispute over part-time/full-time.

Those are two instances under law where employers are brought into court. Employers do not make these medical decisions. They would not be subject to this lawsuit.

Please bear with me for a minute. This is the most important amendment we will consider on this bill.

The Senator from New Hampshire corrected me. He is right. It does not keep 123 million Americans out of court. It keeps 120 million Americans out of court. I stand corrected, I say to the Senator. He is right. It is only 120 million Americans and their families who will be denied a day in court by the Republican amendment, an amendment which is a Federal prohibition against State lawsuits against health insurance companies.

Across the street at the Supreme Court building, you will find the phrase, ''Equal Justice Under Law.'' This amendment says to that phrase: Denied; denied. Equal justice under law is denied for those families who want to take health insurance companies into court and hold them accountable for their wrong decisions.

The Senator from New Mexico said: What are we doing taking contract questions into courts? I do not know where that Senator went to law school, and I do not know whether he follows law and order in other programs, but that is what courts do. Courts decide questions like contract coverage. That is part of the law of the land for every business in America, except health insurance companies.

The Republicans have come forward with this amendment, an amendment which the insurance industry wants dearly so that they cannot be held accountable in court. What this means is that families across America, when decisions are made, life-or-death decisions, will not have their day in court. The Republicans want to continue to prohibit American families from holding these health insurance companies accountable for their bad decisions.

From USA Today: The central question is, Should HMOs, which often make life or death decisions about a treatment, be legally accountable when their decisions are tragically wrong? Right now the answer is no.

If we pass the Democratic Patients' Bill of Rights, finally the courthouse doors will open to families across America. If the Republicans and the insurance industry prevail on this amendment, those doors are slammed shut. What will that mean? It will mean not just fewer verdicts, not just fewer settlements, but the continued attitude of this health insurance industry that they are held unaccountable, they cannot be held accountable to anyone. They will make decisions—life and death decisions—for you and your family and never face the prospect of going to court.

This is an internal memorandum from an HMO. This memorandum says it as clearly as can be. What they conclude is: Stick with the current law that keeps us out of court. This gentleman, who is in charge of management, said: We identified 12 cases where our HMO had to pay out $7.8 million. If we had it under the ERISA provisions that the Republicans want to protect, we would have paid between zero and $500,000 to those 12 families.

This is what it is all about. Someone who is maimed, someone who loses their life, their family goes to court and asks for justice. Equal justice under the law, that is all we are asking for.

The Republican majority and the insurance industry do not want to give American families that opportunity.

Vote to make sure we have equal justice under the law.

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

Mr. GREGG. I yield myself 5 minutes off the bill. I will be the last speaker, so Members can understand there will be a vote in about 5 minutes—two votes. I stand corrected.

There have been a lot of representations in this argument in the last hour and a half or so. Let me make a couple points.

First off, once again, the Senator from Illinois cites the wrong number of people covered by this proposal. That does not really go to the core of the issue, but it should be clarified. The Senator from New Jersey said there are only two classes of people who are covered by this type of situation, diplomats and insurance companies. Actually Senators and members of the Government are covered in the same way.

In fact, it was an OPM directive from the Clinton administration on April 5, 1996. I will simply quote from it. It says:

> Legal actions to review actions by OPM involving such denials of health benefits must be brought against OPM and not against the carrier or the carrier subcontractor.

It further states those actions can only be for certain limited amounts of recovery. So essentially we are tracking that proposal which is what Senators are presently covered by.

Also, the Senator from Massachusetts said—and this point was made by the Senator from Washington—that, yes, our proposals cost $13 billion and, yes, your proposals cost billions of dollars.

But there is a little bit of difference. We cut taxes. We give people assets. We put money in their pockets. We say to your folks: You can go out and use that money to benefit your family. Your proposals increase the cost of premiums and drive people out of the health care system and create more uninsured people. There is a fairly significant difference between the two cost functions of these two bills.

But this amendment goes to the fact that the proposal from the other side of the aisle essentially dramatically expands the number of lawsuits which will be brought in the United States, lawsuits which will be brought in all these different areas by aggressive and creative attorneys, lawsuits which today and under our bill would be settled under a procedure which is reasonable, which has independent doctors looking at the issue. Those decisions, by doctors who are independently chosen by independent authorities, are binding, binding on the health care provider group.

So we take out all these lawyers, all these attorneys. I think of this one procedure I cited before where you have literally 137 doctors talking about 82 different ways to treat one different type of health complication. That can be multiplied by thousands, if not millions, giving literally millions upon millions of opportunities for attorneys to bring lawsuits because one doctor shows treatment A and another doctor chose treatment A–82 or B–82.

The fact is the decision should not be made by an attorney. That decision should be made by an outside doctor who has independence, who is chosen by an independent group, and who has binding authority.

The end product of this bill will be to create a lot of new attorneys in this country having a lot of new opportunities to bring a lot of new lawsuits. In fact, there has been an lot of hyperbole on this floor. I want to put it in perspective. It might be hyperbole, but it is still fairly accurate.

There is a show on Saturday morning that I enjoy listening to on National Public Radio. Some may be surprised that I enjoy listening to National Public Radio, but I do. The show is called ''Car Talk.'' In ''Car Talk,'' there is a law firm in Cambridge, MA. I know it is euphemistic, but they call them, so far: Dewey, Cheatum & Howe? They represent the folks on ''Car Talk.'' Their offices are somewhere in Cambridge in Car Talk Plaza, and they represent the Tappet Brothers. Today I think they have three attorneys: Dewey, Cheatum & Howe.

If this bill is passed, Dewey, Cheatum & Howe are going to have to build a new building in Cambridge, and they are going to have all these attorneys working for them because that is how many people will be needed to bring all the lawsuits that are going to be proposed under this bill as a result of its expansion.

What is the serious, ultimate outcome of this? It drives up costs. That is the serious ultimate outcome. It was almost treated as if that was an irrelevancy by one of the other speakers. Well, 1.4 percent of the premiums are going to go up. That does not mean anything? I say 1.4 percent translates into 600,000 people.

There have been a lot of pictures brought to the floor about people who have not gotten adequate health care, and I am sure their stories are compelling. But this floor would be filled if we put up the 600,000 pictures of people who will lose their health care insurance—filled right up to the ceiling by people who no longer have health care insurance as a result of all these lawsuits driving up all these costs for health care.

As the Senator from Pennsylvania pointed out, what will be the outcome of that? What will be the outcome of all these people being put out of their health care insurance because the cost has gone up so much? These are CBO's estimates, not mine. It will be that somebody will come to the floor from the other side of the aisle saying: We have to nationalize the whole system in order to take care of all the uninsured we just created by creating all these lawsuits for all these attorneys to pursue. What a disingenuous approach to health care, in my opinion.

The Republican plan has a constructive way to approach this. It leaves the decision of care to the patient, to be reviewed by a doctor, who is independently chosen, who is in the specialty where the patient needs the care. That decision is binding, binding on the health care provider.

I hope Senators will join me in supporting my amendment which voids the language which expands the lawyers' part of this bill.

I ask for the yeas and nays on my amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The yeas and nays were ordered.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Madam President, for the information of all Senators, I think we are ready to vote on the Gregg amendment, which strikes the liability provision. I also notify Senators that immediately following that vote, there will be a vote on the first-degree amendment, the amendment offered by Senator COLLINS dealing with long-term care deductibility and also dealing with ER and OB/GYN and access. So that vote will be immediately after the Gregg amendment.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 1250. The yeas and nays have been ordered. The clerk will call the roll.

The assistant legislative clerk called the roll.

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

The result was announced—yeas 53, nays 47, as follows:

[Rollcall Vote No. 206 Leg.]

YEAS—53

Abraham	Frist	McConnell
Allard	Gorton	Murkowski
Ashcroft	Gramm	Nickles
Bennett	Grams	Roberts
Bond	Grassley	Roth
Brownback	Gregg	Santorum
Bunning	Hagel	Sessions
Burns	Hatch	Shelby
Campbell	Helms	Smith (NH)
Chafee	Hutchinson	Smith (OR)
Cochran	Hutchison	Snowe
Collins	Inhofe	Stevens
Coverdell	Jeffords	Thomas
Craig	Kyl	Thompson
Crapo	Lott	Thurmond
DeWine	Lugar	Voinovich
Domenici	Mack	Warner
Enzi	McCain	

NAYS—47

Akaka	Feingold	Lieberman
Baucus	Feinstein	Lincoln
Bayh	Fitzgerald	Mikulski
Biden	Graham	Moynihan
Bingaman	Harkin	Murray
Boxer	Hollings	Reed
Breaux	Inouye	Reid
Bryan	Johnson	Robb
Byrd	Kennedy	Rockefeller
Cleland	Kerrey	Sarbanes
Conrad	Kerry	Schumer
Daschle	Kohl	Specter
Dodd	Landrieu	Torricelli
Dorgan	Lautenberg	Wellstone
Durbin	Leahy	Wyden
Edwards	Levin	

The amendment (No. 1250) was agreed to.

Mr. NICKLES. Mr. President, I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, previously I indicated we would have two rollcall votes back to back. Since we found out there is a Special Olympics luncheon several of our colleagues wish to go to, I ask unanimous consent the pending Collins amendment No. 1243 be temporarily laid aside and the vote occur on the amendment first in the next series of votes.

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

Mr. WYDEN addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon is recognized

Mr. KENNEDY. May we have order, Mr. President? Mr. President, the Senate is not in order. We have done very well during the course of the morning. We have had good attention, a good exchange, and good debate. This is an important amendment. If we could make sure the Senator could be heard and the Senators give their full attention, we would be very appreciative.

The PRESIDING OFFICER. The Senate will be in order. Any Senators with conferences, please take them off the floor. Staff will take their conferences off the floor.

The Senator from Oregon.

Mr. WYDEN. I thank the Chair.

AMENDMENT NO. 1251 TO AMENDMENT NO. 1232

(Purpose: To prohibit the imposition of gag rules, improper financial incentives, or inappropriate retaliation for health care providers; to prohibit discrimination against health care professionals; to provide for point of service coverage; and, to provide for the establishment and operation of health insurance ombudsmen)

Mr. WYDEN. 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 Oregon (Mr. WYDEN), for himself, Mr. REED, Mr. HARKIN, Mr. WELLSTONE, and Mr. BINGAMAN, proposes an amendment numbered 1251 to amendment No. 1232.

Mr. REID. 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. REID. Mr. President, the Senator is yielded 6 minutes.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Thank you, very much.

Mr. President and colleagues, I offer this amendment with a number of our colleagues to protect the relationship between health professionals and their patients.

What this amendment is all about is essentially ensuring that patients can get all the facts and all of the information about essential health care services for them and their families.

If ever there was an amendment that does not constitute HMO bashing, this would be it.

I don't see how in the world you can make an argument for saying that in the United States at the end of the century, when doctors sit down with their patients and their families, the doctors have to keep the patients in the dark with respect to essential services and treatment options for them.

Unfortunately, that is what has taken place. They are known as ''gag clauses.''

They are chilling the relationship between doctor and patient, and they are at the heart of what I seek to do in this amendment with my colleagues.

I think Members of this body can disagree on a variety of issues with respect to managed care. I have the highest concentration of older people in managed care in my hometown in the United States. Sixty percent of the older people in my hometown are in managed care programs. We need this legislation, but at the same time we have a fair amount of good managed care.

But today we are saying even though Members of the Senate will have differences of opinion, for example, on the role of government and health care, we will have differences of opinion with respect to the role of tax policy in American health care.

If you vote for this amendment, you say we are going to make clear that all across this country, in every community, when doctors sit down with their patients and their families, they will be told about all of their options—all of their options, and not just the ones that are inexpensive, not just the ones that perhaps a particular health plan desires to offer, but all of the options.

It doesn't mean the health plan is going to have to pay for everything. It means the patients won't be in the dark.

By the way, when I talked to the distinguished Senator from Massachusetts shortly after coming to the Senate, a majority of Members of this body said these gag clauses should not be a part of American health care.

Let's differ on a variety of issues—the role of government, the role of taxes—but let's not say, as we move into the next century in the era of the Internet and the opportunity to get information, that the one place in America where you keep patients in the dark would be when they sit down with their provider and cannot be told all the options.

There are other important parts of this amendment. One that complements the bar on gag clauses, in my view, is the provision that makes sure providers would be free from retaliation when they provide information to their patients, when they advocate for their patients.

This amendment is about protecting the relationship between patients and their health care providers. If ever there was something that clearly did not constitute HMO bashing, it is this particular amendment.

Unfortunately, across this country we have seen concrete examples of why this legislation is needed; why, in fact, we do have these restrictions on what forces health care professionals to stay in line rather than tell their patients what the options are with respect to their health care. We have seen retaliation against health care workers who are trying to do their job.

It strikes me as almost incomprehensible that a Senator would oppose either of these key provisions. What Member of the Senate can justify keeping their constituents in the dark with respect to information about health care services? I don't see how any Member of the Senate can defend gag clauses. That is what Senators who oppose this amendment are doing. This amendment says to patients across America that they will be able to get the facts about health care services.

We talked yesterday about costs to health care plans. What are the costs associated with giving patients and families information? That is what this legislation does. In addition, it says when providers supply that information, plans cannot retaliate against providers for making sure that consumers and families are not in the dark.

We have seen instances of that kind of retaliation. It strikes me that it goes right to the heart of the doctor-patient relationship if we bar these plans from making sure patients can get the truth. It goes right to the heart of the doctor-patient relationship if providers are retaliated against, as we have seen in a variety of communities.

Mr. KENNEDY. Will the Senator yield?

Mr. WYDEN. I am happy to yield to the Senator.

Mr. KENNEDY. The argument on the other side will be, Republicans will say: We ban the actual gagging of a doctor.

The real distinction between the amendment of the Senator from Oregon and the Republican amendment is that this amendment ensures the doctor will not risk his job if he advocates. He might be able to tell the patient they need a particular process, the doctor will be permitted to relay that information, but then he can be fired under the Republican proposal.

Also, they will have the option of giving financial incentives for doctors not to provide the best medicine.

The amendment of the Senator from Oregon is the only amendment that does the job.

Mr. WYDEN. The Senator is absolutely right. What the Senator has pointed out is that you gut the effort to protect patients from these gag clauses unless you ensure that the providers are in a position to do their job and not get retaliated against and not face this prospect of getting financial incentives when they do their job.

The Senator from Massachusetts is absolutely right. We are making sure that providers can be straight with their patients. We are actually giving them the chance to carry out that antigag clause effort by making sure they will not be retaliated against and by making sure they will not face the prospect of their compensation in some way being tied to doing their job.

I am very hopeful all of our colleagues can support this amendment. It tracks what the majority of the Senate is already on record in voting for, the effort that the Senator from Massachusetts and I led in the last Congress shortly after I came here.

I was director of the Gray Panthers at home in Oregon for about 7 years before I came to Congress. I can see a lot of areas where Democrats and Republicans have differences of opinion on

American health care. There are a lot of areas where reasonable people can differ. I don't see how a reasonable interpretation of what is in the interest of patients and providers can allow for gag clauses and then give these plans the opportunity to vitiate any effort to bar gag clauses by saying: If you try to be straight with your patients, we will retaliate against you; we will tie your compensation to your keeping these parties in the dark.

I hope my colleagues will support this amendment. It shouldn't be partisan. It doesn't constitute HMO bashing.

I yield the floor.

Mr. KENNEDY. I yield 6 minutes to the Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I thank the Senator.

I strongly support the effort my friend from Oregon is making to ensure that there is a provision in this bill that is finally passed prohibiting these gag provisions. I think that is very important.

I want to speak about a different aspect of this larger amendment. This is a provision that Senator HARKIN has taken the lead on, that I am cosponsoring with him. It deals with the problem of discrimination against nonphysician providers of health care services.

What am I talking about when I talk about ''discrimination against nonphysician providers of health care services''? I am talking about the people whom everyone, on occasion, wind up going to for high-quality professional health care. I am talking about nurse anesthetists, about speech and language pathologists, nurse practitioners, physical therapists, nurse midwives, occupational therapists, psychologists, optometrists, and opticians. These are health professionals who are licensed to provide particular medical services.

All we are providing in Senator HARKIN's amendment, which I cosponsor, is that a health maintenance organization cannot arbitrarily prevent a whole category of health care providers from providing that health care they are licensed and qualified to provide.

This is an extremely important issue for a State such as New Mexico where we have a great many rural and underserved areas. That is where the impact is the greatest because we have too few physicians in my State. The reality is that if a person is limited in obtaining their health care from a physician, in many cases in many parts of our State they either have a choice of driving a great distance or going outside their health plan and paying out of their pocket for something that ought to be covered by the premium they are already paying.

It is a serious issue that needs to be addressed. In my State, the estimate is that we are losing 30 physicians. I believe it was 30 physicians in 1 month, according to the estimate. So we have a shortage of physicians. We are losing many of the ones that we have. We need to be sure people have access to the nonphysician health care providers who are very qualified to provide some of these services.

Let me show a chart on one of the specialties I am talking about. This is on anesthesia providers.

As I indicated before, nurse anesthetists are covered as one of the groups of health care providers. In our State, if you want anesthesia services, if you have to have anesthesia provided to you, your ability to get that strictly from a physician occurs in only one small area of our State. That is the area in blue. In all of the rest of our State, you are forced to rely upon someone other than a physician to provide that service.

All we are saying is, in the case of anesthesia services, a health maintenance organization should have to allow those services to be provided by another qualified person other than a physician, where that person is available. This is a simple matter of fairness to patients in rural areas. It is something that does not involve significant costs. In fact, the estimate of the Congressional Budget Office is less than half a percent change in cost over a 10-year period.

The reality is that many of these nonphysician health care providers provide these services at a much lower cost than the physician does. So, in fact, it is not a question of increasing the cost. In many cases, it is a question of decreasing the cost.

We offered this amendment in committee when this bill was considered in the Health and Education Committee. I offered this exact language. Senator HARKIN did. Several of our Republican colleagues at that time expressed their support—not with their votes but with their statements—for providing this type of guarantee. So it is nothing radical. This is a simple fairness issue, and it is one that makes all the sense in the world as far as the economics of health care is concerned.

If we are really concerned about getting adequate health care to the rural underserved areas of our country, such as I represent in New Mexico, such as Senator HARKIN represents in his State, it is essential we have this amendment as part of what we pass out of Senate.

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

Mr. BINGAMAN. I am glad to yield.

Mr. KENNEDY. President Clinton, as I understand, has insisted this be part of the Medicare Program. So it is in the Medicare Program. Could the Senator indicate to me how this is working in his own State? Is it working well? It would appear to me to be a precedent for this, unlike other public policy issues, and it appears we have a pretty good pilot program—more than a pilot program. Perhaps the Senator would share with us his experience.

Mr. BINGAMAN. I thank the Senator for that question. It is an extremely good point. This is the nondiscrimination requirement that was put into the Balanced Budget Act in addition to Medicare.

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

Mr. KENNEDY. I yield another minute.

Mr. BINGAMAN. I thank the Senator. In relation to Medicare managed care plans, and in relation to Medicaid, it has worked extremely well in those cases. As far as I know, there has been no objection raised to it.

So I believe what has worked there makes good sense in this area as well. I believe it is very important we have this provision included in the bill we finally pass.

One other example. In my State, certified registered nurse anesthetists are the sole anesthesia providers for 65 percent of our rural hospitals. If our rural hospitals are going to continue to function, as they must, then we need to be sure the nonphysician providers who are able to provide services in these smaller communities are able to do so and be compensated through these health maintenance organizations.

I think this is an important provision. I hope very much Senators support it and we can get this adopted as part of a bill we finally pass.

I yield the floor.

Mr. REID. Mr. President, the minority yields 6 minutes to the junior Senator from Iowa.

The PRESIDING OFFICER. The distinguished Senator from Iowa.

Mr. HARKIN. Mr. President, I join my friend and colleague from New Mexico. Together, we are cosponsoring this very important, vital amendment.

Again, I will repeat some of what the Senator said. The most important thing I heard him say was, in the State of New Mexico, only 65 percent of the State has nurses that provide anesthesiology.

I have a map of my State of Iowa. There are a lot of different colors on it, and I will not go into all the explanation, but the reality is, the vast majority of the State of Iowa only has certified nurse anesthetists to provide services to all of the State of Iowa. We have a few counties, about nine or 10, that have doctors, MDs. The rest are registered nurses. That is all. So someone up here in northwest Iowa or southwest Iowa, someplace up in this area, would have to drive hundreds of miles just to access an MD who is an anesthetist.

Here is a letter from Preferred Community Choice PPO. I will not read the whole thing. It says:

> At this time, participation is limited to MD and DO degrees only.

I ask unanimous consent the entire letter be printed in the RECORD.

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

PREFERRED COMMUNITYCHOICE PPO,
Mountainview, AR, November 1, 1995.

GREETINGS: Thank you for recent inquiry regarding participation in our network of

providers. At this time, participation is limited to MD and DO degrees only. We have created a file for interested providers who fall outside of these two categories. Should we expand the network in the future, we will use the information that you have provided for future contact. We appreciate your interest in Preferred CommunityChoice.

MICHAEL H. KAUFMAN,
Provider Relations.

Mr. HARKIN. That is what we are trying to get over with our amendment. As the Senator from New Mexico pointed out, this would cover such things as physician assistants, nurse practitioners, psychologists, optometrists, chiropractors, et cetera. This is not an ''any willing provider'' amendment. We are not saying that. We are not saying that we require a plan to open up to any provider who wants to join. We are simply saying a health plan cannot arbitrarily exclude a health care professional based on his or her license. That is all we are saying: They cannot do it based upon licensure.

Second, this provision does not require health plans to provide any new benefits or services. It just says, if a particular benefit is covered and there is more than one type of provider that can provide a service under their State license or certification, the health plan cannot arbitrarily exclude this class of providers. For example, if a plan offers coverage for the treatment of back pain, it cannot exclude State-licensed chiropractors.

Third, and I want to make this point very clearly, this provision would not expand or modify State scope-of-practice laws. Decisions about which providers can provide which services are left where they belong: to the States.

Again, I just want to remind everyone, this Congress supported this concept when we passed provider nondiscrimination language as part of the Balanced Budget Act for Medicare and Medicaid programs. The Senator from Massachusetts made an inquiry. He said: How is this working? I can tell you, it is working great in my State for elderly people under Medicare because now a lot of elderly people, who live in sparsely populated areas of my State, can access, for example, for back pain, chiropractors. They can access nurse practitioners, physician's assistants, a whole host of different providers under Medicare who are licensed by the State of Iowa. That is what our amendment does.

Again, I have to ask, if people in these programs, people in Medicare and Medicaid, have the right to choose their provider, should not all Americans?

That is why this is a very simple and straightforward amendment. Thirty-eight States have recognized the need for this provision by passing similar legislation. Thirty-eight States have passed legislation providing that people can have their choice of providers as long as they are licensed or certified by the State.

You might say, why would we do it here if 38 States already cover it? The problem is, the State laws do not apply to the 48 million Americans who are in self-funded ERISA plans. That is the problem. That is the loophole we are plugging.

This provision is critically important for those who live in rural areas; those who do not have access to an MD or a DO; those who rely upon others who have State licensure or State certification to provide the kind of medical services they need.

In our amendment, the amendment by the Senator from New Mexico, Mr. BINGAMAN, and me, we are basically saying we want to give people a little more power, to empower them a little more, and to provide freedom of choice for the American consumers. It is very simple. This provision says a managed care plan cannot arbitrarily exclude a health care professional on the basis of the license or the certification.

It is a simple and straightforward amendment. It has broad-based support. I have a list of all the different associations supporting it. I would point out the broad-based support that it indeed does have, by everything from the American Academy of Physician's Assistants, nurse anesthetists, chiropractors, nurse midwives, the American Dental Association, American Nurses Association, Occupational Therapy Association of America, the American Optometric Association, the Physical Therapy Association, Speech, Language, and Hearing Association, and the Opticians Association of America. A broad range of providers support this provision.

The PRESIDING OFFICER (Mr. BUNNING). The Senator's 6 minutes have expired.

Mr. HARKIN. Mr. President, I hope at least we can support this and provide our people freedom of choice.

Mr. REID. I yield the Senator from Rhode Island 6 minutes.

Mr. REED. Mr. President, I rise in strong support of this amendment. There are many very important provisions, but I want to focus on one provision, and that is the creation at the State level of ombudsman programs or consumer assistance centers. I have been working on this provision, along with Senators WYDEN and WELLSTONE. We introduced separate legislation, and today, as part of this amendment, we are considering this very valuable and very important opportunity to empower consumers of health care services in this country.

One of the persistent themes we have heard throughout this debate is how do we give consumers more leverage in the system against these huge HMOs, against what appears to be illogical, indifferent decisions about the health of themselves and their families.

We rejected some proposals which I believe we should have embraced. For example, we just defeated an opportunity to give people a chance, in extremist, to go to court if necessary. This is something that has been adopted in Texas and is working very well. If we cannot do any of those things, then I think we must do at least this; and that is, to give the States the incentive to develop consumer assistance centers so individual health care consumers—patients—when they have frustrating denials, have someplace to turn.

We all know, because we all listen to our constituents, that every day there are complaints about the inability to get straight answers from their HMO, of the inability to get coverage, the inability to get what you paid for. Where do they turn? Too many Americans cannot turn anywhere today. If we pass this amendment, we will give them a chance to turn to a consumer assistance center.

I will briefly outline the provisions of the legislation. We provide incentives to four States to set up consumer assistance centers. These centers will operate as a source of information. They can give direct assistance in terms of advice or assistance to someone who is in a health care plan who has a question about their coverage. They will operate a 1–800 hotline. They will be able to make referrals to appropriate public and private agencies. They will not be involved in any type of litigation. This is not an attempt to provide an opportunity to recruit litigants. This is a consumer assistance center concept. I hope also that these centers will educate consumers about their rights.

This is something that has been promoted by many different organizations. The President's health care advisory commission in 1997 pointed out this is efficiency and every State, every region should have these types of centers.

We have similar centers with respect to aging and long-term care ombudsman programs working very well. Several States—Vermont, Kentucky, Georgia, and Virginia—have adopted these programs because they want to give a voice and give some type of power to their consumers in health care. Florida and Massachusetts have programs they are trying to get up and running, and just a few weeks ago on this floor in response to profound concerns we have about the military managed care program, the TriCare program, we adopted legislation that would set in motion the creation of an ombudsman program for military personnel. It is not a controversial idea. We passed this idea with overwhelming support.

This is something we can do. This is something we should do, and, frankly, if we rejected all the remedies we are proposing to give to consumers, we have to adopt at least this one. We have to give an incentive to States for working through not-for-profit agencies to set up these consumer assistance programs. Frankly, this is something that is long overdue, noncontroversial, and it should be done.

I see the Senator from Oregon, who has been a stalwart on this issue, is standing. He might have a comment.

Mr. WYDEN. I appreciate my colleague yielding. I so appreciate his leadership because this is a chance, with the Reed proposal, to make sure the consumers in this country can get what they need without litigation. I hope Members of the Senate will see this ought to be the wave of the future. It is a revolution in the concept of consumer protection because what this part of our proposal does, under the leadership of the Senator from Rhode Island, is essentially say: Let's try to help the patients and the families early on in the process. Let's not let problems fester and continue and eventually result in huge problems which can lead to litigation.

It seems to me—I want the Senator from Rhode Island to address this—what he is doing is essentially changing consumer protection so it ought to be at the front end when problems have not become so serious.

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

Mr. WYDEN. I ask the Senator from Rhode Island be given 2 additional minutes.

Mr. KENNEDY. I yield 1 minute.

Mr. WYDEN. I do not think there is a good health plan in America that cannot support the idea of a good ombudsman program so we can solve problems without litigation. I thank my colleague.

Mr. REED. I thank my colleague from Oregon. Let me reaffirm what my colleague said. This whole concept of ombudsman and consumer assistance centers is designed to allow the consumer in the first few hours, or even minutes, when they encounter problems in the health care system, to get advice and assistance. This is not a theoretical concept. It works already in several States.

California has a model program around the Sacramento area. People have benefited from this. This is what we want to see in every State in the country.

Again, if we cannot be sensitive enough to recognize the need for consumer assistance early in the process, then I believe we are failing the American public miserably. I hope we can embrace, support, and adopt this amendment, particularly this provision with respect to the ombudsman consumer assistance program.

I yield back my time.

Mr. KENNEDY. I yield 4 minutes to the Senator from North Carolina.

The PRESIDING OFFICER. The Senator is recognized for 4 minutes.

Mr. EDWARDS. Mr. President, I rise in strong support of this amendment. I particularly want to address the issue of financial incentives, which this amendment addresses, which essentially is HMOs and health insurance companies providing financial incentives for physicians to provide less than appropriate care to limit the treatment options for patients or, in the case I am about to talk about, not calling in other physicians or doctors when they may be needed under the circumstances.

This is the story of something that actually happened in North Carolina.

A young mother was in labor. During the course of her labor, she was being overseen by an obstetrician/gynecologist who was responsible for her care. Unfortunately, this single OB/GYN was responsible for the care of a number of mothers in labor on this night.

During the course of the evening and the morning, the mother developed severe complications with her labor. There were clear signs the baby was in serious trouble and was having trouble getting oxygen and needed to be delivered. Something needed to be done immediately. The nurses taking care of this mother did exactly what good nurses would do under the circumstances: They paged the doctor. They called the doctor who was on call. They could not get him there. They had no understanding of why he was not responding to the call. They notified, by way of the call, that it was an emergency situation. Still no response.

More and more time was passing when the child within the mother's womb was not receiving the oxygen it needed and continued to suffer injury and damage.

Finally, the doctor appeared and delivered the baby by cesarean section. Unfortunately for this child and the family, it was too late. The child suffered severe and serious permanent brain injury. The child has severe cerebral palsy and, essentially, will require extensive medical care for the course of its life.

Later we learned that what happened was the physician who was in charge of this patient's care had a financial incentive, because of his contract with the HMO, not to call in additional physicians. In other words, he was rewarded where, on a consistent basis, he did not call in backup help—even though in this situation he was taking care of too many patients, too many mothers.

There was an emergency, and the bottom line is this: Because of a financial incentive, an insurance HMO credit with its doctor, we have a young child who will have cerebral palsy for the rest of his life. This is the kind of thing that should not happen in America. This is what this amendment addresses. It specifically deals with the issue of financial incentives in a thoughtful, intelligent way, limiting the financial incentives that can be allowed and requiring their disclosure—both of which are absolutely needed and absolutely necessary.

I might add one final thought. This child, who for the rest of his life will be severely brain damaged, will require extensive medical care, very expensive medical care, running in the many millions of dollars. His family, who are responsible for this child's care, who live with this problem 24 hours a day, day in and day out, year after year—this child's medical care is being paid for by Medicaid.

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

Mr. EDWARDS. If I may have 30 more seconds?

Mr. KENNEDY. I yield the Senator 30 more seconds.

The PRESIDING OFFICER. The Senator is recognized for 30 seconds.

Mr. EDWARDS. Since this child suffers from a severe injury as a direct result of an incentive that the HMO, the health insurance company, provided to the doctor, since this child suffers this severe injury and will have millions of dollars of medical problems over the course of his life, the question is, Who pays for this cost? The HMO is not going to pay for it. Who is going to pay for it is the taxpayers of America, through Medicaid.

So the financial burden of what happened as a result of this financial incentives clause, a clause which is absolutely fundamentally wrong and should not be allowed, is that every American taxpayer is responsible for carrying the burden of these millions of dollars in medical costs.

Thank you, Mr. President.

Mr. KENNEDY. I yield 9 minutes to the Senator from Minnesota.

The PRESIDING OFFICER. The Senator from Minnesota is recognized for 9 minutes.

Mr. WELLSTONE. Thank you, Mr. President.

I thank the Senator from Massachusetts, the Senator from North Carolina, and the Senator from Oregon for their work on the floor of the Senate.

Mr. President, I say to Senator WYDEN from Oregon that I did not get a chance to hear his remarks on the floor of the Senate, but I think this whole question of whether or not doctors and providers can advocate for their patients and speak up when they think their patient is being denied care unfairly is extremely important. It is a little shocking, but it is really true that we all hear from doctors who tell us that they do not believe they can do that. They have no protection. They are worried about losing their jobs.

So I just say that if we are about being on the side of consumers, which I think is what we are about, Senator WYDEN's amendment is extremely important.

I will speak to another provision in this amendment which we actually have not discussed on the floor of the Senate. Of course, my fear is that Republicans will come out with a second-degree amendment and try to essentially wipe this amendment out. I wish—in fact, I would give up half of my 9 minutes if somebody from the other party would come down here; I would give up 4 and a half minutes just to get their other point of view, because the argument I am about to make goes as follows.

This is about ''points of service,'' which actually is about consumer choice. What we are saying in this provision is that if you are paying extra or

are willing to pay a little extra, you should have the choice to be able to stay with your doctor, to be able to go to the clinic to which you have been going.

For example—and this just drives people in Minnesota crazy—an employer may shift a plan, and then what will happen is, even though you have been taking your child or your children, or you yourself have been seeing the same doctor whom you trust, who knows you well, who knows your family well, all of a sudden you no longer can see them.

What we are saying is, don't the consumers and don't the families in Minnesota and Oregon and Massachusetts and Kentucky—all around the country—have some choice? My gosh, if people are willing to even pay a little extra in premium, how can anybody come out on the floor of the Senate and say they are not entitled to some continuity of care and some choice when it comes to being able to continue to see their doctor?

I can give a lot of examples. Let me simply go through the Republican proposal for a moment and then come back to some examples.

In the Republican proposal, only if the employer has 50 employees or more is there any discussion at all about any alternatives; and even there, it is two panels of providers. But two panels of providers does not make for choice. And if it is under 50 employees, there is no choice at all.

We have gone over this over and over again. For the 115 million people who are excluded, they do not have any protection whatsoever.

So again, the clock is ticking away. But if, in fact, any Republican wants to come and debate me, I would be pleased to give up my 4 minutes or 3 minutes or whatever.

Again, this is about choice. We are saying is that if you and your family have been seeing a doctor and going to a clinic for 5 or 6 or 7 years, if you have paid extra, and all of a sudden your employer shifts plans or your managed care plan narrows the number of doctors you can see, you ought to be able to continue to see your doctor, you ought to be able to continue to go to that clinic.

We have all had this experience of—well, maybe we have not; I have. You go into the hospital; you put on one of those gowns. I think I could become rich by coming up with an alternative gown that does not tie in the back, because it just makes you nervous right away; you are very nervous, and you do not know what is going to happen to you.

You know what? It sure makes a difference if it is your family doctor who is there with you. It sure makes a difference if you have the sense that there is a doctor or a nurse or people from the clinic who have recommended you need to have the surgery who are there with you, who care about you, who know you, who love you.

I will say it again, consumer choice is what this amendment is about. How can the Republicans come to the floor of the Senate with a piece of legislation that they claim is patient protection and not give families this choice? If a family in Minnesota wants to pay or can pay a little more in premium to make sure that if their employer shifts plans they will be able to stay with their family doctor, or if you are an elderly citizen and you have Parkinson's you will be able to stay with your neurologist, or you have a child who is very ill with cancer you will be able to stay with your pediatric oncologist, I would think, for gosh sakes, we would want to allow a family to have that choice.

I do not want to hear my colleagues on the other side of the aisle talk about freedom of choice if they are going to come out here with a second-degree amendment that is going to wipe out this very important choice that this amendment says people and families should have in our country.

Mr. President, how much time do I have left?

The PRESIDING OFFICER. Three minutes.

Mr. WELLSTONE. If I only have 3 minutes left, since we are in the last day of the debate, I want to try to pull this into focus, at least as a Senator from Minnesota.

I would like to say one more time, if you take, for example, this amendment—and I do not have the time to read it, this amendment has the support of the Patient Access Coalition with 134 members. Every kind of consumer organization, provider organization, children's organization, women's organization, and advocacy organization for people with disabilities, all are saying: Please make sure that families in this country have a choice and do not get cut off from seeing their doctor, do not get cut off from seeing a specialist who can really help them. I see the same pattern in all of this. We have said we ought to cover all 165 million Americans. We shouldn't be covering 43 million Americans. We ought to have some standard of protection for all families in the country that States can build on. Republicans say no.

We say you ought to have a guarantee of access to specialists, if you need those specialists. There should be a panel in the plan. If there isn't a specialist in the plan to help you or a member of your family, you ought to be able to go outside the plan and receive that care. Republicans vote no.

Then we say, if you are denied care, there ought to be an appeals process. You ought to have a right to seek redress of grievance. When you do that, there ought to be an independent appeals process, and there ought to be some people you can go to. There ought to be some advocacy for consumers. On that strong consumer protection amendment, Republicans vote no and basically want to stop it.

I think the logic of this debate is clear. I have seen a little bit of confusion in a couple of articles. I do not believe this is about Senators who cannot sit down in the same room and agree with one another, and therefore, why can't they do that. What is wrong with them?

I think this is a very honest debate where you have two different definitions of what is good. I think we are talking about two different frameworks of self-interest and power. I think there is a reason that every single children's consumer and provider organization has supported our amendment and wants to see real patient protection. There is a very good reason why the insurance industry is the only interest that is supporting the Republican proposal.

It is because the Republican Party, the other side of the aisle in this debate, is marching lock, stock, and barrel with the insurance industry, and we are on the side of consumers and families. As Democrats, that is exactly where we should be.

I yield the floor.

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

Mr. KENNEDY. Mr. President, I yield 3 minutes to the Senator from New York.

Mr. SCHUMER. I thank the Senator from Massachusetts.

Mr. President, I rise in support of this amendment. It looks as if even this amendment will be defeated, if the past is any pattern. It is so minimal: the right to ombudsman, points of service, a gag rule so your physician can tell you the truth, financial incentives. It is hard to believe this amendment is going down, but it is, and so is every other reasonable provision.

So as we come to the close of this week's debate, it is worth looking at what has happened in the Senate. What has happened this week can be summed up in one sentence: The insurance industry won; American families lost.

The insurance industry won and American families lost because the right to emergency room treatment at the nearest hospital is not granted. The insurance industry has won and American families have lost because access to specialists is not guaranteed. The insurance industry has won and American families have lost because the right to appeal an unfair decision by the HMO is not guaranteed. The insurance industry won and American families lost because the right to sue, even the most egregious, outrageous behavior by an HMO, is not granted.

The insurance industry won and American families lost because the right of so many women, the desire of so many women to have an OB/GYN as their primary care physician is not there. And most of all, the insurance industry won and the American people lost, because instead of covering 161 million people, we are only covering 48 million people. Even the minor changes that were made by those on the other side of the aisle are underscored by these two numbers: 161/48, 161 million

people covered by our proposal; 48 million by theirs.

What about the other 113 million? They get no rights at all.

I am going to make a prediction. This will not be the last time we take up the Patients' Bill of Rights.

The PRESIDING OFFICER. The Senator's 3 minutes have expired.

Mr. KENNEDY. How much time do I have?

The PRESIDING OFFICER. The Senator has 3 minutes.

Mr. KENNEDY. I yield a half minute.

Mr. SCHUMER. I thank the Senator. I was just finishing my thought.

The mothers and fathers of America, who have been wrestling with the HMO bureaucracy, struggling with it, are not going to have their problems solved. They will come back to us, and we will be back to pass a better bill.

Mr. KENNEDY. Mr. President, I think we have 2½ minutes. How much remains on the other side?

The PRESIDING OFFICER. Fifty minutes.

Mr. KENNEDY. I will withhold the remainder of my time to respond to some of the points made on the opposite side.

PRIVILEGE OF THE FLOOR

Mr. WELLSTONE. Mr. President, if I may, I ask unanimous consent that Sofia Lidskog be granted the privilege of the floor during the duration of the debate.

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

Who yields time?

The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I yield myself such time as I might take for some additional views.

During the Health, Education, Labor, and Pensions Committee consideration of S. 326, I asserted strong positions on several key components of the managed care reform debate. These additional views are intended to reiterate my support for S. 326, provide the committee with a cohesive explanation of my position on specific policy, and express my appreciation to the committee for reporting to the full Senate a good bill for health consumers.

S. 326 offers a series of patient protections to consumers in Employee Retirement Income Security Act (ERISA) regulated health plans. Direct access to OB/GYN and pediatric providers, a ban on gag clauses, a prudent layperson standard for emergency services, a point-of-service option, continuity of care and access to specialists will provide consumers in self-funded plans the same protections being offered to state-regulated plans participants. Additionally, all ERISA regulated plans will be required to disclose extensive comparative information about coverage, networks and cost-sharing. This requirement is complemented by the establishment of a new binding, independent external appeals process, the lynchpin of any successful consumer protection effort.

I believe the two most contentious elements of the managed care reform debate are addressed favorably for consumers in S. 326. The first is holding health plans accountable for medical versus coverage decisions; the second is ensuring that health plans cannot manipulate the definition of ''medical necessity'' to deny patient care.

S. 236 does not expand the liability of ERISA plans by exposure to state tort laws, which has been proposed as a way to hold health plans accountable for medical decisions. Rather, S. 326 gets patients the medical treatment they need right away through a timely appeals process. Get the care; then worry about the problems. It doesn't require them to earn it through a lawsuit. I do understand the frustration expressed by physicians who are held liable for their medical decisions. It is for that very reason that the bill I support securely places the responsibility for medical decisions in the hands of independent medical experts. These decisions are binding on health plans, who run the risk of losing their accreditation, daily fines and, ultimately, their stake in the market.

Likewise, the external appeals process in S. 326 prohibits plans from hiding behind an arbitrary definition of medical necessity to deny care. S. 326 expressly establishes a standard of review, including: the medial necessity and appropriateness, experimental or investigational nature of the coverage denial; and, any evidence-based decision making or clinical practice guidelines, including, but not limited to, those used by the health plan. This is in subtitle C. Sec. 503(e)(4). In other words, the independent external reviewer—required by the bill to have appropriate medical expertise—will have access to the patient's medical record, evidence offered by the treating physician and all other documents introduced during the internal review process. Additionally, the reviewer will consider expert consensus and peer-reviewed literature, thus incorporating standards of ''medical necessity'' clearly outside those prescribed by the plan. The bill also requires that, during the internal appeals process, the medical necessity determination is made by an independent physician with appropriate expertise—not by the plan.

Since its inception in 1974, this is the first major reform effort of ERISA as it pertains to the regulation of group health plans. The focus of the mission—regardless of politics—should be to protect patients. Protecting patients means not only improving the quality of care but expanding access to care and allowing consumers and purchasers the flexibility to acquire the care that best fits their needs. The contention has been how to do this in the context of our health delivery system. I believe S. 326 is a responsible approach to protecting consumers in the managed care market.

While bipartisanship was in short order during committee consideration of S. 326, it is my hope that through the balance of this process we will continue discussions among Members to advance needed patient protections without jeopardizing access to health care. While we have been unable to bridge some of the partisan barriers during floor consideration, I believe a better plan for health care consumers is being passed today.

I suggest the absence of a quorum and ask unanimous consent that the time be charged to our side.

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

The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

The PRESIDING OFFICER. Who yields time?

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

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

Mr. FRIST. Mr. President, I rise today pleased with the discussion and the debate which has taken place over the last 4 days, recognizing that we have a number of other amendments as we go forward and hopefully look for a vote later today for final passage.

I want to mention a couple of things I haven't had the opportunity to speak on earlier yet I continue to be asked about by my colleagues and by various people in the media and constituents continue to call about. One of them has to do with an issue we debated yesterday, which will be voted on at 3:30; that is, access to specialty care.

A number of issues have arisen. I think it is important that our colleagues all understand that the Republican bill ensures access to specialty care. Again, the easiest way for me to take care of that, without getting involved in a lot of the rhetoric that goes back and forth, is with the wording in the underlying bills that is a little bit different. ''Specialty'' versus ''specialty care'' has all kinds of connotations that allow people to confuse the issue.

But in section 725 of our bill, it states that plans—and I begin my quotation by saying—''shall'' ensure access to specialty care as covered under the plan.

What is important is that people understand that the ultimate decision of what is ''medically necessary and appropriate''—those exact words that are used in the various bills and amendments that have come forward to ultimately decide what is ''medically necessary and appropriate''—ends up being with a physician who is independent of the plan, who is a medical expert, who is a specialist, who is appointed not by the plan.

We have heard again and again that in some way this independent reviewer is tied to the plan. The words are written in the bill. I don't know how much

more we can do in terms of distancing this reviewer, this physician, this independent reviewer, who is appointed by an entity, which is regulated by the Government, and is another sort of separation from the plan. This entity can be approved either by the Secretary of Health and Human Services or by the State or by the Federal Government. This entity appoints this third party reviewer who ultimately decides what is ''medically necessary and appropriate.''

When we use those words ''medically necessary and appropriate,'' again and again it has come back that at least we should consider putting it in Federal statute and defining in Washington, DC, what ''medically necessary and appropriate'' means.

I reject that, and I think we should reject that because it is difficult—I think it is impossible, but I will say it is difficult—to define what is ''medically necessary and appropriate.'' To pretend that we can do it on the Senate floor is misleading. In fact, many think tanks and many Senators, Congressmen and women have tried to do it, and we haven't been able to define it in Medicare or in CHAMPUS. The President's Quality Assurance Commission was unable to define what is ''medically necessary and appropriate.''

Thus, we don't attempt to define it. We say it is important, but we say ultimately it has to be defined by an independent medical specialist, independent of the managed care company. Then we have a whole list of things that he or she has to take into consideration.

We continue to limit what that third party independent reviewer—he or she—actually considers the best practice of medicine, which is very different, I should say, from ''generally accepted medical practices.'' ''Generally accepted medical practices'' haven't been defined very well. There is not a book of ''generally accepted medical practices.''

I say that because if your sick heart is not beating very well, there are procedures that may not be ''generally accepted'' but they can be lifesaving. They may not be done very much in a community. Whether you do a transplant, or you put a wrap around the heart, or you take out a section of it, that may not be the overall best practice, but it could be ''generally accepted practice'' or ''generally accepted'' but not the ''best medical practice.'' I don't want to get into writing these definitions into Federal statute.

The distinction that has been made in several bills when we talk about ''medical necessity'' is also a very important issue because for the layperson, or the patient sitting out there, you would think that ''medical necessity'' would be easy to define. But saying what is going on out there in the health care arena, what is the range of treatment—we have seen charts on the floor that basically show that the range of treatment is huge in America, charts on how to treat urinary tract infections 80 different ways by 170 different physicians.

What that basically says is the range of treatment is huge—the variety. It doesn't say whether all of those are good or whether all of those are bad. But the fact that it doesn't say that and the practice is so wide, we don't want to make that the gold standard. If we were going to write something into Federal statute, we shouldn't say ''generally accepted medical practices'' because in truth it takes not the lowest common denominator but it takes the common denominator and makes that the standard.

I think it is very dangerous to say ''best practices'' will be the standard. That is why I don't think ''best practices'' should be written into Federal statute as the definition.

Why is that? It is because ''best practices'' are evolving over time. Yes, you can have studies in the New England Journal of Medicine and in the Journal of the American Medical Association of the greatest breakthrough, but you can't expect that greatest breakthrough which might be in truth the best practice 3 or 4 or 5 years later to immediately be disseminated to hundreds of thousands of physicians the next day across the United States of America.

I am trying to spend a little bit of time with this because I think it is dangerous to try to define ''medical necessity'' in Federal statute. We can still use the terms. You need ''medical necessity'' in there—what is ''medically necessary and appropriate''—but I don't think we should. I think we are doing a disservice if we try to define it. I struggled. We tried in our committee and in our staff to come up with a good definition. It doesn't mean that health care plans aren't going to try to define what is ''medically necessary and appropriate.''

The reason this bill is necessary is that some managed-care plans have terrible definitions. They say what is ''medically necessary and appropriate.'' They might say that it is effective and that it has had proven efficacy in the past. But some will go so far as to say what is the most efficient or what is—they don't say it this way—but what is the least expensive, and once they have put it in the contract, the people will come back and point to that.

Those are bad definitions. But that same sort of risk of writing in the definition in Federal statute, again, can be very dangerous if we are looking for quality of care in an evolving health care marketplace.

The beauty of our bill is that we fix the system. We go to where the problem is. We don't bring in a trial lawyer or a lottery where people wait 5 years on average to have a medical malpractice lawsuit.

I didn't participate in the earlier discussion today. But when you look at medical malpractice, my experience in medicine is that when you look at health care and lawyers, it is in medical malpractice. Basically, we know that is a very costly system. Most people just want to get something covered and don't know how to go out and hire a lawyer. Most lawyers, because they are operating on contingency fees, aren't going to fool with the $5,000 case, or the $20,000 case, or the $50,000 case. They will fool with the $1 million case. Then it becomes very arbitrary. You have a costly system that is an arbitrary system.

The third point is that it takes forever. It is a time consuming system. Earlier studies, I am sure, were quoted on the floor. The average malpractice case takes 5 years before recovery is made. That is an average of 5 years. That means some are 6, 7, 8, or 9 years.

The American people want to fix the system. They want the reassurance that their managed care plan is not denying coverage.

I yield myself 3 more minutes, and then I will yield to the Senator from Texas, if I may. I will finish this one thought.

What the American people want is for us to get away from this fear that managed care is overriding what they or their physician, in consultation with each other, think and believe is appropriate and, in truth, provides good quality of care. The reason I believe we were stuck on this vote earlier is the American people are saying let's fix the system, but let's make sure that we remove the barrier to the coverage that I deserve, that I expect, and that is appropriate for me, and that it is delivered in a timely way.

That is not helped by a very expensive lawsuit which is not going to be settled for about 5 years, at least in medical malpractice. It will not allow a person to get coverage for that cleft lip repair of a child or the appendectomy or the laryngitis.

We want to do what is best for Americans, best for children, and allow that timely access of care, removing unnecessary barriers. There will be certain barriers. remove the unnecessary, unjustified barriers, so that Americans can rest assured they can, in a timely way, receive good, quality care. That is the purpose of this bill.

I have been pleased with our discussions. As we accept some amendments and reject others, I know we can come up with a good bill later today.

I yield such time as necessary to the Senator from Texas.

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. Is it possible to have 20 minutes?

Mr. FRIST. I yield 20 minutes.

Mrs. HUTCHISON. I thank Senator FRIST for his leadership in this area. Certainly all Members look to the one doctor in our body to give us advice, not only on what we need to do to make patient care better but to know the system well enough to know what will cause more harm than good. I appreciate the steady level-headedness of

the Senator from Tennessee. We are fortunate to have a physician in our midst.

Our Nation has the highest quality health care anywhere in the world. There is no question about that. In my home State of Texas, in our largest city of Houston, the biggest employer in the whole city is the health care industry, the Texas Medical Center. It contains world-class hospitals, including the renowned University of Texas M.D. Anderson Cancer Center, which is the finest cancer treatment center in the world. Baylor College of Medicine, too, is a world leader in the treatment of cardiovascular disease. Houston is the home of the fathers of modern heart surgery: Dr. Michael DeBakey and Dr. Denton Cooley.

In the city of Dallas, TX, the University of Texas Southwestern Medical School has four Nobel laureates. They are doing research that is changing the quality of health care for our future. They are doing it because we have a system that allows for the investment in research. It allows for the treatment that is the best for diseases.

We don't want to break something that isn't broken. We don't want to try to fix something that isn't broken. We want to make sure we are giving better quality health care, that we are going to continue to have research and be in the forefront of research and technology as we go into the next millennium, trying to make sure we are doing the right thing.

There are problems. We have too many uninsured. Too rapid growth of HMOs and other service providers has caused some to be left behind. We must address these problems. Are there problems with HMOs? Absolutely. Do we need to increase the number of insured Americans? Of course.

If the American people remember the health debate we had in 1993, this Nation soundly rejected an outright Federal takeover of health care. That bill went down once America realized that their doctor, their hospital, everyone involved in the health care industry in this country would have to answer to a massive bureaucracy in Washington, DC.

Under global cost limits, total health care spending in this Nation would be capped by Washington. Any way you slice it, what the administration offered was Government rationing of health care.

Today, we are considering legislation that would impose 350 new Federal mandates and regulations on our Nation's health care system. There has been discussion about the cost of these mandates, whether they will cost as much as a Big Mac or a McDonald's franchise. Either way, there will be increased costs, and more Americans could lose their insurance.

Once a mandate becomes law, a Federal agency here in Washington will issue regulations or interpretations of that mandate. We have only to look as far as the Health Care Financing Agency to see what a total disregard of congressional intent can do in the health care industry. While Congress did mandate more efficiencies, they did not mandate the cuts that HCFA made in our hospital industry and to our health care providers, such as physicians and home health care service agencies. We can see what Federal control of a health care industry does by looking at what HCFA is doing to the health care providers in this country today.

I think we need to move very carefully into the arena of more Federal regulations of our health care industry. We do need to do something more than we are doing right now. However, I think we need to be very aware that we could go too far and throw out the baby with the bathwater.

I believe Democrats and Republicans want to make sure patients have basic rights when they and their family members need health care. It is wrong for an HMO to deny coverage for medically necessary treatment. It is wrong to allow a patient to get lost in red tape and unnecessary delays.

Both of our bills seek to empower patients when they are dealing with their health care industry and their insurance companies. However, there are three major differences in the way in which Democrats and Republicans are approaching the issue of managed care.

First, we believe that cost matters and that higher costs will translate into more Americans losing their coverage.

Second, Republicans recognize that the Federal Government and a Federal bureaucracy should not impose a one-size-fits-all approach to ensuring quality care.

Third, we believe good health care is better than a good lawsuit.

With regard to costs, the Congressional Budget Office has said that the Democrats' plan will cause health insurance to increase in price by 6 percent above the current rate of inflation. By some estimates, that could lead to an estimated 1.8 million Americans losing their health coverage.

Mr. President, 1.8 million people is a city the size of Houston relying on free clinics or charity coverage. That is what the Democrat bill will do.

The new mandates in the Democratic bill will also cost an estimated 190,000 American jobs and additional out-of-pocket costs by the average family of $207 a year. This is not acceptable. The average cost per family for employer-provided health premiums has already more than doubled over the last decade from $2,530 in 1988 to $5,349.

The provisions of the Republican bill will also cost money, but the total cost of our bill as calculated by the Congressional Budget Office is less than 1 percent in increased health premiums. These increases are more than offset by the provisions in our Patients' Bill of Rights Plus that will make health care more accessible and affordable for all Americans.

For the self-employed, our approach will make 100 percent deductibility of health insurance available next year—not in 5 years, as currently envisioned. Next year, every small business owner, every stay-at-home parent with their own business, will get exactly the same tax treatment for health insurance that corporations presently enjoy. This is long overdue.

The bill will allow employees the so-called flex plans or cafeteria plans to roll over to the next year up to $500 in unused funds to health insurance premiums or other out-of-pocket health costs. Under the present use-it-or-lose-it flex plans, they are not able to keep the money they have not spent. We want to encourage them not to spend money they do not need to spend by allowing them to roll it over.

The second major difference between our two bills and our two approaches is that the Democratic plan assumes Washington knows better than individuals, States, and health care providers what is in their best interest. We heard so much this week about how some of the provisions of the Republican bill do not apply to all private health care insurance. That is true. For those health plans that are now regulated exclusively by the Federal Government, we ensure that patients have their rights, such as direct access to OB/GYNs, direct access to pediatricians, access to specialists, and access to emergency room care. But, for the vast majority of Americans with health care, it is the States that have jurisdiction over their plans. This has been the case for several decades, ever since there has been health insurance in our country. Since the advent of HMOs, more and more States have acted to regulate managed care plans to ensure that the residents of their States enjoy the same protections we are proposing for the federally regulated plans. Every State in America has some regulation of their managed care companies today.

There are wide differences in approach by various States, but there are wide differences among the States. Why should there not be wide differences if the States are acting on behalf of their own constituents, which they know better than we do? Who is to say the patient protections and regulations in New York are the same that the citizens of Texas would want? I do not want to take responsibility for deciding that New York should be doing something because Texas likes it.

The Democratic bill is too federally centered and heavyhanded in other areas as well. We have heard much discussion of medical necessity. The Democrats say they only want to allow physicians to do what is medically necessary. That sounds fine, but what do they mean by medical necessity? It goes to an agency that will have 250 pages of regulations about what is a medical necessity. And there we have it again, one-size-fits-all.

By trying to do this in Federal law, the Democratic plan empowers a Federal Government employee to make those decisions, not your doctor talking to you about your needs. Under our

system, we let an external review board of professionals, who are not associated with the HMO, decide who is right in making the call for the care. If the HMO says they are not going to cover a certain procedure, and the patient and the doctor decide that is not the right decision, the patient can internally appeal within the HMO, within a short period of time, and then appeal again to an outside panel of experts not associated with the HMO. That is the system we have in Texas, and it is working.

In 1997, Texas enacted an innovative and broad set of managed care reforms, including a host of patients' rights that are included in our bill today. The Texas plan includes the right to both internal and external appeal if the HMO denies a claim. In fact, in Texas, before you can even think of suing your HMO in court, you must exhaust your administrative remedies, and because the State tried to apply its external review provisions to federally regulated as well as State regulated HMOs, a Federal court has struck down part of the State law. But it was working very well.

The State recently acted to revive the external review section of the law. Now the system is voluntary. But, surprisingly, HMOs and other health plans are still willing to participate and be bound by the external review process in Texas. And it is working.

The Republicans' Patients' Bill of Rights Plus establishes a national, internal, and binding external appeals process using the Texas statute as a guide. It is a good system. I think it will work for the federally covered plans as it has worked in Texas. In fact, in Texas it has worked so well that, of more than 300 appeals heard under the external review system, only one lawsuit has emerged, and the appeals have gone about 50–50 in favor of both patients and health plans.

This brings me to the third major difference between the Democrat and Republican approach, and that is they believe lawsuits are the answer to better care, and we disagree. Good health care is prospective. A lawsuit is retrospective. An adequate external review process helps ensure that HMOs will not arbitrarily deny coverage for benefits. It will make them want to improve the quality of the care and services they provide in the future. A lawsuit, on the other hand, only seeks to shift money around long after the fact, to try to determine who was at fault and how much they owe. At that point, patient care is obsolete. We are talking about fault. I would rather focus on what we can do to give that patient the care when the patient needs it.

All one needs to do, if the suggestion is that more lawsuits are the answer, is to look at our current medical malpractice tort system. Many physicians in this country may be upset with the growth of managed care, but most of them are far more concerned with the tidal wave of lawsuits against doctors and other health care providers that we have seen in recent decades. These lawsuits, costing hundreds of billions of dollars, have done little to improve the practice of medicine in America. In fact, I wonder if they do not cause more defensive medicine rather than better care. In fact, in some ways, I think they have alienated the doctor-patient relationship.

So look at the range of views here. The Washington Post said last year that expanding lawsuits in this area was probably wrong. The Post wrote:

> There appears as well to be an impulse among congressional Democrats to make insurers and companies that self-insure liable for damages. The impulse is understandable but the threat of litigation is the wrong way to enforce the rational decisionmaking that everyone claims to have as a goal. The proposed appeals system should be given a tryout. ''First do no harm'' is the rule of medicine. It should be the rule on legislating as well.

Mr. President, I know my colleagues across the aisle are trying to address complaints they have heard from their constituents. But rather than again mandating new rules that will drive up the cost of health care, the American people would be much better served with a carefully tailored approach that respects the ability of patients, professionals, and State regulators to make their own decisions about what is best practice in their States and within their communities.

The Patients' Bill of Rights Plus does just that. It makes sure that HMOs are accountable, without scaring employers away from even offering insurance to their employees. It gives patients rights without encouraging inflationary rises, and empowers health care providers to provide the care their patients need but without Washington having to look over everyone's shoulder. It is the right answer, and it is the right time.

Mr. President, I thank the leadership, Senator FRIST, and Senator COLLINS, and those who have worked closely on the task force to make sure we do provide the rights to patients in an affordable way that will not drive up costs and drive people out of the system. That should be our goal.

I yield the floor.

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

Mr. KENNEDY. Mr. President, we have 2 ½ minutes left. I will use those minutes.

I want to point out for the benefit of the membership, we have almost concluded our 50 minutes of debate. The debate has included a number of different amendments. All are very important because they all relate to the doctor-patient relationship. That is the heart of our entire bill. The heart of our bill is to make sure that medical professionals are able to practice the best medicine and make the best recommendations and that the insurance companies will comply with those recommendations. The heart of our bill is maintaining the relationship between the doctor and his or her patient. That is the heart of our bill. We still have not had any real criticism, observations, or comments on those issues.

We had some debate in the HELP Committee when these matters were raised. I note the proponents of those particular amendments—those who were on the committee and those who were not—were on the floor ready to respond to questions. Nonetheless, we have heard debate on the overall legislation. We still have not heard a response to what I think has been a powerful presentation in favor of these measures. Again, I will mention very quickly what this amendment is about.

This amendment is critical to preserving the relationship between medical professionals and patients, as well as providing fair information to consumers. Today, medical professionals are too often gagged, harassed, and financially penalized if they advocate for their patients.

I am reminded in my own State of Massachusetts of Barry Adams who was fired for simply reporting quality of care problems to his superiors. This happened just 3 months after he received a glowing evaluation that said he was an excellent role model, conducted himself in a professional manner, was an advocate for patients, and channeled his concerns appropriately.

Yet after he spoke up about his concerns, the facility mounted a campaign to oust him. The month he was fired, a woman died from a morphine overdose given by an unsupervised junior nurse. This was the very type of incident Barry reported previously, the very type of incident that Barry reported in the complaint that led to his firing. The facility also retaliated against two of his colleagues who reported unsafe patient conditions.

Barry fought back, and more than a year after he was fired, a judge ruled that Barry's termination was unlawful. The judge ordered the hospital to reinstate Barry, pay all back wages and expunge his record. He won. But the point is, he never should have been fired in the first place. This amendment prevents that from happening.

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

Mr. KENNEDY. Mr. President, if patients cannot count on their doctor, quality medical care is impossible. If doctors cannot do their best for their patients without fear of retaliation, quality medical practice is impossible, too.

This amendment protects the relationship between the doctors and their patients. The Republican bill protects only the insurance companies. Part of the doctor/patient relationship is being able to go to the medical professional of your choice, not the HMO's choice.

This amendment establishes a point-of-service option that guarantees that choice. The Republican bill offers no meaningful guarantee.

Without the type of information the ombudsman program provides, too

many consumers will simply be unable to exercise the rights this bill proposes to grant. As our friend and colleague, Senator REED, pointed out, giving consumers information so they will have their rights protected under their HMO is so important. This amendment provides basic, commonsense protections for health professionals and patients, and I know of no valid reason that it should be opposed.

Mr. President, I reserve the remainder of my time. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. ENZI. Mr. President, I rise in opposition to the amendment.

I have sat here and listened to the arguments from the other side. There is part of this amendment the Democrats didn't even talk about. The problem is that this part of the amendment will make things worse, and not just for doctors and nurses. It will put patients at risk by allowing providers to release the intimate details of a patient's treatment without having to worry about being accurate or even truthful.

Here is how. Under the Democrat amendment, any provider could disclose any information about a patient at any time for any reason. This fact is so important that I want to say it again: under the Democrat amendment, any provider could disclose any information about a patient at any time for any reason. And as bad and unbelievable as that is, that's not even the worst of it. This amendment allows a provider to do the worst of all things—not only to give out information about a patient, but even lie about it—and not be held accountable. How can that be possible, you ask? Isn't that against the law? Not if this amendment passes, it's not. If this amendment passes, that possibility is a reality, and your private health records will be held hostage by a provider who can make an unchecked decision to disclose them without asking your permission and who can't be penalized for doing so.

But that is not all. There is no requirement in the Democrat amendment that when a provider exposes your confidential records, that the provider make disclosures only within his area of expertise. So if an anesthesiologist wants to reveal something about the way your ear exam was performed, the Democrat amendment says that is okay. There is nothing saying that the person disclosing your information has to know anything about either the procedure or your case before revealing everything about it—in fact, he doesn't even have to witness the treatment or ever have met you—and there's nothing saying he will be held accountable if he's mistaken or just flat out wrong. Adding insult to injury, the Democrat amendment doesn't even say that the disclosure has to relate to safety and health. All the amendment says is that the disclosure must be based on squishy terms that aren't even defined. For example, the amendment says that the disclosure must be based on information, and I'm quoting here, that the provider ''reasonably believes * * * to be true.'' It is unbelievable to think that this flies under the Democrat amendment. It is unbelievable that the amendment would allow a patient's health information, records, and private treatment details to be jeopardized and publicized without his consent, based on something that a total stranger ''reasonably believes to be true'' and is not even related to the patient's own safety. Exposing patients to such a high degree of risk without tying disclosures to patient safety, expertise or even accuracy is not only unacceptable, it's just plain wrong.

What the Democrat amendment completely ignores is that procedures specifically related to the health care industry are in place for reporting problems with patient safety and health right now. The amendment also completely ignores and steam rolls all the state law in this area. I find it fascinating that the other side has said over and over and over again in this debate that their bill will not shift decisionmaking from the state capitals to Washington bureaucrats, and then they propose an amendment like this.

I want to talk about what this does to state law, and then talk about the procedures that are in place now.

On the first day of this debate, I heard no less than four Senators on the other side of the aisle characterize our ''states rights'' argument as being ''tired'' and ''old.'' Well, while I might take issue with it being ''tired,'' I certainly agree that it is ''old.'' In fact, it's as old as the Constitution. And if you are tired of hearing about it, think about this: How many times have you been to Wyoming? What do you know about the folks there? I can tell you that it's true they need access to good health care, and I can also tell you that folks there don't want the Federal government to step in and trump what the Wyoming Legislature has done to protect them. They don't want one standard that applies to everyone regardless of who they are, where they're from, and how they live. And if those on the other side of the aisle think that the people I represent in Wyoming are exactly like New Yorkers or Californians, then I suggest you head back to Cheyenne with me this weekend and see if you change your mind.

One size fits all doesn't fit when we are talking about giving providers ways to report patient safety problems and protecting them when they make disclosures. Over 25 states have their own language prohibiting employers from retaliating against providers who disclose information relating to patient safety within a recognized framework. That's over 25 states with different laws and different reporting procedures; 25 states that offer different rights and responsibilities. I cannot underscore the importance of this enough. To a Democrat caucus that has repeatedly said that their bill will not shift the decisionmaking from the state capitals to Washington bureaucrats, I challenge you to tell me how such a statement jives with an amendment such as this one that fully wipes out state law. Not only that, I challenge you to tell me how this flawed amendment is better than the law that exists on the state books. More on this in a minute.

Bottom line, this amendment allows providers to file complaints disclosing confidential patient information without permission. These complaints don't need to relate to safety and health. The provider does not need to know anything about who or what they are disclosing—whether it be the specific patient treatment or the patient himself. And finally—and most ridiculously—the provider doesn't need to be accurate because he can't be penalized for inaccurate statements, misleading information or even downright lies about the patient or other health care providers. How in heaven's name could any state law anywhere be worse, or more destructive, than this? Indeed, having no law whatsoever would be vastly better.

But you do not have to take my word for it. Just take a look at some of the State laws. In California, for example, providers cannot disclose information that violates the confidentiality of the physician-patient privilege. An important provision. Is it anywhere to be found in the democrat amendment? No. The amendment ignores it entirely. What about a Rhode Island law that eliminates any protection for providers who participate or cause the problem being reported, or who provide false information? That one is pretty important, too. Also nowhere to be found in the Democrat amendment.

The body of state law that it would destroy is incredibly vital whether we're talking about ERISA plans or not, because the courts have definitively held that where quality of care is concerned, state law trumps ERISA. As the Supreme Court has held, ''the historic powers of the State include the regulation of matters of health and safety.'' Another seminal third circuit case has held in citing the Supreme Court that, while the quality control of health care benefits might indirectly affect the sorts of benefits an ERISA plan can afford, they have traditionally been left to the states, and there is no indication in ERISA that Congress chose to displace general health care regulation by the states. It's clear: the courts have deferred to the states when it comes to quality of care. I think that the democrats should take a lesson from this.

I have heard it said, however, that we need not worry about the overhaul of state law that occurs under the Democrat approach to health care because their bill will merely set a ''floor'' upon which States can build. Such a

statement is questionable given an amendment such as this that is so flawed that it actually protects those who publicize confidential patient information and lie about it without giving the patient or other accused providers an opportunity to object. As a former state legislator, I say respectfully, ''thanks, but no thanks.'' The only floor this sets for the States is the one they will stomp on when they take one look at this bill.

So who should investigate claims of wrongdoing and retaliation? I have mentioned that lots of other procedures are in place that allow for reporting and are specific to the health care industry. One of the biggest and most far-reaching of these is the reporting mechanism in place at the Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission covers over 80 percent of the approximately 6,200 hospitals in this country that receive Medicare payments. These charts I have next to me are blow-ups of information taken directly off of the Joint Commission's website and show not only how reports and concerns about patient care can be disclosed, but also what followup occurs in response.

Here is how the process works. If a provider wants to report an alleged problem, that provider has several choices under the Joint Commission. He can e-mail a complaint, fax a complaint, mail a complaint, or call the Joint Commission directly using their toll free number. And there are a couple of points I want to make about why this process is so much better, more related to the health care industry, and has much stronger teeth than this amendment. First, using the Joint Commissions' toll free number, reporting concerns can be immediate and confidential. Not only that, communications with the Joint Commission can be made in English or in Spanish. Second—and this one's really important, too—all complaints must relate to quality of care issues and patient safety unlike the democrat amendment which can relate to anything. Third—and perhaps most important of all—where serious concerns have been raised about patient safety, the Joint Commission will, and I emphasize ''will'' conduct an unannounced, on site investigation. Period. And with the Joint Commission, there will never be any concern over who's investigating problems. The Joint Commission's standards are recognized as representing a contemporary national consensus on quality patient care, and these standards are continuously reviewed to reflect changing health care practices. This is a real solution that combines a proactive reporting method to make sure that patient quality is not compromised, with an appropriate and strong follow up with mandatory, unannounced, on site inspections by an organization that knows the health care industry as well as anyone.

In addition to all the State laws setting up reporting procedures and protections for providers, and in addition to the practices in place such as the Joint Commission, there are other controls. Hospitals that receive Medicare payments and that are not accredited by the Joint Commission are certified by the states. All these hospitals are required to provide patients with a document that explains their rights including a phone number where they can call a state agency to make a complaint about quality of care issues. These rights must also be posted. Yet another control is that patients—and even providers—can anonymously complain to the Medicare Program's Peer Review Organization on quality of care matters. Providers may also complain to HCFA's regional offices, state survey agencies and professional licensing boards.

I have heard the stories about providers who have disclosed information and then were retaliated against. What I don't know is why the state laws, the Joint Commission's reporting process, state reporting processes, Medicare reporting processes, HCFA's reporting processes, and the professional licensing board—among other protections—are not working. I have in my hand a copy of the HELP Committee's report on the Patients' Bill of Rights and all of the amendments introduced to the bill. You may remember that an amendment similar to the democrat amendment introduced here today was introduced during the markup of this bill. I happened to remember that amendment, too, and so I picked up a copy of the committee report and began to leaf through the minority comments to find their explanation of the amendment. I was looking for some reason—other than pure politics—about why an amendment like this is needed, about what isn't working in the system that must be fixed, and about why current laws, practices and procedures aren't enough. This is what the committee report is for, right? So I looked, and I looked. Out of the report's main body of 108 pages, 99 pages were written by the majority to explain and to support our bill. Only nine pages were written by the minority—nine. So out of nine pages, you would not think it would take too long to find some information—any information—about one of the minority's major amendments. I did not think so either, but I was wrong. I did finally find the minority's reference to the amendment, though. It was three sentences long. Three sentences out of nine pages on a major amendment. Let me read them to you: ''Doctors and other providers must be able to give every patient their best possible advice, without fear of retaliation or financial penalties.'' So far, so good. ''Out plan bans abusive insurance industry practices that undermine the integrity of the doctor-patient relationship. The committee legislation does not.'' So I kept reading. I scanned the page. What abusive industry insurance practices? I wanted to know. Why do providers fear retaliation? Why are current law, current practices, and current procedures not working? Nothing. Wouldn't you think that if the majority was able to spend its time writing 99 pages supporting its position, the minority might have been able to spend just a little more time adding even one paragraph to its nine pages on this? Not even one paragraph on an amendment that the democrats say is so vital. It just doesn't make any sense.

I have heard time and again that Republicans are weeping ''crocodile tears'' about our bill. In fact, out of those mere nine pages in the minority's committee report, an entire sentence was wasted making this statement. But it seems to me that when you lay down amendments and don't share information about why we should trump state law in support of an amendment that protects providers who disclose misleading and confidential patient information unrelated to the patient's safety, then I think it is the democrats who are the ones crying crocodile tears when people like me are baffled by their empty allegations and outlandish solutions.

Mr. President, I yield the floor.

Mr. KENNEDY. I yield back any time I have on the amendment.

Mr. FRIST. I yield back the remainder of our time on this amendment.

AMENDMENT NO. 1252 TO AMENDMENT NO. 1251

(Purpose: Enhancing and augmenting the internal review and external appeal process, covering individuals in approved cancer clinical trials, improving point-of-service coverage, protecting individuals when a plan's coverage is terminated, and prohibiting certain group health plans from discriminating against providers on the basis of license or certification)

Mr. FRIST. 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 Tennessee [Mr. FRIST], for Mr. ASHCROFT, for himself, Mr. KYL, Mr. MACK, Mr. FRIST, Mr. SESSIONS, Ms. COLLINS, Mr. CRAPO, Mr. ABRAHAM, Mr. JEFFORDS, Mr. ENZI, Mr. DEWINE, Mr. GRASSLEY, Mr. HATCH, and Mr. HELMS, proposes an amendment numbered 1252 to amendment No. 1251.

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

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

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

Mr. FRIST. Mr. President, very quickly, because we have a lot of ground to cover over the next 100 minutes, the amendment that has been sent to the desk involves basically five components. I will be relying on a number of my colleagues coming to the floor, all of whom have worked for weeks and months and, in some cases, well over a year on these amendments.

The first of these components is on external appeals. As we continue to address the issues before us, it is very important to have the American people

recognize we are going to continue to improve this bill as we go through.

A second component is the clinical trial issue, an issue Senator MACK and I have worked very aggressively on over the last year with a number of our colleagues on both sides of the aisle, an issue that had been addressed initially earlier in the week that, as we said before, we are going to come back to and lay out what we think is the most reasonable way to achieve a very important goal, and that is to increase access to important clinical trials.

A third component a number of Senators, again Senator COLLINS and Senator GRASSLEY, will be speaking to is on provider nondiscrimination, and we will be looking at some protections that are similar to those in Medicare and Medicaid.

A fourth component of this amendment—again a very important one because it involves choice, and again we are working to improve this bill as we go through with the amendments—is on point of service where we expand choice, which again is a basic underlying principle of the Republican efforts in this bill.

The fifth component that will be addressed is continuity of care, again a very important issue, the whole issue of extending the transition period for patients.

We have a lot to cover over the next 100 minutes. To me it is very pleasing, having participated so much on each of these issues, that upon passage of this amendment with its five components, we will do a great deal to improve the quality of care of individual patients. That is where our focus must be.

We are going to begin with the issue of clinical trials, again picking up on the discussion earlier in the week. I yield 12 minutes to the Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida.

PRIVILEGE OF THE FLOOR

Mr. MACK. Mr. President, I ask unanimous consent that Dr. Larry Kerr, a health fellow for the Judiciary Committee, be granted the privilege of the floor for the remainder of the debate on the Patients' Bill of Rights.

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

Mr. MACK. I thank the Chair.

Mr. President, I am pleased to be joined by Senator FRIST, Senator JEFFORDS, and Senator COLLINS, and others, as we offer this amendment to provide cancer patients with coverage of health insurance benefits when they participate in approved clinical trials.

Many health plans will not pay for the cost of routine patient care if patients want to participate in a clinical trial. As a result, beneficiaries with cancer are denied access to these trials of promising new therapies because these therapies are deemed ''experimental'' by most health plans and, therefore, not qualified for coverage. This means many cancer patients have two choices when they have exhausted all traditional therapies: either pay the cost of participating in a clinical trial themselves or go without additional treatment.

For all but the most wealthy patients, it is cost prohibitive to take part in a clinical trial. This amendment will help ensure that a patient's decision about whether or not to participate in a clinical trial is based upon science and not cost.

Clinical trials are one of the most effective ways of determining which treatments are beneficial. Yet cancer researchers have told me they have had difficulty enrolling the required number of patients to participate in the clinical trials they are conducting. Scientists have identified noncoverage by private insurers, as well as Medicare, as one of the primary reasons why patients do not participate in clinical trials.

For example, approximately 2 percent of cancer patients are participating in clinical trials. This amendment will help scientists recruit cancer patients who wish to participate in clinical trials by breaking down the financial barriers which may preclude most patients from participating.

Clinical trials are one of the most effective techniques for assessing the effectiveness of a scientific and medical intervention. Many of my Senate colleagues have joined with me in a bipartisan effort to double biomedical research funding through the National Institutes of Health. Last year, Congress appropriated $15.6 billion for NIH. This represented a $2 billion increase, the largest increase in NIH history. At a time when American researchers are making such tremendous progress in scientific areas such as cancer genetics and biology, it is essential that this knowledge be translated into new therapies through well-designed clinical trials. This amendment is a natural extension of the historic effort to double funding for medical research in our country.

When my brother, Michael, was diagnosed with cancer, there were only three basic forms of treatment—surgery, radiation, and chemotherapy. Today, scientists are revolutionizing the treatment of cancer by developing many new weapons to kill cancer, including gene therapy and immunotherapy.

On a personal note again, every time I get into these discussions, and every time I see the new efforts that are being pursued, and the successes that have been developed, I cannot help but think if Michael's melanoma had been discovered or if he had found the disease much later in his life, when these new procedures—gene therapy and immunotherapy were available—and if he had been able to participate in a clinical trial, which he attempted to do throughout his treatment many years ago, his life may have been saved.

This amendment will help scientists continue the unprecedented progress being made to find new methods of treatment.

Coverage of cancer clinical trials is a bipartisan issue. Earlier this year, for example, Senator ROCKEFELLER and I introduced legislation to provide for Medicare coverage of cancer clinical trials. I am pleased to say that 36 additional Senators, from both sides of the aisle, have cosponsored this legislation. I look forward to working with my colleagues to pass this important legislation during the 106th Congress.

The reason Senator ROCKEFELLER and I targeted our legislation to cancer is the same reason we have targeted this amendment to cancer today—there is a legitimate debate about what the true cost may be. Senator ROCKEFELLER and I believe the cost will be insignificant. And we have the studies to prove that.

However, there are legitimate concerns with respect to cost which have been raised. Both the amendment we offer today and the Rockefeller-Mack legislation, call for a study and report to Congress in 2005 on the cost implications of covering cancer clinical trials.

I support comprehensive coverage of clinical trials. But, at this time, we need more information before we go further. This amendment will help provide the information we need to make a better informed decision.

During markup of S. 326, the Senate Committee on Health, Education, Labor, and Pensions considered an amendment offered by my friend and colleague, Senator DODD, to provide clinical trial coverage.

Since then, my colleagues and I have more thoroughly studied this amendment. We have examined what barriers exist that impede enrollment in clinical trials. We looked into the cost implications. We considered the best way to define the term ''routine patient costs.''

Let me first highlight the many similarities in our amendment and the amendment which Senator DODD offered during committee consideration.

Our amendment requires plans to provide coverage of routine patient costs. I will get back to that term in a few minutes.

Our amendments ensures that health plans are not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of a clinical trial. This includes tests or measurements conducted primarily for the purpose of a clinical trial.

Our amendment permits plans to require clinical trial participants to use in-network providers, if they are available. If coverage is provided by a nonparticipating provider, payment would be at the same rate the plan would pay for comparable services to a participating provider.

Our amendment is limited to those health plans over which Congress has sole and exclusive jurisdiction.

Our amendment is limited to only the highest-quality clinical trials. These include trials approved and funded by the National Institutes of Health, the Department of Veterans Affairs,

and the Department of Defense. Only those trials which have undergone the rigors of peer-review will be considered.

Our legislation differs with Senator DODD's proposal in three ways.

The first difference is how to best define the term ''routine patient cost.'' In researching this issue, we have found that there is not a generally accepted definition of the term, ''routine patient cost'' associated with participation in a clinical trial. The Balanced Budget Act required the Institute of Medicine to conduct a study on the issue of cancer clinical trial coverage, including the definition of routine patient costs. This study is due in September, and it will likely help us to better define this highly technical term. There are other experts who have opinions on how to define the term ''routine patient cost.'' We believe it is best to leave this task to patients, employers, health plans and those with true expertise in the field of clinical trials.

It is essential to remember that protocols for clinical trials vary widely, and routine patient costs for clinical trials also vary. Scientific researchers have indicated that developing one standard for determining routine patient costs will be a daunting task. I don't believe Congress is best qualified to make this important scientific determination.

Therefore, our amendment provides for a negotiated rulemaking process to establish a time-limited committee charged with developing standards relating to the coverage of routine patient costs for patients participating in clinical trials. This way, organizations representing cancer patients, health care practitioners, hospitals, employers, manufacturers of drugs and medical devices, medical economists and others will be involved in the process of defining routine patient costs with respect to clinical trials.

By May, this committee is required to develop standards for routine patient costs for individuals who are participating in those trials. If the committee is unable to reach a consensus, then the Secretary must develop these standards and publish a rule by June 30, in the year 2000. In either case, coverage for these benefits would begin for plans beginning on, or after, January 1, 2001.

We believe that a negotiated rulemaking process is the best way for organizations representing all who are affected to collectively determine what costs should be considered in ''routine patient costs.'' These decisions will have a major effect of the cost of covering clinical trials.

I will just underscore that again. These decisions will have a major effect on the cost of covering clinical trials.

Under the Democratic bill, these organizations can only submit a comment to the Secretary, who has broad authority to determine what constitutes routine patient costs. However, those comments could be rejected out-of-hand by the Secretary.

By contrast, the negotiated rulemaking process ensures that all who have an interest in the outcome have a seat at the negotiating table to make the decision. We believe it is essential that cancer patients have an opportunity to be involved in establishing standards for routine patient costs, and a negotiated rulemaking procedure affords them that opportunity.

Second, as I mentioned earlier, our amendment differs from the Dodd amendment in that it is limited to cancer clinical trials. There are more clinical trials involving cancer than perhaps any other disease. This targeted approach will not only provide a needed benefit to a large patient population, but it will also provide significant information for the study and report called for in this amendment.

Finally, our amendment includes a study and report to Congress on the costs to health plans and any impact on health insurance premiums. Senator DODD's amendment did not include this study and report, which I believe is extremely important. Congress can then use this important information to determine if they wish to expand coverage for patients with other diseases.

Like most of my colleagues, I am very concerned about the ever-increasing costs of health insurance. According to the Congressional Budget Office, our amendment will result in an increase in health insurance premiums of less than one-tenth of one percent. The Dodd proposal would cost five times that amount.

I have met with thousands of cancer patients throughout Florida and the rest of the United States, patients desperately wanting to participate in clinical trials when traditional therapies are no longer beneficial.

Let me conclude my comments here today by relating an experience which puts a human face on why this issue is so important.

As my colleagues may know, I frequently visit the National Institutes of Health to meet with scientific reserchers so I may gain a better understanding of the many advances which are taking place to detect and treat cancer and other diseases.

Over the years, I have been fortunate to get to know Dr. Steven Rosenberg, a world-renowned scientist and oncologist who is an expert in the field of melanoma research and treatment. I first met Dr. Rosenberg after reading his book, ''The Transformed Cell.''

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

Mr. MACK. I ask for 2 additional minutes.

Mr. FRIST. I yield an additional 2 minutes.

Mr. MACK. Last year, I was meeting with Dr. Rosenberg to learn about a clinical trial he is conducting on a state-of-the art melanoma vaccine. During our conversation, Dr. Rosenberg mentioned that one of my constituents was at NCI participating in that clinical trial. I asked if I might meet him. Before we went to his hospital room at NCI, Dr. Rosenberg showed me photographs which had previously been taken. This patient had purple, bulbous melanoma lesions several inches in diameter down the side of his body.

Dr. Rosenberg introduced me to my constituent, and we engaged in casual conversation.

At one point I asked him how he was doing. To show me how he was doing, this brave man took off his hospital gown and showed me that these lesions of huge size on both his arm and his side were totally gone. That is why I think it is so important that we have this amendment included in the legislation, so that other cancer patients will have the same opportunity.

To conclude, what is this amendment really about? Most importantly, it is about giving patients fighting cancer the hope that an experimental therapy being tested in a well-designed clinical trial might save their lives. In addition to providing hope, it paves the way for new therapies that will, one day, not only provide hope, but a cure. It is about allowing cancer patients to make what may be the final major health care decision of their lives—whether to participate in a clinical trial.

Mr. President, I've met with many patients who were participating in clinical trials. To me, these patients are, in many ways, like America's astronauts. Later this month, we will celebrate the 30th anniversary of man's landing on the Moon. Like the astronauts of Apollo, clinical trial participants are pioneers. They are heroes, who are helping to push science and medicine into new frontiers. We must provide hope to these brave Americans.

I urge my colleagues to support this amendment.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, the facts are that the Republican majority have offered a number of feel-good amendments. Everyone should understand that these amendments, even if they pass, will only cover 40-plus million Americans. Our amendment covers over 160 million Americans. Even though the provisions they have stuck in this amendment are weakened compared to the Democratic provisions dealing with external appeals, provider nondiscrimination, points of service, continuity of care, it is just the same as the amendment we offered for 50 minutes. Advocates of that amendment came from the minority side and presented their arguments to the Senate, to each other. The majority was not here. They did not offer a single word in opposition to the amendment that was offered by the minority.

This can best be summed up not by a Senator, not by some paid advertisement on television. I think the best

way to sum this up is by a New York Times statement by Bob Herbert today entitled, ''Money versus Reform.''

Donna Marie McIlwaine was 22 when she died on Feb. 8, 1997. She is buried in the Chili Rural Cemetery in upstate Scottsdale, N.Y.

The managed-care reform legislation that has been the focus of a furious debate in the Senate was essentially an effort to make it easier to save the lives of patients like Ms. McIlwaine.

The Republican Party, flooded with money from the managed-care industry, gives lip service to the idea of protecting patients, but then does the bidding of the companies that are the source of all that cash.

It's a tremendous scandal. No one can seriously argue that lives are not being lost.

Ms. McIlwaine went to the doctor several times in the week before she died, complaining of pains in her chest and shortness of breath. According to her family, she was diagnosed with an upper respiratory infection and ''panic attacks.''

In fact, she was suffering from pneumonia and a blood clot in her left lung. Her mother, Mary Munnings, told me yesterday that her daughter had been screaming from excruciating pain before finally lapsing into unconsciousness and dying at home on a Saturday night.

There was no need for her to die. Ms. Munnings said that when she contacted the office of her daughter's primary-care physician the following Monday, she learned that Ms. McIlwaine had not been sent for the laboratory tests that would have properly diagnosed her condition. She said that when she asked why not, she was told that ''they couldn't justify'' the tests to her health maintenance organization.

So we have Donna Marie McIlwaine dead at age 22.

Most of the country understands that an unconscionable obsession with the bottom line has resulted in widespread abuses in the managed care industry. Simply stated, there is big money to be made by denying care. It is now widely known that there are faceless bureaucrats making critical diagnostic and treatment decisions, that some doctors are being retaliated against for dispensing honest advice, that women have had an especially hard time getting the care they need, and that patients have died because they were unable to gain admittance to emergency rooms.

Mr. President, that is what this debate has been about. I quote further:

The so-called patients' bill of rights, sponsored by Democratic Senators Tom Daschle and Edward Kennedy, was an attempt to curb these and other abuses. The managed-care industry wanted no part of the legislation, which meant the Republicans wanted no part of it. The Democrats had to virtually shut down the Senate before the Republican majority would even agree to bring this matter to the floor for a debate.

The Republican whip, Don Nickles of Oklahoma, could hardly have been clearer about his party's desire to avoid the issue. ''I don't want our members to go through a lot of votes that can be misconstrued for political purposes,'' he said.

The Democrats succeeded in forcing debate on the bill, but they haven't gotten the patient protections they sought. What occurred on the floor of the Senate this week was a G.O.P.-sponsored charade in which one Republican senator after another talked about protecting the health of patients while voting to protect the profits of this industry.

It was a breathtaking exercise in hypocrisy. It was as if George Wallace had spoken earnestly about the need to admit black students to a public school in Alabama while standing in the doorway to block their entrance.

Some face-saving measures were passed by the G.O.P. majority, but the essence of managed-care reform was defeated. In the end, it didn't matter that Mary Munnings had needlessly lost her daughter, or that a parade of managed-care victims had traveled to Washington to detail their horror stories, or that organizations representing doctors, patients and their families had lined up en masse in support of reform.

All that mattered was the obsession with the profits of the insurance companies and the H.M.O.'s.

Eventually substantial improvements will be made in the delivery of effective and affordable health care to Americans. It will take years but it will happen. And then the country will look back and wonder (as we have with Social Security, Medicare and the like) why anyone was ever opposed.

Mr. President, that is what this debate is all about. It is a debate about protecting the insurance industry or protecting American patients. I am sad to report, money is going to win. Money is going to prevail over American patients who need help. It is as simple as that.

It is whether or not a doctor can make a decision for a patient or a bureaucrat is going to make a decision for a patient. It is a question of whether we are going to be driven by profits or patients. Let us hope some day patients will prevail.

I yield 3 minutes to the Senator from Maryland.

Ms. MIKULSKI. I thank the Democratic whip for yielding me this time.

Mr. President, I am troubled about the pending amendment because one of its components my colleagues might not be aware of is that it strips the Democratic provision to provide continuity of care.

This is pretty serious because what continuity of care means. What does continuity of care mean? Under our proposal, continuity of care means just because your company changes HMOs, you should not have to change your doctor, or if your doctor is put out of the network, you shouldn't have to leave your doctor.

I hope we can make sure that we keep continuity of care in. If we lose it, we are going to have our own amendment. Senator Bob KERREY and I are going to offer our own amendment on continuity of care. I will tell you why we feel so strongly about it.

We think the most important thing in getting well is the doctor-patient relationship. You need to have a doctor who knows you, and you need to keep your doctor who has prescribed a course of treatment and who knows you as a person, not as a lab test, not as a chart. We do not believe doctors are interchangeable. We believe you should be able to keep your own doctor. Let me tell you what the Democratic provision does. Under the Democratic proposal, if your company changes HMOs, you get to keep your physician through at least a 90-day transition period.

So if you are a diabetic or if you are engaged in a particular course of treatment, you get to keep your doctor.

Then we have three provisions that make sure you keep your doctor when you are facing significant medical circumstances. What would be a significant medical circumstance? It means, for instance, when you are pregnant. We think that when you are having your baby and you have an OB/GYN and a course of treatment, you should be able to keep that same doctor all the way through your pregnancy and through your postpartum recovery.

Why is that important? Suppose you are a diabetic, or suppose you have kidney problems, or suppose you have a whole variety of other medically indicated symptoms that require very special monitoring; you can't just change your doctor. We certainly don't want to change doctors in late-term pregnancies. We have talked a lot on this floor about late-term pregnancies. Well, let's make sure you get to keep the same doctor during late-term pregnancies.

Let's take another issue. If you are terminally ill, under the Republican school of thought you would lose your physician—if you are terminally ill and your company changes providers. We think if you are dying of cancer, if you are in the last stages of any illness, or if your child is in the last stages of illness, you shouldn't have to change your doctor. We truly believe that when a little boy or girl is dying of leukemia and the family is facing the heartbreak of that, they should at least be able to keep the same doctor through the course of treatment.

The other exception we provide is if you are in an institution or a facility. So if you are in a mental facility and you are getting well, you are working hard to get well, let's keep the doctor while you are keeping up the fight to get well. If you are also recovering from a stroke and you are in a rehab center, we say you should be able to keep your doctor and the same set of providers throughout that course of treatment.

We are being bashed on this floor about how we are for lawyers. Well, I am not for or against lawyers, but I am for doctors. I am really for the doctors and the other appropriate health care providers. I think that if you are pregnant, or terminally ill, or if you are in an institution trying to get better, you ought to be able to keep your doctors, and maybe we would not have to turn to the lawyers.

I yield the floor.

Mr. FRIST addressed the Chair.

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

Mr. FRIST. Mr. President, we are currently debating an amendment that we have introduced on several topics. One is external appeals, strengthening that external appeals process.

No. 2, and one that I have been intimately involved with, is expansion of cancer clinical trials, to make those

trials more available to the American people. We have a very important issue on provider discrimination and continuity of care. Senators COLLINS and ENZI will be responding later to the comments that were just made, which I thought were very positive in terms of what is necessary and what the American people expect in terms of continuity of care.

We want to address the fifth issue at this juncture, and that is the point of service. I yield 5 minutes to the Senator from Alabama.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, I thank the Senator from Tennessee, Dr. BILL FRIST, for his leadership and effort in this bill to craft a responsible and effective piece of legislation that will increase protections substantially for consumers' medical care and do so in a way that enhances the quality of that care. Dr. FRIST is an extraordinary physician. He has given his life to medicine. He was the first person to do a lung transplant in the State of Tennessee—not an inconsiderable event. The thought of that is beyond my comprehension. And he has certainly provided great leadership here.

One of the concerns I have heard a lot about from my doctors and dentists in the State of Alabama is that closed plans prevent patients from having any opportunity to go outside that plan to seek another physician, if that is whom they choose. As a Republican, and as an American, I believe in achieving freedom as much as we possibly can and giving people choices. So we have sought to listen to those physicians and dentists, to try to understand what they are saying and try to provide that kind of option for Americans.

I am glad Dr. FRIST and the leadership on this side have concurred that we can take a major step forward, that we can say that every American in one of these self-insured plans—not regulated by the State—can have the option to choose a plan that allows them to go outside that plan if they want to pay the extra expense to go to a doctor who may charge more. They would pay the difference for that extra privilege. I think that is good policy. It promotes freedom, and in this day of computers and high technology, it is not impossible to maintain the different accounting procedures that may be necessary to handle a different offering in that regard.

So I am excited about this step. We already have a provision in our bill that is similar to this amendment, but it doesn't provide a guarantee it in the way this one would. After talking to physicians, dentists, and small business groups, we have decided to maintain an exemption from this provision for businesses with 50-employee or less. Small businesses may be unduly burdened administratively as it may be more difficult and time-consuming for them to process claims. Furthermore, we have discovered that fewer than 4 percent of people covered under our bill are employed by these small businesses.

So, Mr. President, I am delighted to see this occur. I believe it will have broad-based support. The cost is negligible —almost none—because if the person chooses the point of service option, they would pay the additional cost for it.

I want to mention something and clarify an issue. The National Association of Insurance Commissioners testified on our bill and has written the Senate, a letter in March of this year, in which they state unequivocally that:

> 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, and Congress should focus attention on those consumers who have no protections in self-funded ERISA plans. The States have already adopted statutory and regulatory protections for consumers and fully-insured plans and have tailored these protections to meet their State's consumer health care marketplace. Many States are supplementing their existing protections during the current legislative session [right now], based upon particular circumstances within their States. We do not want States to be preempted by congressional or administrative actions.

What we are primarily concerned with regarding this piece of legislation is Federal ERISA plans, which States cannot regulate. That is why we are here. We are going to leave the other plans to the States who are already regulating them.

I see my time has expired. I will again express my delight that we are able now to say that the individuals who come in will be able to receive point-of-service option.

Mr. KENNEDY. Mr. President, I inquire on my time and will yield the Senator 2 minutes. This change will, of course, only be for the self-funded program, and of course there are no changes in excluding any employer that has less than 50 employees. That hasn't been changed, has it?

Mr. SESSIONS. That is correct. But we know, for example, in Alabama, only 4 percent of the self-insured plans would fall under that group because most of the self-insured plans are for the larger businesses. We have also found that, in Alabama, for example, 75 to 80 percent of the state-regulated plans already offer point-of-service choice now. So it is not as critical as it might appear.

We don't want to see the trend go the other way. It could turn the other way. Physicians are afraid that HMOs will build up walls and block out physicians and choice in the future. So they want this protection. I think it is legitimate, and I think the Senator favors that.

Mr. KENNEDY. If I could continue, I yield myself another minute. Is the Senator saying that of all the self-funded programs, only 4 percent have fewer than 50 employees?

Mr. SESSIONS. Yes. Actually, 4 percent less than 100.

Mr. KENNEDY. Four percent less than a hundred. So, effectively, this won't apply, I imagine, to any of the mom-and-pop small businesses; they won't have those kinds of protections, will they, in Alabama?

Mr. SESSIONS. Only four percent under our bill will not be guaranteed that protection, but many are already providing it. Furthermore, 75 to 80 percent of plans regulated by the state of Alabama plans do offer it.

Mr. KENNEDY. What percentage of Alabama, just for my own information, works in plants with less than 100 employees?

Mr. SESSIONS. Most of those plants don't have self-insured, and they are already subject to State regulations.

Mr. KENNEDY. So they wouldn't be affected by the Republican program in any event.

Mr. SESSIONS. In the State of Alabama, and in most States, I think, the smaller companies use traditional plans that are subject to State regulations, I think our primary focus in this body has been to deal with those plans that are not regulated.

Mr. KENNEDY. I thank the Senator.

Mr. SESSIONS. I thank the Senator.

Mr. KENNEDY. I yield the Senator from New York 3 minutes.

The PRESIDING OFFICER. The Senator from New York.

Mr. SCHUMER. Thank you, Mr. President. I thank the Senator for yielding.

We are coming to the close of this debate. The amendment the Senator from North Carolina and I offered on appeal has been replaced by a much weaker version. We allow an independent review process. We allow that, if your HMO should say to you, you can't have this medicine, you can't have this procedure, you can't see this specialist, you would get an independent review as to whether that was right or wrong.

Under the proposal that was passed by the other side, very simply, that review will not exist except by somebody appointed by the HMO itself—not independent and not real. But, in general, in this debate, and what has happened again is what has happened this week, which is simple, the insurance companies won and American families lost. As a result of what we have done today, the vast majority of American families will not get access to emergency rooms, access to specialists, the right to appeal an unfair decision, the right to sue, and the right to have an OB/GYN physician be their primary care physician.

If we could sum up this debate, it is in two charts. It is in three little numbers. First, under the Democratic plan, 161 million people are affected. Under the Republican plan, 48 million people are affected—161 million or 48 million.

What do the American people want? My guess is they want as many people covered as possible.

As for cost, it is $2 a month more. As the Senator from Massachusetts has said repeatedly, that is not more than the cost of a Big Mac a month. We could cover all of these people, and we

could have emergency room access, we could have access to a specialist, and a right to appeal an unfair decision.

I ask the American people to remember this day as a day when the Senate turned its back on them and their wishes; as a day when the special interests, particularly the insurance companies, prevailed over common sense and wisdom; as a day when this Senate chose to have only 48 million people covered, not 161 million; and a day when this Senate said you can't get emergency room coverage, you can't get access to a specialist, and you can't get the right to appeal an unfair decision by the HMO because it cost $2 more a month per worker.

It is a sad day for the American people. It is a day when this body chooses to follow the whims of the insurance industry rather than the desires of the American people.

Oh, yes. There are some placeboes. In fact, the bill we are passing today is a placebo. But by definition a placebo is only affected when there is nothing wrong with the patient. If you are well and you are never going to get sick, you love the Republican plan. But if you have had to go through the agony and ordeal of having an HMO reject medicines, doctors, and procedures that are desperately needed by you or a loved one, you will rue this day.

I say to my colleagues: Wake up. Our health care system is ill. A placebo won't work. This bill is a placebo. Managed care needs real medicine to become well again, and this placebo will not do the job.

It seems very clear to me that this will not be the last time we take up the Patients' Bill of Rights. The reason this won't be the last time we will take up this bill is because the families of America will find out in the next year that the HMO beast has not been tamed, that the good that HMOs have brought in terms of reducing costs is being outweighed by the bad in terms of cookie-cutter decisions made by accountants and not by doctors.

We will be back. We will argue this issue again and we will prevail because the American people want real medicine—not a placebo prescribed by the insurance industry.

Thank you, Mr. President.

I yield the remainder of my time.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. ASHCROFT. Mr. President, I yield up to 5 minutes to the Senator from Texas.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, I guess, despite the rules of the Senate, we all have our own rules that we apply to ourselves about what we say.

One of the problems is that if one side of the debate insists on getting up and saying things that are verifiably false, we end up with a shouting match going back and forth.

Our bill guarantees access to emergency care. Our bill guarantees that any woman at any point at any time can get access to an OB/GYN physician. Our bill deals with people under the Federal jurisdiction because the States have already done a very good job in dealing with the people under their jurisdiction which they cannot reach without Federal action.

We have talked at great length. Our colleagues keep saying this bill cost $2 a month. The problem is that the Congressional Budget Office, the nonpartisan budgeting arm of the Congress, says this bill will cost $72.5 billion, this bill will take insurance away from 1.9 million Americans, and this bill will end up driving up costs for Americans who are able to keep their insurance.

Obviously, anyone who follows the debate around here realizes that Democrats aren't very much worried about cost. But why are we so worried?

No. 1, we are worried about 1.9 million people losing their insurance. We believe we can fix what is wrong with HMOs, and do it without driving up medical costs so much that people lose their health insurance.

But I would like to make two final points which I think are critical to this entire debate. If you came from outer space this morning and you listened to our Democratic colleagues, you would think they are opponents of HMOs. But let me read for you from congressional debate on February 10, 1978. I quote:

> I authored the first program of support for HMOs ever passed in the Senate. The Carter administration has made the promulgation of HMOs one of its major goals. Clearly HMOs have done their job in proving themselves a highly desirable mechanism for medical care delivery.

That is Senator TED KENNEDY. That is not PHIL GRAMM.

Our Democrat colleagues are the fathers and the mothers of HMOs. Yet today they have decided to vilify an institution they created. Rather than fixing the problems that exist, they have decided, for political reasons, it would be basically a good idea to destroy HMOs.

Why are we concerned about destroying the private health care system? Why are we so concerned about cost? The reason we are so concerned about cost, the last time we had double-digit health care inflation, the Democrats and President Clinton sent a health care bill to Congress, the Clinton health care bill, that would have had the Government take over and run the health care system, a bill that would have required every American to buy their health care through a Federal health care collective.

Today, our Democrat colleagues are very concerned about ''medical necessity.'' We have heard them talk about it all day long. When we open the Clinton health care bill, which they supported, on page 86, it mentioned ''medical necessity'' under exclusions. Let me read their solution to the problem of medical necessity when they wanted the Government to take over and run the health care system.

Their bill says, on page 86, line 10, under ''Exclusions'':

> Medical necessity. The comprehensive benefit package does not include any item or service that the National Health Board may determine is not medically necessary.

Today, our dear Democrat colleagues are all concerned about ''medical necessity,'' but when they wanted the Government to take over and run the health care system they defined medical necessity as whatever the National Health Board determined it to be, and the National Health Board was the Federal Government.

Today, our colleagues have gone on and on about medical access and point of service. When the inflation rate on health care was above double digit and they proposed having the Government take over the health care system, do you know what their point of service option was? If you didn't join the Government plan, you got fined $5,000. The choice they provided in their point-of-service option is if the doctor who had to work for the Federal Government provided care he felt you needed but their Government health board felt you didn't need, he got fined $50,000 for doing that. If he provided a service they didn't allow and you paid privately for it, the physician could go to prison for 15 years.

Now, the same people who proposed all these things and came within a heartbeat of forcing Americans into this totalitarian system because they wanted to deal with inflation and access, today they are proposing legislation that would drive the inflation rate up by 6.1 percent and would, by Congressional Budget Office numbers, force 1.9 million people to lose their health insurance.

Why are we so concerned about starting runaway medical inflation again? Part of it is because we care about the people who lose insurance. Part of it is because we care about the $72.5 billion in costs for people who get to keep their insurance. But a lot of it is because we remember what Bill Clinton and the Democrats wanted to do the last time we had runaway medical inflation.

I am sorry, but I have a very hard time listening to my Democrat colleagues talk about medical necessity when only a few years ago they proposed to let Government define what medical necessity was, and if their board didn't say it was necessary, you didn't get it. I have a very hard time listening to them talk about a point-of-service option when virtually every one of them supported and cosponsored a bill that would have put a physician in prison for 15 years for providing a service that their Government board said was not needed.

In listening to our colleagues, it's easy to forget their support of legislation for the last 25 years that created HMOs. One forgets they love HMOs so much that they tried in 1994 to force every American into an HMO run by the Government. And one forgets that

they were so concerned about patients rights they let the National Health Board determine what was medically necessary with no review whatever, and they put a doctor in prison for 15 years if he didn't comply with their rules.

There is a certain disconnect between what they are saying today and what they have proposed in the past.

I yield the floor.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. ASHCROFT. I yield myself 8 minutes, and I ask to be notified at the conclusion of 8 minutes, and at the conclusion of my time, I yield 6 minutes to the Senator from Maine.

Mr. REID. Mr. President, I respectfully suggest we have been going back and forth and we have had Members waiting for well over an hour. It is not appropriate to yield to successive people. It should be our time.

Mr. ASHCROFT. How much time does the Senator desire?

Mr. REID. I yield 3 minutes to the Senator from Oregon, who has been here for about 3 hours.

Mr. ASHCROFT. I am very sorry. I didn't intend to deprive him of that opportunity. When I came in, I failed to observe him in the Chamber. I am happy to have him go ahead.

Mr. REID. I know the Senator from Oregon has been here a long time, but the Senator from Connecticut left a hearing and came to speak on the clinical trials.

Would the Senator allow the Senator from Connecticut to speak next?

Mr. WYDEN. Yes.

Mr. REID. The Senator is yielded for 5 minutes.

Mr. DODD. I appreciate the courtesy of the Senator from Oregon. I apologize for not being here during the presentation of the amendment dealing with clinical trials by my friend and colleague from Florida, Senator MACK. He made numerous references to the amendment I offered yesterday, and I want to address those concerns.

While I have deep appreciation for the motivations behind the amendment offered by our colleague from Tennessee, Senator FRIST—and I will speak specifically on the issue of the clinical trials—the amendment offered by Senator MACK, if you look at it in the totality, says no to 9 out of 10 people in this country. How does that work, 9 out of 10?

The clinical trials are limited to cancer therapies only; only for cancer. We all agree we ought to have clinical trials for cancer. No one disagrees with that. In a way, it is very cruel to say we can have experimental testing for cancer patients, but we cannot for people with AIDS, Parkinson's disease, diabetes, and heart and lung disease. A long list of patients are excluded.

Today, if you are watching this debate and you have cancer and this amendment is adopted, you are OK, but God help you if you fall outside the cancer area and you need the clinical trials, or you want to get involved in that because it could save your life, save your wife's life, or your child's life. You would like to get in the clinical trials. If you adopt this amendment, you cannot.

The argument is, we need to study the issue more. If we need to study clinical trials, why make an exception for cancer? If we don't need to study the clinical trials for cancer, it seems to me we don't need to study them when it comes to other life-threatening, devastating diseases where the only option can be the clinical trial.

As I said to my colleagues yesterday, this is the only option we offer in our amendment. It has to be clinical trials approved by NIH or the Department of Defense or by the Veterans Administration. There must be no other alternative available, and it only picks up routine costs. The cost of drugs and medical devices is not included.

I don't understand how we say to someone with mental illness, osteoporosis, cystic fibrosis, multiple sclerosis, stroke, blindness, arthritis, Lou Gehrig's disease, and more areas where clinical trials can make a difference for people. By adopting this amendment, we are excluding the option of people to utilize what may be the only avenue available to them to save their lives or the lives of their family.

Obviously, we acquire necessary information that allows a product or a device to become available to the public at large, saving future generations.

So I urge my colleagues, with all due respect, while it is hard to argue with this limited amendment, we will have a broader amendment that covers all of these areas which are so critically important to people.

Mr. KENNEDY. Will the Senator yield?

Mr. DODD. I will be happy to yield.

Mr. KENNEDY. The Senator pointed out for those who might be watching that if they had cancer, this amendment, if agreed to, would at least assure them of coverage. Of course, two-thirds of those individuals will not be in the plans that would be covered by this proposal. So two-thirds of those who have cancer, on the face of it, would not be protected. Contrast this with the amendment the Senator from Connecticut offered, which would have applied to all private health plans and would have included all diseases.

The PRESIDING OFFICER (Mr. FITZGERALD). The time of the Senator has expired.

Mr. KENNEDY. I yield 1 additional minute.

Mr. DODD. I deeply appreciate the Senator from Massachusetts raising that point. He is absolutely correct. It does cover the cancer patient, provided you are part of that small minority that gets coverage. But if you are part of the 113 million and have cancer, you are out. It is an important point to make. If you are part of the 48 million, you are out there completely. You are just gone. I think this is a tragedy.

Every single cancer group in this country does not support this amendment. No cancer group at all endorses this amendment because they understand it is a great deprivation and liability to their efforts. They understand how important it is to cover these other illnesses as well. These groups, by the way, also have supported unanimously the amendment we offered, which would have covered clinical trials for all patients.

The PRESIDING OFFICER. The additional minute of the Senator has expired.

Mr. DODD. I ask unanimous consent for half a minute.

Mr. KENNEDY. Yes.

Mr. DODD. On this issue, on the clinical trials, to deny people across the board the ability to access clinical trials is one of the great shortcomings of the Republican proposal here. This will do a lot of damage to an awful lot of people, unnecessarily. The application of clinical trials is the only course available to people to save their lives and to save future lives. By excluding AIDS and the other diseases I have mentioned from the clinical trial approach, not to mention 113 million people who are excluded, we do a great disservice, at the end of this century, to people who expect more of this body.

I urge the rejection of this amendment.

Several Senators addressed the Chair.

Mr. REID. I yield 3 minutes to the Senator from Oregon.

Mr. WYDEN. Mr. President, well over 2 hours ago I offered the first-degree amendment that deals with an issue that ought to be totally nonpartisan, and that is protecting the relationship between health care professionals and their patients. The distinguished Senator from Texas is on the floor. I think he illustrated what the debate has now become. He wanted to talk about the Clinton health care plan of 1994. What my colleagues and I are here to talk about is giving patients and their families a voice in 1999.

In over 2 hours of discussion on the floor of the Senate, there has not been one argument—not one argument—advanced against our provision involving gag clauses; not one argument advanced against our provision protecting the providers from retaliation; not one argument advanced as it relates to this matter of making sure there are not financial incentives to keep the patients in the dark.

In 2 hours on the floor of the Senate, not one single argument was made against those positions. I think it is because the Senate understands that the free flow of information between patients and health care providers is at the heart of what we want for our health care system. It is also what this country is all about. It is what the first amendment is all about.

I know this has been a very hard debate to follow. We have had discussions about HCFA. We have had discussions

about the Clinton health care plan of 1994. We have heard discussions about costs, about making sure that patients get all the information from their health care providers, and that providers are free from retaliation when they do give out that information, that is not going to cost a good health care plan a penny. Maybe if you are offering poor quality care it may end up costing you a little bit of money but giving people information, protecting their first amendment rights, is not going to cost a penny.

I am very hopeful our colleagues, when we get back to it, will support the first-degree amendment that was before the Senate a little over 2 hours ago, and recognize that, in the space of that time, not one single argument—not one—has been advanced against the idea that there ought to be a free flow of information. We ought to protect the relationship between health professionals and their patients.

I yield the floor.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. ASHCROFT. Mr. President, I yield myself 6 minutes. I ask to be informed at the conclusion of the 6 minutes.

By agreement, I believe Senator COLLINS was to have 6 minutes at the conclusion of my remarks.

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

Mr. ASHCROFT. Mr. President, I thank the Republican Members for their effort on assembling a very good plan. It is a plan designed to protect the interests of individuals who receive their health care through HMOs. It is designed so that, if the HMO denies a particular kind of treatment as not being necessary, there is an appeals process, and the appeals process is first to the HMO, asking them to correct a faulty decision. But if the HMO does not respond constructively, there is an appeal to an independent appellate authority, an independent appeals officer.

I wanted to make sure the Republican bill's effort to have this appeals process, which gives people the chance to make sure they are treated fairly, has the right enforcement to it. The right enforcement, in my judgment, is to send people to treatment, not to send people to trial. It would be possible to have a big legal arrangement where the person does not get treatment, they die, and the relatives then go to court. Instead of getting treatment, you get a trial and you may get a lot of money, but you have a dead relative. I think it is important to understand this is a health care effort we are waging.

So I wanted to do some things to strengthen the enforcement provisions in the Republican proposal which relate to the external review. That is the final appeal to a person outside the HMO, a qualified individual. This is what I think we must do.

First of all, we must make sure that the HMO acts promptly. While the Republican bill provides there should be certain designations within 5 days, there is a place where the HMO has to provide the reviewer, or the appeal authority, with the documents of the case. We put in a time limit on that. We put in a stiff penalty for failure to meet that time limit. It simply is saying we will not allow an HMO to drag its feet in order to avoid the review by an independent authority. So I wanted to make sure we had that.

Second, I want to make sure the person whose case is being reviewed has the right to present evidence to the appeal authority. I think this is implicit in the Republican bill, but I want it to be explicitly stated that when a person files a review petition, they have the right to say this is the reason you should set aside your judgment; this is the reason you should make a determination that the treatment is appropriate in my case—not only the person but the doctor who made the original decision. And that is important as well, making sure they are involved.

Then I want to make sure the person conducting the review of a physician's work would be a qualified physician or would be a person who was qualified to be the same kind of specialist the treating physician was so we would not have some bureaucrat or some individual who was interested in or more well trained, perhaps, in business making judgments about things that were medical. That is provided for in this particular matter. So it makes it clear we want to have the physician doing the kind of assessment in the appellate process.

However, I wanted also to make sure we had HMOs willing to carry through on the decision of the appeals process. I thought to myself, what if the patient lost the appeal in the HMO, made the appeal to the external authority—and this can be done very rapidly because the timeframes are tight in this instance, and should be, and we always include even expedited timeframes for medical exigencies— what if the appeal goes to the external appeal authority and then the HMO refuses to provide the treatment in spite of the determination by the external authority?

One option in that situation, I suppose, would be to say you go to court. But if you are sick and you call an ambulance, you expect the ambulance driver to take you to the hospital, not to the courtroom. What we need for people is not to be provided with a trial; we need people to be provided with treatment.

What we have done in this amendment is simply this: If you had this opportunity for an expeditious appeal that has gone through the HMO and the external authority, the external appeal officer is to write in any appellate decision a date by which treatment is to be commenced. If treatment is not commenced as of that date, the system converts to a fee-for-service system so the patient has the right to get whatever service is needed at the expense of the provider which failed to provide it in accordance with the directive of the appellate officer.

Furthermore, it provides a penalty, an immediate $10,000 payment to the patient—not to the Government, not to the Department of Labor, not to an administrating bureaucracy—to the patient for having been dislocated and for having arranged for other things.

The business of the HMO is to arrange for medical services, and this is a plan which simply says we are going to deliver to people medical services. We are not going to deliver them somewhere else. We do not want you to end up with a good lawsuit; we want you to end up with good health care. And if the HMO does not provide the health care in accordance with the appeal, then it is time we turn loose the patient who paid the premium, and that patient has the right to access the care of his or her choice to get it done, and the responsibility of payment for that falls upon the noncomplying health care provider in the HMO. That makes sense. Instead of getting a good lawsuit because you did not get health treatment and you got sick, you get good treatment. It seems to me that should be the objective to have. That is basically what we have done.

We have made sure there are time lines.

The PRESIDING OFFICER. The Senator has used his 6 minutes.

Mr. ASHCROFT. Mr. President, that is kind of you, and I yield myself an extra 30 seconds. We made sure there are enforceable time lines. We have made sure physicians will be the appeals officers on the work of physicians. We have made sure the responsibility to deliver the process to the appellate appeals officers, both internal and external, is expedited. And we have made sure, in the event of noncompliance, the patient gets treatment. We convert the system to fee for service, and you can access treatment on your own.

It is with that in mind that I am pleased to conclude my remarks and yield to the Senator from Florida 5 minutes for his remarks.

Mr. MACK. Mr. President, I am not sure I need 5 minutes. I could not help but listen very closely to my colleagues on the other side of the aisle with respect to the issue of clinical trials and the idea of targeting clinical trials to cancer.

One could draw the conclusion from what they had to say either they never heard of the idea of targeting clinical trials to cancer or there was some confusion. I remind my colleagues on the other side of the aisle who have supported a clinical trial expansion of the Medicare program that is limited to only cancer —let me say that again. The clinical trial legislation that Senator ROCKEFELLER and I introduced earlier this year is limited to cancer only; just as this amendment is limited to cancer: Senator FEINSTEIN, Senator SARBANES, Senator JOHNSON, Senator

BINGAMAN, Senator KERRY, Senator LEAHY, Senator KERREY, Senator SCHUMER, Senator AKAKA, Senator MURRAY, Senator BREAUX, Senator MIKULSKI, Senator CONRAD, Senator WELLSTONE, Senator MOYNIHAN, Senator INOUYE, Senator GRAHAM, Senator HARKIN, Senator KENNEDY, Senator BOXER, Senator DURBIN, Senator ROBB, Senator BIDEN, Senator DODD, and Senator HOLLINGS.

I submit that one of the reasons we have this not only in this amendment but also in the Medicare approach is because there is truly a concern about what the true cost of clinical trials is. As I said in my earlier comment, Senator ROCKEFELLER and I happen to believe the cost is quite small. In fact, there are arguments out there that Medicare is already picking up the cost of those clinical trials. We have limited it to cancer because we, in fact, believe we can develop information that will allow us to expand it.

Mr. DODD. Will my colleague yield?

Mr. MACK. If the Senator would wait. What I have found, as I have listened to this debate now for 4 days, is the term ''compartmentalization'' comes back into my mind: The ability on the other side of the aisle to think of one procedure, one amendment, one concept at a time, as if it has no influence or no effect on the cost of health care and what it might do to those individuals who could lose their health care coverage because of increased costs. It is very reasonable to ask the question: What does it cost; how do you define certain aspects of the clinical trial that is going to take place?

I will be glad to yield.

Mr. DODD. I thank my colleague for yielding. I suppose the best evidence I can offer is, in fact, a significant number of HMOs today are offering full clinical trials. What we are talking about are the few who are not. My amendment is not designed to deal with every HMO. Most of them today provide clinical trials on a wide array of issues. We are, by our amendment, saying: Shouldn't those few HMOs that are not doing this do what the others are doing?

Sloan-Kettering and M.D. Anderson cancer research centers did independent studies on costs. I think they are world-class institutions. Their conclusion was the clinical trial was less, lower cost——

The PRESIDING OFFICER. The 5 minutes allotted to the Senator from Florida has expired.

Mr. DODD. I ask the Senator have an additional 1 minute.

Mr. MACK. Can I inquire who is going to use that minute?

Mr. DODD. Two minutes.

Mr. KENNEDY. I yield 2 minutes, Mr. President.

Mr. DODD. I thank my colleague. Mr. President, let me know when I have a minute and give the Senator from Florida a minute to respond to what I am saying.

The CBO estimates 12 cents per patient per month. That is their estimate. Sloan-Kettering and M.D. Anderson say it is lower than standard cost, less than the cost that would be otherwise. We limit, by the way, how the clinical trials are approached so that you have to have no other available option. It has to be life-threatening. It is only NIH, Department of Defense, and Veterans Affairs.

We have narrowed it and also said, as important as cancer is—and I am a cosponsor of the bill of the Senator from Florida, but I hope my cosponsoring of clinical trials for cancer is not interpreted to mean that I do not think there ought to be clinical trials for diabetes or AIDS or mental illness or heart and lung disease or multiple sclerosis osteoporosis—all these other areas in which it can make a difference. I applaud my colleague for his bill. That was to deal with cancer, but we do not exclude these other options which most are doing today. Most are, but this is for the few that do not.

Mr. FRIST. Mr. President, I yield myself 4 minutes. I know we have a number of other speakers on the floor. After our discussion two nights ago, I looked at the two studies the Senator from Connecticut used. This is one of the problems. There is not good data on what are routine costs. I went through this the other night. I cannot be any clearer.

I have personally read the studies, as many as I could find. The two presentations you made in the data on how much money it saves is not peer review. It has not been published, to the best of my knowledge. Both are presentations made on May 7, 1999, at the National Coalition for Cancer Research. The data probably is good, but I cannot go back and see what the methodology is. Let me say that is the problem, that there are only three prospective, randomized clinical trials I could find and we were able to find in the committee. There may be more trials out there. But three clinical trials, not the ones you are talking about, that, again, show the cost, with some variation, might be zero—I am not sure what the lowest is—but up to 10 percent.

Mr. DODD. Both Sloan-Kettering and M.D. Anderson, did they say it is lower cost? Am I accurate?

Mr. FRIST. You are exactly right. I do not question the data. But it is unpublished data with no explanation given for methodology on either one. The cost of clinical research in the M.D. Anderson study or the Sloan-Kettering study—no details were given about methodology. So, yes, you say it is cheaper, but I have no idea how they determined that, whether they are accurate or not.

To the best of my knowledge, that has not been peer-reviewed. All that does not matter very much, except when you go back to an earlier question of why we focus on just cancer. I was not on the floor, but I had heard the argument, why not other diseases, such as Alzheimer's and cardiovascular disease, and others? I think that is legitimate.

Let me tell you my rationale for starting with something that is focused. The NIH has about 6,000—maybe it is 5,000; maybe 7,000—clinical trials out there, about 6,000 and 2,000—1 out of 3—are in cancer. The others are scattered among different disease processes.

So we said, since we do not know what the routine costs are —the other day I talked about the difficulty of defining ''incremental costs,'' using the example of medical devices. There are no studies—prospective, randomized clinical trials—to know what the incremental costs are for devices.

So what we are arguing is, instead of opening that door broadly, to start with a foundation of information about which we know. The clinical studies on routine costs all apply to cancer, which happens to be about one out of three trials that are out there today.

That is the base we are going to start with as we get into this subsidy—a good subsidy—that is in our private health care system which is passed on by increased premiums, or some way you are taxing people out in the private sector who are listening to this right now. We are going to tax you to pay for these trials.

We simply say, let's do it in a systematic way, starting with the body of knowledge we know about, which happens to be in cancer, and then letting it expand, potentially, over time based on our findings.

One last thing, in our amendment, as was pointed out, we also have a study, a very important study, that will expand so we will not have three studies. You will not be presenting data that has not been published yet, which I think is part of our amendment.

I will yield to the Senator from Florida, and then we will come back.

Mr. DODD. Just to make a couple quick points.

Mr. FRIST. I yield 1 minute to the Senator from Florida.

Mr. MACK. I believe the Senator from Florida has been graciously given 1 minute by Senator KENNEDY.

Mr. DODD. If my colleague will yield at this time?

Mr. FRIST. I yield and reserve my time.

Mr. KENNEDY. Mr. President, I think the Senator from Florida has 1 minute. Then I would be glad to yield another minute and a half to the Senator from Connecticut.

The PRESIDING OFFICER. The Senator from Florida.

Mr. MACK. First of all, the impression created that HMOs or most HMOs cover all clinical trials is inaccurate.

There is a second component to this thing. ERISA plans versus the plans that we have control over may be confusing the issue as well.

In addition, though, I think it is important to focus. Again, this discussion has come down to a discussion about cost. I happen to agree with the Senator from Connecticut about the data that we have from those two health organizations. But I think he knows as

well that there are those out there who make claims that the cost of the clinical trials would be substantially higher than that—from OMB, CBO, the administration.

So the point is that there is a legitimate debate about the cost of clinical trials. I am saying I think, before we go to the full extent of comprehensive coverage, we ought to fully understand what we are getting ourselves involved in.

With that, I yield the floor.

Mr. DODD addressed the Chair.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Let me just say, the Congressional Budget Office estimates that 90 percent of HMOs provide broad-based clinical trials. They did the study on the 12-cent per month cost; and 90 percent do. Our amendment deals with a handful who are not.

Ironically, the adoption of this amendment may encourage some of these HMOs that are today providing clinical trials across the board to reduce actually the number they provide. That is No. 1.

No. 2, I say to my friend and colleague from Tennessee, these HMOs, the 90 percent that are providing broad-based clinical trials, have obviously done an economic study or they would not do it. They are not mandated under current law to do it. So the vast majority providing clinical trials beyond just cancer have, obviously, made the financial calculation that this is something they can afford to do. So in addition to Sloan-Kettering, M.D. Anderson, and the Congressional Budget Office—the costs are relatively low. They are providing the benefit.

What we were saying in the amendment that was defeated yesterday is you ought to be for those 10 percent or 12 percent that are not providing the clinical trials in these other areas. You ought to do so. That is the distinction, and there is ample data.

The PRESIDING OFFICER. The time has expired.

Mr. FRIST. I ask Senator KENNEDY, does he have somebody from his side?

Mr. REID. Mr. President, I yield Senators HARKIN and BINGAMAN 1 minute each.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, earlier today Senator BINGAMAN and I offered an amendment to provide nondiscrimination, so the plans could not discriminate against providers on the basis of their license or certification.

Now I see the Republicans have offered that amendment. I read through it. It is almost word for word the same as ours. Gee, here is an amendment I could vote for on the Republican side, until I read the fine print. What is the fine print? The fine print is this: Senator BINGAMAN, in our amendment, covers 161 million people; the Republicans' amendment covers only 48 million people.

It is sort of like this. A doctor prescribes an antibiotic for you to take every day for 7 days. The Republicans come in and say you can only take it for 2 days. It is probably better than nothing, but it is not going to cure the illness.

The Republican amendment on provider nondiscrimination is not going to cure the discrimination against chiropractors, against optometrists, against nurses and nurse practitioners, and physicians assistants. That is why I cannot support it.

The PRESIDING OFFICER. The 1 minute has expired.

The Senator from New Mexico has 1 minute.

Mr. BINGAMAN. Mr. President, I thank the manager of the bill.

Let me add one other thing. We need to ask, who are the 48 million people who are covered under the Republican plan and under this amendment they have offered on nondiscrimination against providers? They are people who work for large employers primarily who are self-insured. The employers have their own insurance programs.

Unfortunately, in my State, there are very few of those large employers. You have to have over 100 employees, essentially, before it makes any sense to be self-insured.

In New Mexico, people work for small employers, by and large. Even those who work for larger employers generally are not working for self-insured employers. Essentially, the folks I am representing in the Senate are not going to be covered by the amendment as it is offered. I think this is a serious defect.

There is one other thing I want to say in relation to Senator DODD's point. The American Cancer Society does not support an amendment or provision that does not apply to all insured individuals, that requires a commission to determine routine patient costs, and delays access to clinical trials until the year 2001. The American Cancer Society maintains that all patients with a serious and life-threatening illness should have assured access and reimbursement for clinical trials.

Mr. President, I yield the floor.

Mr. JEFFORDS addressed the Chair.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. I yield the Senator from Maine 5 minutes.

Ms. COLLINS. Thank you, Mr. President.

This amendment includes two provisions that are intended to strengthen the Patients' Bill of Rights that was reported by the Senate HELP Committee. We do not have much time, but I would like to take a moment to describe two of the provisions that are of particular concern and interest to me.

First, our amendment includes provider nondiscrimination language. During the HELP Committee markup, as the Senator from New Mexico will recall, I pledged I would attempt to come up with language on the floor because we shared many of the same concerns, reflecting, I think, the populations of our State. So we have done just that.

The exclusion of a class of providers solely on the basis of their license or certification unfairly restricts patients' access to qualified professionals who are licensed and certified by the various 50 States. This is a very important issue in rural areas because there may not be a sufficient supply of physicians to provide the care that the health plan has promised. In these areas, if, for example, a plan discriminates against optometrists, the result may be that patients have to travel long distances in order to get eye care or, conversely, they have to pay out of their own pockets for services that are supposed to be covered benefits.

Maine, for example, has optometrists in virtually every community in the State, but we have very few ophthalmologists, and they are located primarily in southern Maine, primarily in our larger cities.

In 1982, 17 years ago, to respond to this problem, Maine specifically passed legislation requiring State-regulated health plans to have nondiscrimination language with regard to optometrists. The Republican amendment tracks similar protections that are provided for Medicare and Medicaid beneficiaries in the Balanced Budget Act of 1997.

Our amendment would prohibit federally regulated group health plans from arbitrarily excluding providers, based solely on their licensure or certification, from providing services for benefits that are covered by the plan.

Let me be clear about what this amendment does not do. It does not require the plans to cover new services just because the State may license a health care professional in that area. For example, there are some States which license aromatherapists. Just because aromatherapists may be licensed by a State doesn't mean the health plan has to cover those kinds of services. Moreover, nothing in our amendment would require the health plan to reimburse physicians and nonphysicians at the same rate.

The amendment also makes clear—and this is really critical—that this provision is a nondiscrimination provision. But it is not a willing provider requirement. It does not require health plans to take all comers. It simply says that a managed care plan cannot exclude a health care professional's entry into that plan solely on the basis of licensure or certification. Senator GRASSLEY, Senator HATCH, Senator JEFFORDS, and Senator ENZI have all worked with me on drafting this provision.

The second provision, which is of particular concern to me, improves upon the continuity of care provisions in the HELP Committee bill. Our amendment would affect the legislation in two different ways.

First, it recognizes that it would be unconscionable to require a patient

who is terminally ill to change health care providers in the final months of life just because the health plan either stopped contracting with that particular provider or the employer providing the health plan switched plans, thus causing a change in the providers under contract. Our proposal would extend the transition period for patients who are terminally ill from 90 days until the end of life. This proposal is one that I know is of concern to Senator MIKULSKI, and it is something on which I completely agree with her.

Second, it would require a comprehensive study—I don't believe this is part of the Democratic proposal—into the appropriate thresholds, costs, and quality implications of moving away from the current narrow definition in Medicare of who is considered terminally ill and toward a definition that better identifies those with serious and complex illnesses. This study was suggested by the group, Americans for Better Care of the Dying. Senator JAY ROCKEFELLER and I have worked with this group in proposing our end-of-life care legislation.

The PRESIDING OFFICER. The Senator's 5 minutes have expired.

Ms. COLLINS. I ask unanimous consent for 1 additional minute from the underlying bill.

The PRESIDING OFFICER. Who yields time?

Mr. JEFFORDS. I yield 1 additional minute from the bill.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. This study, as I said, was suggested by the group, Americans for Better Care of the Dying. It is intended to help us shift the paradigm in this country of how we view serious illness. Medicare currently defines terminally ill people as those having no more than 6 months to live. It is often very difficult to predict with any certainty how long exactly a seriously ill person is likely to live. This study will help us to provide better care for that broader category of patients who are terminally ill and have the need for more coordinated care but who may well live longer than a 6-month period.

I thank Senator ENZI and Senator GRASSLEY for their work and joining with me in improving the continuity of care provisions of the bill.

I yield the floor and reserve the remainder of our time.

Mr. ABRAHAM. Mr. President, I rise to address provisions included in this amendment on behalf of Senators ASHCROFT, KYL, and myself. These provisions concern external review of denial of coverage. In my view, they will improve the underlying Republican proposal in several important respects.

Mr. President, I believe the Republican proposal takes the steps necessary to ensure that every American has access to high quality medical care. In my view, the overriding goal of this legislation is to empower patients and their physicians. By putting medical considerations first, we will protect patients against arbitrary actions by health care bureaucrats. Republicans have put in place an external review procedure which will guarantee a patient's right to appeal adverse decisions by providers and to receive the care he or she deserves.

The purpose of an external review is to ensure that an unbiased, medical opinion can be offered when coverage has been denied on the basis of medical necessity and appropriateness or because a treatment is considered experimental. The changes contained in this amendment will guarantee an unbiased, timely and appropriate decision and I believe they will help ensure that the external review process works effectively. In particular, I would like to focus on three changes which resolve issues that were brought to my attention by the Michigan State Medical Society:

First, we clarify that appeals which are considered emergencies be made with the expediency necessary for the emergency, but in no case should the emergency decision take longer than 72 hours.

This clarifying language ensures that decisions are made in an expedient fashion, especially in case of emergencies.

Second, the amendment language clarifies that the independent, external reviewer shall be a physician in the same specialty area dictated by the case in question. This only makes sense, Mr. President, and I appreciate the sponsors willingness to clarify the language in this regard.

Third, in the Patients' Bill of Rights Plus, the independent external reviewer must take into consideration several factors in making his or her final decision. Some of those factors include: Any evidence-based decision making or clinical practice guidelines used by the group health plan or health insurance issuer; timely evidence or information submitted by the plan, issuer, patient or patient's physician; the patient's medical record; and expert consensus and medical literature.

This amendment clarifies that expert consensus includes both generally accepted medical practice and recognized best practice.

Senators KYL and ASHCROFT have also included other provisions to tighten the external appeal process which I support. I note my full support for these provisions and ask my colleagues to support them as well.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, the majority has about 2 minutes remaining on the amendment. The minority has about 15 minutes—about 12 minutes, I am sorry. So with the permission of the manager of the bill, I yield 3 minutes——

The PRESIDING OFFICER. The Senator has 15 minutes.

Mr. REID. I yield 3 minutes to the Senator from Minnesota, Mr. WELLSTONE; 3 minutes to the Senator from Nebraska, Mr. BOB KERREY; and 3 minutes to the Senator from North Carolina, Mr. EDWARDS.

Mr. KERREY. Would the Senator mind if the Senator from Nebraska went first?

Mr. REID. If the Senator will withhold.

Mr. JEFFORDS. Does the Senator intend to go one after the other?

Mr. REID. Yes, since the majority has 2 minutes remaining.

Mr. JEFFORDS. I want to accommodate the Senator from Wyoming—we only have a couple of minutes left—if he could speak now.

Go ahead.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. KERREY. Mr. President, I see the Senator from Maine heading for the door. With great respect for her, I want her to hear this observation. She talked about continuity of care and said that she and Senator GRASSLEY and Senator ENZI had worked on language in this amendment that provided continuity of care for people with terminal illness. I call her attention to pages 49 and 50 of this bill. It does not do that. It says specifically, under terminal illness, it is subject to paragraph 1, which says the general rule is just for up to 90 days. The only exception under continuity of care with this bill is for pregnancy, which was in the original bill.

Ms. COLLINS. Will the Senator yield for a clarification on that?

Mr. KERREY. I only have 3 minutes. I am sorry.

I call the Senator's attention to continuity of care. Look at the language of the bill because on page 49 it describes this transitional period.

This is something that is very important to me. I received health care in 1969 after I was injured in Vietnam. I have a very passionate concern for people now who are in managed care.

I must say, the problem we are experiencing with managed care is not self-funded ERISA plans. That is what the Republican proposal is going to do. It is going to solve almost a nonexistent problem that may, in fact, as a consequence of setting the bar low, encourage people who are in HMOs and who are in the marketplace providing those plans to say: I see the bar is low; we are going down to that lower standard. That is a major concern I have with this proposal. It does not cover the plans that are the biggest problem.

I call your attention to pages 49 and 50. Under the continuity of care provisions, the only continuity of care that would be provided would be women who are pregnant. They could go beyond 90 days under this provision, but those who were terminal would not. Terminal illness is subject to paragraph 1, according to the language of the bill itself, which does not provide for an extension.

Our proposal would go beyond those three general categories, not just terminal illness, not just institutionalized

people, not just women who are pregnant—all three reasonable—and certainly not just self-funded ERISA plans, which are hardly receiving any complaints at all.

That is the odd thing about this debate. We are going to take care of a problem that doesn't exist under the guise of—I have heard people come down saying: We are going to address a problem with HMOs. Well, you would address the problem of HMOs if you changed your bill.

This bill doesn't take care of HMOs. It takes care of self-funded ERISA plans. Go to your mailbox and see if you have any complaints about self-funded ERISA plans. You won't find any complaints about that. The complaints are about HMOs.

We have watched the market move more and more into business decisions when it comes to health care. And I am for the market. I like what the market can do. When we regulate the market, we say——

The PRESIDING OFFICER. The Senator's 3 minutes have expired.

Mr. KERREY. I will come back to this later, Mr. President. This bill does not provide continuity of care except for pregnancy. Those with other health problems would not be covered under this proposal.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. WELLSTONE. Mr. President, I came to the floor earlier today and said I have a proposition for my colleagues. It is this: Let's give people freedom of choice. If people have paid extra premiums and their employer should shift insurance company plan or managed care plan, and they want to be able to take their children to the same family doctor they have been going to for 10 years, they ought to be able to do so.

I waited for the response.

Now I notice my colleagues on the other side of the aisle come out here with an amendment and they say this deals with the problem. First of all, they give freedom of choice to 48 million Americans, one-third of those who would be eligible. Only 48 million people in self-insured plans are covered. Another 115 million people aren't covered.

Two-thirds of the families in our country that need some protection and need freedom of choice aren't covered. Then I look at this bill and I notice that even among the 48 million people, if you were in a plan where you are working for an employer with fewer than 50 employees, you would not be covered. Subtract that number of Americans. Now we are well below 48 million people, well below one-third of the citizens in this country.

Finally—and I don't even know what this means, but we need to look at the fine print—they have an exception in terms of points of service or freedom of choice:

> It shall not apply with respect to a group health plan other than a fully insured group health plan if care relating to point of service coverage would not be available and accessible to the participant with reasonable promptness.

I have absolutely no idea what that means. Obviously, consumers and families would be going to a doctor who would be prompt in giving them or their children the care they need, unless this is some kind of an open-ended escape clause.

I am telling you, the more the people look at the fine print and the detail of what the Republicans are offering on the floor of the Senate, the more they will see a consistent pattern: Offer as little as possible, covering as few people as possible, with as little protection as possible, so you don't offend the insurance industry.

That is what it is all about. We should be representing the people in our States. We should be advocates for people in our States. We should be advocates for families, advocates for children. We don't need to be advocates for the insurance companies. They already have plenty of clout.

I yield the floor.

Mr. REID. Mr. President, I will yield our final 3 minutes to the Senator from North Carolina.

I ask for the yeas and nays on the underlying amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The Senator from North Carolina is recognized.

Mr. EDWARDS. Mr. President, let me address the external appeals part of this amendment. Yesterday afternoon, we had a debate, at which time I brought to the attention of my colleagues on the other side the fact that, essentially, we had no enforcement mechanism for any of the provisions passed because there was no meaningful external review, the reason being insurance companies got to write the language on what is medically necessary, and the only thing that was appealable was what is medically necessary.

That being the case—that the insurance company totally controlled whether there could be an appeal at all—not having a meaningful appeal is similar to having a law without a police force or a court system. There is no way to enforce it. The law is meaningless. All of these provisions we pass are meaningless unless they are enforceable.

This amendment attempts—and I applaud my colleagues for making this effort. I think it is the result of a discussion we had yesterday. It attempts to address that problem, but it still has an enormous problem in it. There are two parts of an appeal process. The first is, do you get to appeal? The second is, if there is an appeal, what can be considered?

What they have offered by way of different language today, for the first time in the course of this week, is some change in what can be considered if there is an appeal. They don't change, in any way, what is appealable. Once again, the only thing appealable is medical necessity. You can't appeal whether you have access to a specialist. You can't appeal whether you were reasonably prudent in going to the emergency room. All that long list of things which are contained in the various provisions that have been considered are not appealable. The only thing appealable is medical necessity. The insurance company writes what medical necessity means. They can write it any way they want.

So the problem is, while they have attempted to address the second part of the appeals process—and I applaud them for that —they have not addressed in any way the first part, which means the insurance company lawyers can write the contracts in a way that essentially makes appeals impossible by simply drafting very narrow language of what medical necessity means. If they do that, then nobody gets their foot in the door.

What we have done basically is we have taken a door that was completely closed and put a very tiny crack in it. That is all that has happened. Instead of what we ought to be doing, which is to have a simple, plain provision—and I don't know why my colleagues won't agree with this; maybe they will if we talk about it—a plain provision which says any right provided in any part of these amendments and bills that have been passed is appealable.

Why not make them all appealable? That way, we have an enforcement mechanism. We have a police force, a court system, and we have a way to make the rights that we are attempting to create meaningful because if we don't do that, essentially what happens is we pass laws that are totally unenforceable. The result is the insurance company totally controls what occurs. What we have today is a situation where HMOs and insurance companies are totally in control. That is what we are about this week. We are about changing that.

I do applaud my colleagues for making some effort to address that issue. But what has happened is they only address the second part, which is what can be considered. They still, I might add, allow the party considering the appeal, which is chosen by the insurance company through another entity, to consider what the HMOs' own plans and procedures are. So the bottom line is this, Mr. President—

The PRESIDING OFFICER. The Senator's 3 minutes have expired.

Mr. EDWARDS. The bottom line is this: What we have is a provision that does not cure the problem. There is a simple cure, and if we are doing this in good faith, I ask my colleagues to join me in that cure, which is a simple provision which says that any right created in these amendments, in these patient protections we are attempting to debate and pass on the floor, is appealable. It is that simple, that straightforward. If we want to enforce these

laws against the insurance companies, that is what we ought to be doing. It is simple and straightforward and it will work.

I thank the Chair.

Mr. JEFFORDS. Mr. President, I yield 5 minutes off the bill to the Senator from Wyoming.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I rise in support of the amendment. I want to particularly congratulate the Senator from Maine for her care and concern over the 2 years she has been involved in drafting this bill. I want to particularly express my pleasure at the improvement to the continuity of care provision she put into this bill. From our base bill, we further extend our continuity of care for terminally ill patients through the end of life.

While the language in our committee bill followed the recommendations of the President's Quality Commission and the National Committee on Quality Assurance, both of which recommended ninety days for transition for all chronically ill patients, we feel very strongly that terminally ill patients and their families deserve to remain with their providers.

Extremely important is the other piece of the continuity of care provision. It would require the Agency for Health Care Policy Research, the Medicare Payment Advisory Commission and the Institute of Medicine to conduct a multi-pronged study into the appropriate thresholds, cost and quality implications of moving away from the current narrow definition of ''terminally ill'' towards identifying those with ''serious and complex'' illness.

This study was suggested by the groups who advocate for patients suffering with terminal illness. Unfortunately, many patients are not captured by current efforts to address the coordination and care needs of those who have several years, rather than several months, to live. This is because ''terminally ill'' is a narrowly construed concept. These patients may be better captured as ''serious and complex.'' This study is designed to help shape those parameters and seeks to improve the care for all patients with terminal illnesses.

Again, I commend the Senator from Maine's leadership on this important matter.

I yield the floor and reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, we are at the conclusion of another part of this debate. There is an amendment that includes a variety of different provisions trying to upgrade the Republican proposal and make it more acceptable and responsive to the points that have been raised during the course of the debate. Most importantly, the points have been raised by doctors, nurses and patients all over this country. Still, they fall short.

These amendments are another testament to the priority the Republicans place on protecting profits instead of patients. Every time we point out the severe defects and loopholes in their plan, they say: Oh, no, we will improve it. Then the so-called improvements come, and they are virtually meaningless. It is botched cosmetic surgery; all the wrinkles still show. You can put lipstick on a pig, but it is still a pig. And you can call something a patients' bill of rights, but it is still a patients' bill of wrongs.

Every single one of these amendments leaves a profit-protection proposal, a sham proposal, a triumph of disinformation. We have voted on 10 of the amendments that have been offered by the other side, and we will have this amendment—10 amendments. There isn't a single amendment that has the support of a patients' organization or a medical organization—not one. I think that is a fair indication as to what those amendments are really about.

On the contrary, each and every one of the positions we have taken had the strong support of the medical profession. Each and every amendments we have offered—each and every one of them—had the strong support of the medical profession. I think that speaks volumes about who is really interested in protecting the patients and not the profits of the HMO.

Let's look at these proposals individually. The so-called independent appeals provision leaves every fundamental flaw in the original bill uncorrected. The HMO still chooses and pays the review organization. The HMOs own definition of ''medical necessity,'' no matter how unfair, still controls the whole process. That has been pointed out by our colleague, the Senator from California, Mrs. FEINSTEIN. That particular loophole remains in the bill.

The clinical trials proposal applies only to cancer patients and only to those in self-funded plans. Two-thirds of Americans are left out. Two-thirds of cancer patients are left out.

All of the cancer organizations have rejected this proposal. We have printed their positions in the RECORD. They all reject this particular proposal.

If you or your loved one has heart disease or Alzheimer's, cystic fibrosis or multiple sclerosis, a spinal cord injury or diabetes or AIDS, you are out of luck under the Republican plan. And if you are a farmer or small business employee who belongs to an HMO and you develop cancer, you are out of luck.

The continuity of care provision has not changed a bit. If you have a terminal illness and are fortunate enough to live more than 3 months, they can cut you off; you have to change doctors. If you have a long, ongoing illness—even cancer or life-threatening heart disease—you have no transition at all. And if you are one of the 113 million people not in a self-funded plan, you are not protected at all.

Let's go back to the basics. Again, after 4 days and 10 amendments, they have not presented a single proposal supported by any group of doctors, nurses, or patients—not one, zero.

Their bill is supported by the insurance companies that profit from abuse. Our bill is supported by 200 groups; doctors, nurses, and patients who want to end these abuses.

The Senate should stand with the health professionals and the patients, not with the powerful special interests.

We will have another opportunity in a few moments to stand again with the patients. Let's hope the Senate will.

I reserve the balance of the time.

Mr. JEFFORDS. Mr. President, I yield the Senator from Maine 2 minutes off the bill.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I recently discussed the continuity provisions which are included in the amendment before us. This is one of the rare areas of agreement on both sides of the aisle. We both agree that if someone is terminally ill, and if there is a change in health care providers, the terminally ill patient should be able to stay with that provider until the end of his or her life.

Our amendment clearly says that the care shall extend for the remainder of the individual's life for such care. There is, however, a technical mistake which could create some ambiguity in that provision.

I ask unanimous consent, since the yeas and nays have been ordered, that I send a modification to the desk to correct that technical amendment. I hope my colleagues will agree to that.

Mr. REID. Objection.

The PRESIDING OFFICER. Objection is heard.

Ms. COLLINS. Mr. President, since there has been an objection, which I think is very unfortunate, the technical correction will be included in the final Republican package that will be offered.

As I said, I think the intent is very clear. The majority of the language is very clear. But there is an ambiguity in one section which will be cleared up in the final language.

Also, at this time I request the yeas and nays on the underlying Collins amendment which was set aside.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient.

The yeas and nays were ordered.

Mr. KENNEDY. I yield to the Senator from California 1 minute off the bill.

Mrs. BOXER. Mr. President, by popular demand, I have my scorecard back. It was 8 to nothing. And then I gave two points to the liability, one, because that is crucial. Unfortunately, we lost that—the patients did. The HMOs won. They still will be able to get away with hurting people and not paying any price whatsoever.

So we are 10 to nothing.

We are about to have two votes. The Collins amendment is opposed by the obstetricians and gynecologists who

have sent out a letter saying it is nothing; it is a cruel nothing. I have their exact words at everybody's desk.

I hope we will vote that down. It doesn't do anything about the specialists. It doesn't do anything about OB/GYNs. It doesn't do anything about emergency rooms. Senator GRAMM pointed that out. They are still going to be charged.

Again, we have a sham proposal. I hope it will be 10 to 2 after the next two votes. But I am afraid it is going to be 12 to zero.

I yield the floor.

Mr. KENNEDY. We yield back any time remaining on our amendment.

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

The PRESIDING OFFICER. Two minutes.

Mr. FRIST. Mr. President, shortly we will be voting on two amendments. The first vote will be an amendment which was carried over from this morning on long-term care, deductibility, access to emergency room services, access to specialists, and access to OB/GYN services, after which we will be voting on the amendment that we have been talking about over the last 100 minutes, which is an amendment we have introduced on external appeals with a Republican amendment that provides a specific timeframe for expedited external review, No. 1.

No. 2, on coverage of clinical trials, our amendment provides coverage of routine patient costs associated with participation in an approved trial in the field of cancer.

No. 3, provider nondiscrimination, where our amendment offered protections similar to those provided in Medicare and Medicaid, and the balanced budget amendment of 1997.

No. 4, a point-of-service aspect, where we extended the point-of-service option to beneficiaries beyond what was in the underlying bill.

No. 5, continuity of care, which has been discussed by Senator COLLINS.

I very much believe these amendments will strengthen the underlying bill.

I urge their approval because I think they go right to the heart of what the American people want, and that is to keep the focus on the patient, on the individual, to ensure quality and to ensure access.

I yield the remainder of our time.

POINT-OF-SERVICE OPTION AND ANTI-DISCRIMINATION AMENDMENT

Mr. GRASSLEY. Mr. President, I am pleased to support this amendment with my colleagues, Senator COLLINS, Senator SESSIONS, and others. This amendment will offer freedom of choice to millions of Americans and will ensure they have access to a wide range of providers.

Our amendment would provide individuals with the option of choosing a point-of-service plan when no such option exits. I support this because I want to give people choice and the ability to go out of network if they need to. They may have to pay more for this freedom, but they should at least have this protection if they want it.

I have been a long-standing supporter of the point-of-service option. This provision was part of my Medicare patients' bill of rights in 1997. I also supported a similar amendment offered by Senator HELMS on the Senate floor several years ago.

I believe people should have this option when they are willing to pay for it. Point-of-service provides people with the security of insurance coverage to see providers outside the plan if they need to. Many people are will to pay for this extra security. But for people who don't want to pay for this, they won't have to. They can choose another plan that better suits their needs.

In addition, this amendment ensures that managed care plans do not discriminate against any class of providers, such as chiropractors or optometrists. This is important to patients because it ensures they have access to certain providers or services they prefer who may be left out of the network. Classes of providers, who are not medical doctors, are sometimes excluded from participating in managed care plans to restrict patients' access to their services. Our amendment would ensure this does not happen by prohibiting plans from discriminating against any class of providers who are licensed to practice in their state.

This amendment is about choice, freedom, and security. It is about allowing patients to choose a plan or provider that best meets their health care needs. I hope my colleagues on both sides of the aisle will vote in favor of these very important patient protections.

The PRESIDING OFFICER (Mr. THOMAS). The question is on agreeing to amendment No. 1243, as amended. On this question the yeas and nays have been ordered, and the clerk will call the roll.

The legislative assistant called the roll.

The result was announced—yeas 54, nays 46, as follows:

[Rollcall Vote No. 207 Leg.]

YEAS—54

Abraham	Frist	McConnell
Allard	Gorton	Murkowski
Ashcroft	Gramm	Nickles
Bennett	Grams	Roberts
Bond	Grassley	Roth
Brownback	Gregg	Santorum
Bunning	Hagel	Sessions
Burns	Hatch	Shelby
Campbell	Helms	Smith (NH)
Cochran	Hutchinson	Smith (OR)
Collins	Hutchison	Snowe
Coverdell	Inhofe	Specter
Craig	Jeffords	Stevens
Crapo	Kyl	Thomas
DeWine	Lott	Thompson
Domenici	Lugar	Thurmond
Enzi	Mack	Voinovich
Fitzgerald	McCain	Warner

NAYS—46

Akaka	Bingaman	Byrd
Baucus	Boxer	Chafee
Bayh	Breaux	Cleland
Biden	Bryan	Conrad
Daschle	Kennedy	Murray
Dodd	Kerrey	Reed
Dorgan	Kerry	Reid
Durbin	Kohl	Robb
Edwards	Landrieu	Rockefeller
Feingold	Lautenberg	Sarbanes
Feinstein	Leahy	Schumer
Graham	Levin	Torricelli
Harkin	Lieberman	Wellstone
Hollings	Lincoln	Wyden
Inouye	Mikulski	
Johnson	Moynihan	

The amendment (No. 1243), as amended, was agreed to.

Ms. COLLINS. Mr. President, I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

VOTE ON AMENDMENT NO. 1252

The PRESIDING OFFICER. The question is on agreeing to amendment No. 1252. The yeas and nays have been ordered. The clerk will call the roll.

The assistant legislative clerk called the roll.

The result was announced—yeas 54, nays 46, as follows:

[Rollcall Vote No. 208 Leg.]

YEAS—54

Abraham	Frist	McConnell
Allard	Gorton	Murkowski
Ashcroft	Gramm	Nickles
Bennett	Grams	Roberts
Bond	Grassley	Roth
Brownback	Gregg	Santorum
Bunning	Hagel	Sessions
Burns	Hatch	Shelby
Campbell	Helms	Smith (NH)
Cochran	Hutchinson	Smith (OR)
Collins	Hutchison	Snowe
Coverdell	Inhofe	Specter
Craig	Jeffords	Stevens
Crapo	Kyl	Thomas
DeWine	Lott	Thompson
Domenici	Lugar	Thurmond
Enzi	Mack	Voinovich
Fitzgerald	McCain	Warner

NAYS—46

Akaka	Edwards	Lieberman
Baucus	Feingold	Lincoln
Bayh	Feinstein	Mikulski
Biden	Graham	Moynihan
Bingaman	Harkin	Murray
Boxer	Hollings	Reed
Breaux	Inouye	Reid
Bryan	Johnson	Robb
Byrd	Kennedy	Rockefeller
Chafee	Kerrey	Sarbanes
Cleland	Kerry	Schumer
Conrad	Kohl	Torricelli
Daschle	Landrieu	Wellstone
Dodd	Lautenberg	Wyden
Dorgan	Leahy	
Durbin	Levin	

The amendment (No. 1252) was agreed to.

Mr. NICKLES. Mr. President, for the information of our colleagues, we are coming to closure on this bill. I think the procedure is that now the Democrats, if we continue our alternation, have a second-degree amendment which will be offered to the underlying amendment, and we will consider that. We will vote on it. Then it is our expectation that we will have the passage of the substitute amendment, to be offered by Senator LOTT on behalf of us, that will be wrapping up some of the changes we made to S. 326 in the consideration of this bill.

We will offer that immediately following disposition of the Democrat amendment, and that will be the final

vote of the evening. At least that is our expectation. For Members' information, we will be voting on the next amendment no later than 6:50, hopefully before 6:50. Then it is our intention to vote on final passage no later than an hour or 2 hours after that. That would be closer to 9.

It is our hope that we can shave off some time and have final passage much closer to 8 than 9. Members can plan accordingly. Please plan on two more votes, one on the Democrat amendment, which will be offered momentarily, and then basically the final passage or the Republican wraparound amendment—we might call it that—or a substitute. It would incorporate all the changes we have made on the floor to S. 326.

I yield the floor.

Mr. KENNEDY. Mr. President, may we have order. This is a very important amendment, and the Senators are entitled to be heard. We are enormously grateful for the attention that has been given to the debate generally, but this is in many respects one of the most important amendments. The Senators should have a chance to have the attention of the membership.

The PRESIDING OFFICER (Mr. SMITH of Oregon). The Senate will be in order.

AMENDMENT NO. 1253 TO AMENDMENT NO. 1251

(Purpose: To provide for a transitional period for certain patients)

Mr. KERREY. Mr. President, I send an amendment to the desk on behalf of myself, Senator MIKULSKI, and Senators SCHUMER, GRAHAM, KENNEDY, MURRAY, DASCHLE, DURBIN, ROCKEFELLER, and TORRICELLI, and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

Mr. REID. Mr. President, the Senator from Nebraska is yielded 7 minutes.

Mr. JEFFORDS. Mr. President, I ask that we suspend temporarily for a motion.

The PRESIDING OFFICER. The Senator from Nebraska has the floor.

Mr. KENNEDY. If the Senator will yield temporarily, as I understand, the Senator is going to make a motion to reconsider and lay on the table.

Mr. JEFFORDS. Mr. President, I move to reconsider the vote on the amendment just passed.

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

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Nebraska [Mr. KERREY], for himself, Ms. MIKULSKI, Mr. SCHUMER, Mr. GRAHAM, Mr. KENNEDY, Mrs. MURRAY, Mr. DASCHLE, Mr. DURBIN, Mr. ROCKEFELLER, and Mr. TORRICELLI, proposes an amendment numbered 1253 to amendment No. 1251.

Mr. KERREY. 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. KENNEDY. Did we yield 7 minutes to the Senator?

Mr. KERREY. That is correct.

Mr. President, this proposed change in the law would provide protection for every single American who has health insurance in this country—not just those that are in self-funded ERISA plans, as the Republican alternative would do. That is the most important distinction. I have been asked, well, if our amendment fails, will I vote for the Republican alternative? My answer is no. I believe that would be a step backward because it will say to the marketplace that you can fall to the lowest possible standard, which is what the Republican proposal does.

Every step of the way, we have seen a sort of grudging retreat from our challenge to change the law and intervene in the marketplace. There is cost to this, Mr. President; I acknowledge that cost. But as with all regulation, we have to measure the cost versus the benefit. That is what we intend to do with this amendment—talk about the benefit to people who will be able to get continuity of care, and not just if they are pregnant, which the Republicans included in their earlier alternative, but to take care of people with terminal illness, for example. I understand it that there will be a modification to the Republican bill on this point. But you have to be declared terminal.

What if you have cancer and you believe you are going to survive treatment? What if you have diabetes or some other complicated medical condition, and you established, over the years, a relationship with your physician who watched for changes in your physical condition, looked at your symptoms and determined the kind of treatment and response to those symptoms, and suddenly you are told your doctor was either removed from the managed care group, which happens, or your doctor changes venue and moves to some other locality and you are told by your managed care organization that you have to pick a different doctor. Your relationship with this physician is over.

This amendment puts the law on the side of those individuals and says you can continue care with that doctor for 90 days for most conditions, and for three conditions this time can be extended. It is reasonable.

Is there cost? Yes. Measure the cost against the benefit of having the law on your side when it comes time that you are told that your doctor now is different and you have had a relationship with that doctor. The doctor has diagnosed your cancer and told you here is the treatment, or has been your doctor treating your diabetes or your cardiovascular disease, or your doctor has told you what the treatment is going to be, and suddenly you have a new doctor. You have to pick somebody new. That is what this amendment does. It puts the law on the side of every single American, not just those in self-funded ERISA plans, as the Republican version would do. This takes care of everyone.

I have real passion on this subject because on the 14th of March, 1969, I was a healthy human being with the U.S. Navy SEAL team, and I thought I could accomplish everything on my own. I didn't think I needed any law to support me or take care of my needs. Then I was injured. In an instant, I went from being able to take care of myself on my own to not being able to do anything at all, including going to the bathroom, without asking somebody else for help. So they sent me to the Philadelphia Naval Hospital, and I recovered there.

Well, in 1989, when I came to the Senate, I was fortunate enough to be able to be a member of the Appropriations Committee, and we were marking up a bill—a law that this body considered. It occurred to me we were appropriating money for military hospitals—including the one that I had gone to in 1969. Well, in 1969, I didn't understand the relationship between that law and me. That hospital was not there because of Sears & Roebuck.

I love the marketplace. I come from the business sector and I love what the market can do. But the market has limitations. My life was saved by a hospital that was authorized by this Congress. The appropriations were authorized by this Congress not because I made a financial contribution, not because I was able to come and influence anybody in this Congress—there wasn't a politician in America in 1969 I liked, let alone been willing to make a contribution to. Yet Congress passed, and the President signed, a law which saved my life—not the marketplace but a law.

Was there cost? You're darn right there was cost. What was the benefit to the rest of America? I hope the benefit was being able to say we live in a country where we want our Congress to pass laws to take care of our own. We want to take care of each other. It isn't just about me. I am healthy today, and the independence I have and the health I have came as a consequence of that law. That law gave me independence.

Roughly 10 days ago, we all celebrated the Fourth of July. That is Independence Day. This Nation has an over 200-year tradition of making independence meaningful by fighting against illiteracy, fighting against intolerance, and fighting against illness. If you are sick or disabled and you don't have health insurance and reliable health care, you are not likely to feel independent. It is likely to be meaningless to you.

So what this amendment does is to say if you have a relationship with a doctor, and the doctor is treating you, and the market determines that the doctor no longer can treat you, you will have a right, under the law, to

continue to have the care of that physician for 90 days. If it is one of the three exceptional conditions, this right can be extended.

As I say, there is cost. I don't disregard the cost at all. I have heard many Senators come down and talk about how this is going to increase the cost of our insurance. I am willing to pay it. Why? Because Americans were willing to pay the bills for me. That is why we are a great country. We don't just take care of ourselves; we take care of each other. We recognize, as great as the marketplace is, as wonderful as free enterprise is in creating jobs and generating wealth, there are limits. If all we care about is the bottom line and generating profit for our businesses, we will forget the need to put the law on the side of human beings when, through no fault of their own, the bottom drops out of their lives.

So I hope and pray that the Republicans will give this amendment consideration. It is the last amendment we will consider before we shut this thing down permanently. At least for the rest of this week, we are not going to have a chance to change the law and put it on the side of Americans out there who desperately need it.

I understand there are costs to it. If I talk to people in Nebraska and they ask why we do this, I will not only use myself as an example, I will use hundreds of others who had the law on their side. Medicare beneficiaries have had the law on their side, and they are better off as a consequence.

I yield the floor.

Mr. KENNEDY. Mr. President, I yield 5 minutes to the Senator from Maryland.

The PRESIDING OFFICER. The Senator from Maryland is recognized.

Ms. MIKULSKI. Mr. President, we are in the closing hours of this debate now. I want to thank the distinguished Senator from Massachusetts for his steadfast advocacy not only this week, but his whole life has been devoted to making sure that people have access to health care, and to believing that in the United States of America there is an opportunity structure where we give help to those people who try to practice self-help—we have done that in education and in our legal framework—and also to be sure that if you have something happen to you in terms of your physical, emotional, or mental well-being, you should have access to health care in the greatest country in the world.

I thank Senator KERREY for offering this amendment. I think it is an outstanding amendment and I am pleased to be a cosponsor. I lend my voice to this amendment that the Senator has offered, and I hope that at least once this week we can pass an amendment 100–0, and that we put the profits of an insurance company aside, put the politics of party aside, and that we take a moment to think what is in the best interest of the American people.

I hope that on this amendment we can come together. Senator KERREY's amendment is one that I offered in the committee. It was defeated along party lines. But I understand committees. That is the way it goes. But I don't understand how we are doing this on the floor of the Senate because, first of all, we are advocating continuity of care. What does that mean?

It means just because your boss changes insurance companies, you don't have to change your doctor. It also means if your physician is pushed out of a network, you are not pushed aside from seeing that physician.

Why is this important? It is important because doctors are not interchangeable. The hallmark of getting well and staying well is the relationship between a doctor and a patient. We have known this throughout history. This is nothing new. This goes back to Hippocrates and the earliest basis of medicine. Your doctor knows you as a person—not as a chart or a lab test. Your doctor knows you, your history, your family's history. Your doctor knows what is best for you and how to act in the most prudent way in regard to what is medically necessary or medically appropriate or medically indicated.

Why is this important?

There are those who will say this will cost too much. I say, if we don't have it, it will be penny-wise and pound-foolish.

If you are dumped from seeing the doctor you currently have and you have to start all over again, that doctor is going to have to take a complete physical. The doctor is going to have to take complete tests and in many instances start all over with you. Diabetes is treatable and diabetes is manageable, but if you are a diabetic and go to a new doctor, that doctor has to know you and your history and your family history, and start again with complicated tests and complicated evaluations. That is penny-wise and pound-foolish. You should stick with your own doctor, or at least come up with a transition plan.

What about the terminally ill?

This amendment Senator KERREY has offered says if you are terminally ill, or your family member, or your child, is terminally ill, you get to keep your doctor. What happens if your child has a terminal illness? You are struggling with this illness. Imagine being a father wanting to be at the bedside of a child who is terminally ill. Instead he is in the other room calling an insurance company finding out if his son's doctor is in his new plan's network because the company he works for has changed HMOs. So he is up there not talking to the doctor about his son, or not even talking to his son, but trying to figure this out.

I think that is cruel. I think it is cruel and unusual punishment.

What happens if you are recovering from a stroke and you are in a rehabilitation hospital?

Under the Kerrey-Mikulski amendment, you will get to keep your doctor during that rehabilitation, so you can return and not be having to try to find out who your physician is going to be.

What happens if you have been admitted to a mental hospital for an acute psychiatric episode and you have chronic schizophrenia, but you also have a physician who has been treating you, who knows you, and in those 90 days you have to change doctors just when you are trying to get your mental health back again?

This is what we are talking about—continuity of care, so for those undergoing an active course of treatment and for all Americans who have insurance you would get at least 90 days to come up with a transition plan.

But in three categories—if you are terminally ill; also if you are within an institution or facility; or if you are pregnant—you get to keep your doctor for a longer period.

We think this is what should happen. This isn't just BARBARA MIKULSKI making this up.

I will submit a letter from the Consortium of Citizens with Disabilities. These are people who strongly support the Kerrey-Mikulski amendment.

This is what they say:

> Protecting continuity of care is not some wonky technicality. It will have a real impact on the quality of care for many people with disabilities and anyone who is undergoing active treatment. Consider for a moment what could happen to a child with cerebral palsy if their parent's employer changed health plans and there was no opportunity to adequately plan a transition to new plan and new providers. It can be assumed this child would be receiving ongoing physical therapy.

This could be potentially expensive and exhausting for the family. There may be a variety of other reasons for this.

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

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

CONSORTIUM FOR CITIZENS WITH DISABILITIES,
Washington, DC, July 12, 1999.

Re CCD strongly supports the Kerrey/Mikulski amendment on continuity of care.

Hon. J. ROBERT KERREY,
U.S. Senate, Washington, DC.

DEAR SENATOR KERREY: We are writing as Co-Chairs of the Health Task Force of the Consortium for Citizens with Disabilities (CCD) to express our strong support for the amendment you intend to offer with Senator Mikulski during the upcoming debate on the Patient's Bill of Rights. Your amendment will ensure that continuity of care is protected when health plan contracts are terminated. This is a critical issue to people with disabilities. CCD is a Washington-based coalition of nearly 100 national organizations representing the more than 54 million children and adults living with disabilities and their families in the United States.

For people with disabilities, planning a transition from one health plan to another requires great care and much coordination. If an employer switches health plans or if enrollees experience a change in health plans for any reason, persons with disabilities need to be guaranteed that they will have adequate time to manage the transition to new

providers. For persons undergoing active treatment for serious conditions, patients should be permitted to continue being treated by their existing provider until the serious condition has been positively resolved or for at least ninety days.

Protecting continuity of care is not some wonky technicality. It will have a real impact on the quality of care for many people with disabilities and anyone who is undergoing active treatment. Consider for a moment what could happen to a child with cerebral palsy if their parent's employer changed health plans and there was no opportunity to adequately plan a transition to a new plan and new providers. It can be assumed this child would be receiving on-going physical therapy, they would potentially be taking extensive prescription medications, they would have an on-going need for various types of durable medical equipment such as a wheel chair or other devices that help them to function. They may also be receiving personal assistance services. If a transition to another plan is necessary, should the care of the child be abruptly terminated without any planning to manage the transition to a new plan and new providers?

What is most perverse about such a situation is that if care is interrupted, this child could develop an acute health problem that requires a hospitalization. Is this in the best interest of that child or the health plan? This type of scenario is not limited to this example.

Anyone who is receiving on-going care needs an opportunity to plan and manage a transition to a new health plan, and if necessary a new provider. We are frustrated that such a straightforward issue is not adequately addressed in the Republican Leadership proposal.

There are many complex issues that will be raised as the Senate debates the enactment of a Patient's Bill of Rights. Continuity of care is not one of them. Your amendment provides a straightforward solution to a simple problem. Under current law and the Republican Leadership proposal, health plan enrollees could be stranded and life-prolonging health care could be abruptly interrupted through no fault of their own.

The CCD Health Task Force is grateful for your leadership on this critical issue and we look forward to working with you and your staff to ensure that this amendment is adopted.

Sincerely,

JEFFREY CROWLEY,
National Association of People with AIDS.
BOB GRISS,
Center on Disability and Health.
KATHY MCGINLEY,
The Arc of the United States.
SHELLEY MCLANE,
National Association of Protection and Advocacy Systems.

Ms. MIKULSKI. Mr. President, we have letters from parents. We have letters from advocacy groups that say in the United States of America when you get health care it shouldn't have term limits on it.

I yield the floor.

Mr. REID. The Senator from New York is allocated 4 minutes.

The PRESIDING OFFICER. The Senator from New York.

Mr. SCHUMER. Mr. President, I thank the Senator from Nevada for yielding.

It has been a long week. I know there will be many who will say that this week was not as productive as it might be. I agree with that completely.

But this is one good point that has emerged. We have debated, as we asked, the Patients' Bill of Rights. It is now an issue that is before the American people. They know there will be a time when they don't have to put up with HMOs that are dictating policy.

The American people know that in the doctor-patient relationship there does not have to be a third person in the room all the time—an actuary, an accountant with no medical experience. They know it is possible for this Senate and this Congress to pass a law that might say that if your doctor says you need a medication, and says you need a procedure, and says you need an operation, and your HMO denies it, you have the right —you could, if this Senate had the courage—to an independent appeal.

Unfortunately, amendment after amendment that would have protected the average American was rolled back. Unfortunately, we are in a situation where the insurance industry has all too often dictated what has happened on this floor. Instead of stepping up to the plate and voting for the protections for which our constituents are literally clamoring, this Senate buckled to the insurance industry and passed a bunch of amendments that are aimed at looking good and doing nothing. The look-good, do-nothing amendments will not prevail because next week, and the week after, as Americans visit their doctors and their HMOs deny them service, deny them things they need, they will know.

This entire debate can be summed up in three numbers. Who is covered under the Democratic plan? One hundred and sixty-one million people. We lost on that amendment. The Republican plan, which covers 48 million people, prevailed.

What are we saying to the 113 million who will not get coverage? The main argument against the legislation is that it would cost too much. The cost is $2 a month. How many Americans wouldn't pay $2 a month to have their doctor determine what medicine, what operation, what specialist they need?

I think the only Americans who would not vote to have that $2 a month in exchange for what they need medically are in this Senate, and in a few of the HMOs.

My colleagues, my friends, this is not the Senate at its greatest hour. This is a time when we, once again, succumb to the special interests and deny what the American people want.

But we will be back. The American people will demand we come back. They will demand the pendulum swing back to the middle so actuaries don't make policy, but doctors do.

We shall return. We shall, not tonight but in the future, prevail.

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

As we near the end of this debate, I want to share a few thoughts generally on the proposals we are discussing. Quite frankly, we just had an opportunity to see the amendment which has been offered. Our crack Senators are reading it over to study the measure. They will shortly have comments to offer on that.

I want to talk about some areas that I think have become very obvious as we have moved forward in this debate. The first thing we ought to emphasize is that both sides are going to deal with the managed care problems and concerns. We have heard from patients in our States. I have heard a lot of rhetoric and a lot of name-calling about what the various bills do. The simple fact of the matter is, the people of Missouri, the folks who talk to me, the people who are concerned about health care—the small businesses are particularly sensitive—have some things they don't want to do.

The first rule of medicine is to do no harm. They want to make sure we don't make it worse. I believe the amendments we have adopted and the direction in which we are going will make the situation better. We are going to assure patients in a managed care plan, if they are turned down for coverage, they can go to a physician for an external appeal, and thanks to the very wisely crafted provision of the amendment offered by my colleagues—Senator ASHCROFT, Senator KYL, and Senator ABRAHAM—if the managed care organization doesn't provide them with that coverage of services that the external appeal said they are entitled to, they will be able to go out and get it someplace else and bill the HMO.

What we are saying is, we don't want to give people a lawsuit, a cause of action or, even worse, give their widow or their orphans a cause of action. We want to give them health care. We want to give them a treatment. We want to give them a treatment, not a trial. We want them to make sure they can get health care. That is the important point. That is what the provisions we have adopted do.

One of the things we don't want and one of the things our colleagues on the other side of the aisle seem to want is another bureaucratic nightmare. Do we really want to turn the regulation of our health care system over to the Federal Government, to the bureaucrats at the Health Care Financing Administration? I say not. We have had a lot of experience with HCFA, and it has not been good.

The Republican bill is based on the premise that States can do a good job monitoring what is going on in the world of managed care, they can do a good job of deciding what is the appropriate legislative response. Some may do better, some may not do as well. But the nice thing about the laboratory of States is that we can see which States are doing the best job and we can change the law.

During my time and service in State government, we worked on assuring better regulation. The States will move

forward. My State has passed a Patients' Bill of Rights. Most States have. They are looking to see how it works. The States that make it work the best are going to be followed by others.

The Democratic bill, the Democratic approach, is based on the premise that States can't handle managed care regulation and that Federal bureaucrats are better equipped to do it. The Democratic bill will overturn a host of State laws and replace them with the interpretations of the Federal Government employee. These are the same bureaucrats who produced one nightmare after another in trying to impose their regulatory monstrosities from Washington. Now they want the entire health care system turned over to them.

We have already had examples of HCFA's failures related to the issue of consumer protection, the very topic that the Democrats want to turn over to HCFA lock, stock, and barrel. Back in 1996, we entrusted HCFA with more responsibility when Congress passed the Kassebaum-Kennedy health care bill designed to make sure health care was portable. How well did HCFA handle this responsibility? According to the General Accounting Office, HCFA admits they pursued a Band-Aid, minimalist approach for protecting consumers.

The GAO has another finding that HCFA ''lacks the appropriate experience or expertise to regulate private health insurance.'' These are the people to whom we want to turn over regulatory responsibility for the entire health care system? When they are entrusted with the entire responsibility, when they are incompetent or mess up, the whole country suffers.

One of the things I have done as chairman of the Small Business Committee is to try to ensure that Federal agencies live up to the requirements of the law passed in this body and the other body unanimously to reduce redtape, to make sure that Federal agencies take into account how their activities and their regulatory actions would impact small business. We found there were several agencies that weren't doing a very good job. The regulatory process was clogged up.

I initiated the ''Plumber's Friend Award'' to unclog the regulatory pipes in these agencies. Needless to say, HCFA and the Department of Health and Human Services were one of the first. We give these awards to Federal Departments which blocked the flow of public participation because they failed to reduce unreasonable and burdensome regulations affecting small business. HCFA and HHS qualified for the award by repeatedly disregarding Federal laws designed to make it easier for small businesses to deal with the massive amounts of regulation and paperwork required by Federal bureaucrats.

That is an example of the nightmare HCFA is creating. We saw the nightmares. They were going to impose surety bond requirements on home health care agencies, many of them small businesses in my State. HCFA decided they were going to require the small business home health care agencies to purchase surety bonds that would cover up the Federal Government's mistakes. In other words, they had to provide insurance so if the Federal Government made a mistake, the surety bond would be responsible. A home health care operator told me with tears in her eyes she couldn't raise the money to buy a surety bond.

Then they imposed cuts on the home health care agencies that have been putting them out of business left and right. Under the Balanced Budget Act, they were supposed to save $16 billion a year over 5 years. They cut back on the amount of reimbursement so much that they would wind up saving $48 billion a year. They were imposing a system of reimbursement that penalized the good providers, that penalized the providers who were providing the most intensive care in the home. They were penalizing the providers in the most difficult areas—precisely the kind of service we want to keep.

HCFA has had a bad track record. Ask anybody who has had to deal with HCFA, and they will say, whatever the problem is, HCFA is not the answer.

There are some who think that maybe our colleagues really want to get back to the era of another health care proposal that came from the White House. Known as Clinton Care, the 1993 health care plan was going to be a Federal takeover of health insurance. The wisdom of the Federal Government was going to run health care.

Senator GRAMM has done a good job this week talking about some of the possible horror stories that could and would have happened if we passed the Clinton health care bill. Fortunately, we didn't. Some of my colleagues are running around saying they personally helped kill the Clinton health care bill. That sucker wasn't killed by any Republican. It died of its own weight. The Democratic majority leader didn't even bring it up because once they looked at it, they said, this thing isn't going to work. It was dead on arrival.

Let me state some of the likely results had we adopted the President's proposal to socialize medicine. Expensive mandates on the Nation's employers would have cost jobs, insurance premiums that would likely skyrocket. It would create 50 new Federal bureaucracies, a new trillion-dollar Federal entitlement. These were the items we would have received.

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

Mr. BOND. Mr. President, I ask for another 3 minutes.

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

Mr. BOND. The bottom line is we would have had 1,200 pages of mandates, rules, requirements, and penalties. It died. But let me remind my colleagues what the President said just a couple of years ago, in September 1997. Talking about his failed effort to impose this failed health care bureaucracy on the American people, he said:

> If what I tried before won't work, maybe we can do it another way. That is what we tried to do, a step at a time until we have finished.

That is what I am afraid of. That is what we were trying to do, to get to the point where we had socialized health coverage in the United States.

Costs are clearly a problem. Costs are going to be a lot more than $2 million, or one Big Mac, $2 a month or one Big Mac a month, as some of my colleagues on the other side have said. If you have a $2,600-a-year family health insurance program and you have a 5-percent raise, it is a whole lot more than $2 a month. It is about $180 a year, something similar to that. It is a lot more. And when costs go up, people lose their health insurance.

We need to fix some of the problems. We need to do it without driving people out of the system. We already have 40 million uninsured people in America. I can tell you one thing that is clear: small businesses are very much concerned about ensuring they do not get priced out of the ability to compete by their health insurance costs.

There is an excellent article in the Wall Street Journal on Thursday, April 15. I ask unanimous consent it be printed in the RECORD.

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

[From the Wall Street Journal, April 15, 1999]

TAKING CARE: SMALL EMPLOYERS OFFER HEALTH BENEFITS TO LURE WORKERS IN KANSAS CITY

(By Lucette Lagnado)

KANSAS CITY, MO.—When Stephanie Pierce took over as director of the Broadway Child Enrichment Center in December, she faced a hiring crunch.

The small, church-based day-care center was enrolling more children than ever, and Ms. Pierce needed to keep the staff she had and bring on more. It was no small challenge in Kansas City's strong economy, where newspapers are flush with help-wanted ads and workers can brush off day-care work, with its low pay and high pressure.

So, Ms. Pierce made a move her hourly workers could never have imagined: She scrutinized her budget, swallowed hard and decided to offer medical benefits to employees.

That put the day-care center out of sync with small employers in many U.S. cities. But not in Kansas City.

Nationwide, the problem of people living without any health insurance is growing. It is estimated that they total more than 40 million, and their numbers are increasing as welfare recipients who had Medicaid leave the rolls for jobs that don't offer health benefits. In addition, fewer small businesses are offering medical benefits to workers, says a study by the Henry J. Kaiser Foundation. It puts the share at 54 percent last year, compared with 59 percent in 1996.

But Kansas City is moving the opposite way, thanks not only to its tight labor market—a 2.8 percent unemployment rate, vs. 4.2 percent nationally—but also to a Chamber of

Commerce initiative and to competition for workers from an industry that does offer medical benefits: riverboat casinos.

As small employees such as the daycare center offer this coverage for the first time, some interesting things are happening. The employees are facing the pain of rising health costs, just like their big brethren. But they are also learning something else that large companies know: In some ways, offering health benefits saves money. As for workers, they are finding that coverage can be a psychic as well as physical benefit.

The first change Ms. Pierce noticed at her day-care center went pretty directly to the bottom line. Sick days declined. In February, overtime costs for her 14-member staff totaled $120, down from a monthly average $420 last year.

It seems that before, sick workers who were uninsured would commonly stay home to try to nurse themselves back to health, or would get stuck for hours in a hospital emergency room or free clinic. Now, they can get timely medical attention from private physicians in their health plan and often return to work sooner.

That means Ms. Pierce no longer has to pay as many other workers to pull overtime, at higher pay. ''It's better to pay an employee to be there at work than to be sick. It helps your cash flow,'' Ms. Pierce says. Having a staff that has health benefits is ''a whole new world,'' she says.

For the staff, the changes are greater still. Before she got insurance, employee Towanna Smith says, being ill meant ''terrible'' waits at a hospital emergency room, not to mention other indignities she perceived. She and a friend were in a car accident last year. ''My friend had insurance and I didn't, and I noticed that the doctor treated her differently. He went over her thoroughly,'' says Ms. Smith, who is 26 years old.

Last month, Ms. Smith, now in a health plan, went to a doctor for a swollen arm that has nagged her since the accident. ''I brought out my insurance card, and I got special treatment,'' she says, smiling, ''I said, 'Thank you, Jesus.''''

She might also thank the riverboat casinos. About four years ago, out-of-town gambling companies arrived in an already-tight labor market here and began hiring thousands of people locally, leaving in place companywide policies that called for full-time workers to get medical coverage. ''The boats put people in a tizzy,'' says Scott Samuels, an adviser to hotels and restaurants. ''People were flowing to the casinos to work, and I know that employers in the hospitality field, out of sheer need, had to offer greater benefits and incentives to employees.''

Quick to react was Peter Levi, president of the local Chamber of Commerce. To help local employers compete, he teamed up with an insurer, Blue Cross Blue Shield of Kansas City, to devise a healthcoverage plan that a mom-and-pop business could afford. Blue Cross capped premium increases at about 9% a year.

In three years, more than 3,000 businesses here have begun offering the plan. Blue Cross officials expect the number to increase 15% this year.

Some other insurers, noting this success, also began offering small-employer health-benefits plans. HealthNet, a health plan partly owned by the eight-hospital St. Luke's-Shawnee Mission Health System, last summer unveiled a program for tiny businesses and has signed up 200 of them, covering 4,000 employees and dependents, including the Broadway Child Enrichment Center.

Frances Cox, who has operated a 77-room Best Western Hotel for more than a decade, began offering medical benefits for the first time in 1997. She chose Kaiser Permanente, the big health-maintenance organization, and agreed to pay 100% of the premiums, prompted by the need to compete with the casinos for reliable workers. ''It is the cost of doing business,'' she sighs. ''You have to stay competitive.''

Only seven or eight of her 20 employees took the coverage. That surprised her, but she learned that some were covered through their spouses, while others had Medicaid, the federal-state program for low-income people, which they preferred to an HMO requiring copayments.

As a recruitment tool, the benefits do the trick for Ms. Cox. She has attracted people like her new 29-year-old head of housekeeping, Lewis Nicholson.

Mr. Nicholson had worked at a fast-food outlet for 14 years without getting benefits, and he held a second job cleaning office buildings by night, just to get medical coverage. A year ago, he decided to take advantage of Kansas City's booming job market. ''In looking for a job, I looked to see what type of benefits'' were offered, he says. Result: no more fast food, just one full-time job at the Best Western, where Ms. Cox says he is already one of her most valued employees.

Ms. Cox makes sure she gets her money's worth from Kaiser Permanente. If a sick worker has trouble getting a quick doctor's appointment, ''I will call and say, 'This is Fran Cox and I am director of operations. Can't you see this person?'' she says. ''When they develop a better relationship with their doctor, that gets them back to work faster.''

She adds that as after employees ''become exposed to insurance, they begin to appreciate what the benefits are. They know that they can go to a single doctor and receive excellent care. They are being educated.''

So is she—in costs. The first year, 1997, the HMO coverage cost her $110 a month per employee. That rose to $120 in 1998, and then, for 1999, Kaiser Permanente jolted her with a boost to $157 a month per covered worker. Though Kaiser eventually agreed to shave this by $5 in return, she says, for boosting workers' copayments, ''a jump like this pretty much scares the jeepers out of me,'' Ms. Cox says, and makes her wonder ''how long can we continue'' to offer free medical coverage. One option she is considering is requiring employees to pay part of the premium.

Some employers find they can't offer health benefits even if they want to. Patti Glass ran the nonprofit Jewish Family and Children Services, assisting the frail elderly. She was paying $6.50 an hour—and hemorrhaging workers. Ms. Glass looked into health plans but found them prohibitively expensive for her mostly middle-aged workers. Even a basic plan would add $1.35 to her hourly wage costs, she figured, and she would still have to offer a pay increase to be competitive.

''Adding the cost of health benefits was going to make the service unavailable. It was going to make the cost astronomical,'' she says. The upshot: Ms. Glass chose simply to raise wages 30%, to $8.50 an hour, and forgo a health plan.

As an alternative, some employers merely give workers an opportunity to get in on group insurance, but contribute nothing toward paying the premiums. There are also bare-bones plans that do little more than give employers the right to say that they offer a medical plan.

Still, even a number of fast-food outlets here now offer some sort of medical coverage to certain hourly workers. David Lindstrom, a former Kansas City Chiefs lineman, owns three Burger King franchises, including one in suburban Johnson County, an area of million-dollar mansions, feverish construction and an unemployment rate of about 2%. For his ''key approved'' employees—full-time workers who can open and close restaurants—he offers Blue Cross medical coverage and pays much of the monthly premiums.

To him, offering benefits ''was a competitive decision we needed to make, and we think that long-term it will reap rewards for us. Already, it has allowed us to retain employees.''

People like Kathy Wilson. A nine-year employee, Ms. Wilson arrives at 4 a.m. to get ready for the day, and soon becomes a whirling-dervish of activity, rushing from station to station. ''I cook the eggs, I cook the sausages, I heat up the Cini-Minis,'' she says. Then the customers arrive, and she really gets busy.

FInding medical coverage became a top priority for Ms. Wilson, who is 29, a few years ago after she had a baby. Paying for everything out of pocket was a huge strain. It wasn't long afterward that Mr. Lindstrom began offering insurance, and she jumped at it. Out of her pay of $8.75 an hour, Ms. Wilson contributes $25 every month for medical coverage, plus a discretionary $85 to cover her son.

Though her employer pays half, some fast-food operators have chosen no-frills health plans that require workers to pay 100% of the premiums, for very basic coverage. Several McDonald's and Godfather's Pizza outlets here have signed up with Star Human Resources Inc., a Phoenix company that sells plain-vanilla health plans known as Starbridge. One of them costs only $5.95 a week, usually paid by the workers themselves, and provides a narrow array of benefits with strict limits.

Marilyn and Thomas Dobski, owners of a dozen McDonald's outlets, offer Starbridge, and about 40% of full-time hourly employees take it. Shift managers, who typically earn about $7 an hour, can enjoy a fancier, $50-a-month Starbridge plan subsidized by the Dobskis.

Mike Rogers, a Star salesman in Phoenix, explains that his company provides a limited plan for working population that ''most insurers don't want to mess with.'' He is quick to concede it isn't comprehensive: ''If they have a catastrophe, our little plan won't be adequate.'' But Mrs. Dobski, defending it, says the plan offers workers ''much more than nothing.''

The uninsured in Kansas City still total between 9% and 12% of the population. But that is far below the nationwide average, 18%, or New York's 28%. The number of uninsured patients showing up in St.-Luke's Shawnee Mission emergency rooms for free care has at last leveled off, says Richard Hastings, chairman.

Kansas City's experience intrigues E. Richard Brown, a professor at the University of California at Los Angeles who studies health policy. He warns that the medical benefits popping up could disappear fast if the local ecomony weakened and competition for workers eased up. But another student of these issues is more hopeful. William Grinker, president of Seedco, a nonprofit New York organization, says, ''Historically, once you have benefits, it is much harder to take them away.''

These days, benefits are a new goal—beyond just a job—at Kansas City's Women's Employment Network, which helps low-income, often poorly educated Kansas City women find work. ''We actually coach the women so they don't simply settle,'' says Leigh Klein, the network's executive director. In January, the network placed 25 women. The average wage was $7.87 an hour and 18 of the jobs came with benefits of some sort, more than half of them medical.

The importance of benefits is something the center drums into its clients. It is a crucial lesson, because if they are giving up welfare to take a job, they will also lose Medicaid after about three years.

Charlotte Jones, a spirited 20-year-old attending one recent session, has learned will. ''I worked at lots of fast-food places—Texas Tom and White Castle,'' that didn't offer medical benefits, she says. As her classmates nod, she adds: ''If I had a job that paid even $7 an hour, but it had benefits, I would snatch it up.''

It is nap time at the Broadway Child Enrichment Center. Ms. Pierce, the director, lowers herself onto a red plastic toddler's chair to explain how she picked a benefits plan. Keeping costs down was the overarching priority. She reviewed $120-a-month HMOs, plus a HealthNet Preferred Provider plan for $137 a month.

''I gave the staff a spreadsheet and let them help me with the decision,'' she recalls. Wary of HMOs, they chose HealthNet, whose coverage includes doctor's visits (with a $15 co-payment) and maternity care and hospitalization.

The director, for one, couldn't be happier. Before the employeers got coverage, Ms. Pierce says, ''these girls would spend two to four days at home being sick. Now, they don't have to—they call, get an appointment, get a medication and return to work.''

Mr. BOND. It talks about small businesses in Kansas City, MO, getting health insurance coverage. But the costs are still the problem, and there are examples of people who are trying to provide health care coverage, but when the costs continue to go up, then they have to drop it. They are fighting over $5 a month. Some of the people who wanted to provide health care for their employees figured they could not afford $1.35 an hour in addition which, on a 2000-hour-a-year job, would come out to around $2,700. They aren't able to afford the increased cost of insurance.

If we drive the costs of health insurance up, we are going to find people who cannot afford it. We are going to find employers who drop it. Particularly, if we give the employee the right to sue their health care plan or their employer, as my friends on the other side wish to do, they are not going to provide it.

We need to make health care better, more affordable, more accessible. We do not need to drive people out of the health care system.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I yield myself 9 minutes.

We are drawing to a close on this debate. While I am pleased that our colleagues have addressed an issue related to genetic discrimination in their bill, I am very concerned about the way in which this has been approached and I regret that we have not had sufficient time to focus on this issue. I was a cosponsor of Senator SNOWE's original bill in the 105th Congress, which contained strong penalties and disclosure prohibitions. Unfortunately, the Republican bill will not stop genetic discrimination, because it lacks three key provisions.

First, the Republican bill does not prohibit discrimination by employers. If we only address health insurance, we could actually increase employment discrimination. Second, the Republican bill does not prohibit health insurers from sharing the information with each other and with employers. Finally, the Republican bill lacks teeth. The only penalty in the Republican bill for genetic discrimination is a fine of $100 a day. Do we really think that $100 a day will deter the health insurance industry from practicing genetic discrimination?

That is why Senator DASCHLE, Senator HARKIN, Senator DODD and I introduced legislation earlier this month to truly prevent genetic discrimination. Our bill prohibits disclosure of genetic information to employers, prohibits employment discrimination, and contains strong penalties.

The bottom line is that people are afraid, and that prohibiting health insurance discrimination is not enough. We have letters from patient groups, women's groups, medical groups, and labor groups, asking us to stop employment discrimination, place some limits on disclosure of predictive genetic information, and back up these prohibitions with strong penalties. I look forward to passing a meaningful genetic discrimination bill after this debate.

As to our debate this week on the Patients' Bill of Rights, I think it is fair to look at the reaction in communities across the country. I would like to share this with our colleagues.

Here is the St. Louis Post-Dispatch editorial, July 14 of this year:

The Republicans keep asking the wrong question about health care. Instead of asking how to keep the quality of health care high, their primary concern seems to be how to keep the cost of health care down. They are paying too little heed to the symptoms of an ailing health care system, which are hard to miss. There is a drumbeat of HMO horror stories.

Sure, people want inexpensive health care. But it is increasingly apparent that neither doctors nor nurses nor patients are willing to have appropriate medical care dictated by HMO bureaucrats with their eyes on the bottom lines.

Dayton, OH:

The Republican's bill is largely a statement of goals. The Democrats' bill provides better support for patients and medical-care providers. . . .

The Atlanta Journal and Constitution, July 15:

It's called the Patients' Bill of Rights but by the time the U.S. Senate gets done with it a better title will be ''The HMO Protection Act.''

On amendment after amendment this week, Senate Republicans have had their way, creating a bill that seeks to limit the rights of HMO patients, not protect them. . . .

Relying on the mercies of the marketplace and the HMOs to meet America's health care needs has not worked and will not work. Patients need protections. That's what Congress ought to provide.

New York Times, July 15:

What occurred on the floor of the Senate this week was a GOP-sponsored charade in which one Republican Senator after another talked about protecting the health of patients while voting to protect the profits of industry.

It was a breathtaking exercise in hypocrisy. . . .

All that mattered was the obsession with the profits of the insurance companies and the HMOs.

Newsday, July 15:

Medical insurance? Try malpractice by GOP.

The Fort Worth Star-Telegram, July 13, a column by Molly Ivins:

We are watching a classic political shell game: There's the Patients' Bill of Rights that actually gives the patients some rights and there's the Patients' Bill of Rights that doesn't. . . .

The reason we know this is pure hooey is because the very bill they are opposing has already been in effect in Texas for over two years and none of the heinous consequences they predict has occurred here.

If the Republicans and the insurance industry have their way, the old shell game will run right through the Senate and we'll get something called a bill of rights that has no remedies in it.

The Seattle Post Intelligencer, July 8:

The health insurance industry is back again with a misleading campaign opposing a patients' bill of rights.

Just as the industry did successfully in 1994 with its Harry and Louise ads that misled the public about President Clinton's health care reform—falsely claiming that people would lose their right to choose their own doctor—the new campaign is designed to convince us that a patients' bill of rights will cause many people to lose their health insurance.

Like the Harry and Louise ads, the campaign relies on fear rather than fact. . . .

Consumers need avenues of redress when dealing with health care providers. . . . [T]he ability to sue their health care provider and portability of their health care should they change jobs or move to another area[,] those are all fundamental rights to which consumers are entitled. No one should be fooled by this later effort to distort the issue of health care.

The Charleston West Virginia Gazette, July 14:

Democrats have a proposal called the Patients' Bill of Rights. Republicans have called theirs the Patients' Bill of Rights-Plus Act. If truth-in-advertising laws applied to Congress, the GOP would have to call its bill the Patients' Bill of Rights-Minus Act. . . .

Some cost-saving measures may be necessary to keep health care spending under control, but when HMOs sacrifice patient health for profits, they must be held accountable. Democrats want that. Republicans apparently don't.

The News and Observer, Raleigh, NC:

The GOP is up against it, because this bill of rights, [referring to the Democrats'] is hardly a revolution: It would ensure that people could choose their doctors and their specialists, would allow them to go to the closest emergency room instead of one specified by an HMO, would enable them to keep a doctor who has begun treating them even if that doctor were dropped by the HMO. Republicans rail against regulation of this type, but they fail to see the American people are ready for it.

These are just a few examples of editorials being written all across the

country this week. Why do they all get it and no one gets it in here except Democrats and the two or three of our Republican friends who have supported the Patients' Bill of Rights? Why is the debate so different all across the country than it is, apparently, here in the Senate? Why is it that we have all the nurses supporting us? Why is it that we have all the doctors supporting us? Why is it that we have all the health professionals and all the patients groups supporting us? And why is it that newspapers and editorials all over the Nation, north, south, east, and west get it?

We wonder whether this is really an issue. We are asked: is this really an issue out there? I can tell you, just from the cases I have had in my own office, that this is an issue. I received a call this morning from Kathy Mills, a registered Republican who called my office from Tulsa, OK. She said her husband was literally ''killed by an HMO'' last July, and she has been trying to find someone to listen to her story. She has given up her efforts to contact her own State Senators because they have not responded to her numerous calls.

On July 16 last year—1 year ago tomorrow—Mrs. Mills' husband, who had a history of severe congestive heart failure, was seen by an internist at their new HMO for severe chest pain. Without taking a thorough patient history and despite a positive EKG, the doctor sent Mr. Mills home. As Mrs. Mills was later told by doctors at the HMO, their policy is to refer patients to a cardiologist only after waiting 10 days, unless the patient is ''having a heart attack on the table.'' Mr. Mills was released to go back to his job, working outside in 100-degree weather.

Mr. Mills died later that day of a massive heart attack.

The HMO doctors have been forthcoming, and after extensive inquiry Mrs. Mills feels certain it is HMO policy that is at fault for her husband's death. Unfortunately, her attorney has informed her she does not have the right to sue the HMO.

Mrs. Mills just this morning offered to fly to Washington with what little money she has left to tell her story to the Members of the Senate. Her conviction is that in the future injustices like the unnecessary death of her husband will be prevented, or at the least that when they occur the Americans victimized will have some means to redress the wrong.

People ask whether this is still going on. This is yesterday. Here is a story about Jacob. Jacob is 4 years old and lives in a midwestern State. Jacob's mom has asked that we not use his last name or the name of the HMO because she is afraid of what the HMO will do.

Jacob was diagnosed with a rare form of cancer. The course of treatment recommended by Jacob's doctor was called monoclonal antibody treatment, and it is only available at Memorial Sloan-Kettering Hospital in New York. Jacob could participate in a clinical trial at Memorial Sloan-Kettering that would involve complex surgery, transplant, radiation, and chemotherapy treatment.

When Jacob's parents inquired into the clinical trial, their physician told them it was not experimental. Their physician told them that monoclonal antibody treatment is the standard of care for Jacob's type of cancer, and has been standard treatment in use since 1987. Even though this recommended course of action is the standard treatment, because Jacob's treatment could only be obtained through a clinical trial, his HMO denied him this needed therapy. After many months of fighting the HMO from both inside and outside the system, the company approved the first stage of Jacob's treatment.

However, the story does not end there. Jacob's only hope for a cure is to complete the entire course of treatment which comes in four stages. Jacob's family continues to live in fear of their HMO because he has not completed the treatment yet and, in the words of his HMO, ''This determination to provide coverage . . . may be terminated at any time, even if the condition or treatment remains unchanged.''

Jacob and his family are currently receiving treatment, but they live in fear.

I can give you the story that I received last Friday, a very powerful case involving a small boy and how he was denied needed surgery by one of the major HMOs in this country.

This is happening every day, every hour. People all across the country understand it. Certainly the parents of these children understand it. Mrs. Mills understands what is happening. I doubt there is a Senator's office that hasn't received similar calls in the last few days.

We have had a series of votes in the last 4 days, and each of these votes has been decided in the interest of the insurance industry. They have prevailed over patients' interests, but only by a narrow margin. That is only temporary.

Mr. President, I yield myself 2 minutes on the bill. We may have lost the battle for the minds of Republican Senators, but we are winning the battle in the minds of the public.

Once the debate is over and the votes are counted, the action will move to the House of Representatives. I believe we will do better in the House because of the groundwork we have laid in the Senate. We intend to keep the pressure on. There is still a good chance that a strong Patients' Bill of Rights can be enacted into law by this Congress this year. A switch of only two or three votes would have given us victory after victory on each of these specific issues.

If there is an attempt to bury this issue in the Senate-House conference, the consent agreement makes clear that we can raise it again and again in the Senate this year. Every day, every week, every month we delay, more patients suffer.

This is a Pyrrhic victory for the Republicans. If they keep taking marching orders from HMOs, they will keep losing public support. The American people will not be fooled by hollow Republican promises and cosmetic Republican alternatives. Patients deserve real protections, and not just some patients, but all patients.

You should not have to gamble on your health. You should not have to play a game of Republican roulette to get the health care you need and deserve. This issue is not going away. Too many people have had too many bad experiences with abuses by HMOs and managed care health plans. They know the horror stories firsthand. Everyone knows these abuses are wrong, and, frankly, we have only just begun to fight.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. I yield to the Senator from New Mexico such time as he may consume.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. I thank the chairman. Mr. President, I ask unanimous consent that I be permitted to speak for 30 seconds as in morning business.

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

Mr. DOMENICI. I thank the Chair.

(The remarks of Mr. DOMENICI pertaining to the introduction of S. 1379 are located in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

Mr. DOMENICI. Mr. President, I wish I had brought a prop with me. It would have been the front page of the New Mexico papers in 1997, because in 1997 across New Mexico there were front-page stories and headlines. Guess what they said: ''New Mexico Passes Patients' Bill of Rights.''

Six months later, in July of 1998, there could have been a comparable headline across New Mexico, my State, the State in which the Democrats want to cover every single person who has health insurance. There could have been another headline saying: ''Patients' Bill of Rights Now Effective in New Mexico.''

Maybe if I had brought that newspaper with me, some people from that side of the aisle would understand. They do not trust the States and even if the States already have protection through a bill of rights, they still want to take over nationally.

Forty-two States have protections for some or all of the very same things that are in the Democratic bill that the editors across America, at least to the extent identified by the distinguished Senator from Massachusetts, seem to be supporting. They do not even say in our State we already have the protection, except they imply it in Texas by saying: How can it get to be so expensive when we already have it?

I ask the question: If they already have it, why do we need to pass one? Our premise is that 42 States already

have many of the protections being suggested here. Some of them are moving in the direction of covering more than is being proposed here. Why do we insist that they would be better enforced in Washington, DC? I submit to anybody who understands the bureaucracy in Washington, do you really want every State's protection under a bill of rights to be dependent on HCFA? HCFA cannot handle in any diligent manner, with any reasonable conclusion, the work we have given them on Medicaid and Medicare and benefits and figuring out who can pay what. And now they want to give HCFA, from every State in the Union, huge numbers of the very people the other side of the aisle is crying for but who are already protected.

I do not know if we will ever get anybody, outside of those who hear what I am saying, to write that and check it out. It does no good to say the Democrat plan covers 161 million Americans. The question is, Why do we cover 161 million Americans?

I will introduce as part of my remarks the entire list of patient protections and mandates that are already in New Mexico's law. It reads like a litany of the issues we have been debating: Emergency room, OB/GYN, and how you get protection under it.

Everybody in New Mexico, on all the issues we have been discussing, is already covered, except whom? Except those the Republican bill covers as we introduced it and have debated it, for it goes out into the land and says there are some people the Texas Bill of Rights does not cover because they cannot; it is not legal for them to cover them. Some people in New Mexico are not covered. I wish I could tell you how many, but nobody knows how many. Some have insurance, and we cannot cover them with New Mexico's rights. So we are covering them here. So it is a bill of rights for those who are uncovered in America.

I do not know how we will ever make the point, but let me just say, if you do not need coverage under a bill of rights because you already have it, then how does anyone get by with coming to the floor and saying: We're covering it anyway, and the other side of the aisle isn't covering it and they don't care? How do you get away with that?

Mr. GRAMM. Say it 200 times.

Mr. DOMENICI. I think you just keep saying it, like they have been saying it. It can be nothing else. In fact, there are many States with broader bill of rights' protections today than the Democrat bill, if it were passed. So why do they need it?

Mrs. BOXER. Would the Senator yield for a question?

Mr. DOMENICI. I want to finish. It is the first time I have had to speak. I looked over and you spoke at least 10 times, and you did beautifully.

Mrs. BOXER. Not quite.

Mr. DOMENICI. I would like to finish and then answer any questions when I finish.

Mrs. BOXER. Good.

Mr. DOMENICI. So I decided the best thing I could do is come here to the floor and see if I could express, in as simple language as I could, why the Congress needs to pass a Patients' Bill of Rights. I think I have tried my very best today to say we probably need one for those who are not covered or cannot be covered in our States because, by operation of law, the States do not cover them and cannot cover them.

Actually, I wish we could say that 200 times. Maybe we ought to. Every time somebody stands up, we ought to say: We're covering those who are uncovered in America. Now let's go on to the rest of the debate, and then put up a sign and say: We're covering 48 million—put it up there—because they are the only ones who either do not have this protection or cannot have it. These people are not covered because the law says you cannot cover them, the States simply do not have the authority to provide these rights to these people, vis-a-vis, the health insurance they have.

Having said that, I believe that answers most the questions that have arisen in this debate. But, then I understand there remains—I see this as only four issues—another very interesting issue. Because at this stage of the evolution in the United States of America of settling disputes one goes to court and asks a jury to do it even though plenty of criticism exists from laymen and professionals on how inefficient, how lacking in rationale the decisions are that are rendered by juries and trial lawyers bringing cases. The Democrats insist that we put that in here as the mechanism, the means, the way to settle disputes over scope of coverage, whether you have given somebody what they are entitled to under an insurance policy or not, or given them the specialists they are entitled to.

Can you imagine, we are making a major issue here out of whether the lawyers and juries and courtrooms ought to decide that? Can you imagine that we could stand up before a group of people and say, just as the millennium arrives, we have concluded that with all the knowledge we have, everything we know about arbitration, mediation, ways to avoid going to juries and courtrooms, that this was the way to resolve this issue, and if we do not do it, as our opposition says, we are denying people insurance coverage?

What we need to look at before the day is over—and what I hope those who wrote editorials will look at—is did the Republicans have in their bill a method and means of resolving these disputes which are legitimate disputes? Do we have a method of resolving them that is apt to do it expeditiously, professionally, and is it apt to be right?

I believe, with what has been added here on the floor and will be in the bill tonight, when we finally vote on it, that we can stand up and say, there is a way.

We think enough of this issue that we have made it nationwide, as I understand it. There will be no insurance policies that do not have this approach to settling the solutions across the land. That is pretty fair. Because it is sort of generically necessary for whatever set of rights you are giving to people.

So there are two issues. Frankly, for me, they are both very simple. I have explained the one on scope of coverage, and I have just explained the one on why in the world would you get lawyers and juries involved in the disputes between patients and health care systems on coverage. If doctors perform their service improperly, we still have medical malpractice. That is not being changed here. It is when you sit down and have an argument about a specialist, can you get a decision quickly.

I have heard from our side, from some very good experts—and as a matter of fact, we on the Republican side are very fortunate. We have a great doctor helping us. Frankly, when he tells us about this, I am not even sure we need a second opinion. He seems to know the answers very well, and we seem to rely on him. We are very glad to have him. He suggested, along with Senator ASHCROFT and others, that we ought to have a more straightforward, forthright, expeditious, and enforceable provision to handle the disputes between patients and their insurance coverage as to what they are entitled.

Those are two of the issues. To tell you the truth, if those two issues could be resolved, we would be well on our way to having it done.

There are some other issues that are around on the scope of what exactly we ought to mandate? They are not as important as these two. Who should we be covering? Should you let lawyers instead of doctors, lawyers instead of independent professionals, determine the scope of coverage and the entitlement of people to coverage under insurance, and the delivery of health care under new insurance approaches in the United States?

My last point, those couple of editorials my friend from Massachusetts read were written by editorialists who said we should not be concerned about cost; we should only be concerned about care. Let me tell you, one of the reasons we do not have enough coverage in the United States is because health care is expensive. While there are some who think the money just flows down from heaven and we pay for coverage, most people know somebody is paying for it—a business. In my State thousands of small businesses are paying for it.

If you think it is not important to them as to whether they maintain coverage, how much coverage they are going to pay for it, and whether their insurance costs go up 6.1 percent or not, then I guarantee you, you have not been reading the letters I am getting in my office from small businesspeople saying: You cannot give us too many mandates and you cannot have lawyers suing us because of the kind of coverage we have.

You may be surprised, but businesses do not have to provide health care. That is the law in America. It is voluntary on the part of most businesses. I am very pleased that most businesses are moving as rapidly as they can to buy insurance.

But I guarantee you, the other issue is, how much do we have to add to health care costs to get a reasonably good system for patient protection that is not now available in America? That is what we have been talking about, doing that where it is not available because of the operation of law.

We could go into three or four more issues, but I choose to give my own summary and my own understanding of the real nature and philosophical difference between that side of the aisle, the Democrats, and this side of the aisle.

Frankly, everyone around here knows I am not a Senator who votes one way all the time. I have been known to have a big argument with my friend from Texas, and he votes one way and I vote another. I will not chalk up the results, like that scoreboard: DOMENICI—6; GRAMM—0. But in any event, we have had those disagreements.

Mr. GRAMM. It was the other way around.

Mr. DOMENICI. He will think it was the other way around.

But in any event, the point of it is, it does not normally fall on this Senator to come to the floor and brag about our side of the aisle being right. But I can tell you, on this one I am very pleased with what has happened. I never have felt more comfortable than I have with this task force of Republicans who have handled this issue.

They have been good. They have been sharp. They know the issues, and there has never been a shortage of Senators arguing on this bill. I have been very pleased that they are willing to answer questions far more than I am. They know much more than I do.

I believe the issue is as I have painted and described it today. If it turns out that by beginning to cover a bunch of people who aren't covered, we only add eight-tenths of a percent to the cost, we don't inject into the system lawyers and courtrooms and jury trials to determine disputes between a provider and patient, and we provide for resolution of disputes in an expedited manner, as is going to be done in the bill we will introduce when we wrap this thing up tonight, I think we are on the right track.

I don't believe the American people, contrary to what my good friend, Senator KENNEDY, said, are going to be fooled by this. I don't think when it is over they are going to say: Boy, we would have had much better health care if the Democrats would have won their way. I think many are going to say it would have been a lot more expensive. I think many of them will say: We would be back in Washington every week trying to get the rules out of HCFA, which can't handle what it has now, much less handling all the States in terms of the Patients' Bill of Rights and the remedies available under it.

I thank everybody who worked on our side as diligently as they have. I particularly say we are lucky in the Senate to have Dr. BILL FRIST as a Senator. He is on my Budget Committee. I had trouble. I used to say his name ''First'' instead of FRIST. It took me a while. He tried to correct me six or eight times, and I finally got it. I think we are very fortunate to have him here because when he tells us how this works, and he shares the opinion of how the medical people are looking at it and what the reality is, I end up thinking Tennessee did us a very special favor by sending him to us.

I close by saying, I hope after all this work, the proposal that the Democrats offer will get defeated and that the final Republican bill, which will be explained again in depth by others, passes. Let's go to conference and see how it all turns out.

Mrs. BOXER. Will the Senator yield for a question?

Mr. DOMENICI. How much time do we have remaining?

The PRESIDING OFFICER. Twenty minutes.

Mr. DOMENICI. Do you have any time?

Mr. REID. I yield 2 minutes on the bill to the Senator from California.

Mrs. BOXER. Mr. President, I say to my friend, who is my chairman, how much I respect him and also how much I disagree with him.

I ask my friend a question. The Senator said—and I think he said it very clearly and straight from the heart—the Democrats are wrong, it is a philosophical difference, that we are wrong to say we need a national bill because the States are taking care of this problem.

Senator DORGAN has a chart. I want to ask the Senator if he will take a look at it. Thirty-eight States have no protection for their people when it comes to access to specialists. It goes down the list. Many States have virtually no protection on most of the issues we are debating in this Patients' Bill of Rights. The question is, How does the Senator respond to that?

He has said States are taking care of it when, just taking specialists, there are no protections for people getting specialists in 38 States, and there is a whole other list that I won't go into. I think that is an important question. I would like to hear the Senator's response to it.

Mr. DOMENICI. Sure.

Mrs. BOXER. The fact of the matter is, he says unequivocally, States are taking care of it when people in those States are writing to us and telling us: We need a Patients' Bill of Rights at the national level. We have no protection.

Mr. DOMENICI. Mr. President, I tried as best I could to say 48 States have patients' bills of rights. I did not say 42 States have every single item that the Democrats want in the Patients' Bill of Rights, but they do have the authority to put in as much as they want. So if the sovereign States, their Governors and legislatures, think your litany of things ought to be there and they are that important, they have the authority to pass it.

Mrs. BOXER. Mr. President, if I may take back my time, I ran for the Senate on a lot of issues. My friend has been elected many more times than I have to the Senate. We stand up and we say what we believe.

For example, I know the Senator is very strong on mental health protection. I have been with him on that. For me to think that I am going to sit here and say some legislature in some other State knows more than what my people tell me, I think we are here to do the people's business. When we look at this list, when we see how many things people don't have, I think it is ducking responsibility to say we should walk away from it.

By the way, the Republican bill claims to give people specialists, so the Senator himself has argued in favor of it for 48 million people.

Mr. REID addressed the Chair.

Mr. DOMENICI. I already have answered.

Mr. GRAMM. Will the Senator give me 10 minutes?

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. We have 31 minutes; they have 12 minutes. The minority yields 5 minutes to the Senator from Illinois, Mr. DURBIN.

Mr. DURBIN. I thank the Senator from Nevada.

Mr. President, for those who have followed the debate this week, there have been some very clear-cut issues decided on the floor of the Senate. Sadly, I must report that the Republican majority and the insurance industry have prevailed on every single effort by Democrats to provide protections to families across America when it comes to their health insurance.

Take a look at the scoreboard. On the Democratic side, we offered protection to 113 million Americans who were left high and dry by the Republican side and the insurance industry. We lost.

We offered an amendment saying that every woman in America could choose her OB/GYN as her primary care physician and could not be overruled by an insurance company. We lost.

We offered an amendment saying that emergency room care could be at the hospital closest to your home instead of that dictated by the health insurance policy. We lost.

We offered an amendment saying that doctors should make medical decisions and not the health insurance companies. We lost.

We offered an appeal process that gave families a fighting chance when the health insurance company turned them down for coverage. We lost.

We offered an amendment for access to specialists, when your doctor says that is in your best interest, in order to come out of a process healthy and well. We lost.

We offered the latest treatments, clinical trials, prescriptions that doctors recommend to save the life of someone in the most perilous of circumstances. We lost.

I have to give credit to the insurance lobby because, through their efforts on the floor this week, they have rejected every effort we have made to provide protection for America's families when it comes to health insurance. I used to think the gun and tobacco lobbies were the big ones on the floor of the Senate. My hat is off to the insurance lobby. They have really done a job. With the Republican majority, they have defeated us time and time again on 11 different amendments, 11 different efforts to protect American families.

There may be dancing tonight, when this is all over, in the boardrooms of the health insurance companies in America, but there won't be any dancing in the family rooms for those American families who realize that tomorrow they are just as vulnerable to a decision made by a health insurance company clerk as they were yesterday. There won't be any dancing in the emergency rooms across America, as the nurses and doctors there respond to emergencies, never knowing whether or not the insurance company will reimburse them for their heroic efforts to save lives. And there won't be any dancing in the doctors' offices, as they leave the room with the patient to go to a backroom and call an insurance company and beg them for the right to make the best medical decision for an individual.

I know the Republican side has criticized us for bringing pictures of real people to the floor of the Senate. I know it scalds their conscience to see these pictures, pictures of kids such as Rob Cortes, a little 1-year-old, a little boy I met last Sunday. Every time I voted on an issue this week, I thought about this little boy and his family in the Chicago area. This little 1-year-old breathes with a ventilator, as my colleagues can see. He has spinal muscular atrophy. His mom and dad fight every day so he can live, and they fight the insurance company every day to make sure they have an opportunity and access to the miracle drugs they need to give this little boy a chance.

The Republicans tell us this is unfair. Don't bring us pictures of real people. We want to talk about statistics. We want to talk about the 1993 Clinton health care bill. Give me a break.

I say this: If doubletalk were electricity, the Senate floor would be a powerplant after the debate that we have had this week on health insurance. I think the American people know what is at stake. They realize they had a chance, with the Democratic Patients' Bill of Rights, to have some rights and some protections when it comes to their health insurance, but they have lost.

There has been a decision made by the Republican side of the aisle and the insurance companies that they are going to create and protect a privileged class in America, the health insurance companies. They won't be answerable to the law, and they will not have to provide the kind of medical protection that every family counts on in America. Time and again, as we have offered these amendments, the Republican majority has defeated them. It is true that two or three of them have crossed the aisle from time to time to join the Democrats, but never enough to make a difference.

Sadly, that is how this debate is going to end. But it isn't going to end today. This debate will continue because we are calling on American families across this Nation to join us, to let the Senators on the other side of the aisle know that there are more important things in this town than the health insurance industry. Let them realize that this is the only building in America where health insurance reform is a partisan issue, because in every house I have visited in Illinois, families have told me time and again, whether you are a Democrat, Republican, or independent, you are vulnerable to an accident or illness that can leave you at the mercy of a health insurance clerk who will overrule your doctor and make a decision that can make your life miserable. That is what this is all about.

Vice President GORE came up here today with a last-minute plea to the Members of the Senate to pass a bipartisan bill to protect families. He told the story of a doctor who was working in the emergency room and a man came in and had a cardiac arrest before him. This doctor used a defibrillator and brought the man back to life. When the hospital turned in the charges, the HMO rejected him, saying it wasn't an emergency, it was only a cardiac arrest.

Let me tell you, this issue is not cardiac arrest; it is alive and well, and we will continue to fight it.

The PRESIDING OFFICER (Mr. BENNETT). Who yields time?

Mr. JEFFORDS. Mr. President, I yield the Senator from Texas 10 minutes.

Mr. GRAMM. Mr. President, one of the frustrating things about this debate is that when facts are established, our dear colleagues on the other side of the aisle continue to use information that has no foundation in fact and which, in fact, is at variance with the facts. So what I would like to do is to go through and present the facts, not as I would like to make them up, or as our colleagues may have made them up, but the facts in terms of the findings of the Congressional Budget Office, the nonpartisan arm of Government which does estimates on the basis of which we run Government.

First of all, the CBO estimate which I have here says that the ultimate effect of the Kennedy bill would be to increase premiums for employer-sponsored health insurance by an average of 6.1 percent. That is not my number, that is the number of the Congressional Budget Office. That converts into $72.7 billion of costs that will be borne by companies that pay insurance and employees that often match that expenditure.

Senator KENNEDY has made headlines by saying we are talking about a hamburger a month. The reality is that the estimate of the Kennedy bill by Congressional Budget Office is enough money to buy every franchise of McDonald's in America. It is estimated that this cost will mean that 1.8 million Americans will lose their health insurance. That is 1.8 million people who won't have access to health care at least paid for by insurance of any kind.

Our colleagues on the Democrat side of the aisle don't seem very concerned about 1.8 million people losing their health insurance. But we are very concerned. We looked at public opinion strategies nationwide poll of small businesses which asked what they would do if the Democrat bill were adopted and you could sue not only the HMO, or the health care provider, but sue the company that bought the insurance policy. The responses indicated that 57 percent of small businesses in America say that they either would be very likely to drop health insurance coverage, that is 39 percent, or somewhat likely, 18 percent. That is 57 percent of the insurance for some 70 percent of the working people in America that would be jeopardized by this bill. Yet, over and over and over again, we hear this talk as if there are no costs involved.

Now our colleagues go on and on as if repeating something would make it true, by saying that their bill covers 161 million people and our bill covers 48 million people. The way Federal law and State law is structured, the federal government has jurisdiction over 48 million people in terms of health insurance under a Federal law called ERISA. My State has passed a comprehensive health care Bill of Rights. Maybe Senator BOXER would not support their Bill of Rights, but Senator BOXER would not be elected in Texas. I might not support the Bill of Rights in California, but I probably would not be elected in California.

The point is, who elected Senator BOXER to write health care policy for State insurance in Texas? Nobody in Texas elected her. Nor did they elect me for that purpose. If I wanted to write State insurance policy in Texas, I would have run for the Texas senate and not the U.S. Senate.

So we have this absurdity that is stated over and over again that they are covering more people than we are. We are covering the people in America who are under Federal jurisdiction. They are preempting State law in every State in the Union, and Senators

who have never been to some States in the Union are dictating to them about the jurisdiction of their legislature. Yet, somehow it is suggested that I don't care about people in Oklahoma. I care about people in Oklahoma so much that if the State has the power to write their own health care Bill of Rights—which they do in Oklahoma—I want them to write it. That is how much I care about them. But in that area where it is Federal jurisdiction, I want us to write it.

In terms of continuity of care, if there has ever been any debate in history that could be referred to as somewhat contradictory of a previous position, it is this. I want to remind my colleagues who today aren't concerned about a 6.1-percent increase in the cost of health insurance, who aren't concerned about 1.8 million people losing their health insurance, who in 1994 they were so concerned about double-digit health inflation—an inflation rate we would match if their bill passed, they were so concerned that they wrote the Clinton health care bill. And they were so concerned about medical necessity that when they wrote it, here is what their medical necessity was:

> The comprehensive benefit package does not include an item or service that the national health board may determine is not medically necessary.

Today they are jumping up and down about medical necessity. They want a doctor to choose. They want us to write in our bill that we are going to let the Federal Government define it. But when they wrote their health care bill in 1994, they said that a national board would decide.

They talk about point-of-service option. But when they wrote their health care bill, if you didn't join their health care collective, you would be fined $5,000. If your doctor prescribed a health treatment that was not approved by the Clinton administration, your doctor would be fined $50,000. And if they provided a health service that wasn't prescribed and you paid for it, your doctor could go to jail for 15 years.

Now, that is how much they cared about all these things when they were trying to put America under socialized medicine. They were trying to do it because people were losing health insurance, because costs were going up.

Yet today they are trying to pass a bill that would drive costs up and that would deny people their health insurance.

Having spent all of this time answering all of this misinformation, let me spend the rest of my time saying a few things that I feel strongly about.

No. 1, I have never been prouder of the Republican majority than I am today. I have never seen greater collective political courage than I have seen today.

It would be very easy with all of this demagoguery about insurance companies, HMOs, health, consumers, and charts showing scores of HMO's 12, consumers 0.

I remind you that our Democrat colleagues invented HMOs. TED KENNEDY in 1978 said:

> I authored the first program of support for HMOs that passed the Senate. Clearly HMOs have done their job.

What is TED KENNEDY saying today? He loved them so much that he wanted to put the whole Nation under one run by the government. But, today, he is trying to kill HMOs.

We are not trying to kill HMOs. I am not ashamed of that.

I want to give people a choice so that if they don't want to be in HMOs they can get out. We broaden their options. We give people the right to fire an HMO.

Senator KENNEDY gives people the right to sue one. We guarantee people the right to see a doctor. He guarantees the people the right to see a lawyer.

I am proud, when it has been so easy to demagogue this issue, that we have stood up for the interests of this country.

We have written a very good bill. It cleans up the things in HMOs that needed to be cleaned up. But it doesn't kill off the only mechanism we have to control costs.

We provide tax deductibility for the self-employed. That will mean millions of people will get health insurance that do not have it today.

We let people have medical savings accounts—a new, innovative way to let people choose their own doctor and control costs at the same time.

I am proud of what we have done. It is easy to demagogue, but it is hard to lead. We have led, and America is going to benefit from our leading.

Finally, let me say we have come forward with a bill that works—a bill that works for people, a bill that holds down costs, a bill that promotes equality.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I yield 5 minutes to the Senator from North Dakota, Senator BYRON DORGAN.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, I guess my favorite Will Rogers quote is the old one that we all know. He said, ''It ain't what he knows that bothers me. It is what he says he knows for sure that just ain't so.''

I heard a lot of discussion today about facts and about whose side is right. In fact, we just heard the two stages of denial on the central argument of the Republicans against our real Patients' Bill of Rights.

The first stage is that States provide all of this protection, so we shouldn't have to do it. And when informed the States don't do it, they say, well, that might be true, but the States could do all of it if they wanted to. That is the second stage of denial, of course.

Let me talk again about some of the people involved in this debate, if I might. This is, after all, fundamentally about patient care. It is not a debate about theory.

I want to talk about Ethan Bedrick once again. This young boy pictured here was born under very difficult circumstances. During his delivery, the umbilical cord wrapped around his neck and consequently, he was born with cerebral palsy and a condition called spastic quadriplegia. He can't get the rehabilitation services he needs to help him because his HMO says there is only a 50-percent chance of his being able to walk by age 5 and that chance is insignificant. The HMO called a 50-percent chance of being able to walk by age 5 a minimal benefit. His parents appealed and appealed. Guess who they appealed to—the same people who turned them down.

We know that in 31 States there is no right to an independent, external appeal. The Republican plan says that Ethan Bedrick and citizens in 31 States are denied coverage. Denied. That is the fact. Dispute it if you can, but those are the facts and they are stubborn.

Or what about Jimmy Adams. Jimmy Adams doesn't have hands or feet today because his folks had to pass three hospital emergency rooms before they got to the fourth hospital where the HMO would pay for his emergency care. On the hour-long trip to the further hospital, his heart stopped beating. They were able to revive him, but too much damage had already been done by the lack of circulation to his limbs. This young child lost his hands and feet due to gangrene.

Our opponents say, young Jimmy Adams can stop at any emergency room under the Republican bill. Sorry; not true. The Republican bill doesn't cover over 100 million people, and there are 12 States that have no protections with respect to emergency room care.

With respect to Jimmy Adams, or a Jimmy Adams of the future, the Republican plan says this: Denied.

What about this young fellow born with a severe deformity? Dr. Greg Ganske, our Republican colleague over in the House, does reconstructive surgery. He surveyed his colleagues, and 50 percent of them had HMOs deny reconstructive surgery for young patients with birth defects such as this.

Here is the picture Dr. Ganske used when he described the kind of circumstances these children live with.

What about an appeal for this young fellow? What about the access to the specialist services needed? The Republican plan says ''denied'' to this young child—denied. Under the Republican plan—and in 38 States—there is no provision for access to specialists for reconstructive surgery.

Those are the stubborn facts.

Let me show you the bright morning of hope for a young child who was born with a cleft lip who has had access to the appropriate reconstructive surgery. This is the same child I just showed you.

Here is the way this child looks with reconstructive surgery. What a world

of difference this makes in a young child's life.

This is called patients' rights.

Some say it doesn't matter; we don't need it. We say these rights are critical to the health of the people in our country. This is about children, men, women, families.

Would anyone in here, if this were your son or daughter or your parent, really stand up and say let the States protect his or her. Would you really vote against these basic protections, such as access to specialists, if it were your child's health on the line? You know the answer to that. Of course, you wouldn't.

We just heard a fill-in-the-blank speech from about three people. You could fill in the blank. Over and over, in debate after debate, year after year, the subject changes, but the mantra remains the same: Let the States do it.

During the debate to create Medicare we heard the same thing: We don't need Medicare; let the States do it.

On minimum wage—Let the States do it.

On protections for residents of nursing homes—Let the States do it.

On efforts to create a safer workplace or prevent child labor—Let the States do it.

That speech has been given in this Chamber for 150 years, and it is so tired, rheumatoid, and calcified that I don't want to hear it anymore.

We have had to fight for every step, for progress on such issues as creation of the Medicare program, a safe workplace, and minimum wage. Tonight we are fighting for something called a Patients' Bill of Rights. All along the way, we see people digging in their heels saying for lots of reasons that they don't want to do it.

We need to do it for these children. No longer shall we deny them the rights they deserve in our health care system.

The PRESIDING OFFICER. Who yields time?

Mr. REID. Mr. President, I yield 5 minutes to the Senator from North Carolina, JOHN EDWARDS.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Thank you, Mr. President.

Mr. President, actually for almost 20 years before I came to the Senate, I had an opportunity to see firsthand what insurance companies do to people because of the type of work I did.

What I saw was they take people's money. They deny them coverage when they need it, and when they need them the worst, they are never there.

What I have seen on the floor of the Senate for the last week is what insurance companies do in Washington.

What they do is this: They make certain that the power in the health care industry in this country remains with them.

They have done that in a remarkably effective way. It has been extraordinary to watch what has happened over the course of the last week.

It boils down to—at least, to me as a first-time observer of this—a very simple fact. On the floor of the Senate this week, insurance companies have won and the American family has lost. The children, parents, and members of American families have lost and the insurance companies have won. This is what has happened.

No. 1, insurance companies cannot be held accountable. They absolutely cannot be held accountable. They have done everything they can do to make sure that occurs. The reason for that is very simple. I have listened to my colleagues on the other side argue with great emotion that we want to turn health care over to lawyers.

Exactly the opposite is true. This is why. What happens, in every amendment, in every single bill—including the underlying bill offered by the other side—this language appears: ''when medically necessary and appropriate under the terms and conditions of the plan.'' That language is the killer language. It is the language the insurance companies need, that they desperately want, and that they have gotten. It is the language that is going to remove any power from any patient or any family or any doctor in America as a result of what is passed on the floor.

The reason they are wrong about lawyers is because the plans control. Under what has passed during the course of this week, the plans always control. They control what benefit patients receive to begin with; they control what patients can appeal; they control what happens on appeal.

I ask the American people: Who do you believe writes these plans for the big HMO companies of America? Who do you think writes these plans? Lawyers. Their teams of lawyers write these plans.

When we leave the floor tonight, starting tomorrow, everything that is passed will be handed to the HMOs; the very first thing they will do is get in their cars and drive down to their big law firms and hand these over to the lawyers and the lawyers will go to work. What the lawyers are going to do is write health care plans that make absolutely certain the insurance companies have total control over what happens, they have control over the initial benefit, they have control over the appeals process, and that they cannot, under any circumstances, be held accountable.

Mr. REID. Will the Senator yield?

Mr. EDWARDS. Yes.

Mr. REID. It appears what the Senator has said as an experienced trial lawyer from the State of North Carolina, the lawyers will be under the control of the insurance companies?

Mr. EDWARDS. That is absolutely true. These are lawyers hired by the insurance companies.

Mr. REID. The talk of the lawyers controlling what is going to happen with the Patients' Bill of Rights is a flip-flop. The lawyers will control what goes on with health care in America as a result of what has happened here, is that right, because the patients have lost and the insurance companies have won?

Mr. EDWARDS. Absolutely.

What will happen is that the lawyers will write the plans, and under every single thing we have passed during the course of this week, the plan controls; the insurance company controls.

If anyone thinks for a minute that the lawyers who are hired by these insurance companies are not going to write the plans in a way that protects the plan and the HMOs and never protects the patient, they are living in never-never land. That is exactly what will happen.

As a result, in its simplest terms, the insurance company and their team of lawyers have won this battle. The patients have lost.

One last thing. We have heard lots of talk about cost from the other side. That is a false argument. It is a false argument for a simple reason. No. 1, what will happen under our real Patients' Bill of Rights is that we get patients to emergency rooms, to specialists, to the doctors who they really need to see as quickly as possible. That has an extraordinarily important cost effect, which is they get treated more quickly, their condition and disease is diagnosed more quickly, and as a result the long-term costs associated with that are reduced.

Our bill will reduce costs over the long haul. It will absolutely reduce costs when the long-term expenses and costs are considered.

Second, when an HMO or health insurance company acts recklessly and irresponsibly and a child, for example, is severely injured and that child incurs millions and millions of health care costs over the course of his or her lifetime, the health insurance will not be held accountable. No way are they held accountable. Those costs—the millions and millions of dollars—don't go away.

The question is, Who pays? The American people pay. The American taxpayers pay. They pay through Medicaid. That is the only way those costs will be paid. Instead of an HMO being responsible for paying, the American taxpayer pays. The people listening to this pay.

Mr. REID. I yield 2 minutes to the Senator from California.

Mrs. BOXER. Mr. President, we are in the final inning, so it is time to bring out the scoreboard.

HMOs, 12; patients, zero. It is a shutout. On every amendment, patients have lost and the HMOs have won. Mr. President, 12–0 and counting.

The Republican bill will pass. It is a bill supported by the insurance industry. It is a bill supported by the HMOs.

This is what it leaves out: It leaves out OB/GYNs for women, the right to a specialist, the right to an emergency room, the right to a clinical trial for every fatal disease, the right for all Americans to be covered—70 percent of

Americans are not covered in the Republican bill. It leaves out the right to hold HMOs accountable if they kill you, if they maim you, if they hurt you or any member of your family.

The Republican bill is a shutout. The American people are shut out from any protections. Patients are shut out. Decency and fairness are shut out. And the HMOs will continue to put their dollar signs ahead of our vital signs.

We will not give up. The innings may be over on this particular battle, but we are going to be here. We will be here for several more years and we will fight this. As Senator DORGAN said, a lot of these fights took a long time. It took a long time to get Medicare. There were fights from the other side of the aisle that it was a horrible idea to give senior citizens coverage.

I could go back in history. We will be on the right side of history because we are fighting for what is right for the patients of this country, for the people of this country. It has been a good debate. I am glad we have had it. I think it does show the difference between the parties. I think we are very open and honest about our differences. I am proud to stand on this side of the aisle on this Patients' Bill of Rights.

Mr. REID. Mr. President, I yield the final 4 minutes to the person who offered this amendment with Senator KERREY, the junior Senator from the State of Maryland, BARBARA MIKULSKI.

Ms. MIKULSKI. Mr. President, it has been interesting to me that during the two hours I have been here, in the time allocated to this amendment, no one from the other side has debated the merits of the Kerrey-Mikulski amendment.

We have heard about the health care plan, we heard about Mrs. Clinton's health plan, but no one challenged the fact that the American people should have continuity of care. Just because a business changes their insurance company, you should not have to change your doctor.

Also, we heard a great deal about the States—let the States do it. I bring to the attention of my colleagues, only 22 States have a continuity-of-care provision; 28 States do not. So, 28 States are vulnerable to the lack of a continuity-of-care provision.

Also, all 50 States have a Constitution. So why should we have one ourselves? Why should we have one? The reason we have a Federal Constitution is that we are one nation under a law that should protect all American people and we also have a Federal Constitution that we love and cherish because we have a Bill of Rights.

Imagine if we were still waiting for the 14th amendment, if we were doing it one State at a time. Imagine if we women had gotten the right to vote, if we had done it one State at a time. Do you think the railroads would have let us have the direct vote by the people of the Senate? No; I think we would still be choo-choo-ing along under the old system.

Let's talk about the cost. I think that is a fallacy in the argument. This Congress is going to debate in the next week or two a tax bill that could plunge us into a deficit. Sure, we think we have a surplus, but it is a promissory note surplus; it is not a guaranteed surplus. So while we are going to talk about cost, just wait until we start talking about that tax bill.

The other thing is, we did not hesitate to pass the national ballistic missile system. I will tell you something. My constituents in Maryland are more at risk for their lives and safety from insurance gatekeepers preventing them from having access to the medical care they need than they are of some missile striking us in Baltimore, Crisfield, Hagerstown, or all around the State, or this country.

So let's not talk about cost. And let's not invent phony arguments. Let's go back to what we are debating, the Kerrey-Mikulski amendment that says let's provide continuity of care. It is very straightforward. It would allow for a transition that, when a doctor is no longer included as a provider under a plan, or employers change plans, it would provide 90-day transitional care for any patient undergoing an active course of treatment with a doctor.

That means if you have diabetes, it means if you have high blood pressure, it means if you have glaucoma, that you can at least have a transition plan to have someone meet your needs.

Then we make three exceptions. We make them for pregnancy, we make them for terminal illness, and we make them for someone who is institutionalized.

A patient who is dying should not have to change a doctor in the last days of his or her life. If you are pregnant, I think you ought to have the doctor through post-partum care that is directly related to delivery. That's what we are fighting for today, and I hope we pass this amendment. I yield the floor.

Mr. JEFFORDS. I yield 3 minutes to the Senator from Alabama.

Mr. SESSIONS. Mr. President, I just want to say something and get it off my chest. It is offensive to me, and almost demeaning to this Senate, for people who disagree with the work that has been done by people such as Dr. BILL FRIST, and Senator COLLINS from Maine, and Senator JEFFORDS, who worked hard on this bill, to suggest that they are bought and paid for by insurance companies and HMOs.

I haven't talked to an HMO, but I have talked to some people who are concerned about expanding costs of health care. It is Alabama businesses. We had the Business Council of Alabama in my office just a few days ago, a group of them. It is the biggest group in the State. The first thing they said was: JEFF, please don't vote for something that is going to skyrocket health care costs. We are afraid of that. We have already got an 8-percent inflation cost increase predicted for next year; 8 percent already. You vote on a bill, the Kennedy bill, with 6 percent more? Please don't do that. We can't afford to cover our employees. They are going to lose health care.

And the numbers back that up. This is what we are about.

It offends me to have it suggested that some insurance company is here—HMOs are not even here, that I have observed. They do not care what the rules are. You tell them what the coverage is, what the rules are, and they will write the policy and up the premium to pay for it. And working Americans are going to pay for it. That is what is really unfair to me.

For Senators to suggest that there is a scorecard and only truth and justice and decency and fairness occur when her amendment is voted on? We have amendments. This whole bill mandates and controls and directs HMOs on behalf of patients. Everything that is in it, that is what it does. Some just want to go further, and whatever you do is never enough. There is always another amendment to go further.

It is a sad day when we have a group of fine Americans who worked on this legislation for 2 years or more, to present a bill that is coherent, that improves and protects the rights of people who are insured to a degree that has never happened before, and have them accused of being a tool for some special interest group. It is just not so. The Members on the other side know it, and they ought not to be saying it. It is wrong for them to do so.

I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. Mr. President, I yield 3 minutes to the Senator from Tennessee.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Mr. President, I want to comment on the process. We have seen pictures of infants with various medical challenges that I need to clear up. It keeps coming back and back again. The example of cleft palate is being used over and over. I want to demonstrate, to help educate our colleagues, because obviously it is not coming through what is in the bill, what will be in the final bill tonight.

No. 1, let's just say the baby is born with a cleft palate, which is a defect in the upper part of the mouth. The doctor recommends surgery, regardless of what is in the health plan. The HMO contract says ''cosmetic'' surgery is not covered.

So the medical claim is made. The doctor and the patient say: Yes, this thing is medically indicated. The plan has written down that cosmetic surgery is not indicated. So they say: We want to do something about it.

Today they have to throw up their hands. There is nothing they can do. That is why we need a Patients' Bill of Rights. What happens? We have an internal review built into the plan. So if there is a disagreement, the doctor and

the patient disagree with the plan, there is a process, for the first time for most of these plans, for internal review. They may have other physicians who are affiliated with the plan making that decision. Let's just say they came up with an adverse decision. Basically, the second opinion inside the plan, the internal review, said: No; I am with the plan. We are still not going to cover it.

Well, is it eligible, or is it not, for external review? Remember the external review plan. You have the managed care company; you have the entity that is government regulated; State, Federal, Department of Health and Human Services regulates this entity. This entity appoints an independent doctor, a medical specialist, if necessary, to do the review: Is it eligible or is it not?

The key worlds are, ''Is there an element of medical judgment?'' There clearly is, because you have a doctor saying that cleft palate needs to be repaired. So automatically—and that is the trigger—it goes to an independent external review.

We have heard a lot of people say it is not independent. It is pretty independent if you have a managed care company, you have an entity that is government regulated here that is unbiased—the words are actually in the plan—appointing an independent reviewer, who is a doctor. Or, if it happens to be a chiropractor of concern—it can be a chiropractor, I might add, who is independent, a specialist in the field, who makes the final decision.

In the independent external review, the reviewer makes an independent medical determination made on a whole list of things that we have in there—not just what the plan considers, but best medical practice, generally accepted medical practice, the peer reviewed literature, the best practices out there, what his colleagues are doing—and then a decision is made and whatever decision is made, it is binding. It is binding on the plan.

Let's just say it is binding on the plan, so let's have ''repaired'' here. Let's say the plan says, ''We are still not going to do it. I don't care what the reviewer says.'' You are going to see in the final bill that they have to do it. If they do not do it in a timely fashion—I want everybody to read the bill—they are going to be fined.

Mr. President, I ask for an additional 2 minutes.

The PRESIDING OFFICER. The Senator is recognized for an additional 2 minutes.

Mr. FRIST. I thank the Chair.

So the decision has been made by the independent reviewer, and it is binding on the plan that you do the repair, that it is medically necessary and appropriate. The plan has to do it. We are still worried. What about that plan, if it just doesn't want to do it? Basically, what we have are penalties that are built in the bill. They have to do it, they have to do it in a timely fashion, and if they do not they are fined $10,000. Not only that, if they are fined $10,000 and still don't do it, immediately you can go to somebody else and have it repaired. And who is going to pay for that? The initial plan.

To me, that is the way the process works. You have an independent reviewer. You guarantee the patient gets that repair in a timely fashion, if in that independent review it is thought to be medically necessary and appropriate, regardless of what the HMO contract says.

Internal appeals, external appeals, independent reviewer with penalties built in if that is not carried out in a timely fashion, and the guarantee that the care can get done because you can go, even have a third party do it and charge it back to the initial plan—unbiased, independent, internal, external appeals, and that is the accountability provisions that are built into this bill. I am very proud of the fact it is there. It will change the way medicine is practiced by managed care.

I yield the floor.

Mr. DORGAN. Will the Senator yield?

Mr. NICKLES. Mr. President, how much time do we have remaining?

The PRESIDING OFFICER. The Senator has 2 minutes 35 seconds.

Mr. KENNEDY. Just for a question, may I yield a minute to Senator DORGAN?

Mr. NICKLES. Yes. Sure.

Mr. DORGAN. I just wanted to observe for one moment, I listened to the presentation. That presentation works with respect to the people who are covered. But there are 120 million who are not covered. If one says those who are not covered are covered by a State, we must point out that 38 States do not have provisions that guarantee access to specialists. I want to make the point.

Mr. FRIST. Say again, covered by that?

Mr. DORGAN. There are 120 million people, roughly, not covered. And we have 38 States—if the proposition is ''but if we don't cover them in our bill, the States do,'' there are 38 States that do not cover them either.

Many of these children will simply not have access to a specialist. Those are the facts.

Mr. FRIST. May I respond on his time? This is a critical point because we have been debating scope. It is very important for the American people to understand and for our colleagues to understand that scope, and when it comes to accountability, the internal and external appeals, the independent reviewer does not just apply the 48 million people not covered by the States. It is covered by people who are both ERISA covered, federally regulated, as well as the States, and it is important my colleagues understand that because that is a huge part of our bill. In many ways, it is the heart of our bill for the appeals process, the accountability, what I just went through, both ERISA, federally regulated plans, and State plans. That is why it is so hard, in the last hours of this debate when it is so misunderstood what is in this plan. That is why I tried to go through it very clearly. It covers all 124 million people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, how much times remains?

The PRESIDING OFFICER. Two minutes 21 seconds.

Mr. NICKLES. Mr. President, I appreciate the clarification made by our colleague from Tennessee. My colleague from Tennessee said we have this appeal process which applies to all plans, State-regulated plans as well as federally regulated plans, and that is very important. For people to say this would not have an appeal process, it would not apply to them, they are absolutely wrong. Any employer plan in the country would, from the internal and external appeal under the bill which hopefully we will be passing shortly.

For the information of our colleagues, we are going to be voting in the next minute or two on the pending amendment, and then we will take final action on the substitute that will be offered by Senator LOTT and myself and others. We expect to be voting on that, just for the information of our colleagues, by 8:15, hopefully no later than 8:30. We are going to be wrapping this up.

I have one final comment. I urge my colleagues to vote no on the pending amendment. The pending amendment deals with continuity of care, all of which we support, but it tells the States: We don't care what you are doing. It is another one of these examples of we know better, we can define continuity of care better from Washington, DC, than the States. That is a serious mistake.

In addition to overruling State laws, it also takes away an existing right under ERISA. It eliminates injunctive relief which would apply to everybody in the plan. It eliminates class action and injunctive relief on page 8 in the amendment. I do not know why they put it in. It is wrong. It is in the amendment. A person can go to court and say: I am entitled to the benefit under the plan, and the judge can agree, but the court can only agree for that one individual. It cannot agree for all the participants in that plan. That is a violation of current law which takes away rights in existing law. It is a serious mistake and should not be allowed. I urge my colleagues to vote no on the underlying amendment.

I yield back the remainder of our time. I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 1253. The yeas and nays have been ordered. The clerk will call the roll.

The legislative assistant called the roll.

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

The result was announced—yeas 48, nays 52, as follows:

[Rollcall Vote No. 209 Leg.]

YEAS—48

Akaka	Edwards	Lieberman
Baucus	Feingold	Lincoln
Bayh	Feinstein	Mikulski
Biden	Graham	Moynihan
Bingaman	Harkin	Murray
Boxer	Hollings	Reed
Breaux	Inouye	Reid
Bryan	Johnson	Robb
Byrd	Kennedy	Rockefeller
Chafee	Kerrey	Sarbanes
Cleland	Kerry	Schumer
Conrad	Kohl	Snowe
Daschle	Landrieu	Specter
Dodd	Lautenberg	Torricelli
Dorgan	Leahy	Wellstone
Durbin	Levin	Wyden

NAYS—52

Abraham	Frist	McConnell
Allard	Gorton	Murkowski
Ashcroft	Gramm	Nickles
Bennett	Grams	Roberts
Bond	Grassley	Roth
Brownback	Gregg	Santorum
Bunning	Hagel	Sessions
Burns	Hatch	Shelby
Campbell	Helms	Smith (NH)
Cochran	Hutchinson	Smith (OR)
Collins	Hutchison	Stevens
Coverdell	Inhofe	Thomas
Craig	Jeffords	Thompson
Crapo	Kyl	Thurmond
DeWine	Lott	Voinovich
Domenici	Lugar	Warner
Enzi	Mack	
Fitzgerald	McCain	

The amendment (No. 1253) was rejected.

Mr. LOTT. Mr. President, I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

Mr. LOTT addressed the Chair.

The PRESIDING OFFICER. The majority leader is recognized.

UNANIMOUS-CONSENT AGREEMENT—AMENDMENT NO. 1251

Mr. LOTT. Mr. President, I ask unanimous consent to vitiate the yeas and nays on the pending amendment No. 1251, as amended.

The PRESIDING OFFICER. Is there objection?

Mr. GRAHAM. Reserving the right to object, could I add a further statement to that unanimous consent request?

Mr. LOTT. Fine.

Mr. GRAHAM. I ask unanimous consent to be able to offer an amendment at this time.

Mr. LOTT. We have to object to that.

The PRESIDING OFFICER. Objection is heard.

The amendment, as amended, was agreed to.

The amendment (No. 1251), as amended, was agreed to.

AMENDMENT NO. 1254 TO AMENDMENT NO. 1232

(Purpose: Providing legislation to improve the quality of health care, protect the doctor-patient relationship, augment patient protections, hold health care plans accountable, and expand access to health care insurance throughout the country)

Mr. LOTT. Mr. President, 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 Mississippi [Mr. LOTT], for himself and Mr. NICKLES, proposes an amendment numbered 1254 to amendment No. 1232.

Mr. LOTT. 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.'')

UNANIMOUS-CONSENT AGREEMENT

Mr. LOTT. Mr. President, I have consulted with the Democratic leader, Senator DASCHLE, on this next unanimous consent request. I know Members will be interested in this.

I ask unanimous consent that the vote occur on passage of S. 1344, as amended, at 8:20 this evening, with the Lott substitute and amendment No. 1232 having been agreed to and notwithstanding paragraph 4 of rule XII and the consent agreement of June 29, 1999.

I further ask that the time between now and 8:20 be equally divided between the two leaders, or their designees.

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

Mr. LOTT. Mr. President, that having been agreed to, the final vote will occur at 8:20, with the time equally divided between now and then. So Senators who want to participate should be prepared to be here to be involved in the debate. Those who want to get supper at this point, now is the time to do it.

Having said that, I want to go ahead and make my statement on this substitute package at this time. Then I will yield to the assistant majority leader, Senator NICKLES, who will divide the balance of our time between Members on our side of the aisle who wish to speak on the final package.

I think we have had a really good debate on this issue. We have been on it 4 full days now, into the night on Monday, Tuesday, Wednesday, and now Thursday. There have been a number of amendments offered. Some of them have passed and some have failed. But I think it has been handled quite well on both sides of the aisle. I believe we are now ready to finish the debate and get to final action on this legislation.

I thank the floor managers for the good work they have done. Senator NICKLES and Senator JEFFORDS on our side have been ably assisted by a number of our colleagues who have spent long hours on the floor, including Senators FRIST, COLLINS, and a number of others. Senator REID has done an excellent job as the whip on the Democratic side of the aisle, working with Senator NICKLES on behalf of the leaders to make sure time has been handled properly, and working out the charts on what amendments would be offered when, which has proven not to be an easy task, but one they have done a great job on.

Of course, I have enjoyed the exchanges that involved Senator KENNEDY and sometimes Senator GRAMM. It has been interesting, and I guess we can say elucidating in some respects. I also thank the task force on our side that has worked for a year and a half on this issue to make sure we were ready to go with an alternative, or to go with a solution to the problems we found in this area. They have done excellent work. Again, this task force was chaired by Senator NICKLES. Other members were Senators ROTH, GRAMM, COLLINS, FRIST, GREGG, SANTORUM, SESSIONS, ENZI, and HAGEL.

There has been a lot of great work by those members of the task force and members of the Health Committee who spent a lot of time and participated in the debate that has gone forward. I have really learned to appreciate the statement I heard on the floor earlier, that with Dr. FRIST, you really don't need a second opinion. He has done a great job. Sometimes it has been hard to understand for those of us who have not been in the medical profession. I appreciate that.

I think it is time we moved forward. We have done good work. Let's report out this legislation and go to conference and let's get a result.

There are certain things patients do need in America. Consumers do need some guarantees. I could go through a list of areas where there are problems, and I am going to go over the solutions we have here. I think the worst thing we can do now is to not wrap this up with a concluding favorable vote.

Now, there are some who will say the President will veto this bill. When we passed the missile defense bill, the word was: I will veto it. But we worked it out and he signed it. It was the same thing on education flexibility. The word was, you have language in here on the Individuals With Disabilities Education Act and we thought we should meet our commitment there before we spent money on a lot of other programs. In the end, we worked out the disagreements and the President signed education flexibility.

Today, for the first time in history, enrolling, signing of a bill was done by Senator THURMOND and by the Speaker, and it was sent by Internet to the White House—the Y2K liability bill. It came out of committee on a partisan vote, but some Democrats worked with all of the Republicans and we got a bill through the Senate. It took us three tries. We were told the President would

veto this bill, but he is going to sign the bill.

The point is, to the President and to those of you who haven't supported the Republican position on this Patients' Bill of Rights Plus, work with us. If you want to get something done, let's make it happen. If you want an issue, you have got enough votes, you will have issues; so will we. And then what? Is America going to be better off? No. Let's get results. We have done that in the past on other issues related to health. So I challenge our Democratic friends to join us in this effort.

This is the main event. We have gone through a number of votes and we have had our debate on these amendments. But now we are dealing with a comprehensive package that the task force has developed on the Republican side of the aisle, and it will strengthen the rights of patients and improve the way HMOs work, without wrecking the American health care system.

The American people don't want the Federal Government to take over health care. They don't want that. They don't want bureaucrats making the decisions, and they don't want it being determined by a bunch of lawsuits. But they do want some action to clarify and solve some of the problems we have.

Make no mistake about it, the version of this bill that we have offered is far superior to the Democratic bill, which I believe contains a lot of bad policy. It is dangerous in many respects: dangerous because, under the guise of humanitarian concerns, it would drive into the ranks of the uninsured some 1.8 million Americans; dangerous because, under its compassionate rhetoric, it would threaten the ability of most small businesses to provide health insurance to their employees; dangerous because it would place the scalpels of litigation into the hands of the trial lawyers and virtually invite them to carve up the Nation's health care system.

I don't believe the American people want that. The system is not perfect. HMOs are not perfect, although the quality of their care, as every other consumer product, can vary tremendously from one group to another, from one region to another. In my own State of Mississippi, we only have about 5 percent of our health care that is provided by managed care organizations—5 percent.

So we have a very different view and set of concerns than do some of the other States where there is a lot more activity in this area.

If there is one thing we have learned from the downfall of the Clinton health package in 1994, it is this: The American people don't want the Government to control health care. They do want solutions, though, to some of the real problems that exist, such as portability, which we did deal with. They want us to recognize the problems where they really exist, but they don't want political grandstanding in Washington to imperil the highest quality health care in the world.

I heard it said yesterday on the floor, ''Health care in America is in real trouble.'' There are concerns about the evolution that is occurring.

But health care in America is still the best that the minds of men have conceived.

My mother is alive today because of medical procedures. She is on her third pacemaker. She is doing fine. If her knees would hold up, she would still be out looking for a date.

And the pharmaceuticals and the medicines they make are miracle drugs.

We should not kill the goose that laid the golden egg.

Can we improve it? Can we work with all those involved in the system to make it better. We can do that. That is what we are doing today.

I hate to think where we would be if the Congress, 20 or 30 years ago, had attempted to micromanage health care the way this Democratic legislation attempts to do now.

I wonder if we would, today, have the non-invasive surgery, the miracle drugs, the sophisticated diagnostics that we all take for granted.

If the Government moved in and said we are going to start dictating this and say what you can do, what you can't do, and when you can do it, we would have a loss of that entrepreneurial, dramatic innovation and spirit that we have had in health care in America today.

The Congress should not imperil the continuing transformation of American medicine. Will it be different in 10 years? You bet it will. So will life in America. It is happening so fast that it is breathtaking.

It is not our job to control or dictate that transformation.

Our job is to find ways for more Americans to have broader access to those innovations in health care.

That is precisely the point of our Republican Patients' Bill of Rights Plus. We want to give more clout to health care consumers while, equally important, making it easier for families to get insurance. They will have a choice. They decide for themselves how they are going to get this care.

All the consumer rights in the world don't matter an aspirin if you aren't able to become a consumer. That's why our Republican bill creates new opportunities for uninsured Americans to buy into the health care system.

For starters, our bill makes all Americans eligible for medical savings accounts, not just the 50,000 currently allowed in a pilot program.

Give people that option to get into a medical savings account and to make the choice as to how they will use it. And give them the reward. If they don't have to spend it, they get to keep it. What a great American idea.

We offer full deductibility for health care costs. That alone will make insurance more affordable for 16 million Americans.

That is the way to go. We should make it deductible—not just for the self-employed, although we ought to do that, but for all of them. That would solve the problem of a lot of these small business men and women who can't afford to provide the coverage for their employees. Let them deduct the cost when they choose what they want.

We provide full deductibility for self-employed persons, so these 3.3 million hard-working people, and their families will have the same tax break that big business has. At least 132,000 households will be able to afford health coverage with this provision for the first time.

At every point, our approach is to expand access to health care. That is our greatest contrast with the other package that has been offered by Senator KENNEDY and Senator DASCHLE.

It is worth repeating.

If we went with their proposal, it would result in the loss of insurance for an estimated 2 million people.

That is far too heavy a price to pay for some of the things we have argued about this week.

This bill, the substitute amendment I am offering, is the main event of the debate of health care this week.

For the 48 million Americans whose health care plans are not protected by existing State regulations—that is a critical point—it will provide these things.

I want to emphasize that. The bill we are about to vote on will provide these things:

Guaranteed access to emergency room care;

Direct access to OB/GYN without prior authorization;

Direct access to pediatrician without prior authorization;

Better continuity of care if your doctor leaves a health plan;

Guaranteed access to specialists;

Improved access to medications;

Protection of decisionmaking by doctors and patients;

And, very importantly, our bill provides a way to get a review.

Dr. FRIST talked a lot about that. If the doctor makes a recommendation, and he and the patient disagrees with what the managed care organization says, they will have a chance to have a review internally, and then one externally with expedited procedures. And, at that point, there is still the opportunity for lawsuits. If they don't comply with the result, there will be penalties for noncompliance.

Again, instead of getting a lawsuit—which may be nice when it is finally concluded for your heirs—you will get action. You will get a decision through an appeals process.

That is the way to go.

I am not critical of lawsuits because I have a problem with lawyers. I am one. I was on both sides of this issue for plaintiffs and defendants when I practiced law. I was a public defender in my home county. I understand there is a necessity and a time for lawsuits. But

I don't think it should be the first resort. It should be the last resort. See if you can work it out. See if you can design an appeals process that will get you to a conclusion and that will get results, rather than a lawsuit that may be great for the deceased person's beneficiaries.

We believe patients should have a timely and cost-free appeals procedure to contest any denial of coverage. We believe patients should not suffer discrimination based on genetic testing. Our bill forbids it.

We believe government should facilitate breakthroughs in medicine and help providers gain access to them. Our bill does that, too.

What we do not do is put American health care in the hands and in the pockets of the trial lawyers.

Senator JEFFORDS has said it best: ''You can't sue your way to better health care.''

In that regard, the Democratic bill that has been before us this week reminds me of the old days of medicine. Well, we will bleed the patients. And, believe me, I think that is what would happen if we went with what they have proposed. It would be bled with Federal-level bureaucrats. They would be bled in the courts.

That is not the answer. I think that is a bad idea. There is a better way—a way that protects the rights of patients without imperiling the Nation's health care system; a way that opens the door to medical care; that gets more people covered by the insurance of their choice; a way that educates consumers so that they, rather than the government bureaucrats, can make their own informed choices.

That is the sum and substance of our Patients' Bill of Rights Plus. It is ''plus,'' because it is a bill of rights, but also it provides some tax opportunities through the medical savings accounts and the deductibility.

I thank many Senators who have worked on this issue on both sides of the aisle.

I think we all know a little more about this subject than we did, and maybe more than we ever wanted to know.

I have every expectation that it will win the Senate's approval and find favor in the House of Representatives.

I am optimistic, as I always am, that we can get a result. If we make up our minds to do that, we will.

This bill addresses the real problems many Americans face with the delivery of health care. It expands access to health insurance and makes it more affordable. It bans genetic discrimination in health care, expands research, and educates the consumers.

In short, it is the right thing to do, and this is the right time to do it.

I yield the floor, Mr. President.

The PRESIDING OFFICER. The Democratic leader.

Mr. DASCHLE. Mr. President, I yield 8 minutes to the distinguished Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. Mr. President, I yield 2 minutes to the Senator from Rhode Island.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. CHAFEE. Mr. President, I am a little bit confused over just what we accomplished in the past week.

As I understand it—I think it is pretty accurate—the Republican bill will pass. However, the President has indicated that he is going to veto this bill. And there is no question that the veto will be sustained. Then where are we? What have we accomplished in a week?

It seems to me that we have let the American people down in a situation such as has been outlined. People can say the President shouldn't veto. He is indicating he is going to do that. That is his privilege, obviously. We have been through that before.

So, therefore, it seems to me that we have to ask ourselves: Could we have done a better job? It seems to me that we could have.

I greatly regret we are not able to present the legislation which a bipartisan group of us had the privilege of working on. We believe that legislation would have accomplished something that we were not able to accomplish, as I previously outlined.

I believe we ought to cover all Americans; that is, all privately insured Americans—164 million. The legislation we will pass will not do that.

I believe we ought to have an effective and timely external review process to resolve coverage disputes. I am not sure the legislation we have before us—and that we will shortly pass and having examined it—accomplishes that.

I think we ought to be able to give patients the right to sue in Federal court for economic damages—only in the Federal court, and not in the State courts. I certainly have supported legislation to prevent the suits in the State courts.

We have dropped from our bill the controversial provisions codifying the Federal law—the professional standard of medical necessity. Instead, we added language to our external review provisions to ensure that external reviewers have a meaningful standard of review.

It is with some regret that I announce that I recognize we are not going to have a chance to present our legislation, and I think it would have been good. I think we would have avoided the problems we currently have before us and that our Nation and our citizens would be better off.

I thank the Chair.

Mrs. MURRAY. Mr. President, as we prepare for final passage of the Republican HMO legislation, I come to the Senate floor to express my disappointment and my frustration with this end product. This bill is a failure and ultimately we will all suffer the consequences of the majority's reluctance to protect patients.

I had high hopes at the beginning of the week that we could come together on some of the key areas of agreement and produce a good bipartisan bill to protect patients. I had hoped for a bill to put the health care decisions back into the hands of patients and consumers.

Our health care system is in a state of flux. It has moved from a system that served people only when they got sick and encouraged overutilization. Now we have a system where economic barriers are erected to prevent patients from accessing care. We have gone from a system of waste and over-utilization to a system where patients cannot get the care for which they paid. Decisionmaking—life and death decisionmaking—is now too often solely in the hands of insurance executives focused on profits and quarterly reports. Who is looking out for the patients?

We need to restore a balance with a system where insurance protects you when you become ill, but also helps prevent you from becoming sick in the first place. We need a system where the ultimate decision rests in the hands of patients based on the medical advice of their physicians. We need a system where people are fighting illness, not fighting the insurance company. We need a system where doctors are not spending 45 minutes on the phone with an insurance company so a sick child can be admitted to a hospital. We need a system where parents are free to stop at the first, closest emergency room and not drive to the one their insurer commands if their child has been hit by a car.

I know such a system does and can exit. One of my greatest concerns is what the failure of Patients' Bill of Rights means to managed, coordinated care. Let me tell my colleagues, I support managed care. I support a coordinated care approach that is focused on prevention and early detection of disease.

HMOs and managed care were born in my state of Washington. The original HMO law, signed by a Republican President in the early 1970's was enacted because of the new, revolutionary form of health insurance still in its infancy in Washington state. I want to be clear, health maintenance organizations are not the enemy. One of my colleagues yesterday made a statement that the Democrats saw HMOs as the bad guys. He tried to make a point that some how supporting the Health Security Act in 1994 and the Patients' Bill of Rights was contradictory. He was wrong. Our intent is to ensure patients the right to receive the care they have paid for, not to eliminate coordinated care.

The experience in Washington state has taught me that we can have a system that reduces overutilization and unnecessary care while actually improving health care benefits. I know that good managed care structure has increased our immunization rates. I know that it has contributed to the fact that almost 70 percent of women in Washington state over the age of 55

receive mammagrams. I know that a good managed care structure has increased our average life expectancy and reduced our infant mortality. It has reduced the number of people who smoke and decreased the incidence of heart disease. We have a healthier population in Washington state, in part because we have the benefits of a coordinated care delivery system that focuses on prevention and reduces wasteful, unnecessary health care services.

Unfortunately, things are changing in Washington. Due to mergers and acquisitions we now have health care plans being run by companies in California and other states. We now have for-profit insurance companies using HMOs and more importantly, we have premiums from HMO participants going to enhance short term profits. Our once envied system has deteriorated. I am hearing more and more from patients and physicians about the obstacles they must over-come to access health care. They must push hard to get wise health care decisions, not just big economic benefits.

I honestly believe that if we fail to restore some kind of balance, managed care will become a thing of the past. People will demand changes and will dismantle managed care. We will then be back to a system where only the very wealthy have regular and consistent access to quality health care and where you only see your doctor when you are ill, not to prevent illness.

I had hoped that a uniformed standard set of protections for patients would restore some trust to managed care. That is the only way we can ensure that the ''outrage of the day'' does not become the guiding force in state legislatures. If my colleagues think that by killing our balanced and fair Patients' Bill of Rights it will end this debate, think again. You can be sure that in the next session of the legislature in each state there will be new patient protection bills ranging from access to expanded, mandated benefits. Patients will demand this.

Ultimately, these single ''outrage of the day'' bills will be the nail in the coffin for managed, coordinated care. We will see the end of a health care delivery system that encourages prevention and keeps people healthier, longer. We will see a return to a system where access is only provided to the ill.

Not only does this jeopardize health insurance, it jeopardizes biomedical research and development. Why invest in research that prevents illness or prevents hospital stays or detects cancer sooner, when no one will have access to it? Why double NIH research dollars, to prevent illness and to find cures for deadly diseases like cancer and MS, if patients are not encouraged to seek care to prevent illness or to seek regular, prevention and early detection care? Doesn't it seem to be a contradiction to encourage biomedical research when we do not have a health care delivery system that invests in wellness?

Our Patients' Bill of Rights will not result in pushing people off of insurance. Our bill is a reasonable, cost effective proposal that does enhance managed care, not diminish it. It rewards those insurance companies that do offer a good package and a good product. They will no longer have to compete with companies that do not look at their beneficiaries as people, but rather premiums. There are good insurance companies out there. I know this to be true as there are several in Washington state. While I have heard of some problems in the state, I believe it is a combination of consumer misinformation and distrust. But, unfortunately these good companies have to compete in a very price sensitive market with companies that have policies in place to limit and deny access to quality care.

I am also disappointed that most of my Republican colleagues refused to engage in an open and honest debate. They offered amendments sold as access to emergency room coverage or improvements in women's health or access to clinical trials, when in fact their underlying bill is nothing more than a simple statement only saying we support patients, but not supporting and enforcing access to care. My Republican colleagues say they want these things, and as participants in the Federal Employees Health Benefit Plan we have these benefits and protections, but they do not provide them to all insured Americans because the insurance lobby has told them to say no.

This is a short sighted strategy as parents with sick children, cancer survivors, patients with MS or Parkinsons, and women denied access to ob/gyn care will ultimately be heard. Wait until they discover that for $2 more a month they cold have gone to the ER or they could have participated in a new life saving clinical trial at the Fred Hutchinson Cancer Research Center. They could have gone to see their ob/gyn when they first found the lump on their breast or their child could have seen a pediatric oncologist following a diagnosis of cancer. What do my colleagues think will happen when families realize that for the price of a Happy Meal each month they could have saved their child? There will be outrage and it will be heard all the way to Washington, DC.

I hope that this issue is not dead. I hope some how this is not the end of the debate and that like so many other issues we will be able to put aside partisan differences and work towards real patient protections.

Mr. LEAHY. Mr. President, we are coming to the close of a vital debate, and I do not use that word casually. The issues we are voting on in some cases have life and death consequences for the people we were elected to represent.

The individual rights spelled out in our Patients' Bill of Rights are clear, and they are specific. They are strong, and they would work. They have been painstakingly drafted and redrafted and then further refined for more than a year.

They have the support of hundreds of medical and consumer organizations whose millions of members work directly in this field. They would achieve for patients the very rights that our constituents have repeatedly signaled that they want and need and deserve in this age of managed health care.

We have offered the Patients' Bill of Rights, point by point, reform by reform. In response, senators on the Republican side of the aisle have cobbled together weak or illusory copies of these reforms, offered them in place of the real thing, and hoped that nobody outside this Chamber would notice the differences.

We have seen this happen with access to emergency case, with a woman's access to an OB/GYN and with a patient's access to specialists.

This flurry of amendments, mixing genuine rights for patients and the phantom versions from the other side, has obscurred some of these issues in a cloud of political dust. Tonight, with the final votes of this debate, that cloud will be lifted. Senators will decide whether they will stand with patients and their doctors, or with the insurance companies.

Senators will decide whether 161 million Americans can enjoy the protections of the Patients' Bill of Rights, or whether 113 million Americans will be left in the waiting room.

There are many key differences between the Patients' Bill of Rights and the fall-back plan that Republican leaders have come up with. But the most important differences are that our bill would cover everyone, our bill lets doctors make the medical decisions, and our plan holds plans accountable to take away incentives to minimize critical health care decisions that can hurt or kill people.

Just this morning, we have heard the Republicans attempt to justify why it is okay to protect HMO's from accountability for their decisions that lead to injury or death. Polls show that the public overwhelmingly supports the key elements of our Patients' Bill of Rights. Americans—the people that Democrats and Republicans alike say we are trying to protect—want the protections the Democratic plan offers.

I have heard from many Vermonters on their experiences with managed care. Each of these moving stories makes you ask: What if it was me, or someone I knew?

When I was home in Vermont last week, I picked up the Burlington Free Press and, beside a guest column he had written, was met with the friendly face of an old friend, Dr. Charles Houston. He and I go way back to my days as a prosecutor in Burlington when he was a prominent physician doing remarkable things in the Vermont medical community. He has been a beacon of good advice to me throughout my time in the Senate. He is an indispensable Vermonter.

Dr. Houston's commentary depicted the devastating and tragic experience

he and his wife had with their managed care company that ultimately led to his wife's death.

My wife is a registered nurse, so I get a dose of the practical reality of these problems across the breakfast table, as well as from the accounts I get from Vermonters. It is these personal accounts, like this one from Charlie, that bring home the need for a Patients' Bill of Rights.

Mr. President, I will ask unanimous consent that Dr. Charles Houston's article be entered into the RECORD.

Mr. President, the question today is this: Will the Senate pass a bill that protects everyone—161 million Americans who get their health care through a managed care program—or just a fraction of those families, the 48 million who are in employer self-funded plans? Will we continue to hear and read stories from the people in our states who have no protections? Will we continue to hear accounts like the tragic one of Charlie Houston's wife? I hope not.

The President has indicated that he would veto a so-called Patients' Bill of Rights if all we send him is one containing the weak Republican provisions.

Maybe then we can rescue those millions of Americans the Senate today has stranded in the waiting room without a real patients' Bill of Rights.

Mr. President, I ask unanimous consent to have printed in the RECORD the article to which I referred.

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

[From the Burlington Free Press, July 2, 1999]

MANAGED CARE NEEDS IMMEDIATE OVERHAUL

(By Dr. Charles S. Houston)

Can anything worthwhile be added to the billions of words written and spoken about health care? Why is our medical care today both better and worse than in the past? What happened?

Here's one story.

An 84-year-old nurse led an active life despite mild chronic lung disease, but after a long plane trip developed pneumonia. Finally admitted to the hospital, she was treated aggressively by an ever-changing group of specialists and nurses and went home after two weeks—but with diarrhea either from antibiotics or a hospital infection.

She was weak and undernourished but her doctors could not visit her at home, insisting she return to the hospital. When she refused, they tried to direct her care by phone. She drafted downhill and died two weeks later, a victim of efforts to reshape medicine by managed care in recent years.

First, traditional care was scrapped and most doctors forced to join systems and to abandon fee-for-service medicine. We are told this was done because: 1. care was getting too expensive; 2. too many people could not get care; and 3. technology had become so complex.

Managed care, we were told, would decrease the cost, eliminate waste, open the system to the needy, and provide highly technical care through specialists. In the capitalist mode, competition would cure all.

The goal became to provide the best possible care to everyone. Who could quarrel with this? Yet a moment's thought shows this was and will always be impossible: There aren't enough providers and other resources. But you don't need a Cadillac to go shopping; any car will do. Instead our goal should be to make appropriate care easily available to all who need and seek it. The treatment should match the problem, the cost must be affordable.

So what has managed care done? 1. The costs of care have skyrocketed even faster; and 2. specialization has led to fragmentation and medical care by committee. What little fraud had existed was replaced by the waste-filled octopus to non-medical insurance administrators who can—and do—overrule caregivers in major medical decisions. Doctors must climb walls of paperwork, distancing them from patients. It has become harder to reach or talk to your physician. Administrators and stockholders in the managed care organizations fatten on profits. Now many HMOs are failing or increasing rates prohibitively.

Two other dominating forces must be mentioned. Medical knowledge has expanded far more rapidly than has understanding of how to use it appropriately. More and more specialists with exotic devices do miracles, So, in part to protect the patient, in part for self-protection, physicians often feel compelled to consult experts, and some are reluctant to take leadership in care of an individual. Fragmentation became a worse danger than concentration of responsibility.

There's no virtue in crying wolf, and screaming catastrophe without offering a way of escape. Having been a practitioner for many years, alone and in groups, and a teacher in our medical school, I have watched and studied the destruction of traditional care with dismay. I'm confident that many patients and doctors feel as I do. Something must be done, and soon. Managed care as we know it must go. Though oversimplified, the following would be a strong start:

End or modify commercialization of health care. By regulation make hospitals, medical groups and insurers non-profit and monitor compliance.

Continue the lead role of a primary care provider as first call and facilitate appropriate consultation and resources.

Require insurers to open enrollment for all, allowing them a fair return on investment.

Since each state has different needs, develop statewide insurance plans to provide appropriate health care to all its citizens. Several years ago the Governor's Health Commission prepared such a plan but it failed. Why? Lobbyists? Economic fears? This plan deserves careful look.

Finally, a sad personal note. The patient described above was my wife of 58 years. She was truly a victim of the new medicine.

Mr. LEVIN. Mr. President, I strongly support the Patients' Bill of Rights which Democrats have offered and fought for during these four days of consideration and which the Republican majority has weakened at every turn. I cannot support the inadequate substitute which Republicans have now put before us. The Republican bill is full of loopholes in the fundamental protections for patients which we seek to provide. In fact, the substitute Republican bill provides almost no protections for nearly two-thirds of Americans with health insurance.

The Democratic bill would guarantee access to needed specialists. The Republican bill fails to guarantee patients access to needed specialists outside the HMO at no extra charge. The Democratic bill would assure access to the closest emergency room. The Republican does not guarantee access without financial penalty and prior authorization. The Democratic bill gives women the right to choose their OB/GYN as their primary doctor, as many women wish to do and protects women from ''drive-through mastectomies''. The Republican version is not adequate. And unlike the Democratic bill, the Republicans fail to hold HMOs accountable when their decisions and practices lead to the death or injury of patients. And, the Republicans would continue to allow insurance company officials to override the medical decisions of a patient's own doctors.

Mr. President, in short, the Republican substitute for the Democratic bill is a mere shadow which does not deserve the title, ''Patients' Bill of Rights''.

The core of the Democratic effort has been to ensure that insurance administrators not overrule a health care professional's medical decisions, that HMOs can be held accountable for their actions which is a responsibility every other industry has to its consumers, and to ensure that all insured are protected. The Republicans have developed a bill that leaves more than 113 million Americans with insurance unprotected because most of the provisions in their bill for the most part are narrowly applied to only one type of insurance, self-funded employer plans, which cover only 48 million of the 161 million people with private insurance.

Our bill ensures that the special needs of children are met, including access to pediatric specialists. It provides important protections specific to women in managed care such as direct access to ob/gyn care and services and the ability to designate an ob/gyn as a primary care provider, and provides specific protections regarding hospital length-of-stay for mastectomy, by allowing the physician and patient to make decisions the length of stay in a hospital following a mastectomy or lumpectomy. The Republican bill does not prevent ''drive-through mastectomies.'' Additionally, our bill speaks to the issue of specialty care. Patients with special health conditions must have access to providers who have the expertise to treat their problems. Our amendment allows for referrals for enrollees to go out of the plan's network for specialty care, at no extra cost to the enrollee, if there is no appropriate provider available in the network. There are about 30 million Americans who have had trouble seeing specialists with their HMO plans. This includes women and children with special needs who either had critical care delayed or, worse, had that care denied. On the issue of emergency services, the Democratic amendment says that individuals must have access to emergency care, without prior authorization, in any situation that a ''prudent lay person'' would regard as an emergency.

Survey after survey reveals that the American people support these proposed protections. And, there are over 200 patient groups and health care provider organizations, workers' unions, and employee groups, that stand behind the need for these patient protections. That list includes the American Medical Association, American Heart Association, American Nurses Association, American Public Health Associations, Center for Women Policy Studies and the Child Welfare League of America. We have a stark choice before us, a strong Patients' Bill of Rights that protects patients or a weak bill aimed at protecting insurance companies.

Earlier this week, Mr. Steve Geeter, husband and father of two young children of Grass Lake, Michigan, stopped by to visit with my office. Mr. Geeter has terminal brain cancer and will be participating in an experimental clinical trial at the National Institutes of Health over the next several months. Mr. Geeter and his wife spent a considerable amount of time with my staff discussing his options and limitations under his HMO plan and the need for reforms, including access to clinical trials. I very much appreciate Mr. Geeter taking the time to share his HMO experiences with my office. They substantiate the need for the legislation before us. Several months ago, Mr. Geeter's HMO plan required that he be released from the hospital after 24 hours of intensive care following brain surgery. The plan's justification was that Mr. Geeter had passed the neurological exams and transfer to a room would cost too much. Mr. Geeter subsequently developed complications and had to be returned to the hospital emergency room. This may have been averted with just an additional 1-day hospital stay-over. The Democratic amendment would have protected patients, such as Mr. Geeter, from an insurance company official requiring that they be discharged from the hospital prematurely. Plans would no longer be able to deny promised benefits based on an interpretation of medical necessity defined by insurance companies rather than the patient's health care provider. The Democratic amendment used a professional standard of medical necessity—based on case law and standards historically used by insurance companies.

Mr. Geeter also expressed strong support for the Democratic amendment on access to clinical trials of experimental treatments, which offer patients access to cutting-edge technology and are the primary means of testing new therapies for deadly diseases. Historically, insurance plans have paid the patient care costs for clinical trials, not the costs of the experimental therapy itself. However, research institutions, particularly cancer centers, increasingly are finding that trials, which once were paid for by health insurance, must be curtailed because of lack of payment by managed care plans. Clinical trials may be the only treatment option available for patients who, like Mr. Geeter, have failed to respond to conventional therapies. Under the amendment, trials are limited to those approved and funded the National institutes of Health {NIH}; a cooperative group or center of the NIH; or, certain trials through the Department of Defense or the Veterans Administration. The Republican bill provides no hope for patients with no options other than a promising experimental treatment down the road. A study is not enough for a patient with a life-threatening disease when there are no other treatment options and there is nowhere else to turn.

In addition to having the benefit of the input of Mr. Geeter, I've communicated with others in my state. Over the past several months, I have traveled around Michigan and met with constituents various communities to get their thoughts on our efforts here in the Senate. I have had discussions with physicians, hospital administrators, nurses, seniors, city and county government representatives and health care advocates.

Ms. Myrna Holland, a resident of Ferndale, Michigan and Director of Nursing Education at Providence Hospital expressed concern that patient choice is limited when HMOs engage in restrictive practices such as ''doctor-only'' policies. These professionals include, but are not limited to, certified nurse anesthetists, nurse practitioners physical therapists, optometrists, podiatrists and chiropractors. This is particularly important for patients living in rural areas. Many rural communities have a difficult time recruiting physicians, and often non-physician providers are the only source of health care in the local area. If a managed care plan covers a particular service, but there is no one in the community to provide it, rural patients are too often forced to drive long distances, incurring expense, to get the care they need. The Democratic amendment would have prohibited HMOs from arbitrarily refusing to allow health care professionals to participate in their plans by virtue of their licensure or certification. The Republican bill would allow HMOs to continue restrictive practices, leaving consumers with an inadequate choice of health care providers or limited access to health care.

Robert Casalou, Acting Administration of Providence Hospital in Michigan, raised concerns about continuity of care. The Democratic amendment assured continuity of care. When health plans terminate providers without cause or when employers switch health plans for their employees, quality of care for patients currently undergoing treatment can be severely threatened.. For example, a patient who is undergoing a course of chemotherapy should not have to change physicians abruptly in the middle of treatment, and a woman who is pregnant should not have to change doctors before she gives birth. The Democratic amendment allowed for a transition to lessen those problems. When a doctor no longer is included as a provider under a plan, or an employee changes plans, our amendment provided for at least 90 days of transitional care for any patients undergoing an active course of treatment with that doctor. The amendment also provided special protections for pregnancy, terminal illness, and institutionalization.

Additionally, Mr. Casalou, and others, expressed support for holding HMOs accountable for their actions. Today, 123 million Americans who receive insurance coverage through a private employer cannot seek redress for injuries caused by their insurer. All they can claim is the cost of the benefit denied or delayed. Even if an HMO has been directly involved in dictating, denying or delaying care for a patient, it can use a loophole in the Employee Retirement Income Security Act (ERISA) to avoid any responsibility for the consequences of its actions. ERISA was designed to protect employees from losing pension benefits due to fraud, mismanagement and employer bankruptcies during the 1960s, but the law has had the effect of allowing an HMO to deny or delay care with no effective remedy for patients. The Democratic amendment would have closed this loophole, ensuring that HMOs can be held accountable for their actions. It did not establish a right to sue. It simply says Federal law will no longer block what the States deem to be appropriate remedies for patients and families who are harmed. The only time an employer can be held responsible is when the employer is involved directly in a specific case and makes a decision that leads to injury or death.

Donald Anderson, who I spoke with in Detroit, is a quadriplegic who is in a wheelchair who changed jobs and also changed health care providers. Donald's new provider would not cover a rolling commode wheelchair for him after the wheel broke on the wheelchair he owned, even though his doctor classified the chair as a medical necessity. Our amendment would have allowed the physician, not the insurance company, to decide what prescriptions and equipment are medically necessary. The amendment provided that a plan may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or particular services if the services are medically necessary. Under the Democratic amendment, Donald would have received a rolling commode.

In Grand Rapids, I spoke with another constituent of mine, Dr. Willard Stawski, a general surgeon. Dr. Stawski told me about a patient of his who did not seek care for her hernia because she was told by her HMO that it was an unnecessary operation. Dr. Stawski told me that after his patient elected not to have the operation, she became very ill. Gangrene set in and she died several months later. Under

the Democratic amendment, this tragedy might have been averted. What a doctor deems to be medically necessary, is the medical treatment that the patient receives. Thus, Dr. Stawski's patient would have had the surgery because Dr. Stawski said that the surgery was medically necessary.

All we were asking for with this amendment is that patients be able to receive the care that a doctor or other medical professionals deems to be medically necessary. Doctors are frustrated, patients are frustrated. The Republican majority defeated our efforts to adopt these good amendments.

Mr. President, while I cannot support the Republican susbstiutute bill, I hope we will have a later opportunity to pass a strong bill of rights. The public wants a strong one and they are right.

Mr. BRYAN. Mr. President, for those Americans who have been harmed by the decisions of managed care plans, this public debate is long overdue. For those who yet face a decision about their health care made by their managed care plan, the end to the wait cannot come soon enough.

The Democrats' Patients' Bill of Rights will ensure those who depend on managed care plans for their health care will not be receiving a lesser standard of care than those who do not.

Last week while I was in Nevada, people voiced concerns about who really makes their medical care decisions if they are in a managed care plan. They wanted to know what would happen, under the Democrats' Patients' Bill of Rights, when a patient is told by his or her physician they need a specific treatment, and the physician informs the patient that the plan must first approve or disapprove his decision.

Would their physician be able to decide what treatments would be appropriate for their medical condition? Or, would they be at the mercy of a managed care plan bureaucrat far removed from the situation who would decide ''yea or nay'' on treatment determined necessary by their physician?

We can all empathize with the stress involved in this situation—your doctor has determined what your medical condition requires for appropriate care, but you must wait to see if what you need is approved by the plan. If the answer is ''no'', then you must either forego the care, or pay for it out-of-pocket —not a very good choice.

And what if you found yourself in the situation of a Nevada man, covered by an HMO plan, who came into an emergency room suffering from an upper gastrointestinal bleed. The emergency room physician called for a gastroenterologist to perform an emergency procedure to halt the bleeding. But the gastroenterologist would not treat this man without a prior authorization from the HMO plan. If he did the procedure without the authorization, he would not be paid. The doctor tried to contact the HMO for an hour to get the necessary authorization. During this time, the emergency room had to give the patient four units of blood, which would not otherwise have been required if the procedure had been done in a timely manner. Finally when it appeared the patient might not survive, the doctor contacted the HMO plan and said if he did not get authorization for the procedure, he would go to the media about this patient. The HMO then authorized the procedure.

The Democrats' ''medical necessity'' amendment would prohibit all managed care plans from arbitrarily interfering with a doctor's decision that the needed health care be provided in a particular setting, or is medically necessary and appropriate.

The amendment's definition uses a professional standard of ''medical necessity''. This is reasonable for both the patient and his or her treating physician, and the particular managed care plan. If a decision on whether or not to cover a particular treatment is made pursuant to a professional standard, it will be based on standards and case law interpretations historically used by insurance companies.

If a managed care plan can use its own definition of ''medical necessity'', any external review of a plan's treatment decisions would be resolved using that definition. This very likely would not work to the benefit of the patient.

The Democrats' approach would also maintain the important relationship between a doctor and the patient. It is a relationship that of necessity must be based on complete communication and trust between the two.

The Democrats' proposal will also ensure patients have a right to an external appeal from the decisions made by their managed care plans. One of the key provisions of this amendment is its requirement the appeal process be timely—for both internal and external appeals. It also requires ''expedited'' reviews when a patient is facing a medical emergency.

The Republican bill provides patients no guarantee of an expedited review for medical emergencies. Additionally, a managed care plan could simply delay sending the information needed for an appeal of one of its decisions. There is no deadline requirement for a plan to respond to a decision made by a reviewer. Without a timeliness requirement, patients are at the mercy of when, if ever, a plan wants to deal with an appealed case.

The Republican bill would drastically limit the application of its proposed patient protections to only one type of health care insurance—the self-funded employer plans. Those types of managed care plans provide the medical insurance for many Nevadans who work in the gaming industry. Those employees should have protections. But, why should 113 million people with private insurance be left unprotected? That is what the Republican bill would do, and it is wrong. For those small businesses which provide health insurance for their employees, almost all must depend upon the private insurance market for their coverage. Why should small businesses' employees have less protection than those workers in larger businesses which can afford to self-insure? Why should Americans who have to purchase their health insurance themselves, because they do not have an employer's assistance, be left unprotected?

The Republican bill will only cover 48 million Americans. The Democrats' bill will cover 161 million Americans—both those covered by self-insured employers, and those covered by private insurance. Why should 113 million Americans be without protection? Should we protect only 48 million, or protect 161 million? It is an easy decision.

Women should be able to designate their OB/GYN as their primary physician, and to have direct access to OB/GYN services without first having to obtain a specialist referral. Women also should make a decision with their physicians about the length of their hospital stay when they have a mastectomy. I have long supported these efforts to level the field of health care services for women. The Democrats' Patients' Bill of Rights will ensure those protections.

For individuals who are chronically ill, or have medical problems requiring access to speciality care, the Patients' Bill of Rights will require plans to provide access to specialists. If plans do not have an appropriate specialist within their plans, then the patient will be allowed to go outside the plan network, at no additional cost. The Democrats' Patients' Bill of Rights will ensure this access.

Every American should be assured the quality of their health care and their access to health care options is not diminished, because they rely upon an HMO for their health care coverage.

All of the 161 million Americans throughout this country who receive their health care through managed care plans deserve the protections included in the Democrats' Patients' Bill of Rights.

The opportunity is before us to ensure those protections. But that opportunity is going to be lost today. And that is a tragedy for everyone who depends on managed health care.

Mr. LIEBERMAN. Mr. President, I have been proud to join with Senators CHAFEE, GRAHAM, and other colleagues to express our shared dissatisfaction with the Senate's progress in reaching agreement on a strong patients' bill of rights, and to prepare a balanced, thoughtfully-crafted alternative that we believe would protect the rights of health consumers and could attract the support of a bipartisan majority of the Senate.

Listening to the deeply partisan discussions we have heard on the floor this week, I am reminded of the movie ''As Good As It Gets,'' which has become a cultural touchstone of sorts for venting the popular hostility toward HMOs.

It is not any particular scene I am thinking of, but the title itself. I am moved to wonder if this debate, which seems to be operating on political autopilot and showing no signs of producing anything other than a Presidential veto, is as good as we get in the U.S. Senate, and as good it gets for the American people, who don't know a second degree amendment from a first degree amendment, but who do know that our managed care system badly needs a transfusion of basic fairness and accountability.

We are here today to say that we can and should do better for America's families, that despite the apparent legislative logjam it is still possible to pass a constructive reform proposal, and that we are eager to offer a plan that Senators CHAFEE, GRAHAM, and many of us have been fine-tuning over the last few days which fits that bill.

While Sherlock Holmes had the 7% solution, we are offering a 70% solution.

Our bipartisan alternative includes roughly 70 percent of the patient protections that most Members already agree on, and strikes some balanced compromises on the remaining issues that continue to divide us.

The liability provisions in our bill are an example of our success in finding a sensible middle ground.

This case, the managed care case, reminds me why we have tort law; why we have negligence law; why we have a system of civil justice. There has been this odd result that ERISA has given total immunity to managed care plans who are today making life and death decisions about our lives.

The question is, how do we respond to that, how do we reform it? I think, with all respect that the Democratic bill goes too far.

It opens up the system to the unlimited right to sue and creates the same prospect for the lotteries that have been going on elsewhere in the tort system. I am concerned that those ills will be repeated here—some will get rich and others, many others, will not be adequately compensated for the injuries they suffer as the result of the managed care plan decisions.

And some small businesses and individual people will be priced out of health insurance by the costs that will be added as a result of runaway judgements.

I think the Republican plan, on the other hand, is not real reform because it essentially allows a patient, who is harmed by a negligent decision of a managed care plan, to be denied any significant compensation for their injury.

Under the Republican plan, patients have to traverse an elaborate series of procedural hurdles to be eligible for compensatory damages. First, the patient has to fight their way through the appeals process. Then the independent appeals body must grant a decision in favor of the patient. Finally, if the plan doesn't accept and deliver that treatment, then, under the Republican bill, the only right the aggrieved health care consumer has, is to go to court for the value of that lost treatment, plus $100 a day.

The amendment on liability which Senator GREGG offered went far beyond striking the liability provisions from the Democratic bill and would deny efforts to adequately compensate patients injured because of managed care plan decisions.

That's just not enough.

I think we've struck a reasonable compromise in our bipartisan bill. You're entitled to sue for economic loss which includes not only the cost of your health care, but lost wages, replacement services, and the value of lost wages and replacement services for the rest of your life based on the injury you've suffered.

And it allows for pain and suffering up to $250,000 or three times economic loss whichever is greater. It has pain and suffering but with a limit on it.

Another good example of our success in finding a sensible middle ground comes in the form of our plan's consumer information section, on which I have worked. Both the Democratic and Republican bills provide beneficiaries with information about coverage, cost sharing, out-of-network care, formularies, grievance and appeals procedures. One area of sharp difference is health plan performance. The Republican bill does not include any requirement that the performance of the plan, its doctors, and hospitals in preventing illness and saving lives be reported.

Our bipartisan alternative requires provider performance report cards because we believe this is critical information for consumers to have in deciding which managed care plan to choose. We also reached back to an earlier bipartisan bill I sponsored with Senator JEFFORDS to include waivers and other language to ease the difficulty of administration for HMOs, PPOs, and providers.

The bottom line here is that patients rights don't have to lead to political fights. There is a path to dependable consumer protections that does not require detours to bash HMOs or our colleagues. We have pled with our leadership to give us the opportunity to offer our alternative as an amendment today and prove our case.

If not, I am prepared, and I believe our coalition is as well, to offer this proposal as an amendment to another legislative vehicle in the Senate this session. The American people deserve more from this critically important debate than high-glossed veto bait. We must show them that we take their concerns and our responsibilities seriously, and pass a law that will in fact improve the quality of health care for millions of American families.

Mr. SARBANES. Mr. President, this week the Senate is finally addressing an issue that is vitally important to the American people—managed health care reform.

The number of Americans who receive health care through managed care organizations continues to increase at a rapid rate. Today, approximately 75 percent of those with employer-provided health insurance are covered by managed care plans.

Although managed care was put forth as promoting both greater efficiency and higher quality health care, all too often the lure of greater profits has resulted in curtailing care to patients dependent on managed plans for their medical needs. The American people are rightly demanding more patient protections, and it is clearly time for Congress to act to guarantee all Americans certain fundamental rights regarding their health care coverage.

The Democrats in both the House and Senate have worked hard to convince the Republican Majority of the need to establish safeguards for patients in managed care. For a long time the Majority chose to ignore the patients' plight and refused to acknowledge the need for any patient protections at all. Last Congress we proposed a comprehensive set of reforms designed to ensure that patients receive the care they have been promised and have paid for. I am proud to be an original cosponsor of this Democratic bill again this Congress.

After seeing how the public responded to this Democratic initiative, the Republican Majority did draft a managed care reform bill. But, unfortunately their bill calls for only the most minimal reforms; in many respects it is a sham. In addition, until this week, they persisted in blocking the issue from being brought up on the floor.

However, the Democrats joined together in insisting that the needs of managed care patients be given careful consideration. After much hard work by the Minority leader and others, an agreement was reached under which patients' rights legislation could be brought up on the Senate floor this week.

The debate which has taken place highlights the difference between the Democratic and the Republican approaches to this issue. The Democrats seek to provide comprehensive coverage and protections; the Republicans are minimalist in both respects. Let us look at some of the differences: the Democrats' bill would protect all 161 million Americans with private insurance; the Republican proposal ignores the over 113 million people who work for other than the large self-insured employers, or State or local governments, or who buy their own insurance.

Our bill would guarantee basic patient protections to all consumers of private health insurance. The Republican proposal would cover only the employees of businesses that assume the risk of self-insuring their employees. Thus, the Republican bill leaves out more than 70 percent of the consumers of private health insurance.

The Democrats' bill provides patients with access to specialists, whereas the

Republican bill is woefully inadequate in this regard. For those who are seriously or chronically ill, receiving treatment from a qualified medical specialist can mean the difference between life and death. Our Patients' Bill of Rights would guarantee that patients with special conditions could go to providers with the expertise needed to treat their particular problems, even if the needed specialist was not a member of a plan's provider network. Under the Republican bill, patients are not guaranteed access to the specialists they need and could be charged exorbitant fees for going to an out-of-network provider—even if the plan may be at fault for not having access to appropriate specialists.

The Democratic bill would prevent HMOs from arbitrarily interfering with doctors' treatment decisions whereas the Republican bill does not address this issue at all. The Republicans claim that our provision would allow doctors to order unnecessary care, but that is not the case. Under our bill, an insurer could still challenge a doctor's recommendation, but their denial of coverage would have to be based on medical facts not on their bottom line.

The Democratic bill would restore patients' ability to trust that their health care provider's advice is driven solely by health concerns, not cost concerns. It would prohibit the coercive practices used by managed care companies to restrict which treatment options doctors may discuss with their patients. The Republican bill would allow HMOs to continue terminating health care providers for having frank and candid doctor-patient communications and would allow HMOs to continue using incentives to bias a doctor's medical decision-making.

Managed care companies regularly refuse to pay for emergency room services without prior authorization. This unreasonable requirement has caused countless tragedies as people are forced to waste critical time finding an emergency room their HMO will pay for.

One of my constituents recently experienced this shocking treatment from an HMO. While hiking in the Shenandoah Mountains, she fell off a 40-foot cliff. She sustained fractures to her arms, pelvis, and skull but was quickly airlifted to a hospital in Virginia. Her HMO refused to pay the over $10,000 in hospital bills because she failed to gain ''pre-authorization'' for her emergency room visit. For over a year, she challenged her HMO and faced personal bankruptcy. Ultimately, the Maryland Insurance Administration ordered the insurer to pay the hospital and fined them for refusing to pay from the outset. However, her struggles with the HMO were not yet over. Within a year, after follow-up surgery for her injuries, she found herself again in need of an emergency room. This time she called the HMO beforehand, but was told they would pay only for her screening fees because the visit was not considered a medical emergency.

The Democratic Patients' Bill of Rights would guarantee that patients could go to the nearest emergency room during a medical emergency without having to call their health plan for permission first. Patients would have the right to receive the medical care they need without the limitations currently imposed by HMOs. The Republicans, on the other hand, would not guarantee patients access to the nearest emergency room and would not ensure that patients could receive full medical care without prior authorization.

Our bill would also provide patients with meaningful recourse if they are harmed by a managed care plan's medical decision-making. Today, there is nothing to discourage HMOs from denying critically necessary care. Thus, our bill creates a fair, independent, and timely appeals process through which patients could challenge a plan's denial of care. Under the Republican bill, HMOs could delay the appeals process indefinitely and many HMO decisions could not be appealed at all. Furthermore, where the Republican bill is silent, our bill would enable those harmed by the medical-decision making of HMOs to hold those HMOs legally accountable for second-guessing the advice of a treating physician. The Republican plan would continue to shield HMOs from accountability for conduct that results in injury or death to patients.

The American people need a meaningful Patients' Bill of Rights. That is why I strongly support the Democratic proposal put forward by Senator DASCHLE.

Mr. BAYH. Mr. President, in a few short moments we will be proceeding to our final votes of our four day debate on the Republican and Democratic versions of the Patients' Bill of Rights. I am taking the floor this evening to explain why I oppose both these proposals and to express my support, again, for the bipartisan approach to managed care reform that I sponsored with my colleagues JOHN CHAFEE, BOB GRAHAM, JOE LIEBERMAN, ARLEN SPECTER, MAX BAUCUS and CHUCK ROBB.

One of the most difficult obstacles to meaningful health care reform is that there is an inherent tension between our two most important objectives.

The first objective is to ensure the highest possible quality care. Regardless of our vantage point on the political spectrum, we can all agree that the United States offers the best quality health care in the world. Men, women and children flock here from every corner of the globe to gain access to our physicians and our hospitals. Maintaining this high standard of care must be at the forefront of any attempt to reform the means by which Americans pay for their health care.

Seemingly at odds with the objective of highest quality care is the need to make sure that health care is affordable. The ability to cure disease or heal the injured is rendered almost meaningless if only a fraction of the population can afford it.

Spiraling health care costs have a negative impact upon society in a variety of ways—some obvious and some not so obvious. I well remember the situation in Indiana when I took over as Governor. In the midst of our worst recession since the 1930s, our Medicaid costs were increasing by 20% per year, an increase that mirrored substantial annual hikes in the private market.

One clear result was that workers around the state were losing insurance as business after business found themselves unable to pay for even basic health coverage.

But for both the state government and for those businesses that maintained health insurance, the spiraling increases crowded out funding for many other significant initiatives and investments. On the state level, paying increased Medicaid bills meant less for education, transportation and child care. For private businesses the choices were equally stark—pay increased insurance costs and in so doing postpone expanding the workforce, offering pay increases, investing in research or modernizing factories and offices.

In 1989, we began to make some very tough decisions in Indiana to bring the Medicaid budget under control; private businesses similarly began to turn to managed care. For the past ten years, those changes have helped to keep health care costs under control and have resulted in continuing insurance coverage without having to choose between offering health insurance or creating new jobs, or maintaining Medicaid or education funding.

But today, there is ample evidence—acknowledged by Democrats and Republicans alike—that the pendulum may have swung too far towards keeping costs down, and as a result, we are jeopardizing the quality of health care that Americans receive.

In trying to redress this imbalance, there are a few lessons that we learned in Indiana that were useful principles for me to keep in mind as this debate progressed.

First, and perhaps most importantly, any significant reform had to be market-based. Any attempt to have the government control the health care system would be doomed to failure.

The Chafee-Graham bi-partisan bill that I have supported since taking office is market based; it sets some basic ground rules but leaves that actual management of health care to the experts in the private sector—the patients, the doctors and the insurers.

Unfortunately, the Republican plan takes the concept of market-based reform to its illogical extreme. That plan falls far short of establishing even the most basic protections for people in managed care. Most egregiously, the Nickles-Lott bill would only cover a fraction—less than 30%—of the people who have private insurance. We have all accepted the idea that there ought to be some minimum protections and

guarantees offered to those in managed care to prevent the abuses that we have witnessed over the past few years. But if all sides have accepted that principle, it seems very unfair that the majority would choose to leave nearly 120 million people out of the protections we all believe are necessary.

I strongly support the elements of the Democratic approach that advance these principles—access to specialists, proper emergency care, access to obstetrician/gynecologists, independent reviews of denial of care—but the bipartisan bill wisely avoids the one element of the Democratic Patients' Bill of Rights that I believe will drive health care costs up: expanded liability.

If health care costs do not remain under control, there are serious ramifications for both the national economy and for the American taxpayer.

The United States already pays more—expressed as a percentage of GDP—for health care than any other industrialized nation. A rise in these costs will have an appreciable negative impact upon our economic strength in an increasingly competitive global environment. With pressure from a unified Europe and resurgent Asia, the last thing this Congress ought to do is to help spur a dramatic rise in health care costs for a liability provision that is unlikely to make any American healthier.

And the American taxpayer is at risk if health care costs spiral out of control because it is the taxpayer who will foot the bill if hundreds of thousands of people are suddenly forced into the Medicaid system if they lose their health benefits. We simply, as a nation, cannot afford a return to the days when health care costs increased by double digits every year.

The bipartisan bill does allow some tightly controlled access to the Federal courts for suits that seek restitution for economic loss. It seems to me that before we expose health care plans and employers to unlimited liability and to punitive damages, we must at least try this limited, moderate approach.

Mr. President today we will face a test of whether Washington can still work. The American people will be watching to see if their cynicism and apathy towards the political process in general and Washington, in particular, will be deepened or whether we can put partisanship aside and restore their confidence in our ability to govern for the benefit of the nation.

Some in this chamber truly do not want to have any legislation that reforms the way in which HMOs operate; some do not want to have any legislation so that they can have an issue for the 2000 elections.

Neither approach serves the American people very well and that is why I support the bi-partisan bill as the only possibility to actually get something done. The Democratic proposal will not pass the Senate; the Republican proposal will be vetoed by the President and that veto will not be overridden. Compromise is the only possibility before us for success in this area.

The bipartisan bill strikes the right balance between additional patient protections and maintaining control of increasing health care costs. In the final analysis, we have a choice to make: do we choose to just give more speeches that won't help anyone, or do we try to get something done? Are we going to insist upon everything that we want, or will we put aside our partisan differences to get some of what the American people want?

It is my hope, even if that vote doesn't occur today, that the members of this Senate will pass the test by finally putting aside the rancor and bitterness of the past four days, to put aside the desire to score debating points off each other, and to rally around this centrist, responsible bipartisan bill that will give the American people the key components of HMO reform that they need and deserve.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. I yield 3 minutes to the Senator from Virginia.

The PRESIDING OFFICER. The Senator from Virginia.

Mr. ROBB. Thank you, Mr. President.

I commend my colleagues from Rhode Island and Florida for their efforts to try to craft a bipartisan compromise.

We succeeded in putting together legislation that I believe would have led us to a bill that could become a law.

As Senator CHAFEE indicated, we are in a situation where a bill that is supported by an overwhelming majority of all of the health-related organizations—doctors, nurses, patients, and providers—is not going to enjoy enough votes on this floor to pass.

The bill that will pass is going to be vetoed by the President.

I hope we can find a way to crawl out of our fox holes and find the common ground that is necessary if we are going to address in a responsible way the issues and the concerns we have been talking about for this entire week. I commend the leadership for sticking to their agreement and giving everyone an opportunity to be heard. I regret there was no sense of compromise on the floor. It is important we do that. I hope we continue with that mission. I appreciate those who have worked hard to achieve that compromise.

I yield the floor.

Mr. GRAHAM. I yield 1 minute to the Senator from Arkansas.

Ms. LINCOLN. Mr. President, I, too, compliment our colleagues from Rhode Island and from Florida. We have had a train wreck in terms of the health care proposals we tried to present this week in the Senate.

For the past few days in the Senate we have had a lot of colorful charts and graphs. We have seen a lot of ads on TV paid for by special interest groups. There has been a lot of partisan maneuvering. What we haven't had, what the American people haven't seen, is a sensible, moderate debate on this critical issue of health care.

Tonight, I am very proud to join my colleagues in trying to provide emergency relief, to find the middle ground in this debate with the proposal that should be acceptable to the majority of the people, the Members of the Senate, and without a doubt is in the best interests of the American people.

This issue is of great importance to the American public and they are waiting to see if Washington—and more importantly, if the Senate—will be able to do their job. And that is to present a plausible response to the reforms that are needed in this Nation's health care program.

I applaud my colleagues.

Mr. GRAHAM. Mr. President, I yield 1 minute to the Senator from Connecticut.

Mr. LIEBERMAN. Mr. President, I thank my friend from Florida.

It has been a spirited debate. We must acknowledge there have been impressive displays of party unity on both sides, but to what end? The end of the sound and fury is we will produce a bill we know the President will veto, and therefore there will be nothing done to help the American people with the problems they have with health care.

It didn't have to be that way. There was a third way. There was a third way that would have recognized and expressed something else the debate has concealed: The fact that across party lines we agree on about 70 percent of the topics we talked about. It was the aim of our bipartisan group to put that majority round of agreements on the bill. Unfortunately, we didn't have an opportunity to have it heard by our colleagues in this debate.

We will be back. We are going to submit our proposals and there will be another day.

I yield the floor.

Mr. GRAHAM. Mr. President, I will consume such time as remains on our side.

There are a series of winners and losers as we conclude this debate. The first winner is the status quo. We all know the result of the effort of the last 4 days will be nothing. We will be in exactly the same position as we were before we started.

The losers are all those American families who have genuine concerns about the way in which they are being treated—the arbitrariness, the inadequacy of services under their current health maintenance organization plan.

The winner is cynicism. The American people will again question whether their political institutions are capable of responding to serious public issues. The loser will be the opportunity we had to bring together in the best spirit of the Senate a bipartisan plan, an American plan that would have dealt with an American problem.

The Miami Herald editorialized yesterday that what the American people want is Senate action, not a showoff dictated by political consultants.

Unfortunately, that is what they have received.

We will continue the effort to fashion a reasonable bipartisan plan that will deal with the legitimate concerns, first of all, of the American people—not a small percentage of the American people. We will do so in a way that will be sensitive to the cost of health care but also sensitive of the fact that people should get what they contract for from their health maintenance organizations and will provide an enforcement mechanism that is meaningful.

This is not the last chapter in this debate. I anticipate that shortly we are going to have the rubble of a collapsed bill under the weight of a Presidential veto.

I urge my colleagues to use the time between now and then to think seriously about whether that is the last record we want to write on this important national issue. I do not think it is what we want. We don't want an issue. We want a result that will help American families.

The day to achieve that result is, unfortunately, not today, but it will come. Hopefully, it will come soon.

The PRESIDING OFFICER. The Democrat leader.

Mr. DASCHLE. I yield 8 minutes to the distinguished Senator from Massachusetts.

Mr. KENNEDY. Mr. President, if the Chair would be good enough to let me know when 5 minutes remain.

Mr. President, a little over 2 years ago, a number of Members were working with those involved in the health care field, those that have been injured because of actions taken by HMOs, and those doctors and nurses who believe that we could do better.

Tonight we are at a point in the development of a policy where we have seen a setback in terms of protecting patients. We have seen a setback in giving patients and their doctors the opportunity to make medical judgments, rather than having their medical judgments overridden by the economic judgments made by gatekeepers, accountants or insurance company officials. We have received a setback, but I, for one, am not discouraged. I believe that as a result of the last 4 days of debate not only do we have a better understanding about what is important, but I think the American people have a much better understanding.

I think the actions we can expect from the House of Representatives as we begin their debate and discussions starts at an entirely different level. I am very hopeful we will get a strong bill out of the House of Representatives.

I am absolutely convinced, as I stand here, that we will have the opportunity to resolve this issue in favor of the concept underlying the Democratic bill, a concept which as been supported by doctors, nurses, by children's advocates, women's advocates, and advocates for the disabled: that when doctors and patients make a medical judgment, patients will get the type of health care they have actually paid for and not be prevented from getting the best health care.

I am absolutely convinced that is a concept that will be accepted. It was not accepted during this debate. Others will have a different judgment on it. I believe that is inevitable. We have seen other battles where we have seen the inevitability come to pass. I am convinced of it.

I, for one, think this has been an enormously constructive and productive debate these last 4 days. Quite frankly, as one who has been fortunate enough to be involved in this debate, rarely have I seen—at least on our side—so much involvement by the Members, and their participation, their knowledge, their awareness and the wealth of experience that was brought to illuminate so many of these issues. I think that has to be to the benefit of the American people.

I am not discouraged. I regret that we were not successful, but we will continue this battle and we will be successful.

In conclusion, I do thank the majority leader and thank the Senator from Oklahoma, for they have responsibilities as leaders of this institution. I thank them for the way in which this debate has been developed and the structures for the discussion that have been afforded to us over the past days.

I thank in particular our leader, the Democratic leader, Senator DASCHLE. I thank Senator DASCHLE on behalf of those of us who feel strongly about this issue—it is not just, I know, those of us on this side. I am sure those on the other side also feel strongly but have come to different conclusions than those we came to about this issue. We would not have had the debate this week if it had not been for Tom DASCHLE of South Dakota. There are no ifs, ands or buts. This has been, I think, an extraordinary service to this institution, and I think it has been an extraordinary service to the patients and the medical professionals in this country.

I thank my colleague and friend, Senator REID, who was so much a part of the leadership, and of such help and assistance during this time.

I thank the members of our committee. I serve on a number of committees and have been proud to serve on all of them. But my heart is with the Health, Education, Labor and Pensions Committee. All of our members were extremely active. Senator DODD; Senator HARKIN; Senator MIKULSKI, who has been so involved in health care issues; Senator BINGAMAN; Senator WELLSTONE; Senator MURRAY; Senator REED—every one of these Senators has been so engaged and involved in this issue.

I pay tribute to our chairman, Senator JEFFORDS, for his courtesies, and Dr. FRIST, for his strong dedication to trying to find ways—which we were unable to on this measure. But I have respect and affection for the members.

I also thank so many others who were not on the committee who were so involved and engaged, particularly those on our side, although there were others on the other side.

I also wish to thank the many staff people who have worked on this issue this week and for the past two years. From my staff, David Nexon, my long time chief health advisor, Cybele Bjorklund, my deputy health advisor, who worked so ably on this legislation, Michael Myers, my staff director, for his leadership on this legislation, Will Keyser, Jim Manley, Connie Garner, Melody Barnes, Carrie Coberly, Matt Ferraguto, Jacqueline Gran, Jon Press, Ellen Gadbois, Stacey Sachs, Theresa Wizemann, Webster Crowley, Andrew Ellner, Paul Frey, Arlan Fuller, Sharon Merkin, Dan Munoz, Malini Patel, and Kate Rooney.

From Senator DASCHLE's staff, Bill Corr, Laura Petrou, Ranit Schmelzer, Mark Patterson, Jane Loewenson, and Elizabeth Hargraves; the staff of the Department of Health and Human Services and the Department of Labor; the staff of the Democratic Policy Committee; and the staffs of so many other Senators that have played a critical role during this debate.

I think, as always, their involvement and their support has been invaluable, permitting us to have a level of discussion which I think was worthy of this institution.

Finally, I want to say on this issue, as all of us would understand in our responsibilities, that we will be back. We may have a setback tonight, but I, for one, do not believe this is a setback in this issue. We will be back to fight, and fight, and fight again, and I believe ultimately to prevail.

I thank the Chair.

Mr. BYRD. Mr. President, I will vote against the Republican alternative to the Patients' Bill of Rights. All week long, I have supported amendments that would have strengthened the Republican bill and would have provided all privately insured Americans with meaningful patient protections. At each step along the way, the Democratic amendments were rejected.

There are major deficiencies in the Republican bill. The bill that will be passed by the majority covers only 48 million Americans who receive their coverage through self-funded plans. What about the 113 million that their bill leaves out? Don't those 113 million people deserve protections too? I believe that all 160 million Americans with private insurance deserve basic protections.

Another important weakness in the Republican plan, Mr. President, is that it does not provide patients the opportunity to hold their health plans responsible under state law. If a health plan's decisions lead to the injury or death of a patient, the plan should not be shielded from accountability.

I regret that the Senate narrowly rejected the Robb amendment, which I cosponsored. This amendment would have provided women with important access to their obstetrician/gynecologist (ob/gyn). The Republican bill does not allow a woman to designate her ob/gyn as her primary care provider.

Another major distinction between the bills is who makes medical decisions. Will it be the doctor or the insurance company? Unfortunately, the Republicans rejected our definition of medical necessity. Under our bill, plans could not deny benefits based on the insurance companies' definition of medical necessity instead of the doctors' definition.

The Democratic version of managed care reform includes access to clinical trials for patients with life-threatening or serious illnesses. The Republican bill provides access to clinical trials only for those suffering from cancer. In addition, their provision applies solely to 48 million Americans. Their bill leaves too many seriously ill Americans without the hope that experimental therapies through clinical trials provide.

I regret that the Senate has squandered this opportunity to enact a true Patients' Bill of Rights and provide important protections to all privately insured Americans. I feel I must vote against this bill that puts health plans' profits ahead of patients' well-being. I hope that we can revisit this issue one day and pass legislation that provides strong patient protections.

The PRESIDING OFFICER. The assistant majority leader.

Mr. NICKLES. Mr. President, I thank my colleague from Massachusetts for his statement, as well as Senator REID. It has been a pleasure to work with both. This has been a very productive and fruitful debate. As a result, we ended up with a very good bill.

I am going to call on several members of our task force who helped put this bill together and worked very hard, not just for a week, not just for this week but, frankly, for the last year and a half. We had countless meetings and a lot of people, a lot of staff, put in a lot of effort. This was an effort that we felt very strongly about because we wanted to improve the quality of health care without increasing costs and increasing the number of uninsured, and I think we have done it.

Mr. McCONNELL. Mr. President, I come to the floor today to express my strong support for the Republican Patient's Bill of Rights Plus Act. As private health coverage has shifted toward coordinated care, many consumers are concerned that their health plan focuses more on cost than on quality. Many consumers fear that they might be denied the health care they need. To respond to these concerns, both parties have developed patient protection legislation.

Our colleagues Senators DASCHLE and KENNEDY have offered a proposal which I believe takes the wrong direction. Their bill tries to impose a one-size-fits-all solution in a manner which would override many of the reforms our states have decided—or, equally important, decided not to—enact. Their proposal includes liability provisions which will dramatically increase premiums and further expand the medical malpractice industry in this country. In fact, their bill should be called the ''Lawyers' Right to Bill'' not the Patients' Bill of Rights and the tragedy of their lawsuit saturated approach is that it would make health insurance unaffordable to 1.8 million Americans—including 30,000 Kentuckians.

I am pleased to say that we have crafted a better proposal for protecting America's families which is embodied in the Patient's Bill of Rights Plus Act. The Patient's Bill of Rights Plus Act provides needed protections for Americans in a way which won't increase the number of uninsured Americans by driving up health care costs.

The Patients' Bill of Rights Plus Act guarantees access to emergency care. It requires plans to pay for emergency medical screening and stabilization under a ''prudent layperson'' standard. If we pass this legislation, we will never again have to hear heart-wrenching stories about families with desperately ill children who bypass the nearest hospital in order to make it to a hospital which is in their plan's network. Under our plan, if you have what a normal person would consider an emergency, you can go to the nearest hospital, period.

The Patients' Bill of Rights Plus Act would provide direct access to pediatricians and OB/GYN's. This commonsense provision would allow parents to take their children directly to one of the plan's pediatricians without having to get a referral from their family's primary care physician. Similarly our legislation would allow women to go directly to a participating OB/GYN, without having to get a referral from their primary care physician.

The Patients' Bill of Rights Plus Act also bans ''gag clauses''. Gag clauses are contractual agreements between a doctor and a managed care organization that restrict the doctor's ability to discuss freely with the patient information about the patient's diagnosis, medical care, and treatment options. Our legislation would put an end to this practice. I believe a doctor should be able to discuss treatment alternatives with a patient and provide the patient with their best medical advice, regardless of whether or not those treatment options are covered by the health plan.

The Patient's Bill of Rights Plus Act also provides strong, independent external appeals procedures to ensure that patients receive the care they need. Many Americans are concerned that their health plan can deny them care. If a plan denies a treatment on the basis that it is experimental or not medically necessary, a patient can appeal that decision. The reviewer must be an independent, medical expert with expertise in the diagnosis and treatment of the condition under review. In routine reviews, the independent reviewer must make a decision within 30 days, but in urgent cases, they must do so in 72 hours. As opposed to the Kennedy plan which mandates a broad, one-size-fits-all definition of medical necessity, our plan allows those decisions to be made on a case by case basis by an independent external medical doctor. Unlike the Kennedy bill which encourages lawsuits, the Patient's Bill of Rights Plus Act focuses instead on giving patients the care they need. After all, when you're sick, don't you really need an appointment with your doctor, not your lawyer?

The most troubling aspect of Senator KENNEDY's legislation is that it will further swell the numbers of uninsured Americans.

The Kennedy plan drives up health care costs and makes health insurance unaffordable for more Americans. According to the very conservative estimates of the Congressional Budget Office, the Kennedy Patients Bill of Rights would increase insurance premiums 6.1 percent (Source: Congressional Budget Office Report on S.6, 4/23/99). This means that 1.8 million Americans would likely lose their health insurance.

In Kentucky, 30,095 people would likely lose their health insurance.

In California, 271,927 people would likely lose their health insurance.

In New York, 118,091 people would likely lose their health insurance.

In Minnesota, 36,315 people would likely lose their health insurance.

Even if the Kennedy bill does not pass, it is expected that health insurance premiums will rise an average of seven percent next year (Source: Towers Perrins 1999 Health Care Cost Survey 1/99). At a time when premiums are rising well above the rate of inflation, do we really want to pass legislation which raise premiums even more? The answer is clearly no.

Our Patients' Bill of Rights' Plus Act takes a better approach to the problem of the uninsured. While avoiding provisions which will drastically raise premiums, it includes important tax provisions to make insurance more affordable. Earlier this week we passed the Nickles Amendment which will allow self-employed individuals to deduct 100% of the cost of their health insurance. This is particularly important to the 124,000 of Kentucky's farmers, ministers, stay-at-home moms, and young entrepreneurs who are self-employed. According to a study by the Employee Benefits Research Initiative, nearly ½ (43.6 percent) of all workers in the agriculture, forestry, and fishing sectors have no health insurance. By allowing the self-insured to fully deduct the costs of health insurance, we are taking an important step in reducing the numbers of uninsured.

There are certainly significant differences between our two bills. However, no single issue distinguishes the two more than the question of liability. I believe we can and should find bipartisan agreement on the important issues of providing emergency care, ensuring direct access to pediatricians and OB/GYN's, banning gag orders, deductibility of health insurance for the self-employed, and a whole myriad of issues except for one thing: The Kennedy bill insists on new powers to sue. Leafing with abandon through the yellow pages under the word ''attorney'' is not what most Americans would call health care reform.

Simply put, I believe that when you are sick, you need a doctor, not a lawyer. I am opposed to increasing litigation because it will drive up premiums, drive 1.8 million Americans out of the health insurance market, prevent millions more uninsured from being able to purchase insurance, and aggravate an already seriously flawed medical malpractice system.

If 1.8 million Americans lose their health insurance, 189,000 fewer women will have access to mamograms and 238,000 fewer women will have access to pelvic exams. I have a question for the supporters of Sen. Kennedy's bill. What kind of reform makes preventative services less available? What kind of reform is that?

As if driving 1.8 million Americans out of the health insurance market wasn't reason enough to oppose the Kennedy bill, I am also strongly opposed to expanding liability because it will exacerbate the problems in our already flawed medical malpractice system. Typically these lawsuits drag on for an average of 33 months. Even if at the end of this 33 months, only 43 cents of every dollar spent on medical liability actually reaches the victims of malpractice (Source: RAND Corporation, 1985). Most of the rest of the judgement goes to the lawyers. That's right, over half of the injured person's damages are grabbed by the lawyers. Why would anyone want to expand this flawed system which is so heavily skewed in favor of the trial lawyers?

The Washington Post said last March that ''the threat of litigation is the wrong way to enforce the rational decision making that everyone claims to have as a goal'' (Source: Washington Post 3/16/99). More recently the Post said that the Senate should enact an external appeals process ''before subjecting an even greater share of medical practice to the vagaries of litigation'' (Source: Washington Post 7/13/99). The Los Angeles Times Editorial page called expanding liability to health plans ''bad medicine for both employees and employers'' and stated that ''The key to fixing ERISA is not in radical measures like more lawsuits. . .'' (Source: Los Angeles Times 2/29/98)

Mr, President, I have always felt that this debate is about improving private health insurance in America. That the debate was about providing better care, for more Americans not less.

We can and we should guarantee access to emergency services.

We can and we should ensure direct access to pediatricians.

We can and we should ban gag clauses.

We can and we should provide an independent external appeals process.

We can and we should provide full deductibility for the self-employed.

By voting for the Patients' Bill of Rights Plus Act, we will have taken all of these important steps and more. However, what we must not do is take action which will deprive 1.8 million Americans of health insurance. Mr. President, I urge my colleagues to vote for this common-sense health care reform.

Mr. FRIST. Mr. President, I rise to address a point of some contention on the floor over the past two days. Two days ago, I twice quoted from Dr. Robert Yelverton, Chairman of the Primary Care Committee of the American College of Obstetricians and Gynecologists. The precise quotes were as follows: First, ''The vast majority of OB/GYNs in this country have opted to remain as specialists rather than act as primary care physicians,'' and second, ''None of us could really qualify as primary care physicians under most of the plans, and most OB/GYN's would have to go back to school for a year or more to do so.''

These quotes, which were taken from the New York Times, on June 13, 1999, were entirely accurate as reported by the Times. I ask unanimous consent to have printed in the RECORD the New York Times article.

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

[From the New York Times, June 13, 1999]

BEYOND THE HORROR STORIES, GOOD NEWS ABOUT MANAGED CARE

By Larry Katzenstein

Most health plans these days are some form of managed care. And for most families, it is the mother who decide which one to use.

''Women visit doctors more than men, and in a family situation, they may be the ones who have primary responsibility for taking children to the doctor,'' said Elizabeth McGlynn, the director of the Center for Research on Quality in Health Care at the Rand Corporation in Santa Monica, Calif.

Wendy Schoales, a homemaker in Everett, Wash., offered another reason: ''We're more picky.''

Mrs. Schoales's husband works or the Boeing Company, which, like many large employers, offers several health-plan options. Several years ago, when she switched her family from traditional fee-for-service care to managed care to cut expenses, an important motivation was her being able to continue to use the obstetrician and gynecologist who had delivered her first child, Ashlyn. ''When you find a doctor you like, you want to stick with him, especially when it comes to an ob-gyn,'' she said.

Two years ago, Mrs. Schoales's second child, Gavin, was born under managed care but with the same obstetrician and gynecologist. The care was just as good as it had been with Ashlyn, she said, and the cost was significantly lower. ''They charged us just one copayment for the whole maternity experience,'' she said.

For the same reasons, Katherine Davidge of Newton, Mass., also fared well under managed care during the births of her two children. Her experience in getting her managed-care plan to cover treatment for depression, on the other hand, was an exercise in exasperation.

Ms. Davidge's plan subcontracts mental-health services to another company, a common practice in managed care. ''I'd call this company and ask, 'Is Dr. X covered?'' she said, ''And they'd say no. And then the same thing would happen for Dr. Y and Dr. Z. So, then I asked for a list of practitioners I could see, and it was really bizarre because they just wouldn't give us the list. They said they typically don't give it out.''

After several months of phone calls and letters, Mr. Davidge said, she received a list. ''It was so small that it was almost impossible for me to find somebody that I knew anything about,'' she said. ''So I gave up.''

Managed care would seem tailor-made for women. It provides a coordinated system of care that makes preventive services readily available—and women use preventive measures at twice the rate men do. Health-maintenance organizations and other managed-care plans remind members to come in for checkups. With a primary-care doctor to facilitate matters, plans are supposed to help route patients to the most appropriate specialist for their ailments—and all this for a more affordable premium and limited out-of-pocket expenses.

''One reason women's preventive services have always been such a leading issue in managed care is that two of the tests it emphasizes, Pap smears and mammograms, provide the best evidence that preventive testing saves lives,'' said Dr. Karen Scott Collins, an assistant vice president of The Commonwealth Fund, a philanthropic foundation in New York City that supports research on health and social policy.

Yet it is the darker side of managed care that has received Most of the attention in recent years—the follies and tragedies caused by restricted choice of physicians, barriers to needed care, delays in service, limitations on care and a zeal for cost-cutting.

Women, especially, could be excused for thinking that managed care is bad for their health, because some of the most highly publicized outrages attributed to health-management organizations, or H.M.O.'s, and other managed-care plans have involved women's issues: drive-by mastectomies, drive-by deliveries, coverage denied for what were regarded as promising breast-cancer treatments and refusal to let obstetricians and gynecologists be primary-care physicians.

The abuses attributed to managed care have caused a backlash in the form of legislation to make it more accountable, particularly to women. This includes the Newborns' and Mothers' Health Protection Act of 1996, which requires a minimum hospital stay of 48 hours after a normal vaginal birth and 96 hours after a Caesarean section, unless the mother and physician agree to an earlier discharge. Laws in many states mandate that women in managed care be given direct access to an obstetrician and gynecologist without a referral from their primary-care physician, and a Patients' Bill of rights Act pending in Congress would make choosing an obstetrician and gynecologist for primary care the law of the land.

Despite the mixed reviews that managed care gets from patients and physicians, findings from a 1998 Commonwealth Fund survey, announced last month, suggest that women in managed-care plans fare better in some important ways than those who receive traditional medical care.

''The joke about managed care is that it doesn't manage and it doesn't care,'' said

Humphrey Taylor, the chairman of Louis Harris & Associates of New York City, which conducted the survey. ''But the findings from this survey suggest that managed care is serving women at least as well as fee-for-service medicine, and certainly better than some of the managed-care horror stories would suggest.''

The survey, conducted by telephone, involved 1,140 women with managed care and 351 women with traditional fee-for-service care, all of them younger than 65. Among the key findings were:

Women with managed care were more likely to identify a particular doctor as their regular source of care (87 percent of them did so versus 78 percent of those with traditional care).

Women with managed care were more likely to say that their health plan sends them reminders for preventive care (27 percent versus 18 percent).

Women with managed care were more likely to have seen an obstetrician and gynecologist as their primary care physician (66 percent versus 61 percent).

Women with managed care were more likely to have received a Pap smear in the last three years (74 percent versus 67 percent).

Among women 50 and older, those with managed care were more likely to have received colon-cancer screening (29 percent versus 20 percent) and to have talked with their doctor about hormone-replacement therapy (56 percent versus 50 percent).

One in five women under both types of coverage reported problems in gaining access to health care, like obtaining an expensive prescription or seeing a specialist.

But the survey has not made believers of many physicians who specialize in women's health. ''As a gynecologist, my biggest problem with managed care is the severe restrictions that have been placed on my ability to make independent decisions on how to treat disorders that might require surgery,'' said Dr. Robert Yelverton of Tampa, Fla., who estimated that 80 percent of his patients have managed care.

Dr. Yelverton said that one managed-care company requires a woman who is bleeding heavily from excessive menstrual flow and has excessive pain with her periods to be confirmed anemic and to be on iron supplements for three months without improvement before being allowed to have a hysterectomy.

That requirement ''is based on the premise that too many hysterectomies are done,'' said Dr. Yelverton, who said he believes that most obstetricians and gynecologists would first try hormonal treatment rather than surgery for such problems. ''But when that doesn't work, we have patients who are miserable,'' he said.

Dr. Yelverton, the chairman of the American College of Obstetricians and Gynecologists' primary care committee, said that one of the most highly publicized improvements is managed care, allowing a woman to see an obstetrician and gynecologist as her primary-care provider, ''hasn't worked out.''

''The vast majority of ob-gyns in this country have opted to remain as specialists rather than act as primary-care physicians,'' he said, attributing this to the stringent standards that managed-care plans have set for primary-care providers. ''None of us could really qualify as primary-care physicians under most of the plans,'' he said. ''And most ob-gyns would have to go back to school for a year or so to do so.''

Health care experts consider the measures assessed in the Commonwealth Fund survey—having a regular doctor or getting regular Pap smears—to be good indicators of quality of care. But the most crucial measures for evaluating any type of care are the results: diagnosing breast cancer at an early stage, for example. A study published last February in the Journal of the American Medical Association looked at this result and found that in this case, too, managed care had the edge over traditional care.

The study involved nearly 22,000 women over age 65 whose breast cancers were diagnosed between 1988 and 1993. Researchers found that women enrolled in Medicare H.M.O.'s were generally more likely than fee-for-service patients to have had their cancers diagnosed at an earlier stage. And among women who underwent breast-conserving surgery, known as lumpectomy, the H.M.O. enrollees were significantly more likely to have received radiation, the medically recommended accompanying treatment.

So, where does that leave matters? ''With three-quarters of all insured women now in some type of managed-care plan, the time has come to shift the focus from whether managed care is better or worse than fee-for-service to making sure that women are receiving quality health care in whatever type of managed-care plan they belong to,'' said Dr. Collins, the Commonwealth Fund executive.

She and other health-care experts applaud a current voluntary program in which managed-care plans are graded on more than 50 measures, several pertaining to women's health.

This set of measures is known as the Health Plan Employer Data and Information Set. It is administered by the National Committee for Quality Assurance, a private, nonprofit organization also involved in accrediting managed-care plans. The committee's most recent compilation of information, known as Quality Compass 1998, includes Health Plan Employer Data scores and consumer-satisfaction data submitted by 447 commercial managed-care health plans that collectively cover 60 million Americans.

Some managed-care plans do not participate in the program. Others do but do not allow their scores to be publicly reported. But several large employers, including Xerox and General Motors, strongly encourage managed-care plans under contract with them to make their scores public. And some states, including New York, New Jersey and Maryland, require plans to release this information. Working with the committee, the states issue annual managed-care report cards through pamphlets and on their Web sites. The www.health.state.ny.us site has information for New Yorkers.

Regarding mammography screening rates, for example, New York residents can learn the names of the seven health plans—CDPHP, CHP/Kaiser, Finger Lakes, Health Care Plan, Healthsource HMO, HMO CNY and Preferred Care—that performed significantly better than the statewide average during 1996 and 1997, and the five health plans—CIGNA Health Care, MVP, Physicians Health Service, Prudential Health Care Plan and United Healthcare-NYC—that performed significantly worse.

Some physicians believe that these efforts are having a positive effect. One is Dr. Jeffrey Hankoff, a family physician in Santa Barbara, Calif., who takes care of a large managed-care population and is the medical director of an independent practice association, or I.P.A., a group of about 30 physicians who collectively negotiate contracts with managed-care plans.

''One thing managed care has brought to the table is that quality is the major focus and not a token effort,'' Dr. Hankoff said. ''Every time a patient writes a letter of complaint, our I.P.A. has a committee that reviews it. We're really attempting to make sure that people are getting the care they're supposed to be getting. In a managed-care operation, that's monitored all the time because the plans demand it and the Government demands it of the plans. It's something that managed care really hasn't received credit for.''

Look at the Stats, Talk to Friends

Here are steps that women can take for choosing a high-quality managed-care plan:

Ask your employer's benefits department if its plans make their Health Plan Employer Date and Information Set (Hedis) scores public, and ask to see them. ''You should prefer a plan that's willing to show its Hedis numbers,'' said Elizabeth McGlynn of the Rand Corporation in Santa Monica, Calif.

Find out whether a plan is fully accredited by the National Committee for Quality Assurance, and reject plans that have applied for accreditation and failed. Accreditation provides assurance that a plan has a quality-improvement program. Accreditation information for most plans is available on the committee's Web site (www.ncqa.org) or by calling (888) 275–7585.

Ask if the plan offers a specific program for women's health, has it own medical director for women's health, or has a network of providers that includes a women's health center. Then try to find out if they're more than gimmicks.

''There are certainly some issues of women's health that have been picked up by managed-care organizations purely for advertising purposes, to attract women,'' said Mark Chassin, chairman of the department of health policy at Mount Sinai School of Medicine in New York City. ''But it has been difficult for women to get customized or gender-based advice about important treatment issues such as heart disease, for example, where women have different risk factors from men and need to be managed differently and to consult with specialists who understand those differences.''

Talk to people in the plan. ''Word of mouth is probably underestimated as a good indicator of quality,'' said Donald Berwick, who directs the Institute for Health Care Improvement in Boston.

Consider the doctors. ''The most important aspect of quality in managed care is the provider you choose rather than the plan,'' said David Blumenthal, director of the Institute for Health Policy at Massachusetts General Hospital and Partners Health System in Boston. Because doctors belong to an average of eight plans, ''in most communities right now, most managed-care companies include most doctors in that community, so you can get almost any doctor on any plan,'' Dr. Blumenthal noted. ''The quality variations among plans probably mostly reflect the different doctors.''

For many people, the worst aspect of managed care is having to stop seeing a doctor who is not in the plan. So before joining a plan, find out if your doctor participates and, if not, what it will cost if you continue seeing that doctor.

Ask whether the plan covers prescription drugs. This is especially important for women taking hormone replacement therapy or oral contraceptives.

If you have children, ask if the plan provides baby-sitting or has provisions for combining child and adult visits.

Mr. FRIST. Unfortunately, before introducing these statements, I apparently misspoke and said, ''Let me share with Members what one person told me.'' I should have said, ''As Dr. Yelverton was quoted in the New York Times as stating.'' So, I wish to clarify the RECORD.

Dr. Yelverton has taken offense at my use of his quotes. In fact, he contends that I ''misused'' his quotes. At

this time, Mr. President, I ask unanimous consent to have printed a letter from Dr. Ralph Hale, with an attached memo from Dr. Yelverton, into the RECORD, so that his views may be clear.

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

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS,
Washington, DC, July 14, 1999.

Hon. BILL FRIST,
Washington, DC.

DEAR SENATOR FRIST: As Executive Vice President of the American College of Obstetrics and Gynecologists (ACOG), I feel it necessary to clarify ACOG's position on the Robb/Murray amendment to allow women in managed care plans direct access to ob-gyn care. I've also attached a memo from Dr. Robert Yelverton, Chairman of ACOG's Primary Care Committee, correcting your misuse of his statements in a June 13 New York Times article.

ACOG and Dr. Yelverton fully support efforts in Congress, including the Robb/Murray amendment, which would enable ob-gyns to be designated as primary care providers. A recent ACOG/Princeton Survey Research Associates survey found that nearly one-third of all ob-gyns in managed care plans are denied the opportunity to be designated as primary care physicians. Ob-gyns are often the only health care provider many women see throughout their adult lives and are best suited to understand and evaluate the health care needs of their patients. While not all ob-gyns may choose to accept a PCP designation, all ob-gyns should have the opportunity to be designated as a woman's PCP under managed care.

We also strongly endorse the Robb/Murray amendment's provision that would require managed care plans to allow women direct access to the full array of covered ob-gyn services provided under the plan.

While the amendment failed yesterday on a 48 to 52 vote, we are hopeful the Senate will take up this important issue again. Dr. Yelverton and I urge you to vote in favor of these important policies.

Sincerely,

RALPH W. HALE, M.D.,
Executive Vice President.

TAMPA BAY WOMEN'S CARE
Tampa, FL, July 13, 1999.

To: Lucia DiVenere, ACOG Government Relations.

From: Robert W. Yelverton, M.D., Chairman, Primary Care Committee.

I received your fax tonight and offer the following in response.

I have never spoken directly to Senator Bill Frist (R–TN) or any member of his staff on the subject of OB/GYNs as primary care physicians or on any other subject. The quote that Senator Frist attributed to me on the floor of the Senate today came from an article in the June 13, 1999, edition of the New York Times. The article may be viewed on the New York Times website (go to www.nytimes.com, then click on Health and Science). I was contacted by the article's author, Larry Katzenstein, and asked to comment on the impact of managed care on women's healthcare in this country. In my interview with Mr. Katzenstein, I discussed ''barriers'' that managed care organizations have raised against the efforts of OB/GYNs to become primary care physicians. The quote attributed to me by Senator Frist was from a non-quote in this article. I told Mr. Katzenstein that some managed care organizations have placed barriers consisting of such stringent (not ''high,'' as Senator Frist stated) standards for their qualifications as primary care physicians that most OB/GYNs would not be able to meet them without further training.

One objective of my comments was to demonstrate that the College's interests were to allow OB/GYNs to provide women's healthcare to their patients unimpeded by the cumbersome requirements of managed care referral systems. Mr. Katzenstein's article did not emphasize to the degree it should have that these were barriers to OB/GYNs being designated primary care physicians—not ''high standards''—as has been discussed repeatedly in meetings of the Primary Care Committee. I went on to say to Mr. Katzenstein that the qualification requirements that some managed care organizations impose on OB/GYNs in certain instances exceeded even those required of family physicians. He chose not to include that statement in his article.

Senator Frist's misuse of my statement in support of his position that OB/GYNs could not act as primary care physicians because of the ''high standards'' that managed care organizations set for primary care physicians, is regrettably misleading, to say the least, and does an injustice to the true intent of my statements.

I personally supported then and I support now the amendment sponsored by ACOG to allow OB/GYNs to act as primary care physicians and to allow direct access for women's healthcare and did, in fact, spend a portion of this very afternoon e-mailing my senators and encouraging them to vote in support of the amendment.

Please contact me at (813) 269–7752 after 9:00 a.m. tomorrow (Wednesday). I will be glad to discuss this matter with you at that time and will support any effort that you want to undertake to clarify this issue now on the floor of the Senate.

Mr. FRIST. The gist of Dr. Yelverton's complaint is that he was informed that I used his quotes to oppose an amendment which sought to allow OB/GYNs to be treated as primary care physicians. Dr. Yelverton supports allowing OB/GYNs to serve as primary care physicians and he supports ''direct access for women's healthcare.'' My position is that we should not be confusing the issue and saying that OB/GYNs—specialists—are ''primary care physicians'' and thus have the implied responsibility of serving as overall gatekeepers for insurance plans. Instead, I believe we should insure that women have direct access to OB/GYNs for obstetrical and gynecological care without going through a gatekeeper. In that spirit, I used Dr. Yelverton's reported quotes.

I continue to believe that our task is to see that women can have direct unimpeded access to OB/GYNs. We will do that, without saying that OB/GYNs must be designated as ''primary care physicians'' who are responsible for treating all aspects of the patient's health needs, including ear infections and the like. I sincerely believe that direct access to OB/GYNs is the issue, not whether we label OB/GYNs as ''primary care physicians.''

Mr. President, I yield the floor.

Mr. DEWINE. Mr. President, as debate draws to a close on managed care reform, I want to talk about a few of the key provisions that I strongly support in the comprehensive legislation developed by the Republican Health Care Task Force and my colleagues on the Senate Health Committee.

All throughout the process of developing responsible managed care reform legislation, I have shared the same overall policy goal held by most of my colleagues: to reform the managed care system without reducing quality, without increasing cost and without adding to the ranks of Americans who cannot afford health insurance. These are important issues for individuals and families.

Just as important to them, and to me, is the impact of managed care on the quality of health care provided to children. That issue, perhaps more than any other, governed how I examined and worked on this very important legislation.

Working with my friend and colleague from Tennessee, Senator BILL FRIST, I worked to ensure that the bill approved earlier this year by the Senate Health Committee protected the interests of families with children. The bill approved by the Committee and included in the Task Force bill provides for direct access to pediatricians. For any family, this is common sense. Pediatricians are general practitioners for children. Why should parents have to take their child to a primary care physician in order to be given permission to have the child see a pediatrician? This ''gatekeeping'' role is just not necessary.

That's why Senator FRIST and I worked to include language in the Committee-passed bill that lets parents bypass the gatekeeper. Under this bill, parents can take their child straight to the pediatrician. The Task Force bill also includes this language.

The larger debate concerns pediatric specialists. My view on this, based, I might add, on considerable personal experience, is that children are not simply a smaller version of adults. Fortunately, for the most part, children are proportionately healthier than adults. This means that for the small number of children who suffer from illnesses and conditions, they are the exception to the rule. To a parent who loves them, however, this is no consolation. Not only is their child suffering, but treatment can also be extremely expensive.

Children who suffer from cancer, to take one example, should be able to see a pediatric oncologist, not an oncologist who was trained to treat adults. That is why Senator FRIST and I worked to include in the Committee-approved bill an amendment that would require the practitioner, facility or center to have, and I quote from our amendment, ''adequate expertise (including age-appropriate expertise) through appropriate training and experience.'' By requiring age-appropriate expertise, we are saying that a child will see a pediatric specialist and an elderly patient will see a geriatric specialist. We are ensuring that the most vulnerable people—the youngest and

the oldest—within our population are referred to the specialists who are trained to treat their particular age group. We have also clarified this language to ensure ''timely'' access to such specialty care.

Mr. President, let's not lose sight of our bottom line goal: to ensure quality health care without compromising access to care. We already have 43 million Americans who are without any health care coverage. Excessive mandates on the quality of care will only drive up the cost of providing care, and could price health care out of the range of affordability. Our legislative efforts must not add to the uninsured. Mr. President, employer-provided health insurance is strictly voluntary—employers do not have to offer health insurance to their employees. So, we are walking a fine line between ensuring that our nation's health care quality remains high, while still keeping such care affordable.

In my home state of Ohio alone, 1.3 million of 11 million Ohioans are uninsured—they have no health care coverage at all. Worse still, in Ohio we have 305,000 children who have no health insurance coverage. With health care costs estimated to increase by 7–8 percent due to inflation alone, it is clear that we should not add to this cost increase.

On this score, there is serious cause for concern. A Lewin Group study found that for every one percent rise in premiums, 300,000 more people become uninsured. The Congressional Budget Office (CBO) estimated that the Daschle-Kennedy Patients' Bill of Rights bill would increase health care premiums by 6.1 percent. That means an additional 1.8 million Americans would lose health insurance if that particular bill becomes law. Based on data provided by the CBO, that bill would add $355 each year to the average worker's health care premium. If that is not enough to drive Americans to the ranks of the uninsured, it will certainly add to the cost of living for American families.

I support the Task Force legislation, which CBO estimated would raise premiums by only 0.8 percent—that's eight-tenths of one percent. This legislation also would provide direct access to pediatricians and access to specialty care. This legislation would provide for an independent external review process for all adverse coverage decisions that are based on a lack of medical necessity or investigational or experimental nature of the treatment. This process will better protect everyone, including children and the elderly, because it would ensure that the independent external reviewer assigned to review an adverse coverage determination has expertise (including age-appropriate expertise) in the diagnosis or treatment under review. All of these patient protections are included, while still keeping health care affordable.

I also support this legislation because it would help 317,000 Ohioans and close to 9 million other Americans nationwide who are self-employed, but can only currently deduct 45 percent of their health care costs. The self-employed are mainly farmers, family-owned and operated businesses, and independent business people and entrepreneurs. They represent the heart and soul of our economy, but the tax code treats these first-class workers like second-class citizens.

Mr. President, in the last several years, I have voted for legislation that would move this important tax break to full deductibility, which large corporations already have. By making such health care costs 100 percent deductible for the self-employed, we have the opportunity to reduce the ranks of the uninsured. We would be making health insurance more affordable, and more accessible for our country's self-employed workers and their families.

These are just some of the provisions that would improve our managed care system—improvements that would not compromise affordability and accessibility. That is why I will vote for the Task Force bill later today.

Mr. WARNER. Mr. President, this week the United States Senate has been debating the provisions of two pieces of legislation dealing with increased patient protections for individuals with health plans. The bill that I support is called the ''Patients' Bill of Rights Plus Act.'' The other bill under consideration is called the ''Patients' Bill of Rights.'' Though these bill have similar names, they differ greatly in what they will in fact accomplish. After I briefly summarize the major components of these bills, it will be clear that the title of the ''Patients' Bill of Rights'' is a misnomer. It will also be clear that the ''Patients' Bill of Rights Plus Act'' is a bill that is truly focused on the American people. Through its major components, this bill will provide consumer protections, enhance health care quality, and increase access to healthcare.

The Patients' Bill of Rights Plus Act contains a number of provisions that are key consumer protections. These provisions will greatly enhance the health plans of the 48 million Americans who are covered by self-funded group health plans governed exclusively by the Employee Retirement and Income Security Act (''ERISA'') and will enhance the quality of healthcare.

First, the Patients' Bill of Rights Plus Act has emergency care protection for consumers. Currently, some plans and managed care organizations require prior authorization for emergency department services and/or have denied payment for emergency room services if it turns out the patient's situation does not meet the plan or organization's definition of an emergency. As a result, a participant may be liable for the entire emergency room bill. This potential large cost to the patient, and the uncertainty of coverage, has a significant negative impact on the patient seeking emergency room care, even if such a visit is reasonable. What a tragedy it would be for a person to die because that person refused to go to the emergency room out of fear that coverage would be denied later?

The Patients' Bill of Rights Plus remedies this situation in a cost effective manner by requiring self-funded ERISA plans that provide coverage for emergency services to pay for emergency medical screening exams using a ''prudent layperson standard.'' The bill also requires these ERISA plans to provide coverage for any additional emergency care necessary to stabilize an emergency condition after a screening exam. Under the prudent layperson standard, an ERISA plan would be required to cover emergency medical screenings if a person with an average knowledge of health and medicine would expect that the absence of immediate medical attention would result in serious jeopardy to the individual's health. For example, let's say an individual is experiencing chest pain. Though I am not a doctor (my father was), I do know that chest pain could at least be a symptom of indigestion, heart burn, or a heart attack. If this individual went to the emergency room because of these chest pains, the prudent layperson standard would cover emergency screening, even if the heart pain turned out to be a case of indigestion.

Another problem that I continuously hear people complaining about is gatekeepers. Many plans require patients to visit their primary care physicians and obtain a referral before they can visit a specialty doctor. These gatekeeping provisions can, in certain circumstances, drive up the cost of healthcare, and also make it more difficult for patients to access appropriate medical care. Moreover, certain gatekeeping provisions fail to recognize that women and children have unique health care needs. The Patients' Bill of Rights Plus Act also remedies these problems by requiring self-funded ERISA plans to provide direct access to routine obstetric and gynecological (''ob/gyn'') care and routine pediatric care without requiring prior authorization.

Third, in addition to improving access to emergency care services, ob/gyns, and pediatricians, the Patients' Bill of Rights Plus Act ensures access to covered specialty care by requiring ERISA plans to provide patients access to covered speciality care within network, or, if necessary, through contractual arrangements with specialists outside the network. While this bill would not prevent a plan from requiring a referral by a patient's primary care physician in order to obtain some specialty services, the bill does require a plan to provide for an adequate number of visits to the specialist when the plan requires a referral.

Fourth, the Patients' Bill of Rights Plus Act also addresses the situation of when a patient's physician under a

plan is terminated or is not renewed by the plan. This bill requires an ERISA plan to continue coverage with a patients' provider, if the patient is undergoing a course of treatment that includes institutional care, care for a terminal illness, or care starting from the second trimester of pregnancy. Coverage duration is for up to 90 days for a patient who is terminally ill or who is receiving institutional care. For a pregnant woman who is in her second or third trimester, coverage is required to be continued through the postpartum period.

In addition to providing these key consumer protections to the 48 million Americans who are covered by self-funded group health plans governed exclusively by ERISA, the Patients' Bill of Rights Plus Act creates appeals procedures for the 124 million Americans covered by both self-insured and fully-insured group health plans. These appeal provisions are essential protections to ensure that Americans receive the service and coverage they are entitled.

Simply put, the Patients' Bill of Rights Plus Act requires an internal and external review process under which consumers can appeal a plan's denial of coverage. A plan must complete a consumer's internal appeal within 30 working days from the request for an appeal. An internal coverage appeal can also be expedited, meaning the determination must be made within 72 hours, in accordance with the medical exigencies of the case, after a request is received by the plan or issuer. In the event that the plan denies coverage because the treatment was not medically necessary or appropriate or was experimental, the internal review must be conducted by a physician who has appropriate expertise and who was not directly involved in the initial coverage decision.

A consumer who is denied coverage and who loses an internal appeal still may have an avenue to pursue coverage through an external appeal. An external review is available when a plan has denied coverage based on lack of medical necessity and appropriateness and the amount involved exceeds a significant financial threshold or there is a significant risk of placing the life or health of the individual in jeopardy. Once an external review is requested, a plan must select a qualified external review entity, in accordance with the medical exigencies of the case. The plan must select the entity in an unbiased manner and the entity must be: (1) an independent external review entity licensed or credentialed by a State; (2) a State agency established for the purpose of conducting independent external review; (3) an entity under contract with the Federal Government to provide independent external review services; or (4) any other entity meeting criteria established by the Secretary of Labor.

The external review entity then selects the independent expert to conduct the external review. This independent expert reviewer must have appropriate expertise and credentials, must have expertise in the diagnosis or treatment under review, must be of the same specialty as the treating physician when such an expert is reasonably available, and must not have certain affiliations with the case or any of the parties involved. This expert's job under the external review is to render an independent decision based on valid, relevant, scientific, and clinical evidence. This includes information from the treating physician, the patient's medical records, expert consensus, and peer-reviewed medical literature to assure that standards of care are reviewed in a manner that takes into account the unique needs of the patient.

This internal and external review process is integral to ensuring that patients get the medical care they need. Again, the bill provides for an Independent medical judgment by a qualified and non-biased medical expert. This will protect against the possibility that a health plan might try to ''short change'' its consumers. Our bill is a responsible approach that will not drive up costs and cause more Americans to lose health insurance coverage.

Sixth, the Patients' Bill of Rights Plus Act protects health insurance consumers against the use of a technological innovation that could prove costly to them. Scientists today believe that most people carry genes with certain characteristics that may place these people at risk for future diseases. Consequently, insurance companies could use this technology and charge higher premiums to those individuals who are genetically predisposed to certain diseases. The Patients' Bill of Rights Plus Act protects against this by prohibiting all group health plans and health insurance issuers from denying coverage, or adjusting premiums or rates based on ''predictive genetic information'' for the 140 million Americans covered by both self-insured and fully insured group health plans and individual health insurance plans.

Finally, this bill protects consumers and increases the quality of health care by protecting patient-provider communications. The communications are protected through the elimination of gag rules, which restrict physicians and other health care providers from discussing patient treatment options not covered by patients' plans. I believe in providing patients with the most information possible so that they can make informative healthcare decisions, in consultation with their health care provider. The gag rule prohibition in this bill will permit health care professionals to discuss treatment alternatives with patients and render good medical advice, regardless of whether the treatments or alternatives are covered benefits under the plan.

Not only does the Patients' Bill of Rights Plus Act provide consumer protections and increase health care quality, this legislation also increases access to the health care system. First, this bill expands the use of Medical Savings Accounts (''MSA''). These accounts were created in 1994 but are currently only available for employees of firms with 50 or fewer employees. This bill expands MSA availability to all individuals. This bill also loosens some of the restrictions on Flexible Savings Accounts (''FSA''). An FSA is an account which an employee can deposit money into to cover healthcare costs that are not covered by the plan. Current law, however, provides that any money in the FSA that is not used by the end of the year is lost. This bill would allow workers to keep up to $500 of unused FSA funds in tax-preferred accounts every year, giving those patients greater control over their health care. I have long been a supporter of giving Americans the ability to better control their own health care costs by purchasing special tax-preferred savings accounts for basic medical expenses. Finally, the Patients' Bill of Rights Plus Act expands access to health care by allowing self-employed Americans to deduct 100 percent of health insurance expenses from their taxes. Combined, MSAs, FSAs, and the full deductibility of health care costs for the self-employed will increase Americans flexibility in health care coverage options and decrease the number of uninsured.

Mr. President, this is just a brief summary that highlights some of the major provisions of the Patients' Bill of Rights Plus Act. As I am sure you can see Mr. President, that this bill is truly a Patients' Bill of Rights. This bill provides consumers with a number of protections against health plans and increases accessibility to the health care system. Consequently, I am proud to be a cosponsor of this important piece of legislation.

On the other hand, because I feel so strongly that we as a Congress must work toward increasing accessibility to the heath care system, I feel compelled to speak out against the so called ''Patients' Bill of Rights.'' This bill, by prescribing more mandates, more regulations, more bureaucracy, and more lawsuits, will certainly raise the costs of health care and close the access door to many Americans.

Health care costs are already high in this country, and many Americans cannot afford health insurance. According to Dan Crippen, director of the Congressional Budget Office, there were approximately 43 million Americans under the age of 65 that lacked health insurance coverage in 1997. As health care costs continue to rise, who do you think is going to pay for the increased cost? Well, I am fairly certain it will not be the insurance companies or the health care providers. Rather, increased costs will be passed on to the consumers through higher premiums and reduced benefits. That means the consumer will have to bear the cost by paying higher premiums for their health plans and receiving less benefits. Higher premiums for consumers

mean even more Americans will be unable to afford health insurance coverage.

Mr. President, I believe the United States Congress should pass a Patients' Bill of Rights that provides consumer protections and does not result in people losing access to the health care system. The ''Patients' Bill of Rights'' does not achieve these objectives.

The Congressional Budget Office has conducted a cost estimate of the ''Patients' Bill of Rights.'' The original cost estimate of this bill was that it would increase premiums 6.1%. It is not difficult to understand that higher premiums are likely to result in some loss of health insurance coverage. If you increase costs, some people will not be able to afford health insurance. Americans should not have to choose between the basic necessities of life like food and shelter and health insurance. Mr. President, given the number of uninsured Americans and the prospect of increasing health care costs, the ''Patients' Bill of Rights,'' by increasing premiums by 6.1%, is simply irresponsible.

Predicting the exact number of Americans that will be uninsured if the ''Patients' Bill of Rights'' becomes law is difficult. However, the numbers the experts keep telling me are that this bill will result in over 1 million Americans losing their health insurance coverage. Of this over 1 million Americans, an economic consulting firm estimates that this bill will cause over 34,700 Virginians to lose their health insurance. Let me reiterate this point Mr. President. The experts have been telling me that due to the 6.1% premium increase in the ''Patients' Bill of Rights,'' over 1 million Americans and approximately 34,000 Virginians are likely to lose their health insurance. This, Mr. President, I cannot accept.

Mr. President, legislation that will cause so many Americans and so many Virginians to lose health insurance coverage is not a true Patients' Bill of Rights; therefore, I am unable to support the inappropriately titled, ''Patients' Bill of Rights.'' On the other hand, the Patients' Bill of Rights Plus Act is a true Patients' Bill of Rights. The Patients' Bill of Rights Plus Act increases access to the health care system and provides key consumer protections. I am proud to be a cosponsor of this legislation, and I urge my colleagues on both sides of the aisle to support this true patient protection piece of legislation.

Mr. GRASSLEY. I commend the leadership, Senator LOTT and Senator NICKLES, and the minority leader, Senator DASCHLE, for coming to an agreement to bring this very important legislation, the Patients' Bill of Rights, to the Senate floor for debate. I know this is a politically charged issue, but I believe there is enough in common on both sides of the aisle to pass a good, strong, bipartisan bill. At the end of the day, we can have legislation that will provide patients with the necessary protections they want, and deserve, without driving up the cost of insurance so high that we add to the number of uninsured.

Many of the provisions in the bills that have been introduced during this Congress and last Congress are similar to provisions I put forth in my Medicare patient bill of rights bill or S. 701, which was adopted as part of the Balanced Budget Act of 1997. The cornerstone of my Medicare legislation was an expedited appeals process with a strong independent external review procedure and user-friendly, comparative consumer information so Medicare enrollees could make informed choices about their health plan options. Although the Medicare program already had an external review process, there were problems with the timeliness of reviews, particularly in urgent situations where a patient's health was in jeopardy. My bill codified the appeals process to ensure that these situations would be rectified. Independent reviews would be completed in 72 hours when considered urgent and 30 days for non-urgent situations.

My legislation also addressed another problem with the Medicare program. The program did not offer enrollees clear, concise, and detailed information about health plan choices and beneficiary rights in managed care. As more and more plans entered the Medicare market, it became increasingly clear that beneficiaries needed access to detailed, objective information about their options and about the protections they have under the Medicare program. S. 701 included new requirements for the program to provide enrollees comparative and user-friendly consumer information that became the foundation for the National Medicare Beneficiary Education program that is in existence today.

In addition to the expedited appeals process and the consumer information program, S. 701 contained other items like prohibiting gag clauses in Medicare managed care contracts, offering a point-of-service option, and assuring access to specialists when medically necessary. Not all of these provisions were included in the Balanced Budget Act of 1997, but I am proud to say most were and, as a result, Medicare beneficiaries enjoy these rights today.

Senator JEFFORDS' bill reported out of committee, and the Republican leadership bill, S. 300, also share many of the patient protections I advanced for Medicare for individuals currently insured under the Employee Retirement Income Security Act (ERISA). While there have been some who have criticized the Republican bill for not covering all insured individuals, the reality is most individuals are covered under state consumer protections. However, for the 48 million people who are solely covered under ERISA, our bill would provide them similar protections to what most individuals enjoy today under their state laws. Furthermore, our bill would extend the two most fundamental and important protections to all employer-sponsored plans—an appeals process with a strong external review mechanism, and detailed, user-friendly consumer information so that individuals can make the best health plan choice possible for their needs. Our bill would not duplicate state regulation, thus avoiding unnecessary costs and regulatory burdens for employers. These costs ultimately get passed on in the form of lower wages, reduced health benefits, and fewer jobs.

To argue that the cost of this additional regulatory burden, and I might add this unnecessary cost, is worth it because everyone should have the same federal protections is short-sighted and just plain wrong. Health insurance coverage is a benefit that Americans want and desperately need. It is a benefit that employers voluntarily provide. If we require that all plans, even those already regulated by the state, be subjected to any new federal law, we will increase the cost of providing health insurance coverage. There is no dispute here. We have the figures from the Congressional Budget Office. In fact, the CBO provided us with a breakdown of the cost of each new patient protection. And guess what? The costs go up as we mandate more government regulation. This is not rocket science, this is common sense.

We need to ask ourselves as members of the Senate if we want to jeopardize the health insurance coverage of hard-working Americans for our own political and personal gain. We have guaranteed health insurance, so we don't need to worry about losing our coverage. But what about the voters, the people we are supposedly trying to help with this bill:

Should we pass this bill without regard to the cost or the impact it will have on people's coverage?

Should we be telling our constituents who are content with their health plan that the cost doesn't matter because what matters most is helping people who were harmed by their managed care plan?

Should our response be to folks back home that they should be willing to pay more for protections they already have under state law so that the federal government can step in to do what the states are already doing?

In addition to the rise in premiums patient protections will most certainly cause, the private sector is now predicting health care costs will increase even further than anticipated. A recent survey released by a human resources consulting firm indicates health insurers and health plan administrators expect HMO costs to increase 6 percent. Point-of-service plans are expected to rise 7.7 percent. According to a General Accounting Office (GAO) report, a 6 percent premium increase will result in approximately 1.8 million Americans losing their health insurance. This is without Congress taking any action. If the Democrats had their way, we would

be adding another 5 to 6 percent on top of the 6 percent increase already projected. What good are patient protections when you don't have any health insurance? And the costs of higher insurance premiums are not only measured by the loss of coverage. Families will have to make choices between a better education for their children; preparing for retirement; starting a business; or simply affording to each out on occasion just to pay their higher premiums to keep their health care coverage.

The survey goes on to cite reasons for these higher than expected premium increases. At the top of the list of reported reasons is new state and federal mandates. Do not be mistaken. The impact of increased regulation is real. And the cost is far greater than some monetary figure or percentage increase can possibly demonstrate. We are talking about peoples' health insurance coverage, and ultimately their health. For research has shown there is a direct correlation between a person's health and whether that person has insurance.

The Republican bill attempts to target protections where no state protections exist under ERISA. It provides two fundamental federal protections to all employer-sponsored plans. One of these provisions, which will offer patients the ability to solve disputes with managed care plans, is the appeals process. This provision, in my estimation, would solve many of the problems people experience with their managed care plans. This approach, unlike the Democratic approach, would provide assistance to the patient when they need it the most—at the time when care is needed. What good is it to know you can sue your health plan when your health has already been harmed or worse yet, you are dead? What good is to sue when most of the money ends up in the hands of trial lawyers?

Our bill would allow for any dispute regarding medical necessity decisions or a treatment determined to be experimental by the plan to be appealed to an external independent review board. This board would be made up of medical experts in the area of dispute. The appeals process would be timely, independent, and binding on the health plan. Patients would get health care when they need it, not a lawsuit after its too late.

The other new Federal protection that is fundamental to consumer choice is the availability of consumer information. The Republican bill would establish new disclosure and detailed plan information requirements for all employer-sponsored plans. This information would be available to people to ensure they understand what their plan covers, how it defines medical necessity, what they should do when a dispute arises, and much, much more. This provision will enable patients to make decisions about their health care and will create greater competition among health plans to provide quality care and service.

Throughout this debate we must remember what the purpose of this legislation is. We must not let rhetoric cloud our judgment about what will truly benefit patients and not special interest groups. We must remember this debate is about patients; not trial lawyers; not doctors; and not bureaucrats in Washington. We need to act responsibly to pass a bill that will provide meaningful patient protections while preserving the health insurance coverage of millions of hard-working Americans. Again, I ask the fundamental question we must consider. What good is a patient bill of rights when you don't have insurance?

Republicans and Democrats agree on a number of issues that really matter to our constituents. We should be able to pass a bipartisan bill with those provisions we all support. Both sides may have to compromise. But that is part of making the legislative process work. I ask my colleagues to remember on whom this debate should focus on. Let us not forget, it is the patients' bill of rights.

Mr. MURKOWSKI. Mr. President, today I rise to join my colleagues in the important debate on ensuring the health care rights of patients across America.

Our nation has the best health care in the world, yet there is a growing concern over changes in how most Americans receive health care. Individuals once accustomed to choosing a doctor and paying for medical treatment are now thrown into managed care systems or HMOs. Too often for the patient, HMO rules, restrictions and concern for profit seem of more consequence than providing quality health care.

The Republican plan, called Patients' Bill of Rights Plus, is a direct response to patient concerns. In a nutshell, the Republican bill guarantees affordable, quality health care and provides access to the best doctors and specialists available.

The Republican bill will protect the unprotected by establishing a Bill of Rights for patients whose plans are not already regulated by existing consumer protection laws. Under our bill, patients will have the right to talk openly and freely with their doctor about all treatment options; the right to coverage for emergency care; and the right to see the doctor of their choice.

It will make health insurance more affordable and accessible by accelerating full tax deductibility of health premiums for the self employed; and expanding the Medical Savings Account pilot program to all of America.

It will empower patients by providing a timely and inexpensive appeals procedure for all patients who are denied coverage by an HMO.

Why is the Republican plan a better alternative?

The Democrat bill, called ''The Patients Bill of Rights Act,'' may have a similar title to the Republican bill, but the two bills represent entirely different approaches to the role of government in health care:

The Democrat bill encourages litigation.

Our plan insures patients will get the care they need, not a trial lawyer knocking at their door. It creates a fair and efficient process to resolve disputes with HMOs.

The Democrat plan, will enhance lawsuits, not the delivery of health care. Mr. President, health care cannot be improved through the court system.

The Democrat plan creates massive Federal bureaucracy. The Democrat plan regulates all health insurance at the federal level—thereby pre-empting state laws. The Democrat plan is a litany of federal mandates on private health insurance. It's one step closer to a federal take-over of America's health care system.

The Democrat plan is a ''one-size-fits-all plan.'' The Democrat bill squeezes patients into a one-size-fits-all health plan. The Democrat plan puts one of the most ineffective agencies, the Health Care Financing Administration, in charge of it all!

Maybe that works in Massachusetts, but it won't work in my State of Alaska. Let me explain.

The Federal Intrusion in Alaska doesn't work. Mr. President, a one-size-fits-all'' approach doesn't fit Alaska's health care needs. Let me tell you the facts:

Alaska contains the most rural, remote areas in the nation;

Alaska is 74 percent medically underserved; and most importantly;

Alaska is a state in which the Federal Government, and in particular, the Health Care Financing Administration, just doesn't understand.

Let me tell you about three health care problems in Alaska that were exacerbated by Federal intrusion:

Federal intervention threatens to destroy Alaska's Rural Physician Residency Program. Alaska's rural health care problems are tough. Physician turn-over rate is high. At Bethel Hospital, 4 of the 16 primary care physicians on staff leave every year. Many villages populated by 25–1,000 individuals never even have access to physicians.

The result is that bush Alaska has the highest rates of preventable diseases in America. Doctor Harold Johnson, head physician of the Alaska Family Residency Program described the physician needs of Alaska as follows:

> The history of physician turnover, isolation and general burn-out had been continuing in bush Alaska settings without any sign of improvement for the last 45 years. The Alaska Family Practice residency is a vital program designed to train a workforce to handle bush Alaska's harsh conditions, isolation and unique culture.

I worked to protect that residency program with specific language in the Balanced Budget Act, but still this important program is threatened.

Why? Because the Health Care Financing Administration (HCFA) improperly interpreted my language, thereby preventing our doctors from training in rural Alaska and other rural areas across the nation. Senator COLLINS and I had to introduce legislation to stop HCFA from harming these rural programs. It's this agency, HCFA, that Democrats now ask to run health care for most of America.

HCFA ignores Alaska's Medicare access problems. Access to health care is the over-riding problem for Alaska's elderly. Fourteen of nineteen primary care physicians in a major hospital in Anchorage will no longer accept Medicare patients. Why? Because doctors in rural areas lose money on Medicare patients in rural areas.

I have stated my concern over and over to the Health Care Financing Administration, but was ignored. As a matter of fact, the Administrator of the agency testified before the Finance Committee on February 26, 1998 that her agency has found ''no overall problem with access to care'' anywhere in the nation.

Why is HCFA ignoring rural America? I have been working with her agency for the past year to educate them—and have even brought representatives up to Alaska. But the problem persists.

Once again I stress that HCFA is not the agency to run all of America's health care. HCFA's approach of a one-size-fits all'' solution never seems to consider rural America.

And, lastly,

Health care access is denied to King Cove, Alaska. This debate is about ''patients rights''—about the rights of American citizens to have certain guarantees when they need medical attention. But when I think of King Cove, Alaska, I can't help but note a certain level of hypocracy by the party on the other side of the aisle.

It was one of the last votes Congress cast last year, ''The King Cove Health and Safety Act of 1998''—here's the background.

King Cove is located in the westermost part of Alaska and is accessible only by sea or air. Air traffic is often completely stopped due to a combination of prevailing northernly winds, heavy snows, strong crosswinds and turbulence.

Since 1981, there have been 11 air crash fatalities and countless other air crashes and injuries from the King Cove airport. One fatal accident involved a medivac flight headed for Anchorage.

The people of King Cove came to Congress to ask for access to health care—to ask for permission to build a small gravel road to a nearby, 24-hour, ''all-weather capability'' airport in the town of Cold Bay. Permission from Congress was needed because the Department of Interior prevented the gravel road from crossing a mere seven miles of federal property.

I am not talking about the ability for a King Cove resident to get an M.R.I., or the ability to choose their own specialist. I am talking about the most basic of all health care rights—access—the ability to simply get to a hospital.

My bill to allow that access was vigorously opposed by the Democrats. And President Clinton threatened a veto. Why? Because a big ''one-size-fits-all'' federal law prevented a 7-mile road. Once again those big ''one size fits all'' laws don't seem to fit Alaska.

Sadly, the majority of Democrats last year voted to deny the most basic right—access to health care—to Alaska residents. So the Democrats can ''talk the talk'' all they want about HMOs, and access to emergency rooms, but when it came time to ''walk-the-walk'' for the people of Alaska, they could not and would not do it.

I ask my colleagues, how can we be on the floor of the Senate debating what happens to a person after he gets to a doctor or hospital when many here were unwilling to provide Alaskans with access to that doctor or hospital?

Mr. President, that is what Federal intrusion has done to health care in Alaska. Again I stress that a ''one-size-fits-all'' package doesn't work in rural America.

Public health is too important to be sacrificed to such a big-government vision.

I favor patients rights that will strike against government control of the health-care system; I favor a plan that makes coverage more affordable and puts patients in control of their medical care; I favor the Republican bill.

I yield the floor.

Mr. MCCAIN. Mr. President, over the past four days, we have cast many difficult votes. Often, as you know, several issues are addressed in a single amendment or series of votes. Therefore, in order to ensure that my positions on these matters are fully understood by my constituents, I ask unanimous consent that an explanation of my votes on health care amendments be printed in the RECORD.

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

SENATOR MCCAIN'S VOTES ON PATIENTS' BILL OF RIGHTS

7/15/99: Kerrey Amendment #1253—JSM voted no because it was too broad in scope requiring an unlimited continuation of care from all plans with too many exceptions causing excessive costs for patients. Failed 48–52

7/15/99: Collins Amendment #1243—JSM voted yes because it made long term health care more affordable while also expanding direct access to obstetric and gynecologist care for women; providing timely access to specialists; and expanding patient access to emergency care. Passed 54–46

7/15/99: Ashcroft Amendment #1252—JSM voted yes because the amendment tightens up the external review process, making it more independent of the influence of insurance companies, and because it moves toward requiring insurance companies to pay for the costs of individuals participating in clinical trials. Amendment was adopted 54–46.

7/15/99: Gregg Amendment #1250—JSM voted yes because the amendment eliminates the provisions in the Democrat bill that would allow excessive and unnecessary litigation. He believes, however, that patients should be permitted reasonable and limited access to the courts to recover compensatory damages when denied proper health care by their insurer. Amendment was adopted 53–47.

7/14/99: Dodd Amendment #1239—No recorded vote on text of Dodd amendment regarding insurance coverage for individuals participating in clinical trials and access to approved drugs and devices; text of amendment was eliminated by adoption of Snowe Amendment #1241.

7/14/99: Kennedy Amendment #1242—JSM voted yes because he believes the patient protections afforded by the underlying legislation should be extended to as many people as possible, without precluding states from establishing additional protections. Amendment failed 48–52.

7/14/99: Snowe Amendment #1241—JSM voted yes because the amendment establishes requirements for extended coverage and overnight hospital care for mastectomies and similar procedures. Amendment was adopted 55–45.

7/14/99: Bingaman Amendment #1243—JSM voted no because he felt it did not fully address the problem which is why he preferred the amendment offered by Senator COLLINS providing timely access to specialists while also expanding access to emergency room services, women access to obstetric and gynecological care and expansion of deductibility of long-term care to individuals. Failed 47–53.

7/13/99: Santorum Amendment #1234—JSM voted yes because the amendment provides for full deductibility of the costs of health insurance for self-employed individuals and restates states' rights to regulate health plans which are not exempt from state control. Amendment was adopted 53–47.

7/13/99: Graham Amendment #1235—JSM voted no because the amendment would allow individuals to receive non-emergency care in emergency facilities if a non-life threatening medical condition was discovered during the course of treatment for a life-threatening condition. He supported the language in the amendment mandating that all patients have access to emergency facilities, but felt that authorizing post-stabilization care in an emergency facility would open the door for people to receive a litany of unauthorized, costly health services if they come into an emergency room under the pretense of a life-threatening condition. Conditions discovered during the course of an examination in an emergency facility, should be handled through the normal referral process using non-emergency doctors and facilities. Amendment failed 47–53.

7/13/99: Nickles Amendment #1236—JSM voted yes because the amendment waives the requirements of the underlying legislation if their implementation would result in a 1 percent increase in premiums or make health care unaffordable for 100,000 Americans. Amendment was adopted 52–48.

7/13/99: Robb Amendment #1237—JSM voted no because the amendment would eliminate the threshold exemptions in the Nickles amendment #1236. He supported the provisions of the amendment that required coverage and established minimum hospital stays for patients undergoing mastectomies and related procedures. These provisions were subsequently adopted in the Snowe Amendment #1241. Amendment was defeated 48–52.

7/13/99: Frist Amendment #1238—JSM voted yes because it made health plans accountable for their actions and delivery of medical care to patients. 52–48.

Mr. GORTON. Mr. President, as a parent and grandparent, I know there is nothing as important as taking care of one's family, especially if a family member is sick. If your daughter gets hurt, you want her healed. If your dad is ill, you want him to get better. It's human nature. Our compassion and desire to help our loved ones is limitless. Caring for your family is as natural as breathing. That's why good medical care is so important to all Americans.

Health care is about security, it's about peace of mind. It's very personal. It's about your doctor, your hospital, and your health care plan. It should not be about attorneys, paperwork, and the massive federal government.

America is blessed with the best medical care in the world, but the quality of our health care will be jeopardized if we fail to prepare for the challenges of this rapidly developing field.

As Congress takes a hard look at the health care system, we need to take a step back from the partisan bickering so often associated with the political system and instead do what's best for our families.

So as this debate in Congress ensues, I will support proposals, from either party, that will make health care better.

These are the principles I advocate:

Ensuring that Americans have access to the highest quality health care available;

Making sure that your medical decisions are made by a doctor;

Access to healthcare that is affordable; and

Creating opportunities for families that are now uninsured to buy health care coverage.

Washington families from Poulsbo to Pullman should have access to the best available care when they need it. Congress should implement common sense consumer protections for patients not covered by existing state laws.

Patients should be able to go to the nearest emergency room without worrying about whether that hospital is a part of his or her insurance plan's network. They should simply get the care they or their families need.

Woman should also have direct access to their ob-gyn for their health care needs, and children need to be able to see pediatricians who specialize in children's health care.

The patient-doctor relationship is unique and very personal. Patients should be able to choose their physician; under the Patients' Bill of Rights Plus Act, which I support, they can.

Patients should also be confident they are receiving the highest quality health care. It is difficult to keep abreast of the new developments and treatments in the fast-changing world of modern medicine. We have learned more in the last five years about how to improve health care than we learned in the prior 25 years. We need to make sure that hard-working doctors have the tools and the best information they need to provide the best care.

Should patients have recourse if they think their plan has been negligent or unfairly denied them treatment? Absolutely. We need to look at models that work during this debate, and adopt health care reforms that move the standard of patient care forward, not back.

Some in Washington, DC want to complicate the health care equation. Instead of a quick resolution and access to care when patients need it, patients would have to wait years for the courts to resolve the issue. The problem with that philosophy is that lawsuits are after the fact—the damage is already done. We should focus on quality health care and on treating patients, not spending all time in court. After all, you can't sue your way back to health.

Who benefits if we have more lawsuits? Clearly not the patients. One GAO study from 1987 found that cases with merit below $50,000 were unlikely to be pursued by plaintiff's attorneys. And, the time to payoff—if any—takes on average 33 months to be resolved; and medical malpractice claimants only received 43 cents on the dollar.

Their plan would allow employers to be sued. But, for many small businesses one lawsuit would put them out of business. In fact 57% of small businesses said they would drop health care coverage for their employees rather than risk a lawsuit that could put them out of business. That is not good for families.

I believe there is a better way. Patients should be able to hold their health plans accountable. New internal and external appeals provisions give all patients in group health plans that ability. If a patient believes his plan wrongly denied coverage for a health care service he can access a timely internal review conducted by the plan. If he still disagrees with the plan's determination, a patient can ask for an independent review conducted by a doctor who is a specialist in the area of dispute. The decision of the external review is binding on the plan and the court is able to award monetary penalties if the plan does not comply.

There are those in Washington, DC that would extend the arm of the federal government into your families' health insurance—requiring you to pay for benefits you may or may not need. The Congressional Budget Office concludes that the bill offered by the Democrats would cause premiums to rise by 6.1 percent, or $355 per family.

Ultimately, increased costs mean more American families can't afford insurance. The Lewin Group estimates that for every 1 percent increase in premiums 300,000 people lose their insurance coverage. A 6.1 percent increase would put health care out of reach for 1.8 million more Americans. In Washington state it means as many as 50,000 more Washingtonians may be unable to afford health insurance. That's unconscionable.

Instead, insurance coverage needs to be more accessible to American families. One way to do that is to allow full deductibility of health insurance costs for those who are self-employed—the same benefit many businesses receive. Employees who pay for their families' insurance premiums should also be allowed that same tax deduction. Medical Savings Accounts should be made more broadly available—37 percent of the people currently enrolled in the MSA pilot program were previously uninsured.

Our mandate is clear: ''first do no harm.'' This time-tested creed of the medical profession applies to this debate. The challenge is to provide common sense improvements to the current system but not at the expense of increased costs, more uninsured families, fewer health care choices, and another layer of government bureaucracy between patients and their doctors.

Let me add, Mr. President, that I think it is important that we have this debate. But, unfortunately, both parties are engaging in political gamesmanship and procedural antics on the Senate floor; each hoping to prove it is the champion of the health care issue. What's the end result? A debate—but, just a debate.

That result—no real progress—seems to me the exact result that political Washington, DC is hoping for. Where there was a glimmer of bipartisanship—for example on amendments that would give patients access to clinical trials or end the practice of drive-thru mastectomies—politics reigned.

In the meantime, there is a growing crisis in our rural areas as seniors continue to lose access and choice in their health care options. We know that as mandates pile up the cost of providing health care increases. Yet, the Administration's answer to Medicare has been across the board reductions in payments to hospitals and insurance plans. Just two weeks ago a number of plans decided they could no longer afford to do business in Eastern Washington. There is now only fee-for-service in most of Eastern Washington meaning seniors will end up paying more for fewer benefits.

Earlier this week, I attended a hearing at which rural hospital administrators testified about the impact of Medicare changes on access to care for seniors in rural areas. As the Administration develops payment systems, and issues its regulations and guidance for Medicare, I continually hear from the medical community, particularly those in rural areas, that the payment reductions and increased paperwork burden are simply intolerable. If hospitals and doctors can no longer do business in rural areas it ultimately means that the quality of care for seniors and other families living in our rural communities is in jeopardy.

We must work towards more choice, access and quality care for all Americans; for those who may be in group health plans, the subject of this current debate, but also for seniors and those Americans living in rural communities.

Congress' focus should be to create new opportunities for covering the uninsured by enacting provisions to make health insurance more affordable and accessible. We should pass common sense patient protections for those who are currently unprotected by state laws and all patients should be able to hold their health plans accountable.

After all, health care is about security, it's about peace of mind, it's about your doctor, and your hospital; but most importantly, its about your family.

Mrs. SNOWE. Mr. President, I rise today to express my strong support of the Patients' Bill of Rights. This bill will provide needed reform to our managed care system and ensure some basic patient protections for those with health insurance who do not fall under state jurisdiction.

This week the Senate debated an issue that goes to the heart of the personal security of every American. . .an issue that underlies all other issues. . .that cuts across racial lines, income levels, gender, or profession. Health care in this Nation affects all of us, touches all of our lives. And I am pleased that we are having this opportunity to discuss how we can ensure that health care delivery in the new century never loses sight of its most important component—the patient.

We need to have this discussion because, to paraphrase the recent car commercial, this is not your father's health care system. It isn't even the system we knew ten or fifteen years ago. Not so long ago, health care was delivered on a fee-for-service basis. Today, an explosion of advances in medicine and technology along with the advent of managed care, HMO-based networks, have changed the face of health care in America. And it is time to take stock.

We need to ensure that medical decisions are dictated by patients and their doctors—not the fine print on an insurance policy. And we must do so in a way that doesn't step on the toes of sound policies already put in place by individual states and doesn't substitute endless courtroom litigation for immediate medical treatment.

As more and more people enter into managed care plans, we hear of more and more problems—in some instances, it seems that patients are barely off the operating room table before they are sent home, whether they are ready or not. Or patients are denied access to a treatment or the specialist they need—something my state staff hears time and time again from constituents.

I happen to think that medical tests and medical doctors should be driving medical decisions, not actuaries or accountants. In all too many cases, it seems as though health care has become too much about crunching numbers and not enough about healing patients.

Indeed, the whole drive toward managed care has been prompted by an effort to contain and reduce health care costs in this nation—by itself, a worthy goal. And by-and-large, managed care has proven less costly than the traditional fee-for-service system—in fact, last year, the average premiums for traditional fee-for-service plans were almost 20 percent higher than HMO premiums and about 7 percent higher than premiums for preferred provider organizations.

But the question is, at what price? There is a real feeling among many Americans that, in some far off place, bureaucrats they will never see are making decisions that will dictate the quality and level of care they will receive. There's a real feeling that the average American has little say in what is probably the most deeply personal issue there is—and that the dollar sign is more compelling than any X-ray or MRI.

This bill addresses these concerns in a number of important and effective ways, all designed to put patients first.

This bill recognizes that medical emergencies are just that—emergencies. If you are being rushed to the hospital with a heart attack, that's hardly the time to have to phone ahead for prior approval—under this bill you'll know you're covered.

This bill protects a patient's right to hear the full range of treatment options from their doctor. It is outrageous that patients are often denied the best possible information just when they need it most, and this legislation would make these so-called ''gag clauses'' a thing of the past.

This bill would allow parents to bring their children directly to pediatricians, instead of having to go through primary care physicians. How much sense does it make that some managed care plans consider pediatricians to be specialists? The last time I checked, being a child is not a sickness—children deserve the quick and direct access they need to doctors who are really just general practitioners for kids, and under this bill they get it.

This bill would protect one's right to see a specialist. If a patient believes that seeing a specialist is the only way to get a sound diagnosis, they should not be denied that option.

And finally, this bill allows patients who are pregnant, terminally ill, or in the hospital to continue to see their current doctor, even if that doctor is no longer participating in the patient's health care plan. It's unconscionable that, after seeing a doctor who knows your condition better than anyone else, you could be asked to return to square one—and that would no longer happen under this legislation.

I realize that both parties have identified some of the more pressing problems with managed care, and both have laid out ideas on how to address these problems. And I truly believe that Senators on both sides of the aisle are concerned with what they've seen and heard from their constituents. The point that must be made here is that it is not so much our goals that differ, but rather the path we take in getting there.

And one of the most glaring differences is the way we approach existing state laws. Not surprisingly, many states have already beaten us to the punch when it comes to patient protections, and this bill respects the work they have done by complementing, rather than undercutting, their efforts.

Maine, for example, banned so-called ''gag clauses'' back in 1995, provided direct access to ob/gyns in 1996, and instituted the prudent layperson standard for emergency care in 1998. Wouldn't it make a lot more sense for the federal government to focus on fixing what's broken, instead of the problems that states like Maine have already fixed?

Yet, the Kennedy-Daschle bill asks us to overturn all the laws duly passed by 50 state legislatures and substitute then with a ''father knows best'' approach. It basically says, ''thanks for all your efforts on this issue —now step aside and let the real experts take over''. We think a better idea is to complement, not displace, state decisions and this bill does just that by providing benchmark protections for patients who are not already covered by State regulated plans.

We also take a different approach when it comes to disputes over care, emphasizing swift access to providers over the slow grind of the legal system. Under this bill, if an individual has a problem with a decision about their health, they can appeal, under an expedited process, to an independent party who is an expert in the condition being reviewed.

Why? Because what patients need first and foremost is medical relief now, not legal relief later. If I were sick today and I didn't believe I was getting the care or treatment I needed, I would rather see a doctor than a lawyer. The bottom line is getting well, and this bill would rather put medication ahead of litigation.

Finally, let me just say that I believe no patients bill of rights could be complete without a provision to protect against genetic discrimination.

Every day, scientists are finding links to a whole host of diseases. An estimated 15 million people are affected by over 4,000 currently known genetic disorders. Today, testing is available for about 450 disorders—but testing is useless if people are afraid to take advantage of it for fear of insurance discrimination.

No wonder then a reported 8 out of 10 people who undergo genetic testing pay for it out of their own pockets. Others simply forgo testing altogether. And still others refuse to participate in important medical research.

This is a travesty that must be remedied, and it would be remedied by this bill, which includes a provision I authored that provides absolutely fundamental protections against genetic discrimination in health insurance. This language has a long history—I first introduced these protections in the 104th

Congress in conjunction with Representative LOUISE SLAUGHTER in the House.

Since then I have worked extensively with Senators JEFFORDS and FRIST to ensure that this bill effectively addresses the need for protections against genetic discrimination in the health insurance industry.

Americans should not live in fear of knowing the truth about their health status. They should not be afraid that critical health information could be misused. They should not be forced to choose between insurance coverage and critical health information that can help inform their decisions. They should not fear disclosing their genetic status to their doctors. And they should not fear participating in medical research.

We have laid out stringent, tough, and sensible guidelines that allow people to use the information that can be obtained from genetic testing without fear. Any of my colleagues who have heard me talk about genetics know about my constituent, Bonnie Lee Tucker, who is afraid to have a genetic test for breast cancer—despite the fact that she has nine immediate family members who have had this killer—and despite the fact that she believes this information could help protect her daughter. Why? Because she is afraid it will negatively impact her ability and her daughter's ability to get insurance.

Our language ensures that people who are insured for the very first time, or who become insured after a long period of being uninsured, do not face genetic discrimination. It ensures that people are not charged exorbitant premiums based on such information.

It ensures that insurance companies cannot discriminate against individuals who have requested or received genetic services. It ensures that insurance companies cannot release a person's genetic information without their prior written consent. And it ensures that health insurance companies cannot carve out covered services because of an inherited genetic disorder.

In short, it ensures that Bonnie Lee Tucker, and the thousands of Americans like her, can take advantage of the latest scientific breakthroughs to protect their health and well-being without losing their insurance coverage.

There will be no issue more important in the 106th Congress than the one before us this week. No issue affects people more personally than health care, and we have a real responsibility to ensure that any changes we make put the patient's interests first. I believe this legislation puts patients first without unnecessary bureaucracy, without excessive involvement from the federal government, without trampling the laws already on the books in all fifty states, without increasing the costs of insurance or increasing the number of the uninsured.

Mr. BUNNING. I rise in opposition to the Kennedy health care bill and in support of the Republican alternative—the Patients' Bill of Rights Plus.

Mr. President, when the rhetoric starts heating up, it is often difficult to tell exactly what is going on.

However, it has been my experience that quite frequently, the best way to determine where people are headed is to look at where they have been. You can often tell where people are going if you look back to where they are coming from.

And, quite honestly, I get a little nervous when I hear people talking about providing a bill of rights for patients that sounds very enticing. Without looking into the facts, I get a little nervous because I know where the supporters of the Kennedy bill have been.

I know where the President has been. We know where they are coming from on health care.

Where are they coming from? Well, back in 1994, these same people were trying to sell us on Clinton Care—the President's misguided proposal which would have taken away a patient choice and freedom and which would have put the Federal Government in charge of the Nation's entire health care system.

Fortunately, that proposal was rejected by Congress and the American people. It failed because it was recognized for what it really was—a big government proposal that would have moved us closer to single-payor, government-run health care system.

And the American people made it clear back in 1994 they simply didn't have a great deal of confidence that letting the Federal Government run health care would be any kind of improvement.

Now, the debate has changed. We are talking about ''expanding patients' rights.'' And who can be against that?

But if you look at the people who are talking the loudest about these new rights, you will see the very same folks who supported Clinton Care—and who have consistently supported single payer, socialization of medicine all along. And that should concern everyone.

Have they changed their spots? I don't think so.

Be that as it may, even if you ignore the past and simply accept the Kennedy bill as a stand-alone measure that has nothing to do with past congressional efforts to put the Government in charge of health care, there are some very good reasons to oppose it. And there are some equally strong reasons to support the Republican alternative.

The reasons to oppose the Kennedy bill are simple. It will increase health care costs. It will increase the number of people who have no health insurance coverage dramatically. And it will seriously threaten our existing system of voluntary employer provided health care insurance.

It promises new ''patient rights'' which sound appealing at first blush, but when you look at it a little closer you discover that the costs are awfully high and the only ones who really benefit from those new rights are the lawyers and the bureaucrats.

I would like to talk about a couple of the problems that I see with the Kennedy bill and then point out a couple of the reasons that the Republican alternative is better.

First is the scope of the Kennedy bill—who will be affected. Today, much of the health care is regulated under the Federal ERISA statute—the Employee Retirement Income Security Act.

Today 42 million Americans get health care insurance through their employer as part of a plan that is directly governed by ERISA.

But, an even larger number—84 million—get their insurance through health plans that ERISA leaves to State regulation. Under the Kennedy bill, this would change.

The scope of the Kennedy bill is so broad that the States would be cut out of health care regulation. Uncle Sam would be in the driver's seat.

That's not what we want. One of the reasons the Clinton health bill failed was because Americans were suspicious of the Federal Government making health care decisions.

Many of us believe these decisions need to be kept as far from Washington as possible. The States have a role to play. Mr. President, even in Kentucky where our States general assembly has made some mistakes with health care recently, we want to keep working before turning everything over to Uncle Same.

So, the scope of this bill is troubling.

But even more troubling is the cost of the Kennedy bill. That is what health insurance is all about in the first place—the cost of health care.

And cost is certainly the one single health care issue that Kentuckians talk the most to me about. The cost of insurance premiums, prescription drug prices, medical equipment.

People are worried about their bottom lines. They are worried about how much is going to come out of their pockets. They want to know if they are going to be able to continue to afford to take care of themselves and their families.

For the folks who are worried about costs, the Kennedy bill is definitely the wrong prescription because it will increase costs, it will raise prices and it will swell the number of uninsured American families.

The nonpartisan Congressional Budget Office reports that the Kennedy bill would raise health insurance premiums 6.1 percent above inflation over the next three years.

In Kentucky this translates into $190 in higher insurance premiums that families would have to pay each year.

The worst part of these higher costs is that they mean fewer Americans will be able to afford health insurance.

CBO estimates the Kennedy bill will cost 1.4 million Americans their health insurance.

As many as 30,000 Kentuckians could lose their insurance coverage because of the higher costs imposed by the Kennedy bill.

According to at least one estimate, all of the new regulations and mandates in the Kennedy bill will cost almost $60 billion.

Somebody is going to pay those costs. Insurers are going to pass their costs along to the employers. And the employers will have to make a decision on whether to pass those increases along to their employees. And some of them may decide to drop the health care benefits they currently offer to their employees altogether.

So, that's the bottom line. the Kennedy bill of rights will mean that fewer people have health insurance—and those who still have it, will pay a lot more for it.

On the other hand, the GOP plan addresses health care quality without significantly raising costs. It would increase costs less than 1 percent.

That's a mighty big difference for the 1.4 million Americans who would be priced out of the market by the Kennedy bill, and for the millions of other Americans who would have to pay more out of their pockets for higher premiums.

A new bill of rights doesn't help you much if you lose your insurance coverage because you or your employer can't afford the premiums.

Our bill doesn't drive up costs, and it won't cause more Americans to lose their coverage because it doesn't have all of the new mandates and new regulations that the Kennedy bill does.

In fact, the Republican alternative actually includes provisions to help expand the availability of health insurance coverage and to help reduce the costs of insurance.

Our bill makes health insurance premiums 100 percent deductible immediately. That makes health insurance more affordable for 125,000 Kentuckians and millions more across the country who are self-employed.

The Republican bill also would lift the cap on the number of medical savings accounts that can be set up. Currently there is a national limit of 750,000. Our bill would allow every American who wants to set up a medical savings account the opportunity to do so.

MSAs might not be the right thing for everyone, but they make sense for a lot of families and they can really cut costs for many of them.

Our bill also improves on the existing ''flex accounts'' that many employees use to get health insurance coverage through cafeteria plans. Right now, many employees can use flex accounts to help cut medical costs and save money. Our bill would give employees even more flexibility to shift their coverage from one insurer to another and to make sure they can continue to see their own doctor.

Our bill contains these provisions to help reduce the costs of health care, and to expand health insurance coverage. The Kennedy bill includes none of them.

Over 40 million Americans have no health insurance coverage at all. The last thing we should do here in the Senate is pass legislation that is just going to make that number rise.

But that is what will happen if we pass the Kennedy bill. The supporters of this legislation claim that they want to give more rights to patients, that they want to protect Americans from the HMOs and the big insurance companies.

But, instead, their bill is an empty promise that would actually give Americans fewer rights. You can't have patient rights to fight your insurer if you can't even afford to buy insurance in the first place.

Imposing more regulations and more requirements on employers and insurers might have a gut appeal, but in the end it's not going to fix anything. It's only a placebo—a sugar pill—that turns out just to be an empty promise that won't cure this patient.

The next issue I want to address has to do with liability and lawsuits.

Everybody has heard the horror stories and a lot of Americans are becoming more and more worried that they are not going to be able to get the care they need because their insurance company refuses to pay for the treatment their doctor recommends.

When that happens, the question for patients becomes—what do you do if your insurer disagrees with your doctor?

The Kennedy bill's answer to this question is simple—it says sue your HMO or your employer. Sue your insurance company. Go to court and let the lawyers fight it out about your health care.

Under current law, patients can already sue their HMO in Federal court, and many of them are doing this. But, the Kennedy bill goes a step further and sets up a litigation lottery by lifting the Federal preemption and making it easier for patients to sue in State courts too.

The bill's supporters make a big deal out of liability and say that lawsuits are the best way to hold HMOs and employers accountable for decisions. And at first, suing your HMO—the big bad insurance company—might sound like a good idea, a sort of rough justice.

But I don't think anyone really believes that getting lawyers involved and going to court is the best way to obtain better medical care.

If your insurance company denies you coverage for a specific problem or a specific treatment, and you need medical care quickly, suing is not a very effective answer.

And I don't see how suing an employer about your health plan is going to help make things better. It's just going to make it more expensive, and give employers an incentive not to offer health care to their employees.

If you do sue under the Kennedy bill, there is no telling how long you are going to be in court, even if you can afford to pay a lawyer to take the case. And going to court to get a judge to rule on medical decisions isn't going to help a patient get help any more faster.

More lawsuits are only going to clog up the courts and increase legal bills, and in the end that is just going to drive up health care cost.

According to the General Accounting Office, it takes 33 months—almost three years—to resolve the average medical malpractice claim.

Some take much longer, and most patients can't wait that long for medical care.

Everyone knows that there are too many lawsuits in America. We hear it all the time. Most of the time in Congress, we are debating changes to the liability rules to cut down on litigation, to keep matters out of the courts.

For instance, we just passed the Y2K bill to give businesses and high tech firms more incentives to fix problems before they occur.

That's what we should do with health care. It just doesn't make sense to say we are going to improve health care by filing more suits in our courts. Making it easier to sue insurance companies or employers is a knee-jerk, feel-good reaction that isn't going to help anybody get medical care any faster.

On the other hand, the Republican bill says that if you are a patient and you think you're not getting a fair shake from your insurer, you can immediately appeal for a speedy internal review of the case. No lawyers, no courtrooms, no legal games.

And, after that review, if you think you still aren't being treated fairly, you can demand a quick and timely independent review by outside experts.

The Kennedy bill claims to have external reviews too. But the bill's primary focus is on making it easier to sue, and that means the primary arena for external reviews is going to be the courts.

The bottom line, Mr. President, patients already can sue their HMOs in Federal court. They have that right today.

But instead of encouraging quick resolutions of disputes, the Kennedy bill encourages even more lawsuits in State courts. This will only shift scarce resources from the operating room to the courtroom, and that's the last thing we need.

You can't sue yourself healthy.

In conclusion, Mr. President, I would like to tell my colleagues about what happened in Kentucky when our State adopted a health care bill that increased regulations, took away patients' freedoms and injected the government further into medical care. It's a living example of what could happen is we passed the Kennedy bill.

a couple years ago our general assembly passed a Clinton-lite health care bill. Back then we heard a lot of the same arguments that we do now about the need for more regulations and more government involvement in health care.

The proponents argued that the government had to step in to protect patients from insurers and to hold the line on costs.

Well guess what happened in Kentucky? We passed a big government health plan with all sorts of new mandates on insurers. The legislation was designed to protect patients, and give them more rights by the power of government intervention.

What happened was predictable. The insurance companies fled Kentucky in droves. For a while there were only two insurers who would underwrite individual health plans in our State—Blue Cross/Blue Shield, and State Government. That's it. Everyone else left us high and dry.

The number of uninsured Kentuckians rose. Costs increased. Medical care became more expensive and harder to get.

Sicne then, our State legislature has been backtracking and paring back those regulations and mandates. And guess what. Insurance is becoming more available again and prices have stabilized.

That's the sort of situation we are looking at if the Kennedy plan passes. More regulation, more government in your personal life, higher costs, and worse health care. It happened in Kentucky, and it can happen in the rest of the country if we pass the Kennedy bill.

Mr. President, I urge my colleagues to oppose the Kennedy bill. It's the wrong prescription for America. We know that more regulation and more government aren't the answer, but we have to keep fighting this battle.

It wasn't the answer in the Clinton health bill, it wasn't the answer when we passed health care reform in Kentucky, and it's not the answer today.

If you want higher medical costs, if you want more uninsured Americans, if you want more government rules and fewer choices for individuals, then support the Kennedy bill.

But, Mr. President, that's not what we really need. We need more affordable, more available, health insurance. We need a reliable, fast, and fair system of reviews to keep insurance companies honest but we don't need a flood of lawsuits. That is what the Republican bill offers.

Mr. MCCAIN. Mr. President, our personal health and the health of our loved ones is the most valuable thing we possess. Unfortunately, we often take good health for granted until tragedy strikes and the health or well-being of a family member is jeopardized by disease, accident, or the ills often associated with aging. This is when we fully appreciate the value of good health, as well as the importance of access to quality health care.

When one of us or a loved one becomes ill, the obstacles of daily life become insignificant in comparison to ensuring the best health care services are available to ensure a full and speedy recovery. Our priority instantly becomes seeking and receiving the best possible care from qualified medical professionals.

Unfortunately, too many Americans feel powerless when faced with a health care crisis in their personal life. Many feel as if important, life-altering decisions are being micro-managed by business people rather than medical professionals, and too many Americans believe they have no access to quality care or cannot receive the necessary medical treatment recommended by their personal physician.

Many Americans work hard and live on strict budgets so they can afford health insurance coverage for their family. Then, the moment they need health care, they are confronted with obstacles limiting which services are available to them: confronted by frustrating bureaucratic hoops; and confronted by health plans that provide little, if any, opportunity for patients to redress grievances. This happens too often and can be attributed to several factors.

Our health care system is very complicated. It is comprised of thousands of acronyms and codes, and even has acronyms for acronyms. Our overly complex health insurance system intimidates and confuses many Americans. Many of us fail to fully examine the coverage provided by our health plans until we become ill, and then it is difficult to understand the legalese of the plan documents. Another contributing factor is the depersonalization of health care, which has become focused more on profits than on proper patient care.

I am not embarrassed to admit that I find the complexity of the health system very disconcerting and am often overwhelmed by its intricacies. I can certainly relate to the majority of Americans who are overwhelmed by a system which does not meet their basic needs in a simple, efficient and affordable manner.

Let me stress that I am not here today to bash managed care. I am not here to condemn Health Maintenance Organizations (HMOs) and the services they provide millions of Americans. I applaud the success of managed care in reining in skyrocketing health care costs, eradicating excessive and costly health care expenditures, and significantly reducing unnecessary overuse of the system. Managed care has played a direct role in reducing health care costs so that health care coverage is affordable for millions of hard-working American families.

However, while I appreciate the important contributions of managed care, we must protect the rights of patients in our Nation's health care system. Too many Americans feel trapped in a system which does not put their health care needs first. They believe that HMOs value a paper dollar more than they do a human life.

I know that my colleagues share my view, as do most managed care companies, that we cannot continue to ignore the rights of patients. For far too long, we have allowed the health care reform debate to be determined by special interest groups. Democrats are perceived as advocating certain principles and priorities for the trial lawyers, who are drooling over the prospect of unlimited and excessively costly litigation against insurers. Meanwhile, Republicans are perceived as working to protect the profit margin of the insurance companies and big business. As a result, this critical debate is overwhelmed with partisan bickering, and millions of Americans are left with no representation and inadequate health care.

It is time for all of us to put aside partisanship and the influence of special interests to work together for what is needed and wanted by our constituents—safe, quality, affordable health care.

I believe several fundamental health care principles must guide our health care debate:

First, we must put Americans in charge of their own health care. There are too many people who feel overpowered and overwhelmed by the current medical system. The current structure has created a caste system, and many patients believe they have become the serfs. Patients and their doctors should control their health care decisions, not HMO bureaucrats or political bureaucrats in Washington. Physicians utilizing the best medical data must make the medical decisions, not insurance companies or trial lawyers. We need to put in place a balanced system that allows managed care companies to reduce costs but also reinvigorates the patient-doctor relationship which is essential for receiving optimal care.

On the other hand, patients need to recognize that they cannot rely solely on doctors to always provide the best medical options. We each have a responsibility to learn how our medical plan operates, read about the options available to us and our family before we become sick, and most importantly, become better consumers of health care. I don't think many people would enter a salesroom or bank unprepared with the pertinent information for purchasing a new car or home, but too many of us blindly enter into major decisions affecting our health without doing any research. I know this is not easy, particularly with our very complex health care system and when so many of us barely find the time for sleep between work and family responsibilities. But we must become better advocates for ourselves in this complex medical system.

To that end, the government should help Americans become educated consumers by ensuring pertinent health care information is readily accessible. I have advocated and will continue to advocate a central web site or other service which simplifies research for Americans as they gather data on available health care options.

Second, we must improve access to affordable health care. It is simply disgraceful that 43 million Americans can not afford health care coverage. This is the largest number of uninsured citizens in over a decade, despite our strong economy and past actions to provide greater access to medical care. We must continue building upon already enacted reforms by expanding medical savings accounts, offering flexible savings accounts, providing full tax deductibility for self-employed health insurance costs, and allowing tax deductibility for long-term care expenses.

We must stop wasting our limited resources on pork and wasteful spending projects, so that we have more money to assist Americans who are uninsured and can not afford to put money away in medical savings accounts or will not be able to benefit from a tax credit. We should provide more funding for our nation's community health centers which are a tremendous resource in helping millions of Americans gain access to health care who would otherwise go without. Community health centers have instituted a sliding fee schedule which allows people to contribute what they can afford and still receive health benefits. We should strengthen and expand these successful centers throughout our country.

In addition, our tax code impedes a competitive market by prohibiting many Americans from truly being health care consumers. Many people lack purchasing power and are dependent on their employers for health care coverage. Tax benefits should not be limited for health care purchased only by big businesses. We should develop a method for providing the same tax benefits to individuals and families.

Third, Americans must have a choice of doctors to meet their health care needs. Today, too many women cannot go directly to an obstetrician or gynecologist for medical care. Instead, they are forced to waste valuable time seeking a perfunctory referral from a ''gatekeeper'' doctor before they can go directly to their OB/GYN. The same is true for children. Mothers and fathers should be allowed to take their children directly to a pediatrician. Instead, the current system forces them to go through a gatekeeper for referral. Women and children must be given the opportunity to seek care directly from the trained professionals best suited to address their unique health needs.

Additionally, Americans should be free to choose their doctors, including specialists, if they are willing to bear the additional costs which may accompany this freedom. People should be able to enroll in a point-of-service plan with access to a multitude of physicians, rather than be limited to an HMO which restricts freedom of choice in doctors.

Fourth, we must guarantee access to emergency care. If a man or woman in Phoenix, Arizona fears they are having a heart attack, they should not be required to seek approval from their managed care company prior to calling an ambulance and going to an emergency room. Any bill we pass must guarantee care in an emergency room without prior approval from an HMO if the person believes that it is an emergency situation.

Fifth, we must ensure continuity of care. Individuals who are pregnant, terminally ill, or institutionalized should be given special consideration so that their necessary care is not interrupted abruptly if their employer changes health plans.

Sixth, doctors must be able to communicate openly and fully with their patients. Today, some doctors are prevented by HMOs from openly discussing all medical treatments available to a patient. This is unconscionable. HMOs must not be allowed to stop doctors from openly discussing all possible care available, even if the procedures are not covered by the HMO. A doctor's loyalty must be to the patient and not an HMO's bottom line.

Seventh, a free and fair grievance process must be available in the event an HMO denies medical care. A mother should have options when she is told her son or daughter's cancer treatment is not necessary and will not be covered by her insurance. We can not support a system that leaves that mother powerless against corporate health care. She must have access to both internal and external appeals processes which are fair and readily available and which use neutral experts who are not selected, paid, or otherwise beholden to the HMO. In life-threatening cases, there must be an expedited process.

Finally, once all options to receive necessary medical care have been exhausted, including an external appeals process, and that care has not been appropriately provided, every American should have the right to seek reasonable relief in the courts. I find it incredible that HMOs and their employees are able to avoid responsibility for negligent or harmful medical care. Americans covered by ERISA health plans should have the same right of redress in the courts as those who are enrolled in non-ERISA plans if they are unable to receive a fair resolution through an unbiased appeals process. We must ensure that patients receive the benefits for which they have paid and rightfully deserve. We must also ensure that unscrupulous health plans not go unpunished when they act negligently, resulting in harm to a patient.

I drafted a compromise on this issue which would be fair to patients and HMOs and would not cause excessive and costly lawsuits. The proposal, which is filed as amendment number 1246, would require patients to go through both the internal and external appeal processes if they were unsatisfied with care or decisions of their HMO. Once the appeal process reached a decision, they could accept the decision, or if they felt they still had not been treated fairly, they could go to the courts. In court, they could receive compensatory damages with a cap of $250,000 on non-economic damages.

I believe this is a fair and reasonable compromise which would allow patients to be compensated, but eliminates the potential for extravagant awards that could drive up the cost of health care. Unfortunately, I was precluded from calling up this amendment and another amendment which would have protected the rights of children born with birth defects (amendment number 1247) because of the stringent controls established by the Leadership for debate on this bill.

It is unfortunate that this health care reform debate has been controlled by special interest groups on both sides and mired in partisan political maneuvering. This has become a debate—not about providing affordable access to quality health care for all Americans—but a debate about preserving the positions of competing special interests. It has become a debate about the interests of trial lawyers versus the interests of insurance companies—not the interests of patients. No reasonable compromise has been offered on either side to resolve issues like liability, choice, access, and cost. Instead, we are voting on competing proposals at the extremes.

This is not a debate. It is a contest—a contest between parties and special interests. And it is a contest that no one—not Republicans, not Democrats, certainly not the American people—wins, except, of course, the special interests who are only concerned about their financial well-being, rather than the physical or financial well-being of every American. It is a shame that this body is so controlled by special interests that we cannot even put the health of the American people ahead of politics.

I cosponsored the original Republican Patients' Bill of Rights, S. 326. And despite the concerted efforts of the trial lawyers and the insurance companies and those more interested in partisan politics than the health of the American people, we have succeeded in adopting some much-needed improvements to the original bill. For example, the external appeal process has been made more independent of the influence of the insurance companies; a small step has been taken toward requiring HMOs to pay for an individual's participation in a clinical trial; it requires expanded access to specialists and emergency medical care; and it mandates extended hospital care following mastectomies and related surgeries. These improvements are a step in the right direction—toward putting the needs of patients first.

Because of these changes, I am reluctantly supporting final passage of this legislation. I am doing this because I believe it is important to move forward and enact legislation to implement

much-needed health care reform. The House will soon take up health care reform, and I hope they will pass a reasonable health care reform bill which honestly puts the needs of patients first. We can then work for a practical and fair compromise during conference.

I want to put my colleagues on notice that, if a conference agreement comes back to the Senate that does not meet the standard of putting patients first, then I will have to oppose that legislation. This is too important an issue to allow the influence of special interests to prevent us from doing what is right for all Americans.

Mr. NICKLES. Mr. President, I call on the chairman of the HELP Committee, Senator JEFFORDS, for 2 minutes.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. Mr. President, I will make my full statement after the vote, but this bill gives new consumer protections to the 48 million Americans in self-insured plans that the States are unable to protect. This bill creates a new, binding, internal/external appeals process for 124 million Americans. This bill also protects 140 million Americans from having their predictive genetic information used to deny them health insurance coverage, and it expands access to health insurance through increasing affordability and choice of health care options.

As we prepared this legislation, we had three goals in mind. First, to give families the protections they want and need; second, to ensure that medical decisions are made by physicians in consultation with their patients; and finally, to keep the cost of this legislation low so it does not displace anyone from being able to get health care coverage.

The Patients' Bill of Rights was not crafted easily and it was not crafted hastily. This legislation is a result of over 2 years of work by the Senate HELP Committee. In March of 1997, I chaired the first of 17 hearings on the topic of improving health care quality. In April of 1998, I chaired a committee field hearing at Fletcher Allen Hospital, in Burlington, VT. Numerous leaders from the Vermont medical profession and Vermont insurance regulators pointed out the State of Vermont already has passed 22 patient protections, including direct access to OB/GYNs and a ban on gag rules and a continuity of health care provision. Vermont's most pressing need, according to these State providers, was to enact protections for those individuals in self-funded plans that the States could not protect.

The Vermont health providers also stressed their strong concern that any Federal health care legislation not increase costs. The Congressional Budget Office estimates that the Kennedy proposal would have raised health insurance premiums by 6.1 percent. A study commissioned by the AFL-CIO concluded that such an increase would cause 1.8 million Americans to lose their health insurance. This would mean approximately 4,000 Vermonters would lose their health insurance. The Vermonter who could still afford health insurance would have to pay an additional $328 a year for family coverage.

During the battles over the last few weeks, we have heard a great deal of biting, political rhetoric. But we cannot forget that the real issue is to give Americans the protections they want and need in a package they can afford and that we can enact. We must pass this bill.

Mr. NICKLES. Mr. President, how much time remains for both sides?

The PRESIDING OFFICER. For the majority, 11 minutes 20 seconds, and 13 minutes 1 second to the Democratic side.

Mr. NICKLES. I yield 2 minutes to the Senator from Pennsylvania, also a very strong contributor to the membership of our task force.

Mr. SANTORUM. Mr. President, I thank Senator NICKLES for his outstanding leadership on this task force. We would not be where we are today, passing what I believe is a very useful and precise way to respond to a very complicated problem. Senator NICKLES shepherded this task force with great skill. He deserves a great amount of the credit for what is being accomplished today.

With respect to the comments that this bill is dead, it is not going anywhere, the President is going to veto it, I would say this: Of all the criticism I heard about the Republican bill, most of it is it just does not go far enough. It is not that what we are doing is not right or it is not in the right direction; it just does not do enough.

I do not know about you, but I have watched Congress for a long time. I have seen a lot of things happen in this institution, where sometimes it is good just to do something in the right direction, that we all agree is in the right direction. I do not think anyone is saying what you are doing is absolutely antithetical to good health care, you say internal/external—no. We need more of that, we need a tougher one, but not to say what we are doing is bad. It just is not enough. I am hopeful people will say doing something that is good should not be the enemy of what some believe is the best.

So I am hopeful we can get together, the House has to act, they are going to pass a different bill, and then we can sit down with the President and our colleagues on the other side of the aisle and do something that is good. Let's do something on which we can agree. Let's do something that can move the ball forward and work together so we can go out and say: We, in fact, did protect patients. We did improve the quality of health care. Maybe not as much as some would suggest we could—I differ with that—but we did do something positive. We did improve access to health insurance. We did not blow a hole and increase costs dramatically to drive people out from health coverage. That is what we need to do, to move forward and do something good.

Mr. NICKLES. Mr. President, I yield 2 minutes to the Senator from Missouri, Mr. ASHCROFT.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. ASHCROFT. Mr. President, we have a great opportunity, which we will capitalize on this evening, by voting for this measure which has been the result of hard work by a team and task force of individuals dedicated to improving the health care of Americans and access to health care. I am grateful for it. I totally reject the notion that this is a victory for the status quo. One person can make this a victory for the status quo. Bill Clinton can. He could veto this. I do not believe we should think that he will. I believe we should continue to work and present him with this great opportunity to lift the status of health care of Americans.

One area I was concerned was that people ought to get the right treatment from HMOs and that, if they have a disagreement with an HMO, they ought to be able to settle that disagreement in a way that gets them treatment. So an appeals process was established for an internal appeal by the patient and an external appeal.

I sought to improve the bill. It did not include this provision, but I offered an amendment which said, if the external appeal agreed with the patient and said that the patient deserved the treatment and ordered the HMO to do it, and if the HMO would not provide the treatment—we have amended this bill now so the person is eligible to go and get the treatment elsewhere and charge the HMO, and the HMO that wrongfully refused the treatment to the patient has to give a $10,000 penalty payment to the patient.

This really gives the patient what the patient needs, health care. The Democratic proposal sends the patient to court. How disappointed would you be, as a person, if you called for an ambulance and you found them taking you to the court instead of to the hospital?

We do not want to end up with a dead relative and a good law case. We want to end up with good treatment, and that is what this bill will do. It has a strong set of enforcement provisions to respect the rights of individuals, and if the HMO fails to comply with that enforcement, we send the people to the hospital, not to the courtroom.

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

Who yields time? The Democratic leader.

Mr. DASCHLE. I yield 3 minutes to the distinguished Senator from Rhode Island.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. I thank the Chair.

Mr. President, I rise this evening with great regret, regret that we have

not done what we should have done to protect the children of America who are in a managed care plan. The bill before us that we will vote upon is a litany of missed opportunities and missed statements with respect to the status of children in managed care. For example, access to pediatricians. They are classified as specialists, so they cannot be automatically the primary care provider to children. Frankly, most Americans believe that is exactly who they are.

Second, there is no guaranteed access to pediatric specialists. We have language in this Republican proposal that talks about age-appropriate specialists. That is language written by HMO lawyers to ensure that they can magically transform an adult specialist, who might have seen a child at 1 year or 2 years, into an age-appropriate specialist, just as they do today.

We have a situation in which we have not provided for expedited internal and external appeals based upon developmental needs of a child. Children are different from adults. They have conditions for which an adult could wait months and months and months for adequate care, but in a child they become critical because the child's development is critical. These are shortcomings that will leave the children of America shortchanged.

We can and must do more. We could have done more, and we could have given all the individuals in managed care the right at least to go to consumer assistance centers, ombudsman programs, so they could have their questions resolved, and we pushed that aside.

Frankly, the greatest disappointment I have is that we heard a lot of discussion this evening and the last few days about the cost of this bill. We could give all these protections to children, every item in the Democratic proposal, and the cost would be negligible, because one of the good news issues is that children are generally healthy. But for those chronically ill children, it would have made all the difference in the world.

Today is not the day we are helping the children of America in managed care, but I hope we will some day, and that day will come, and it must come.

I yield the floor.

The PRESIDING OFFICER. The Democratic leader.

Mr. DASCHLE. Mr. President, for the last 2 years, Democrats have worked tirelessly for this moment. We have been guided by a very simple goal. That goal is to protect the rights of 160 million Americans who have private health insurance. Democrats have tried to answer the question: What should motivate that system, money or medicine? What should be the crux of our health care system? Do we put a money screen on decisions, or do we put a medical screen on decisions? We concluded that when it comes to someone's life, someone's health, the answer to that question is very simple.

Democrats have outlined six basic principles. The first is that all 160 million Americans ought to be covered by patient protections. We offered an amendment to ensure that all 160 million Americans would be covered, and our Republican colleagues defeated it.

The second principle is to ensure we provide access to needed care regardless of circumstances: access to qualified specialists, real access to emergency rooms, access to lifesaving treatments and drugs, access to quality care that is unique to America in some cases. We offered amendments to provide these protections, and our Republican colleagues defeated them.

The third principle is simply this: That doctors ought to make medical decisions. Not accountants, not bureaucrats, not people with green eyeshades who make monetary decisions instead of medical ones. Let doctors make those decisions. We offered an amendment, and our Republican colleagues defeated it.

The fourth principle is quite simple to understand, but extremely important to millions of Americans. Let us, above everything else, protect the doctor-patient relationship. Let us ensure that all doctors can talk about all medical options with their patients when they are facing critical medical decisions. Let us ensure that we protect doctors from retaliation by managed care companies. And let us ensure that chronically ill patients get to keep their doctors.

Mr. President, that is not too much to ask. When we talk about rights, basic rights in this country, what could be more basic than that? We offered an amendment, and our Republican colleagues defeated it.

The fifth principle is one we also feel strongly about, and that is accountability. I have heard many of our Republican colleagues say: You should not have to go to court to get your health care; the important thing is getting the care you need.

We agree with that, and we provide a strong, independent appeals process. But all too often, HMOs make decisions that are wrong. And all too often, patients are left with absolutely no recourse. We simply believe that when this happens, when an HMO or an insurance company makes the wrong decision, you ought to have some recourse. You ought to be able to hold them accountable. You can with a doctor. You can with a hospital. Why not with an insurance company?

Finally, I have never been more proud of our women Senators, and I have never been more convinced that we need more women in the Senate than I am tonight, because they have enlightened us, Mr. President, in our caucus and on the floor. They have sensitized us to women's issues unlike anything I have ever heard before. There isn't a man in the Senate who can tell us what they told us, with the eloquence, with the passion, with the feeling. They told us there are special needs of women that just are not being addressed. If we are going to make this system work better for millions of Americans, we ought to understand that. So we offered an amendment to ensure that women's needs are protected, and our Republican colleagues defeated it.

Tonight, I agree with those who have said we missed a golden opportunity to pass a real Patients' Bill of Rights. We have offered clear choices. The majority has opposed us every step of the way. The majority leader said, let's work together, work with us. We have made every effort to work with our colleagues, but the only thing we have gotten back is what I believe the Republican bill truly stands for when it calls itself HMO reform. In my view, HMO stands for ''half measures only.'' That is all we have gotten—half measures. To those who say, isn't this just a little bit better? my answer is no. In all sincerity, I believe we will actually lower the standard when we pass this bill tonight. We have not made progress; we have moved backward.

I am always amused, frankly, that our Republican colleagues turn to taxes anytime they want to fix a problem. I am surprised there is not a tax break for observing the speed limit. Tonight, there is another $13 billion bill that we will be voting on, most of which is a tax break. I support meaningful tax reform, targeted especially to working families. But when we talk about a Patients' Bill of Rights, are we really talking about the need for a tax break, or a break from the kind of oppression that many people feel with their insurance and managed care companies?

I also regret the fact that we did not have an opportunity to debate the bipartisan bill. I wish we could have had a good debate on the Graham-Chafee bill. I wish we could have at least moved forward with that piece of legislation. I believe there would have been 45 Democratic votes for that bill tonight. The problem is, as I understand it, there are only three on the Republican side.

Even if we offered a bipartisan bill, cosponsored by two very prominent Members of our Senate tonight, we would only have the same 48 votes we had on almost every single amendment we offered.

The President will veto this bill because he and we know we can do better than this, that we should not lower the standard. We should do far more to ensure that we cover all patients, all 160 million. Ultimately, I believe, as Senator KENNEDY noted, we will pass a comprehensive Patients' Bill of Rights.

This afternoon I was reminded again of how critical this is to real people. Throughout this debate, what meant most to me is the experience I have had in talking to real people whose lives have been affected by managed care companies, whose lives have been directly, and in some cases, negatively affected by their decisions.

Justin Dart, a full-fledged lifelong Republican was out on the lawn this afternoon. He was there in his wheelchair, surrounded by medical equipment needed to function and maintain his health. He has experienced medical care. He has benefited from it, and, unfortunately, as he related again today, he has been disappointed by it.

In the most passionate and most eloquent way he could say it, with his lips quivering, speaking to all of us, as he urged the Senate to do the right thing tonight, he said: ''I'll give my life for my country, but I won't give it to an insurance company.''

Too many people have given their good health, and in some cases their lives, because decisions have been made by insurance companies for the wrong reasons. We are going to fix that. I am hopeful, as others have expressed, we can do better, we can find a way to ensure that all Americans are going to be protected, as we know they should be. We should not give up until we know we have done the job right.

Mr. President, over the past three-and-a-half days, we have finally had the opportunity to have a good debate on several critical issues affecting patients' rights. Senate Democrats—and the patients of America—have waited a long time for it. Because of limited time, other critical issues remain to be debated. Still, we are glad the Senate has spent most of this week debating two dramatically different approaches to patients' rights. The American people deserve to understand the differences. They are important.

Mr. President, the Senate has indeed missed a golden opportunity to pass a real Patients' Bill of Rights.

Instead, the Republican majority is handing the insurance industry its version of HMO reform: Half Measures Only.

On critical issues, we gave our colleagues a choice: guaranteed patient access to the closest emergency room versus ambiguous assurances of limited emergency care; access to clinical trials for all life-threatening and disabling diseases versus limited clinical trials only for cancer; medical determinations made by doctors and other health professionals versus decisions made by HMO accountants; the right to hold HMOs accountable for their decisions that harm or kill patients versus the right to live with whatever bad decisions an HMO might make; and, of course, the extension of basic rights to all privately insured Americans versus the exclusion of over 100 million Americans.

The list goes on.

All that was necessary on the Senate's part was to listen to the doctors and nurses and other health professionals. To listen to the American people. Unfortunately, a majority of the Senate chose to ignore those voices and listen instead to the industry that stands to continue to profit from our failure to provide meaningful patient protections. The industry that opposes even minimal protections and any means of enforcing them.

Frankly, we are astounded. Yes, we were told repeatedly by Senator NICKLES and Senator GRAMM and Senator FRIST that this would happen. That their plan was simply to block this legislation from ever coming to the Senate floor, since they did not want to be in a position of having to defend an indefensible position. When that plan failed, they made it clear their strategy was focused on political cover instead of meaningful reforms. (That cynical strategy will ultimately fail, too.)

Still, we held out hope—that reason would win out in the end. That the overwhelming public support for our modest reforms —support that knows no partisan boundaries outside of Washington, DC—would influence at least a handful of Senate Republicans. We are astounded that it did not—that there are not five Republican senators willing to challenge their leadership in order to please over 80% of the American people.

Maybe some of them just didn't read the two bills. The other day, Senator GRAMM again invoked the name of his ''mama'' and said he wants her to be able to call her doctor instead of a bureaucrat when she gets sick. Well, we agree. But, given his concern, Senator GRAMM and the vast majority of his Republican colleagues are supporting the wrong legislation.

It is the Democratic bill that protects patients' rights to communicate directly with their doctor and make medical decisions with their doctor—without inappropriate interference from a nameless, faceless HMO accountant.

Senator GRAMM and other opponents argue: ''The Democratic bill is a step toward government-run health care.''

That charge is simply untrue—under our bill, health care professionals, not the government, would make decisions.

Ours is not a step toward government-run health care; it's a step away from HMO accountant-run health care.

The insurance industry's TV ads opposing the Democratic bill warn that people get hurt ''when politicians play doctor.'' Again, that is the height of irony.

Senate Democrats are not playing doctor. Under the current system, and under the Republican bill, it is HMO accountants who are playing doctor, denying the real doctors the ability to implement medically sound decisions. And real people are getting hurt every day.

Let's be clear—we're not opposed to managed care.

The theory of managed care—that a primary care physician and health network will understand the whole patient and manage his or her care to improve patient health—is a good one. But all too often that theory has been corrupted in practice.

Too often, instead of managed care, we have managed costs.

The Hippocratic Oath is not about saving money; it's about saving lives. And while we should take reasonable actions to curb health care costs, we cannot do it at the expense of Americans' health. Furthermore, any costs associated with the Democratic bill would be minimal—and nonexistent for HMOs that already provide the medical services they should.

The United States has the best health care in the world—the best doctors, nurses, facilities, and equipment. But what good is the best health care in the world if insurance company accountants block your access to it?

Over the course of the last several days, my Republican colleagues have rejected every Democratic proposal to improve Americans' access to better health care. In one twist, they rejected our proposal to protect women from being discharged from the hospital too soon after breast cancer surgery, only to turn around the next day and take credit for that proposal at the same time they denied those same breast cancer victims—and other women and men—access to clinical trials for new, life-saving treatments.

It has been a pattern all week: reject the real patient protections, and, in the specific cases where there's enough of a public outcry, offer up a half-measure that pretends to solve one problem at the expense of another. We saw the same tactic on the juvenile crime bill, when Republicans bent over backwards to avoid any meaningful gun legislation. Their operating principle: block the real solution and take credit for a false one.

Perhaps the most egregious and disheartening example of hypocrisy is the majority's approach to determining which Americans will benefit from the half-measures they are willing to support. Democrats believe all 161 million privately insured Americans should be guaranteed a national floor of patients' rights. We are talking about the basic rights of American patients. Two people living on the same street—possibly insured by the very same company—should not have two different sets of ''basic rights'' simply because they work for different employers.

Under the Republican bill, only 48 million Americans—those in self-funded plans—are covered by the vast majority of their protections. They exclude over 100 million Americans from their so-called protections.

The majority has argued that this exclusion is necessary to satisfy one of their core principles: that the states should be left to regulate HMOs. In the Nickles amendment striking the Kennedy amendment to cover all privately insured Americans, the majority stated, ''It would be inappropriate to set federal health insurance standards. . . . One size does not fit all, and what may be appropriate for one State may not be necessary in another.'' That amendment passed Tuesday, by a largely party-line vote.

So the majority established that as its core principle, one that overrides

the need to provide all Americans basic health care rights. Yet listen to the core principle laid out in the Snowe amendment I mentioned earlier. (Curiously, the Snowe amendment, which every Republican senator supported, extended its protections to all privately insured women.)

In the Snowe amendment, the majority stated a ''core principle'' diametrically opposed to the core principle of the Nickles amendment: ''In order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in 1 State as well as health plans operating among the several States.'' That amendment passed Wednesday at 1:23 pm.

Two-and-a-half hours later, the Republican majority reversed itself once again. They voted against a Democratic amendment to expand coverage to all privately insured Americans, regardless of their condition or disease—not just women with breast cancer. The whole idea behind a comprehensive Patients' Bill of Rights is that it will cover all people and all diseases, not simply those that get the most media coverage.

Some of my colleagues seem to have two contradictory sets of core principles on the same issue on the same day. And, at the end of the day, the result is that, for all but one disease, the majority has chosen to deny more than 100 million Americans any protections at all.

It's a cynical, and destructive, philosophy. The American people are sure to reject it, for they understand this issue far better than some politicians seem to think. How could they not understand? Every American knows someone who has been denied timely, necessary treatment by an HMO that put costs above patient care.

Our bill is a modest one. It would guarantee American patients a minimum level of protection to ensure timely access to quality health care. That's what Americans expect when they buy health insurance, and that's the least they deserve.

I am disappointed that, this week, America's patients were denied that minimal protection. But I can assure them that the fight for their rights is far from over. Senate Democrats—and maybe even a few brave Republicans—are committed to a real Patients' Bill of Rights, and it will pass, whether it's next week, next year, or next Congress. I guarantee it.

Mr. President, I also want to take a moment to thank some of the multitudes of people who have fought so hard for a real Patients' Bill of Rights and who are committed to that fight until we succeed.

I thank Senator KENNEDY. I must say, I do not know if we have a more passionate, more articulate, more aggressive defender for working people in this country than we have in Ted KENNEDY. He is an inspiration. We all are deeply indebted once more for the leadership he has provided not only in our caucus but in the Senate on this extraordinarily important issue. I am proud to have worked with him to develop S. 6. Also, he, like many others, has been tireless on the floor this week, and I commend him for doing such a good job for our entire caucus.

I thank my assistant Democratic leader whose presence on the floor has just been phenomenal. I do not know how I could do what I do were it not for the fact that he is always there—always there.

I thank my caucus. I do not know that I have ever been more proud of the caucus than I am tonight for their participation, for their leadership, for their willingness to roll up their sleeves to do their homework, to come to the floor and debate, as they did so aggressively all week. In one way or another, every member of our caucus has contributed to this debate and to the two-year effort to make it possible. More of them than I could name right now have contributed enormously, often selflessly. Our caucus has never been more unified. We believe in patients' rights, and we are committed to fight for them.

So, I thank every Democratic senator. I say to each of you, it truly would not have been possible without you.

I thank, as well, the majority leader for allowing this debate, and the assistant Republican leader. This debate happened because they agreed to schedule it. It would not have happened were it not for that agreement, and I am grateful for that.

I thank Senator FRIST for his involvement because of his unique experience in life.

A special thanks goes to the more than 200 organizations representing doctors, nurses, and other health care providers as well as consumer groups, that have supported our bill. They pulled out all the stops they could, with whatever limited resources they had, to ensure that they were part of this American Democratic system. Again, I cannot name them all. But their shared commitment to a comprehensive, meaningful Patients' Bill of Rights has been critical to this process. And I say to each of them, don't be disheartened by today's loss. As I said before, we will ultimately prevail, and patients will ultimately be protected.

I should send that same message to Justin Dart and all the men, women, and children who have shared their stories—often painful stories—with us. This debate could not have been held were it not for the fact that they put meaning to this debate in ways that only they can. Their stories remind us that this is not a theoretical debate. It is a real choice affecting real people who have suffered and will continue to suffer in the absence of meaningful reforms. We thank you, and we will continue the fight.

Last, I want to thank the people who are too often thanked last, the staff—the staff in every office who have worked in various ways to ensure our long struggle led to a real floor debate.

Senator KENNEDY's staff deserves special recognition. I'm sure there were many others, but I want to recognize four of them in particular: Michael Myers, David Nexon, Cybele Bjorklund, and Jim Manley. As always, they are as amazing as their boss. They have been absolutely essential to the effort.

Finally, I want to thank my own staff—both those in my own office and those throughout the Leadership Committees. At the risk of leaving someone out, I'm going to try to name most of them. Few people know how hard they work, and their commitment to service and to this cause of patients' rights is unsurpassed.

From my staff, I want to thank especially: Jane Loewenson, Elizabeth Hargrave, Shelly Ten Napel, Pete Rouse, Laura Petrou, Bill Corr, Mark Patterson, Ranit Schmelzer, Molly Rowley, Marc Kimball, Chris Bois, and Elizabeth Lietz.

From the Floor Staff, I thank Marty Paone, Lula Davis, Gary Myrick, and Paul Brown. We are very lucky, as Republicans and Democrats, to have the floor staff that we do. We owe them a big debt of gratitude, because without them we could not do what we do.

From the Leadership Committees, my special thanks to: Bonnie Hogue, Caroline Chambers, Chuck Cooper, Maryam Moezzi, Tim Mitchell, Jodi Grant, Nicole Bennett, Maria Meier, Alexis King, Jamie Houton, Andy Davis, Mary Helen Fuller, Marguerite Beck-Rex, Brian Barrie, Kobye Noel, Katherine Moore, Nate Ackerman, Rick Singer, Clare Flood, Adriana Surfas, Kevin Kelleher, Brian Jones, Russell Gordon, Robyn Altman, Jeremy Dorin, Paige Smith, Chris Casey, Jeff Hecker, and Toby Hayman.

So tonight, Mr. President, the fight goes on. I am optimistic that in the end we will have the opportunity to debate, once more, how we can resolve this issue, how we can stick to those six principles, how we can ensure that this American health system, which is so good in so many ways, can be made better.

I yield the floor.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The assistant majority leader.

Mr. NICKLES. Mr. President, how much time is left on our side?

The PRESIDING OFFICER. Six minutes 47 seconds.

Mr. NICKLES. First, I compliment my colleague and friend, Senator DASCHLE—this has been a good debate—as well as Senator REID and Senator KENNEDY. We have had a good debate, good discussion of the issue. We have never had a cross word. We have had some good debate, excited debate.

I want to call on an additional couple members of our task force—first Senator COLLINS.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Thank you, Mr. President.

I begin by expressing my appreciation to Senator NICKLES and my other colleagues on the health task force. We have labored hard during the past year and a half, and I am very proud of the legislation we introduced.

I also thank our staff, particularly Priscilla Hanley on my staff who has worked night and day during the debate.

We are on the verge of passing landmark legislation that will expand access to health care, that will hold HMOs accountable for providing the care that they have promised, and that will improve the quality of health care in this country.

I am particularly pleased that the final bill contains provisions I offered to provide a tax deduction for the purchase of long-term care insurance, to ensure that women have direct access to OB/GYNs without having to go through a gatekeeper, to guarantee that a terminally ill patient is able to keep his or her doctor even if that doctor has left the HMO network, and to expand patient access to a variety of health care providers.

At the heart of this bill is the internal and external appeals process that will provide coverage and protections to everyone in all employer-sponsored health plans. This appeals process will ensure that consumers receive the care they have been promised up front, before harm is done, and without having to hire an expensive lawyer and resort to a lawsuit in order to get the care they need.

That is the heart of this bill. We have worked hard to provide these kinds of protections which will ensure that people do get the treatment they need when they need it—not damages years later in a courtroom.

I thank the assistant majority leader for the time.

I am proud to be a supporter of this important legislation.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The assistant majority leader.

Mr. NICKLES. I thank the Senator from Maine for her outstanding leadership. I also thank the Senator from Missouri who mentioned a few of the changes he made in the appeals process that I hope my colleagues listened to. He made this a much better bill. I thank my colleague.

When you look at the appeals process that Senator ASHCROFT has explained and Senator FRIST has explained, no one can say this isn't a very substantive bill that applies to all employer-sponsored plans.

Next, Mr. President, I yield 2½ minutes to the Senator from Tennessee.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Mr. President, I just want to openly thank Members on both sides of the aisle. This has been a very challenging bill. Although I think it is going to be more satisfactory to this side of the aisle than the other side, it is a bill that I think we can all, after tonight, go home, think about, talk to our constituents about, and recognize that we have accomplished exactly what at least I wanted to accomplish; and that is, as I said 4 days ago when this first started, to keep the patient at the center of all of this debate—not special interests and not the rhetoric that goes back and forth, but how we can ultimately come up with a bill that helps patients.

We have strong patient protections. We have addressed quality head on and hit it with internal, external review. It has been strengthened from both sides of the aisle. It has been strengthened by recommendations that we have had through our staff and working together.

If we look at the access provisions, they are very strong, the medical savings accounts, the full deductibility for the self-employed, all of which we have done, the gag clauses, the access to specialists, direct access to obstetricians, what we have accomplished in terms of emergency room access, continuity of care. If we put it altogether, it comes back to the benefit of the patients, smack-dab at the heart.

When people ask me all the time, what can you do as a Senator to really help individual people, it comes down to this bill, I believe, a first step.

Our bill does take medical decisions out of the hands of a huge HMO bureaucracy and puts them back to that very special relationship, one I have been blessed to participate in again and again, that special relationship of the doctor-physician, the provider and the patients, who entrust their lives to you, their lives to you, their health care, their quality of life, their ability to see, to walk, to have that heart keep beating. That is entrusted to you. We have benefited that. We have enriched that. We have made that better. That is what we have accomplished tonight.

We have done it without markedly increasing cost because we all know, when cost goes up, out of control, it drives premiums up and access falls, and the number of uninsured are important.

I appreciate the support.

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

The PRESIDING OFFICER. One minute 28 seconds.

Mr. NICKLES. Mr. President, I thank all of my colleagues and, frankly, the entire Senate for a very good debate.

I believe we came up with a very good bill. I think we passed a bill that will improve health care quality. We passed a bill for anybody in America who has an employer-sponsored plan to have an appeal, an appeal that will be decided by doctors, despite some of the advertisements we have seen, appeals that are decided by experts, by doctors. That is binding and that is real. So I hope that maybe some of the rhetoric will tone down a little bit and we will look at what is in it.

We also didn't do damage. We didn't say we are going to turn over health care plans to the Health Care Financing Administration. We are not going to duplicate State regulation. We will not confuse the States and say, no matter what you have done, Washington knows better. We didn't make those mistakes.

We didn't astronomically increase health care costs. We didn't pass a bill that would increase the number of uninsured by a couple million.

Final comment on the President. I hope the President decides not to play politics and say: We are going to veto that bill; it doesn't do what I want it to do.

I hope he will work with us to pass a positive bill that will benefit and improve health care quality for all Americans. If he wants to play politics, that is his choice. If he wants to, then we don't have to have a bill. It is up to him. If he wants to help us pass a good bill, I think we can do so, that would improve health care quality for all Americans.

Mr. President, I yield back the remainder of our time, and I ask for the yeas and nays on the bill.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. Under the previous order, the two pending amendments are agreed to.

The amendments (Nos. 1254 and 1232) were agreed to.

The PRESIDING OFFICER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

The PRESIDING OFFICER (Mr. HAGEL). The question is, Shall the bill, as amended, pass? The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 53, nays 47, as follows:

[Rollcall Vote No. 210 Leg.]

YEAS—53

Abraham	Gorton	Murkowski
Allard	Gramm	Nickles
Ashcroft	Grams	Roberts
Bennett	Grassley	Roth
Bond	Gregg	Santorum
Brownback	Hagel	Sessions
Bunning	Hatch	Shelby
Burns	Helms	Smith (NH)
Campbell	Hutchinson	Smith (OR)
Cochran	Hutchison	Snowe
Collins	Inhofe	Specter
Coverdell	Jeffords	Stevens
Craig	Kyl	Thomas
Crapo	Lott	Thompson
DeWine	Lugar	Thurmond
Domenici	Mack	Voinovich
Enzi	McCain	Warner
Frist	McConnell	

NAYS—47

Akaka	Breaux	Daschle
Baucus	Bryan	Dodd
Bayh	Byrd	Dorgan
Biden	Chafee	Durbin
Bingaman	Cleland	Edwards
Boxer	Conrad	Feingold

Feinstein	Kohl	Reed
Fitzgerald	Landrieu	Reid
Graham	Lautenberg	Robb
Harkin	Leahy	Rockefeller
Hollings	Levin	Sarbanes
Inouye	Lieberman	Schumer
Johnson	Lincoln	Torricelli
Kennedy	Mikulski	Wellstone
Kerrey	Moynihan	Wyden
Kerry	Murray	

The bill (S. 1344), as amended, was passed.

(The bill will be printed in a future edition of the RECORD.)

Mr. NICKLES. Mr. President, I move to reconsider the vote

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

The motion to lay on the table was agreed to.

Mr. NICKLES. Mr. President, I would like to make a couple of comments concerning the bill. I have already stated that I very much respect and appreciate the tenor of the debate that we had throughout this week with proponents and opponents of the legislation we just passed, including Senator KENNEDY, Senator REID, Senator DASCHLE, and others. I think we had an excellent debate.

I also want to thank my colleagues who really did work hard, and especially I thank Senator JEFFORDS for his leadership, and Senator COLLINS, Senator FRIST, and all the members of the task force. They did a fantastic job.

In addition to the Senators I just mentioned, I want to thank other members of the task force, including Senator HAGEL from Nebraska, the Presiding Officer of the Senate, Senator SANTORUM, and other Senators who worked so hard.

Also, Senator ENZI joined us and did a fantastic job on the floor, as well as in the Health Committee.

A lot of people put in a lot of time and effort, and a lot of staff members worked very hard on both the majority side and the minority side. I want to recognize a few.

First, from my staff, I thank Stacey Hughes and Megan Hauck. Eric Ueland, Hazen Marshall, and Mark Kirk did a fantastic job.

In addition, I want to recognize some staff members from other staffs who probably spent more time in the last year and a half working on this issue than any other issue. I can assure you that in the last month, and in particular the last 2 weeks, this has been a full-time job, including Saturday and Sunday, and late nights almost every night: With Senator COLLINS, Priscilla Hanley; Senator DEWINE, Helen Rhee; Senator ENZI, Chris Spear, Ray Geary, and Jen Woodbury; Senator FRIST, Anne Phelps and Sue Ramthun did a fantastic job on a number of provisions; Senator GRAMM, Mike Solon; Senator GREGG, Alan Gilbert; Senator HAGEL, Steve Irizarry; Senator HUTCHINSON, Kate Hull; Senator JEFFORDS, Paul Harrington, who did a fantastic job both in the Health Committee and also on the floor, and Kim Monk, Tom Valuck, and Carole Vannier did a fantastic job; Senator LOTT, Sharon Soderstrom and Keith Hennessy; Senator CRAIG, Michael Cannon; Senator ROTH, Kathy Means, Dede Spitznagel, and Bill Sweetnam; Senator SANTORUM, Peter Stein; Senator SESSIONS, Rick Deeborn, and Libby Rolfe.

This is an understatement because these staff members worked very hard.

In additional, I wish to recognize Senator GRAMM, who worked on this task force, and was the primary promoter of the medical savings account, which is a very important thing for bringing tax equity and relief.

I have already mentioned Senator ROTH helped us, as well as his staff. Senator GREGG, who led the fight, frankly, against having a propensity for lawsuits, did a fantastic job; Senator HUTCHINSON, and Senator SESSIONS.

This was not an easy effort. It was a challenge. I think it was a good effort, and I think we produced a good bill because we had a lot of Senators who were willing to spend a lot of time trying to improve the quality of health care in America.

I hope the President will not look at the rhetoric that was sometimes on the floor, but will look to the substance of the legislation and work with us to see that it will become the law of the land.

My thanks to Senator JEFFORDS and others who worked so hard to make this happen.

I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Mr. President, I truly believe that tonight is a win-win situation. We have made health coverage significantly better for those people who have such coverage today, but, almost more importantly, we make it more accessible for others, and more affordable for others in accomplishing the many patient protections—the improvement in quality, the appeals, internal and external.

A lot of people have been involved over the course of the last year. I simply want to add my thanks to the two leaders in this effort, Senator JEFFORDS, chairman of the Health, Education, Labor, and Pensions Committee, for whose committee this bill passed and was debated. And, through much bipartisan discussion, the amendment process improved a bill that the task force, after about 6 to 8 months of very hard work, developed.

It was under Senator JEFFORDS' leadership that this bill took its final shape so that it finally arrived on the floor, and we were able to debate it.

Senator NICKLES for the last year and a half has chaired a task force, has been the quarterback, the manager of a broad range of people who participated in the study of the issues, true substantive study—not superficial policy reviews but a substantive study of the issues. Senator NICKLES oversaw and managed a group of people on that committee who have already been mentioned, including Senators ENZI, GREGG, HAGEL, and Senator COLLINS who literally has been on the floor for the last 4 days almost without leaving, participating in the debate on issue after issue.

Thanks also to Senator SANTORUM, Senator GRAMM of Texas, Senator LOTT—especially our majority leader, Senator LOTT, who spoke so eloquently a bit ago summarizing what this bill has been about, what it will accomplish, the confidence that he placed in both the task force and the Health, Education, Labor and Pension Committee.

I especially want to thank several staff members: Stacy Hughes and Meg Hauck, who have shown leadership among all the staff members; Anne Phelps and Sue Ramthun, two people with whom I worked most closely with and who have gathered the information, digested the issues, and spent late nights here.

I had the opportunity to work with Sue Ramthun over the last several years on health issue after health issue. This will be the last bill that she participates in, in the Senate—at least for a while. I say ''for a while'' because I am hopeful she will come back to our staff. I recognize her tremendous leadership and her knowledge of what has gone on in this body in the past. It has been immensely helpful to me, coming here just 5 years ago, to be able to work with an individual who understands the institution, understands the issues, and who has been involved in health issues long before I came to this body.

I want to mention Bill Baird, legislative counsel, who over the last 4 days—and also over the past years—has participated so directly in allowing Members to translate these ideas to specific language for the bill we were able to ultimately pass. It is a win-win.

As I said in my closing remarks tonight, the thing I will think about as I go home and reflect on over the last 4 days is we made real progress. We don't have all the answers. We don't pretend this bill has all the answers in establishing an appropriate balance between managed care, coordinated care, and that doctor-patient relationship. But we are getting it back into balance because it has been out of balance for a period of time. Our bill does take that whole doctor-patient relationship and make it the heart of this managed care environment.

In closing, it has been a wonderful opportunity for me to be able to work, again, on both sides of the aisle as we developed this bill which will significantly improve the quality and access of health care for Americans.

Mr. JEFFORDS. Mr. President, this is a time of trial for so many Members to finally come to this end and have a victory which hopefully will not stop here but will continue. There is too much good in this bill not to have it become legislation that will be passed into law. I am confident the President, when he understands what is in here, and we work with the House and make

some changes—I am sure we can accommodate the other side and we can end up with a piece of legislation. Hopefully it will be done this year.

Mr. President, as chairman of the Committee on Health, Education, Labor, and Pensions, which had jurisdiction over this bill, I would like to take a moment to thank all those who have worked so hard to make this bill possible. This legislation has been developed over the course of more than two years, and a great number of people have positively contributed to the process.

This bill represents a tremendous effort by the members of the HELP Committee. I want to thank the members of the Nickles Task Force for their guidance. I wish to thank Senator NICKLES himself, and also the majority leader for their dedication to see this legislation through to the end.

The staff to the members of the HELP Committee have contributed greatly to this bill. Rob Wasinger with Senator BROWNBACK, Prescilla Hanley with Senator COLLINS, Libby Rolfe with Senator SESSIONS, and Kate Hull with Senator HUTCHINSON.

The staff of the subcommittees carried a great deal of weight. This includes Helen Rhee with Senator DEWINE, Chris Spear and Raissa Geray with Senator ENZI, Anne Phelps and Sue Ramthum with Senator FRIST, and Alan Gilbert with Senator GREGG.

The committee markup of this legislation lasted over 11 hours and so I must acknowledge the tireless efforts of Denis O'Donovan, Steve Chapman, and Leah Cooper from the full Committee staff. I also thank Bill Baird of the Legislative Counsel Office. He has provided enormous help.

I am grateful for the efforts by the staff of the GOP Health Care Task Force. Michael Cannon with the RPC, Steve Irizarry with Senator HAGEL, Mike Solon with Senator GRAMM, Peter Stein with Senator SANTORUM, and Kathy Means, Bill Sweetnam, and Dede Spritznagel with Senator ROTH.

Finally, I would like to thank the assistant majority leader's staff for their leadership. Stacey Hughes, Meg Hauck, Hazen Marshall, Matt Kirk, Brooke Simmons, Gail Osterberg, and Eric Ueland were invaluable. As well as Sharon Soderstrom and Keith Hennessy from the majority leader's Office.

On my own staff, I would like to thank Paul Harrington, Sean Donohue, Dirksen Lehman, Kim Monk, and Philo Hall and Marle Power my Staff Director. This certainly could not have happened without my health policy fellows, Tom Valuck, Kathy Matt, and Carol Vannier. I especially want to thank Karen Guice and Pat Stroup, who each provided two years of groundwork on this legislation.

The round the clock work, particularly over the past week, of all the staff involved is greatly appreciated.

Mr. President, I could not be more proud of all these people.

Around-the-clock work, particularly over the past week, of all the staff is greatly appreciated. I cannot be more proud of these people. I want to commend them and thank them profusely. I also thank, of course, the people who work in this great body to make sure that we end up doing the right things at the right time.

MORNING BUSINESS

Mr. JEFFORDS. Mr. President, I ask unanimous consent that the Senate now proceed to a period of morning business with Senators permitted to speak for up to 10 minutes each.

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

OSCE PA DELEGATION TRIP REPORT

Mr. CAMPBELL. Mr. President, I take this opportunity to provide a report to my colleagues on the successful congressional delegate trip last week to St. Petersburg, Russia, to participate in the Eighth Annual Parliamentary Assembly Session of the Organization for Security and Cooperation in Europe, known as the OSCE PA. As Cochairman of the Helsinki Commission, I headed the Senate delegation in coordination with the Commission Chairman, Congressman CHRIS SMITH.

THE PARLIAMENTARY ASSEMBLY

This year's congressional delegation of 17 members was the largest representation by any country at the proceedings and was welcomed as a demonstration of continued U.S. commitment to security in Europe. Approximately 300 parliamentarians from 52 OSCE participating states took part in this year's meeting of the OSCE Parliamentary Assembly.

My objectives in St. Petersburg were to advance American interests in a region of vital security and economic importance to the United States; to elevate the issues of crime and corruption among the 54 OSCE countries; to develop new linkages for my home state of Colorado; and to identify concrete ways to help American businesses.

CRIME AND CORRUPTION

The three General Committees focused on a central theme: ''Common Security and Democracy in the Twenty-First Century.'' I served on the Economic Affairs, Science, Technology and the Environment Committee which took up the issue of corruption and its impact on business and the rule of law. I sponsored two amendments that highlighted the importance of combating corruption and organized crime, offering concrete proposals for the establishment of high-level inter-agency mechanisms to fight corruption in each of the OSCE participating states. My amendments also called for the convening of a ministerial meeting to promote cooperation among these states to combat corruption and organized crime.

My anti-corruption amendment was based on the premise that corruption has a negative impact on foreign investment, on human rights, on democracy building and on the rule of law. Any investor nation should have the right to expect anti-corruption practices in those countries in which they seek to invest.

Significant progress has been made with the ratification of the new OECD Convention on Combating Bribery of Foreign Public Officials in International Business Transactions. Under the OECD Convention, companies from the leading exporting nations will have to comply with certain ethical standards in their business dealings with foreign public officials. And, last July, the OSCE and the OECD held a joint conference to assess ways to combat corruption and organized crime within the OSCE region. I believe we must build on this initiative, and offered my amendment to urge the convening of a ministerial meeting with the goal of making specific recommendations to the member states about steps which can be taken to eliminate this primary threat to economic stability and security and major obstacle to U.S. businesses seeking to invest and operate abroad.

My anti-crime amendment was intended to address the negative impact that crime has on our countries and our citizens. Violent crime, international crime, organized crime and drug trafficking all undermine the rule of law, a healthy business climate and democracy building.

This amendment was based on my personal experiences as one of the only members of the United States Senate with a law enforcement background and on congressional testimony that we are witnessing an increase in the incidence of international crime, and we are seeing a type of crime which our countries have not dealt with before.

During the opening Plenary Session on July 6, we heard from the Governor of St. Petersburg, Vladimir Yakolev, about how the use of drugs is on the rise in Russia and how more needs to be done to help our youth.

On July 7, I had the opportunity to visit the Russian Police Training Academy at St. Petersburg University and met with General Victor Salnikov, the Chief of the University. I was impressed with the General's accomplishments and how many senior Russian officials who are graduates of the university, including the Prime Minister, governors, and members of the Duma.

General Salnikov and I discussed the OSCE's work on crime and drugs, and he urged us to act. The General stressed that this affects all of civilized society and all countries must do everything they can to reduce drug trafficking and crime.

After committee consideration and adoption of my amendments, I was approached by Senator Jerry Grafstein from Canada who indicated how important it was to elevate the issues of

crime and corruption in the OSCE framework. I look forward to working with Senator Grafstein and other parliamentarians on these important issues at future multi-lateral meetings.

CULTURAL LINKAGES WITH COLORADO

St. Petersburg is rich in culture and educational resources. This grand city is home to 1,270 public, private and educational libraries; 181 museums of art, nature, history and culture; 106 theaters; 52 palaces; and 417 cultural organizations. Our delegation visit provided an excellent opportunity to explore linkages between some of these resources with the many museums and performing arts centers in Colorado.

On Thursday, July 8, I met with Tatyana Kuzmina, the Executive Director for the St. Petersburg Association for International Cooperation, and Natalia Koltomova, Senior Development Officer for the State Museum of the History of St. Petersburg. We learned that museums and the orchestras have exchanges in New York, Michigan and California. Ms. Kuzmina was enthusiastic about exploring cultural exchanges with Denver and other communities in Colorado. I look toward to following up with her, the U.S. Consulate in St. Petersburg, and leaders in the Colorado fine arts community to help make such cultural exchanges a reality.

As proof that the world is getting smaller all the time, I was pleasantly surprised to encounter a group of 20 Coloradans on tour. In fact, there were so many from Grand Junction alone, we could have held a Town Meeting right there in St. Petersburg! In our conversations, it was clear we shared the same impressions of the significant potential that that city has to offer in future linkages with Colorado. I ask unanimous consent that a list of the Coloradans whom I met be printed in the RECORD following my remarks.

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

(See exhibit 1.)

HELPING AMERICAN BUSINESSES

Mr. CAMPBELL. In the last Congress, I introduced the International Anti-Corruption Act of 1997 (S. 1200) which would tie U.S. foreign aid to how conducive foreign countries are to American businesses and investment. As I prepare to reintroduce this bill in the 106th Congress and to work on combating crime and corruption within the OSCE framework, I participated in a meeting of U.S. business representatives on Friday, July 9, convened by the Russian-American Chamber of Commerce, headquartered in Denver. We were joined by my colleagues, Senator KAY BAILEY HUTCHISON, Senator GEORGE VOINOVICH and my fellow Coloradan, Congressman TOM TANCREDO.

We heard first-hand about the challenges of doing business in Russia from representatives of U.S. companies, including Lockheed Martin Astronautics, PepsiCo, the Gillette Company, Coudert Brothers, and Colliers HIB St. Petersburg. Some issues, such as export licensing, counterfeiting and corruption are being addressed in the Senate. But, many issues these companies face are integral to the Russian business culture, such as taxation, the devaluation of the rouble, and lack of infrastructure. My colleagues and I will be following up on ways to assist U.S. businesses and investment abroad.

In addition, on Wednesday, July 7, I participated in a meeting at the St. Petersburg Investment Center. The main focus of the meeting was the presentation of a replica of Fort Ross in California, the first Russian outpost in the United States, to the Acting U.S. Consul General on behalf of the Governor of California. We heard from Anatoly Razdoglin and Valentin Makarov of the St. Petersburg Administration; Slava Bychkov, American Chamber of Commerce in Russia, St. Petersburg Chapter; Valentin Mishanov, Russian State Marine Archive; and Vitaly Dozenko, Marine Academy. The discussion ranged from U.S. investment in St. Petersburg and the many redevelopment projects which are planned or underway in the city.

CRIME AND DRUGS

As I mentioned, on Wednesday, July 7, I toured the Russia Police Training Academy at St. Petersburg University and met with General Victor Salnikov, the Chief of the University. This facility is the largest organization in Russia which prepares law enforcement officers and is the largest law institute in the country. The University has 35,000 students and 5,000 instructors. Among the law enforcement candidates, approximately 30 percent are women.

The Police Training Academy has close contacts with a number of countries, including the U.S., France, Germany, the United Kingdom, Finland, Israel and others. Areas of cooperation include police training, counterfeiting, computer crimes, and programs to combat drug trafficking.

I was informed that the Academy did not have a formal working relationship with the National Institute of Justice, the research and development arm of the U.S. Department of Justice which operates an extensive international information-sharing program. I intend to call for this bilateral linkage to facilitate collaboration and the exchange of information, research and publications which will benefit law enforcement in both countries fight crime and drugs.

U.S.-RUSSIA RELATIONS

In addition to the discussions in the plenary sessions of the OSCE Parliamentary Assembly, we had the opportunity to raise issues of importance in a special bilateral meeting between the U.S. and Russia delegations on Thursday morning, July 8. Members of our delegation raised issues including anti-Semitism in the Duma, developments in Kosovo, the case of environmental activist Aleksandr Nikitin, the assassination of Russian Parliamentarian Galina Starovoitova, and the trafficking of women and children.

As the author of the Senate Resolution condemning anti-Semitism in the Duma (S. Con. Res. 19), I took the opportunity of this bilateral session to let the Russian delegation, including the Speaker of the State Duma, know how seriously we in the United States feel about the importance of having a governmental policy against anti-Semitism. We also stressed that anti-Semitic remarks by their Duma members are intolerable. I look forward to working with Senator HELMS to move S. Con. Res. 19 through the Foreign Relations Committee to underscore the strong message we delivered to the Russians in St. Petersburg.

We had the opportunity to discuss the prevalence of anti-Semitism and the difficulties which minority religious organizations face in Russia at a gathering of approximately 100 non-governmental organizations (NGOs), religious leaders and business representatives, hosted by the U.S. Delegation on Friday, July 9. We heard about the restrictions placed on religious freedoms and how helpful many American non-profit organizations are in supporting the NGO's efforts.

I am pleased to report that the U.S. Delegation had a significant and positive impact in advancing U.S. interests during the Eighth OSCE Parliamentary Assembly Session in St. Petersburg. To provide my colleagues with additional information, I ask unanimous consent that my formal report to Majority Leader LOTT be printed in the RECORD following my remarks.

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

(See exhibit 2.)

Mr. CAMPBELL. Thank you, Mr. President, I yield the floor.

EXHIBIT NO. 1

COLORADANS IN ST. PETERSBURG, RUSSIA

Iva Allen, Grand Junction.
Kay Coulson, Grand Junction.
Inez Dodson, Grand Junction.
Isabel Downing, Grand Junction.
Terry Eakle, Greeley.
Betty Elliott, Grand Junction.
Dorothy Evans, Grand Junction.
Kay Hamilton, Grand Junction.
Helen Kauffman, Grand Junction.
Nancy Koos, Denver.
Dick and Jay McElroy, Grand Junction.
Lyla Michaels, Glenwood Springs.
Carol Mitchell, Grand Junction.
Neal and Sonya Morris, Grand Junction.
Pat Oates, Grand Junction.
Kawna Safford, Grand Junction.
Phyllis Safford , Grand Junction.
Dorothy Smith, Grand Junction.
Irene Stark, Montrose.

EXHIBIT NO. 2

COMMISSION ON SECURITY AND COOPERATION IN EUROPE,
Washington, DC, July 14, 1999.

Hon. TRENT LOTT,
Majority Leader, United States Senate, Washington, DC.

DEAR SENATOR LOTT: I am pleased to report to you on the work of the bipartisan congressional delegation which I co-chaired that participated in the Eighth Annual Session of the Parliamentary Assembly of the Organization for Security and Cooperation in Europe (OSCE), hosted by the Russian Parliament, the Federation Council and the

State Duma, in St. Petersburg, July 6–10, 1999. Other participants from the United States Senate were Senator Hutchison of Texas and Senator Voinovich. We were joined by 14 Members of the House: Rep. Smith, Rep. Hoyer, Rep. Sabo, Rep. Kaptur, Rep. Cardin, Rep. Sawyer, Rep. Slaughter, Rep. Stearns, Rep. Tanner, Rep. Danner, Rep. Hastings of Florida, Rep. Salmon, Rep. Cooksey, and Rep. Tancredo. The combined U.S. delegation of 17, the largest representation by any country in St. Petersburg was welcomed by others as a demonstration of the continued commitment of the United States, and the U.S. Congress, to Europe.

This year's Assembly brought together nearly 300 parliamentarians from 52 OSCE participating States. Seven countries, including the Russian Federation, were represented at the level of Speaker of Parliament or President of the Senate. The Assembly continued to recognize the democratically elected parliament of Belarus which President Lukashenka dissolved following his illegal power grab in 1996.

The inaugural ceremony included a welcoming addresses by the Speaker of the State Duma, Gennady Seleznev, and the Governor of St. Petersburg, Vladimir Yakovlev. The President of the Assembly, Ms. Helle Degn of Denmark, presided. The theme for the St. Petersburg Assembly was ''Common Security and Democracy in the Twenty-First Century.''

Foreign Minister Knut Vollenback of Norway addressed the Assembly in his capacity of OSCE Chairman-in-Office to report on the organization's activities, particularly those relating to post-conflict rehabilitation and reconstruction in Kosovo. Vollenbaek urged the Parliamentary Assembly and its members to play an active role in promoting human rights, democracy, and the rule of law in Kosovo. Considerable attention was given to the Stability Pact for Southeastern Europe throughout the discussions on Kosovo.

Members of the U.S. delegation actively participated in a special plenary session on Kosovo and contributed to a draft resolution concerning the situation in Kosovo. The delegation was successful in securing adoption of several amendments; underscoring the legal obligation of State to cooperate with the International Tribunal for the Former Yugoslavia; granting access to all prisoners by the International Committee on the Red Cross; extending humanitarian assistance to other parts of the Federal Republic of Yugoslavia; and supporting democracy in Serbia and Montenegro. Senator Voinovich introduced a separate resolution stressing the urgent need to support infrastructure projects which would benefit neighboring countries in the Balkans region. This resolution was widely supported and adopted unanimously.

Work in the Assembly's three General Committee—Political Affairs and Security; Economic Affairs, Science, Technology and Environment; and Democracy, Human Rights and Humanitarian Questions—focused on the central theme: ''Common Security and Democracy in the Twenty-First Century.''

During discussion in the General Committee on Political Affairs and Security, the U.S. pressed for greater transparency with respect to OSCE activities in Vienna, urging that meetings of the Permanent Council be open to the public and media. Considerable discussion focused on the Assembly's longstanding recommendation to modify the consensus rule that governs all decisions taken by the OSCE. During the closing session Rep. Hastings was unanimously elected committee Vice Chairman.

Members offered several amendment to the draft resolution considered by the General Committee on Economic Affairs, Science, Technology and Environment. Two amendments that I sponsored focused on the importance of combating corruption and organized crime, offering concrete proposals for the establishment of high-level inter-agency corruption-fighting mechanisms in each of the OSCE participating States as well as the convening of a ministerial meeting to promote cooperation among these States to combat corruption and organized crime. Other amendments offered by the delegation, and adopted, highlighted the importance of reform of the agricultural sector, bolstering food security in the context of sustainable development, and regulation of capital and labor markets by multilateral organizations.

The Rapporteur's report for the General Committee on Democracy, Human Rights and Humanitarian Questions focused on the improvement of the human rights situation in the newly independent states. Amendments proposed by the U.S. delegation, and adopted by the Assembly, stressed the need for participating States to fully implement their commitments to prevent discrimination on the grounds of religion or belief and condemned statements by parliamentarians of OSCE participating States promoting or supporting racial or ethnic hatred, anti-Semitism and xenophobia. Other U.S. amendments that were adopted advocated the establishment of permanent Central Election Commissions in emerging democracies and emphasized the need for the Governments of the OSCE participating States to act to ensure that refugees and displaced persons have the right to return to their homes and to regain their property or receive compensation.

Two major U.S. initiatives in St. Petersburg were Chairman Smith's resolution on the trafficking of women and children for the sex trade and Rep. Slaughter's memorial resolution on the assassination of Galina Starovoitova, a Russian parliamentarian and an outspoken advocate of democracy, human rights and the rule of law in Russia who was murdered late last year. The trafficking resolution appeals to participating States to create legal and enforcement mechanisms to punish traffickers while protecting the rights of the trafficking victims. The resolution on the assassination called on the Russian Government to use every appropriate avenue to bring Galina Starovoitova's murders to justice. Both items received overwhelming support and were included in the St. Petersburg Declaration adopted during the closing plenary.

An ambitious series of bilateral meetings were held between Members of the U.S. delegation and representatives from the Russian Federation, Ukraine, Turkey, France, Romania, Kazakhstan, Uzbekistan, Armenian, Canada, and the United Kingdom. While in St. Petersburg, the delegation met with Aleksandr Nikitin, a former Soviet navy captain being prosecuted for his investigative work exposing nuclear storage problems and resulting radioactive contamination in the area around Murmansk. In addition, the delegation hosted a reception for representatives of non-governmental organizations and U.S. businesses active in the Russian Federation.

Elections for officers of the Assembly were held during the final plenary. As. Helle Degn of Denmark was re-elected President. Mr. Bill Graham of Canada was elected Treasurer. Four of the Assembly's nine Vice-Presidents were elected: Mr. Claude Estier (France), Mr. Bruce George (U.K.), Mr. Ihor Ostach (Ukraine), and Mr. Tiit Kabin (Estonia). Rep Hoyer's current term as Vice-President runs through 2001.

Enclosed is a copy of the St. Petersburg Declaration adopted by participants at the Assembly's closing session.

Finally, the Standing Committee agreed that the Ninth Annual Session of the OSCE Parliamentary Assembly will be held next July in Bucharest, Romania.

Sincerely,

BEN NIGHTHORSE CAMPBELL, U.S.S.,
Co-Chairman.

IMPASSE IN IMPLEMENTING THE NORTHERN IRELAND PEACE AGREEMENT

Mr. DODD. Mr. President, today the people of Northern Ireland were denied an opportunity to take a major step forward in making the promise of peace contained in the Good Friday Peace Accords a daily reality. Today, David Trimble, President of the Ulster Unionist Party, refused to lend his party's critical support to the implementation of a key provision of that agreement—the establishment of a Northern Ireland legislature and the appointment of its twelve member, multiparty executive. Ironically, in refusing to cooperate in the formation of the assembly, the Ulster Unionists are further away from their stated goal of ensuring IRA decommissioning of its weapons at the earliest possible date.

Regrettably, despite the herculean efforts of British Prime Minister Tony Blair and Irish Taoiseach Bertie Ahern to move the process forward, the so called d'Hondt mechanism provided for in the agreement has been run and an attempt to form an executive with cross community support has failed. I am deeply disappointed that the leadership of the Ulster Unionist Party has been unable to garner the necessary support of its membership to honor the obligations that the leadership committed that party to when it signed the Accords on April 8, 1998. More importantly, the people of Northern Ireland, who turned out in large numbers to participate in last year's referendum endorsing the Good Friday Accords, must also be deeply disappointed that once again their political leaders have fallen short, let this deadline pass and jeopardized the peace process.

Where do we go from here? Prime Minister Blair and Taoiseach Ahern will meet next week to reassess the situation, including the possibility of implementing those provisions of the agreement that fall within the mandate of the British and Irish Governments. In addition, the parties are required by the terms of the agreement to undertake a fundamental review at this juncture. In the meantime, I would hope that the people of Northern Ireland, Protestant and Catholic, who stand the most to lose if this agreement is allowed to wither on the vine, will let their political leaders know how disappointed they are that the agreement is not being implemented in good faith. I would also call upon those who have resorted to violence in the past to refrain from doing so—violence can never resolve the political and sectarian conflicts of Northern Ireland.

Mr. President, for more than a quarter of a century Protestants and Catholics throughout the North have lived in

fear that a trip to the movies or the market place could prove to be a fatal one because sectarian violence has been a common occurrence in their daily lives. The Northern Ireland Peace agreement was designed to end the cycle of violence that has destroyed so many families in Northern Ireland. It can still accomplish that goal. There is still time for all of the parties to find the political courage to do the right thing for the people who they claim to represent.

Mr. President, I like to think of myself as a realist, yet despite the events of the last several days I am optimistic that the Good Friday Accords remain the key to unlocking the formula for a lasting peace throughout Ireland. With the help of the British, Irish and American governments, there is still time for Northern Ireland's political leaders to find within themselves the courage to move forward with the implementation of the Accords. I hope and pray they do so before that time runs out.

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Wednesday, July 14, 1999, the Federal debt stood at $5,624,306,987,432.02 (Five trillion, six hundred twenty-four billion, three hundred six million, nine hundred eighty-seven thousand, four hundred thirty-two dollars and two cents).

One year ago, July 14, 1998, the Federal debt stood at $5,530,848,000,000 (Five trillion, five hundred thirty billion, eight hundred forty-eight million).

Five years ago, July 14, 1994, the Federal debt stood at $4,624,996,000,000 (Four trillion, six hundred twenty-four billion, nine hundred ninety-six million).

Ten years ago, July 14, 1989, the Federal debt stood at $2,800,265,000,000 (Two trillion, eight hundred billion, two hundred sixty-five million) which reflects a debt increase of more than $2 trillion—$2,824,041,987,432.02 (Two trillion, eight hundred twenty-four billion, forty-one million, nine hundred eighty-seven thousand, four hundred thirty-two dollars and two cents) during the past 10 years.

TWENTY-FIFTH ANNIVERSARY OF THE RUNAWAY AND HOMELESS YOUTH ACT

Mr. LEAHY. Mr. President, this week marks the 25th Anniversary of the Runaway and Homeless Youth Act. I had hoped as part of celebrating the silver anniversary of the passage of this landmark legislation that the Congress would be sending to President Clinton for signature, S. 249, the Missing, Exploited, and Runaway Children Protection Act. This legislation reauthorizes programs under the Runaway and Homeless Youth Act as well as authorizes funding for the National Center for Missing and Exploited Children. Both programs are critical to our nation's youth and to our nation's well-being.

Unfortunately, the bill is still being held up for no good reason. I have been working since 1996 to enact this legislation. Last Congress and again this Congress, we have been able to clear the passage of this important legislation on the Democratic side of the aisle.

I had hoped that by the end of this week my colleagues on the other side of the aisle could be persuaded to let this legislation pass the Senate and President Clinton sign it into law. The many grassroots supporters of this legislation and I remain frustrated.

If we do not pass this legislation soon, I fear it will again, as it was last Congress, be caught up in a more contentious debate on juvenile crime.

I had hoped that we had been able to move away from using this non-controversial legislation to try to pass unreasonable juvenile justice legislation. Last Congress, the Majority was roundly criticized for its tactic, which the New York Times labeled a ''stealth assault on juvenile justice.'' That procedural gimmick cost us valuable time to get this legislation enacted.

This year, it appeared that such procedural ambushes had been avoided in the Senate and minimized in the House. In late May, the Senate had a full and fair debate on a juvenile justice bill. After significant improvements through amendments, the Hatch-Leahy juvenile justice bill passed the Senate on May 20, 1999 by a strong bipartisan vote. The House finally considered juvenile crime legislation in June, although the Republican leadership has steadfastly blocked a House-Senate conference on the Hatch-Leahy bill.

Separately, in April of this year the Senate passed S. 249, the Missing, Exploited and Runaway Children Protection Act of 1999. In May, the House passed S.249 with an amendment. As I explained in a floor statement on June 30, I was hopeful that the Senate would immediately take up and pass the amended version of S.249 and worked to do that. I consulted with the Department of Health and Human Services about certain concerns I had with the House amendment and was reassured that Vermont would not be adversely affected by it. I noted my disagreement with other aspects of the House action and ways to deal with those without holding final passage of S.249 hostage. I regret to report, however, that this important legislation has been in Senate limbo since late May.

The guts of the legislation remain the Leahy-Hatch substitute language to S.249 that was reported by the Judiciary Committee and which passed the Senate in April. We were careful to recognize the important work of these programs in Vermont, as well as the many other programs and staff across the U.S. that are working effectively with runaway and homeless youth and their families. The House-inserted amendments do nothing to change the special care we took in the Senate to craft the main components of this legislation.

The Leahy-Hatch substitute language preserves current law governing the minimum grants available for small States for the Basic Center grants and also preserves the current confidentiality and records protections for runaway and homeless youth.

In addition, our substitute amendment reauthorizes the Runaway and Homeless Youth Act Rural Demonstration Projects. This program provides targeted assistance to States with rural juvenile populations. Programs serving runaway and homeless youth have found that those in rural areas are particularly difficult to reach and serve effectively.

Under the Runaway and Homeless Youth Act, every year each State is awarded a Basic Center grant for housing and crisis services for runaway and homeless children and their families. The funding is based on its juvenile population, with a minimum grant of $100,000 currently awarded to smaller States, such as Vermont. Effective community-based programs around the country can also apply directly for the funding available for the Transitional Living Program and the Sexual Abuse Prevention/Street Outreach grants. The Transitional Living Program grants are used to provide longer term housing to homeless teens age 16 to 21, and to help these teenagers become more self-sufficient. The Sexual Abuse Prevention/Street Outreach Program also targets teens who have engaged in or are at risk of engaging in high risk behaviors while living on the street.

The Runaway and Homeless Youth Act does more than shelter these children in need. As the National Network for Youth has stressed, the Act's programs ''provide critical assistance to youth in high-risk situations all over the country.'' This Act also ensures that these children and their families have access to important services, such as individual, family or group counseling, alcohol and drug counseling and a myriad of other resources to help these young people and their families get back on track.

Runaway and Homeless Youth Services in Vermont show positive results. For those who do not think rural areas have significant numbers of runaway youth, I note that in fiscal year 1998, the Vermont Coalition of Runaway and Homeless Youth Programs and Spectrum Youth & Family Services (''the Coalition''), reported that 81 percent of the 1,067 youths served by the Coalition programs were in a positive living situation at the close of service. They were reunited with their families, living with a friend or relative, or in another appropriate living situation. They were not in Department of Corrections or State Rehabilitative Services (SRS) custody.

Since 1992, the Coalition programs have seen a 175 percent increase in the numbers of youths served: The Coalition programs served 388 runaway and

homeless youths in 1992. This number increased to 1,067 in 1997. In 1998, 61 percent of the youths served were 15, 16 or 17 years old.

The Coalition programs are the ''who you gonna' call'' in cases of family crisis and runaway incidents. They are a critical part of Vermont's ability to respond pro-actively when youths and families are in crisis, and to prevent the need for later, more costly services.

The Coalition average cost per client in fiscal year 1998 was $1,471. Each client has different needs which could mean a week of service, a month, or the entire year. The service could include housing, family counseling, or any of the array of services offered the Coalition programs. The average time a case was open in fiscal year 1998 was 54 days.

The relative costs of various services available to youths experiencing problems frequently associated with runaway and ''push-out'' incidents and other serious family conflict is dramatically higher. For fiscal year 1998, the costs for a bed in Vermont's Juvenile Detention system was over $69,000; a bed in a in-patient adolescent substance abuse treatment facility was over $54,000.

The Vermont Coalition programs provide early interventions that are more humane, and more cost effective. When one youth is diverted from entering state custody, the state of Vermont saves $19,761. If 102 young people, or 9 percent of the 1,067 youths served in fiscal year 1998, were diverted from entering SRS Custody, then Vermont saves over $2,000,000—four times the amount of dollars Vermont currently receives under the RHYA for service to runaway and homeless youths.

The Vermont Coalition and Spectrum Youth & Family Services should be applauded for their important work and I believe the best way to do that is to reauthorize the Runaway and Homeless Act, so programs like these in Vermont have some greater financial security in the future.

I want to thank the many advocates who have worked with me over the years to improve the bill and, in particular, the dedicated members of the Vermont Coalition of Runaway and Homeless Youth Programs and the National Network for Youth for their suggestions and assistance. Without these dedicated public-spirited citizens these programs could not be successful.

The other important piece of S. 249 is authorizing the nation's resource center for child protection, the National Center for Missing and Exploited Children (NCMEC). This center spearheads national efforts to locate and recover missing children and raises public awareness about ways to prevent child abduction, molestation, and sexual exploitation.

Since 1984, when the center was established, it has handled more than 1.3 million calls through its national Hotline 1–800–THE-LOST; trained more than 151,755 police and other professionals; and published more than 17 million publications that are distributed free of charge. The center has worked with law enforcement on more than 65,173 missing child cases, resulting in the recovery of 46,031 children.

Since its creation, the center has helped 83 Vermont missing child cases and has helped resolve 82 of them. Nationwide, prior to 1990, the child recovery rate of the center was 62 percent. From 1990 through 1998, even with increasing caseloads, the recovery of children that are reported to the center has reached 91.8 percent.

Last year, the center launched a new CyberTipline. It allows Internet users to report such things as suspicious or illegal activity, including child pornography and online enticement of children for sexual exploitation.

Each month NCMEC brings chiefs and sheriffs together for special training. To date, the center has trained 728 of these law enforcement officials from all fifty states, including chiefs from Dover, Hartford, Brattleboro, and Winooski, Vermont and representatives from our State Police force.

The center also trains state and local police on crimes against children in cyberspace. Although this program has just begun, already 103 Unit Commanders from 34 states, including Vermont have been trained. In February of this year, Captain David Rich of the Hartford, Vermont Police Department attended this course.

The NCMEC trainers conducted a statewide infant abduction prevention seminar for the Vermont Chapter of the Association of the Women's Health, Obstetric and Neonatal Nurses, attended by 252 nurses and security staff, and conducted site audits at two Vermont hospitals.

I applaud the ongoing work of the Center and hope that the Senate will promptly pass this bill so that they can proceed with their important activities with fewer funding concerns.

Mr. President, S. 249, the Missing, Exploited, and Runaway Children Protection Act, should be passed without further delay.

CONGRATULATIONS TO THE U.S. AIR FORCE

Ms. MIKULSKI. Mr. President, I say to my colleagues in the Senate and to those listening everywhere, I rise to congratulate the U.S. Air Force on their gallantry and their bravery in risking their lives to take much-needed medicine to a woman who is now a scientist working in Antarctica on a National Science Foundation expedition.

This woman recently discovered a lump in her breast and needs medical treatment. She cannot leave Antarctica until the middle of October because of the horrendous weather conditions. She can't get out and nobody can get to her. But God bless the U.S. Air Force. They were willing to step forward at great risk to themselves to take the much-needed medicine, and at a very specific moment, drop the six packages that will be able to provide her with treatment, through the genius of telemedicine.

Imagine the terror of a woman who discovers a lump in her breast. Imagine if this lump is discovered while you are serving at a remote research station on the South Pole, which is completely inaccessible during many months of the year. A plane has never landed on the South Pole during the winter. So how could she hope to get the medical supplies she needed for treatment?

This is the situation faced by a woman serving at the National Science Foundation's Amundsen-Scott research station at the South Pole. She could neither leave the station nor expect outside help until October. We all know when a lump is discovered, immediate treatment is essential. That is part of what we have been arguing about.

But guess what. This is when our U.S. Air Force became involved. We are all so proud of what they do to protect America's values and interests around the world. Most recently, they were successful in ending genocide and ethnic cleansing in Kosovo.

But on this mission to the South Pole, they were called on to act as humanitarians. Flying from New Zealand, the 23-person crew had to fly their aircraft for nearly a 7,000-mile round trip. They had limited visibility. They had to make their drop with great precision—since the medicine and equipment could not be exposed to the harsh conditions for more than a few minutes. Personnel on the ground also showed great skill and courage. They came outside in 70-below degree weather to plot the drop site with a great big letter ''C'' so the supplies could be dropped in the right spot, and they could be there at the right time to get it.

All Americans were awed by their skill and bravery. It was led by Major Greg Pike and his crew. They made their drop successfully, returned safely, and the supplies are now being used.

For those of us who saw the news, we know the U.S. Air Force risked themselves because if that plane ran into difficulty, they were at a point of no return. When they opened up the plane to be able to drop this much-needed medicine, they had to put special gear on because they themselves were facing temperatures at 150 degrees below zero. But they did it because they had the ''right stuff'' to make sure she had the right medicine. I tell you, it was quite a moment to see. Those great guys also sent her a bouquet of flowers and pictures of themselves and their families.

Mr. President, this also reminds us of the bravery of our National Science Foundation staff who have also worked in very difficult conditions to conduct the important scientific research.

We say to her, to the lady in the Antarctic, if she can watch us on C–SPAN: God bless you. We are pulling for you,

and we say here in the Senate, God bless the U.S. Air Force.

I yield the floor.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC–4206. A communication from the Department of State, transmitting, pursuant to law, a report entitled ''Battling International Bribery'', dated July 1999; to the Committee on Foreign Relations.

EC–4207. A communication from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting, pursuant to law, the report of the texts and background statements of international agreements, other than treaties; to the Committee on Foreign Relations.

EC–4208. A communication from the President of the United States, transmitting, pursuant to law, a report relative to the emigration laws and policies of Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan; to the Committee on Finance.

EC–4209. A communication from the Chief Counsel, Bureau of Public Debt, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Final Rule to Amend 31 CFR Part 306 to Prohibit Bearer Reissues'', received July 6, 1999; to the Committee on Finance.

EC–4210. A communication from the Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Early Referral of Issues to Appeals'' (Revenue Procedure 99–28, 1999–29 I.R.B.), received July 13, 1999; to the Committee on Finance.

EC–4211. A communication from the Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Notice 99–37, Information Reporting for Tuition Tax Credits and Qualified Student Loan Interest'' (Notice 99–37), received July 12, 1999; to the Committee on Finance.

EC–4212. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Fosetyl-Al; Pesticide Tolerance for Emergency Exemptions'' (FRL # 6372–3), received July 7, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4213. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Tebufenozide; Benzoic Acid, 3,5-dimethyl-1-1-(1,1-dimethylethyl)-2-(4-ethylbenzoyl) hydrazide; Pesticide Tolerance'' (FRL # 6088–8), received July 7, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4214. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Imidacloprid; Pesticide Tolerances for Emergency Exemptions'' (FRL # 6088–3), received July 13, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4215. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Myclobutanil; Pesticide Tolerances for Emergency Exemptions; Correction'' (FRL # 6089–2), received July 13, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4216. A communication from the Administrator, Agricultural Marketing Service, Marketing and Regulatory Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Sweet Cherries Grown in Designated Counties in Washington; Change in Pick Requirements'' (Docket No. FV99–923–1 IFR), received July 6, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4217. A communication from the Administrator, Agricultural Marketing Service, Marketing and Regulatory Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Cranberries Grown in the States of Massachusetts, et al.; Temporary Suspension of a Provision on Producer Continuance Referenda Under the Cranberry Marketing Order'' (Docket No. FV99–929–1 FIR), received July 6, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4218. A communication from the Secretary of Agriculture, transmitting, a draft of proposed legislation relative to improving and reforming the administration of Department programs, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4219. A communication from the Federal Register Liaison Officer, Records Management and Declassification Agency, Department of the Army, transmitting, pursuant to law, the report of a rule entitled ''Manufacture, Sale, Wear, Commercial Use and Quality Control of Heraldic Items'' (32 CFR Part 507), received June 28, 1999; to the Committee on Armed Services.

EC–4220. A communication from the Federal Register Liaison Officer, Records Management and Declassification Agency, Department of the Army, transmitting, pursuant to law, the report of a rule entitled ''Radiation Sources on Army Land'' (32 CFR Part 655), received June 28, 1999; to the Committee on Armed Services.

EC–4221. A communication from the Director, Fish and Wildlife Service, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Endangered and Threatened Wildlife and Plants; Final Designation for Critical Habitat for the Rio Grande Silvery Minnow'' (RIN1018–AF72), received June 30, 1999; to the Committee on Environment and Public Works.

EC–4222. A communication from the Director, Corporate Policy and Research Department, Pension Benefit Guaranty Corporation, transmitting, pursuant to law, the report of a rule entitled ''Allocation of Assets in Single-Employer Plans; Assumptions for Valuing Benefits'', received July 12, 1999; to the Committee on Health, Education, Labor, and Pensions.

EC–4223. A communication from the Secretary of Health and Human Services, transmitting, pursuant to the Low-Income Home Energy Assistance Act of 1981, a report of the allotment of emergency funds to 16 States and the District of Columbia; to the Committee on Health, Education, Labor, and Pensions.

EC–4224. A communication from the Executive Secretary, President's Cancer Panel, transmitting, pursuant to law, a report entitled ''Cancer Care Issues in the United States: Quality of Care, Quality of Life'' for the period January 1, 1997 to December 31, 1998; to the Committee on Health, Education, Labor, and Pensions.

EC–4225. A communication from the Deputy Assistant Administrator for Fisheries, National Marine Fisheries Service, Office of Sustainable Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries off West Coast States and in the Western Pacific; Western Pacific Crustacean Fisheries; Bank-Specific Harvest Guidelines'' (RIN0648–XA31), received July 12, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4226. A communication from the Deputy Assistant Administrator for Fisheries, National Marine Fisheries Service, Office of Sustainable Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries off West Coast States and in the Western Pacific; Western Pacific Crustacean Fisheries; Bank-Specific Harvest Guidelines'' (RIN0648–AK61), received July 12, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4227. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Revision of Class E Airspace; Atqasuk, AK; Docket No. 99–AAL–3 (7–7/7–8)'' (RIN2120–AA66) (1999–0218), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4228. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Revision of Class E Airspace; Yakutat, AK; Docket No. 99–AAL–2 (7–7/7–8)'' (RIN2120–AA66) (1999–0220), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4229. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Revision of Class E Airspace; Adak, AK; Docket No. 99–AAK–9 (7–7/7–8)'' (RIN2120–AA66) (1999–0219), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4230. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Establishment of Class E Airspace; Palmer, AK; Docket No. 99–AAL–5 (7–7/7–8)'' (RIN2120–AA66) (1999–0217), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4231. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures; Miscellaneous Amendments (104); Amdt. No. 1937 (7–1/7–8)'' (RIN2120–AA65) (1999–0032), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4232. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Standard Instrument Approach Procedures; Miscellaneous Amendments (43); Amdt. No. 1938 (7–1/7–8)'' (RIN2120–AA65) (1999–0033), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4233. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Eurocopter

Deutschland Model EC 135 Helicopters; Request for Comments; Docket No. 99–SW–38 (7–1/7–8)'' (RIN2120–AA64) (1999–0267), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4234. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Boeing Model 747 Series Airplanes; Correction; Docket No. 99–NM–112 (7–7/7–8)'' (RIN2120–AA64) (1999–0266), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4235. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Dassault Model 2000, 900EX, and Mystere Falcon 900 Series Airplanes; Docket No. 99–NM–63 (7–7/7–8)'' (RIN2120–AA64) (1999–0265), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4236. A communication from the Senior Attorney, National Highway Traffic Safety Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Civil Penalties'' (RIN2127–AH48), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4237. A communication from the Senior Attorney, National Highway Traffic Safety Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Importation of Motor Vehicles and Equipment Subject to Federal Safety, Bumper, and Theft Prevention Standards'' (RIN2127–AH45), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4238. A communication from the Attorney, National Highway Traffic Safety Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Tire Identification Symbols'' (RIN2127–AH10), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4239. A communication from the Senior Attorney, Office of the Secretary, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Disclosure of Code-Sharing Arrangements and Long-Term Wet Leases (Delay of Effective Date)'' (RIN2105–AC10) (1999–0002), received July 12, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4240. A communication from the Acting Director, National Marine Fisheries Service, Office of Sustainable Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries Off West Coast States and in the Western Pacific; Pacific Coast Groundfish Fishery; Trip Limit Adjustments,'' received July 13, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4241. A communication from the Acting Director, National Marine Fisheries Service, Office of Sustainable Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Closure for the Shallow-water Species Fishery by Vessels Using Trawl Gear in the Gulf of Alaska,'' received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4242. A communication from the Legal Counsel, Office of Engineering and Technology, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Parts 2 and 15 of the Commission's Rules to Further Ensure That Scanning Receivers Do Not Receive Cellular Radio Signals'' (ET Docket No. 98–76) (FCC 99–58), received July 12, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4243. A communication from the Management Analyst, AMD-Performance Evaluation and Records Management, Office of the Managing Director, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Assessment and Collection of Regulatory Fees for Fiscal Year 1999'' (MD Docket No. 98–200) (FCC 99–146), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated:

POM–249. A petition from the New York State Legislative Commission on Water Resource Needs of New York and Long Island relative to Methyl tertiary Butyl Ether (MtBE); to the Committee on Environment and Public Works.

POM–250. A resolution adopted by the House of the General Assembly of the State of North Carolina relative to the United Nations Convention on the Elimination of All Forms of Discrimination Against Women; to the Committee on Foreign Relations.

HOUSE RESOLUTION 388

Whereas, the United Nations Convention on the Elimination of All Forms of Discrimination Against Women was adopted by the United Nations General Assembly on December 18, 1979, became an international treaty on September 3, 1981; and

Whereas, as of March 1999, 162 countries had ratified the Conventions and six states had endorsed the United States ratification in their state legislatures; and

Whereas, the Convention provides a comprehensive framework for challenging the various forces that have created and sustained discrimination based on sex against half the world's population, and the nations in support of the present Convention have agreed to follow Convention prescriptions; and

Whereas, the State of North Carolina shares the goals of the Convention, namely, affirming faith in fundamental human rights, in the dignity and worth of the human person, and in the equal rights of women; and

Whereas, although women have made major gains in the struggle for equality in social, business, political, legal, educational, and other fields in this century, there is much yet to be accomplished; and

Whereas, the State of North Carolina recognizes the greatly increased interdependence of the people of the world; and

Whereas, it is fitting and appropriate to support ratification of the most important international agreement affecting the lives of women throughout the world; Now, therefore, be it

Resolved by the House of Representatives:

SECTION 1. The House of Representatives urges the citizens of North Carolina to recognize that we are citizens of the world with responsibilities extending beyond the boundaries of our city, State, and nation. The House of Representatives further urges the United States Senate to ratify the United Nations Convention on the Elimination of All Forms of Discrimination Against Women and to support the Convention's continuing goals.

SECTION 2. The Principal Clerk shall transmit certified copies of this resolution to the Secretary of the Senate and to each member of North Carolina's Congressional Delegation.

SECTION 3. This resolution is effective upon adoption.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. SPECTER (for himself, Mr. HELMS, Mr. BIDEN, Mr. DORGAN, Mr. SCHUMER, and Mr. SESSIONS):

S. 1372. A bill to require the filing of Shippers' Export Declarations through the Automated Export System of the Department of the Treasury with respect to certain transactions of proliferation concern, and for other purposes; to the Committee on Governmental Affairs.

By Mr. FEINGOLD:

S. 1373. A bill to increase monitoring of the use of offsets in international defense trade; to the Committee on Foreign Relations.

By Mr. THOMAS (for himself and Mr. ENZI):

S. 1374. A bill to authorize the development and maintenance of a multiagency campus project in the town of Jackson, Wyoming; to the Committee on Energy and Natural Resources.

By Mr. LEAHY (for himself and Mr. KOHL):

S. 1375. A bill to amend the Immigration and Nationality Act to provide that aliens who commit acts of torture abroad are inadmissible and removable and to establish within the Criminal Division of the Department of Justice an Office of Special Investigations having responsibilities under that Act with respect to all alien participants in act of genocide and torture abroad; to the Committee on the Judiciary.

By Mr. HOLLINGS:

S. 1376. A bill to amend the Internal Revenue Code of 1986 to impose a value added tax and to use the receipts from the tax to reduce Federal debt and to ensure the solvency of the Social Security System; to the Committee on Finance.

By Mr. BENNETT:

S. 1377. A bill to amend the Central Utah Project Completion Act regarding the use of funds for water development for the Bonneville Unit, and for other purposes; to the Committee on Energy and Natural Resources..

By Mr. VOINOVICH (for himself and Mrs. LINCOLN):

S. 1378. A bill to amend chapter 35 of title 44, United States Code, for the purposes of facilitating compliance by small businesses with certain Federal paperwork requirements, to establish a task force to examine the feasibility of streamlining paperwork requirements applicable to small businesses, and for other purposes; to the Committee on Governmental Affairs.

By Mr. DOMENICI:

S. 1379. A bill to amend the Internal Revenue Code of 1986 to provide broad based tax relief for all taxpaying families, to mitigate the marriage penalty, to expand retirement savings, to phase out gift and estate taxes, and for other purposes; to the Committee on Finance.

By Mr. HATCH:

S. 1380. A bill to provide for a study of long-term care needs in the 21st century; to the Committee on Health, Education, Labor, and Pensions.

By Mr. COCHRAN:

S. 1381. A bill to amend the Internal Revenue Code of 1986 to establish a 5-year recovery period for petroleum storage facilities; to the Committee on Finance.

By Mr. MCCAIN (for himself and Mr. BROWNBACK):

S. 1382. A bill to amend the Public Health Service Act to make grants to carry out certain activities toward promoting adoption counseling, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Ms. SNOWE (for herself, Mr. REID, Mrs. MURRAY, Ms. MIKULSKI, Ms. COLLINS, Ms. LANDRIEU, Mrs. FEINSTEIN, Mrs. BOXER, Mrs. HUTCHISON, Mrs. LINCOLN, Mr. DASCHLE, Mr. CAMPBELL, and Mr. MACK):

S. Res. 141. A resolution to congratulate the United States Women's Soccer Team on winning the 1999 Women's World Cup Championship; considered and agreed to.

By Mr. BOND:

S. Res. 142. An original resolution authorizing expenditures by the Committee on Small Business; from the Committee on Small Business; to the Committee on Rules and Administration.

By Mr. WARNER:

S. Res. 143. An original resolution authorizing expenditures by the Committee on Armed Services; from the Committee on Armed Services; to the Committee on Rules and Administration.

By Mr. HATCH:

S. Res. 144. An original resolution authorizing expenditures by the Committee on the Judiciary; from the Committee on the Judiciary; to the Committee on Rules and Administration.

By Mr. MCCAIN:

S. Res. 145. An original resolution authorizing expenditures by the Committee on Commerce, Science, and Transportation; from the Committee on Commerce, Science, and Transportation; to the Committee on Rules and Administration.

By Mr. CHAFEE:

S. Res. 146. An original resolution authorizing expenditures by the Committee on Environment and Public Works; from the Committee on Environment and Public Works; to the Committee on Rules and Administration.

By Mr. GRAMM:

S. Res. 147. An original resolution authorizing expenditures by the Committee on Banking, Housing, and Urban Affairs; from the Committee on Banking, Housing, and Urban Affairs; to the Committee on Rules and Administration.

By Mr. HELMS:

S. Res. 148. An original resolution authorizing expenditures by the Committee on Foreign Relations; from the Committee on Foreign Relations; to the Committee on Rules and Administration.

By Mr. DOMENICI:

S. Res. 149. An original resolution authorizing expenditures by the Committee on the Budget; from the Committee on the Budget; to the Committee on Rules and Administration.

By Mr. ROTH:

S. Res. 150. An original resolution authorizing expenditures by the Committee on Finance; from the Committee on Finance; to the Committee on Rules and Administration.

By Mr. SPECTER:

S. Res. 151. An original resolution authorizing expenditures by the Committee on Veterans Affairs; from the Committee on Veterans Affairs; to the Committee on Rules and Administration.

By Mr. MCCONNELL:

S. Res. 152. An original resolution authorizing expenditures by the Committee on Rules and Administration; from the Committee on Rules and Administration; placed on the calendar.

By Mr. WELLSTONE:

S. Res. 153. A resolution urging the Parliament of Kuwait when it sits on July 17 to grant women the right to hold office and the right to vote; to the Committee on Foreign Relations.

By Mr. THOMPSON:

S. Res. 154. An original resolution authorizing expenditures by the Committee on Governmental Affairs; from the Committee on Governmental Affairs; to the Committee on Rules and Administration.

By Mr. GRASSLEY:

S. Res. 155. An original resolution authorizing expenditures by the Special Committee on Aging; from the Special Committee on Aging; to the Committee on Rules and Administration.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. SPECTER (for himself, Mr. HELMS, Mr. BIDEN, Mr. DORGAN, and Mr. SCHUMER):

S. 1372. A bill to require the filing of Shippers' Export Declarations through the Automated Export System of the Department of the Treasury with respect to certain transactions of proliferation concern, and for other purposes; to the Committee on Governmental Affairs.

PROLIFERATION PREVENTION ENHANCEMENT ACT OF 1999

Mr. SPECTER. Mr. President, I have sought recognition today to introduce legislation that will help the United States achieve important non-proliferation and counter-proliferation goals by improving the process through which export data on shipments of proliferation concern is collected and analyzed. By requiring that export data related to shipments of proliferation concern be filed electronically, this legislation will make it possible for agencies with export control responsibilities to do their job more efficiently and effectively.

To minimize the administrative burden on exporters, my legislation phases in the electronic filing requirement 180 days after the Secretary of Commerce and the Secretary of the Treasury certify that a secure, Internet-based filing system is up and running. There is already an electronic filing system available, but the existing system is being replaced with an Internet-based system that will be easier to access and use. When the new Internet-based system is in place, and that is expected to happen by early next year, my legislation will require that shipments of proliferation concern be reported electronically. The net result of enacting this legislation will be enhanced export control monitoring and enforcement, with minimal burden to shippers and exporters.

Let me take a moment to provide some background information for my colleagues, to make it clear what my legislation does and why. Current law requires shippers, forwarders and exporters to file what is known as a Shipper's Export Declaration, or SED. The SED indicates what is being shipped, where it is going, who it is being shipped to. Most of these are now filed on paper, and it is a time consuming and difficult process to sort through all these paper SEDs to identify shipments of proliferation concern, to track them down and check them out. In 1995, the Customs Service and the Census Bureau created the Automated Export System, or AES, which makes it possible to submit SEDs electronically. With the SED information in electronic form, it is much easier to sort through the data and identify shipments of concern.

About ten percent of SEDs are currently filed in electronic form through AES, and almost ninety percent of the forms are filed on paper. The data from the ninety percent of SEDs that are filed on paper is not as easy to review as it could be, and it is not possible to do the type of cross-checking and analysis that is necessary to zero in on the shipments that export officials need to monitor closely, and in some cases, prevent from being shipped. For example, before the 1991 Persian Gulf War, the Iraqis had a very sophisticated procurement strategy for acquiring weapons of mass destruction. They broke down their purchase requests and instead of asking for everything they wanted from one or two companies, asked for a few items from a large number of suppliers. If the Iraqis had grouped their requests, their orders would have raised eyebrows. Someone would have become suspicious, either the suppliers or export enforcement officers who reviewed the export data. As it was, the Iraqis ordered relatively small quantities of dual use commodities, items that can be used to create weapons of mass destruction but also have perfectly ordinary commercial uses, and combined them with shipments from other suppliers, sometimes from other countries, to make weapons of mass destruction. If all SEDs on items of proliferation concern had been filed electronically, as they will be when my legislation is enacted, it would have been much easier to detect what the Iraqis were up to and take preventive action.

Not all of the shipments that are being reported on paper rather than electronically are of proliferation concern. Shippers in the United States export literally hundreds of thousands of items each month that do not raise proliferation concerns; agricultural products, toasters, automobiles, and all sorts of completely harmless goods. But there are other items that we have to watch more carefully; items that are on the Department of State's Munitions List or the Commerce Control List. My legislation will make it easier to track shipments of these items by requiring that SEDs be filed electronically for any item that is on the United

States Munitions List or the Commerce Control List. With this information available in electronic format, agencies with export control responsibilities will be able to enforce our export control laws more effectively and prevent proliferation of WMD. By limiting mandatory electronic filing to items that raise genuine concerns about proliferation, my legislation will maximize the benefit to our national security without unduly burdening shippers and exporters.

Mr. President, I ask unanimous consent that the bill be printed in the RECORD.

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

S. 1372

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Proliferation Prevention Enhancement Act of 1999''.

SEC. 2. MANDATORY USE OF THE AUTOMATED EXPORT SYSTEM FOR FILING CERTAIN SHIPPERS' EXPORT DECLARATIONS.

(a) AUTHORITY.—Section 301 of title 13, United States Code, is amended by adding at the end the following new subsection:

''(h) The Secretary is authorized to require the filing of Shippers' Export Declarations under this chapter through an automated and electronic system for the filing of export information established by the Department of the Treasury.''.

(b) IMPLEMENTING REGULATIONS.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Commerce and the Secretary of State, shall publish regulations in the Federal Register to require that, upon the effective date of those regulations, exporters (or their agents) who are required to file Shippers' Export Declarations under chapter 9 of title 13, United States Code, file such Declarations through the Automated Export System with respect to exports of items on the United States Munitions List or the Commerce Control List.

(2) ELEMENTS OF THE REGULATIONS.—The regulations referred to in paragraph (1) shall include at a minimum—

(A) provision for the establishment of on-line assistance services to be available for those individuals who must use the Automated Export System;

(B) provision for ensuring that an individual who is required to use the Automated Export System is able to print out from the System a validated record of the individual's submission, including the date of the submission and a serial number or other unique identifier for the export transaction; and

(C) a requirement that the Department of Commerce print out and maintain on file a paper copy or other acceptable back-up record of the individual's submission at a location selected by the Secretary of Commerce.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) and the regulations described in subsection (b) shall take effect 180 days after the Secretary of Commerce, the Secretary of the Treasury, and the Director of the National Institute of Standards and Technology jointly certify, by publishing in the Federal Register a notice, that a secure, Internet-based Automated Export System that is capable of handling the expected volume of information required to be filed under subsection (b), plus the anticipated volume from voluntary use of the Automated Export System, has been successfully implemented and tested.

SEC. 3. VOLUNTARY USE OF THE AUTOMATED EXPORT SYSTEM.

It is the sense of Congress that exporters (or their agents) who are required to file Shippers' Export Declarations under chapter 9 of title 13, United States Code, but who are not required under section 2(b) to file such Declarations using the Automated Export System, should do so.

SEC. 4. REPORT TO CONGRESS.

Not later than 180 days after the date of enactment of this Act, the Secretary of Commerce, in coordination with the Secretary of State, the Secretary of Defense, the Secretary of the Treasury, the Secretary of Energy, and the Director of Central Intelligence, shall submit a report to Congress setting forth—

(1) the advisability and feasibility of mandating electronic filing through the Automated Export System for all Shippers' Export Declarations;

(2) the manner in which data gathered through the Automated Export System can most effectively be used by other automated licensing systems administered by Federal agencies, including—

(A) the Defense Trade Application System of the Department of State;

(B) the Export Control Automated Support System of the Department of Commerce;

(C) the Foreign Disclosure and Technology Information System of the Department of Defense;

(D) the Proliferation Information Network System of the Department of Energy;

(E) the Enforcement Communication System of the Department of the Treasury; and

(F) the Export Control System of the Central Intelligence Agency; and

(3) a proposed timetable for any expansion of information required to be filed through the Automated Export System.

SEC. 5. DEFINITIONS.

In this Act:

(1) AUTOMATED EXPORT SYSTEM.—The term ''Automated Export System'' means the automated and electronic system for filing export information established under chapter 9 of title 13, United States Code, on June 19, 1995 (60 Federal Register 32040).

(2) COMMERCE CONTROL LIST.—The term ''Commerce Control List'' has the meaning given the term in section 774.1 of title 15, Code of Federal Regulations.

(3) SHIPPERS' EXPORT DECLARATION.—The term ''Shippers' Export Declaration'' means the export information filed under chapter 9 of title 13, United States Code, as described in part 30 of title 15, Code of Federal Regulations.

(4) UNITED STATES MUNITIONS LIST.—The term ''United States Munitions List'' means the list of items controlled under section 38 of the Arms Export Control Act (22 U.S.C. 2778).

Mr. BIDEN. Mr. President, there is no greater threat to our country than that posed by weapons of mass destruction. Nuclear, chemical or biological weapons—perhaps delivered by long-range guided missiles—could cause more destruction in a week or even a day than we suffered in all of the Vietnam war.

The United States has many non-proliferation and counterproliferation programs, but there are cracks in our organization for combating this terrible scourge.

The Commission to Assess the Organization of the Federal Government to Combat the Proliferation of Weapons of Mass Destruction, also know as the ''Deutch Commission,'' has found those cracks.

Yesterday the Commission gave America a blueprint for repairing them. We dare not ignore its analysis, any more than we would ignore termites in our homes.

My colleague and friend from Pennsylvania, Senator ARLEN SPECTER, also deserves special recognition today. The Commission was his idea; he secured its establishment and later ensured its continued existence. As Vice Chairman of the Commission, he worked to ensure that its recommendations would be practical and politically feasible.

Today Senator SPECTER is introducing legislation to implement one of the Deutch Commission recommendations: that we require electronic filing of Shippers' Export Declarations on a secure, Internet-based system.

This legislation will provide more timely and usable data for non-proliferation analysis by executive branch agencies, without causing any significant burden for exporters or endangering the traditional confidentiality of Shippers' Export Declarations.

I am pleased to be an initial cosponsor of this legislation and I am confident that it will be enacted.

Shippers' Export Declarations are already required under chapter 9 of title 13, United States Code. The content of those Declarations is prescribed in part 30 of title 15, Code of Federal Regulations. This legislation will not require any reporting by industry that is not already mandated under those regulations.

There is also an existing Automated Export System, but its use is voluntary and it has not gained much acceptance. This bill will require that shippers use an Internet-based Automated Export System, once it is certified as being secure and capable of handling the expected volume of information that would be filed.

I want to assure U.S. companies, as I have been assured, that this legislation will not cause difficulties for them. Exporters will have on-line assistance in filing their Declarations and will be able to double-check their Declarations for accuracy after filing them.

In addition, the Director of the National Institute of Standards and Technology, which maintains the security of unclassified Federal Government communications, must join in certifying that the Internet-based Automated Export System is ready for use and has been successfully tested.

That will ensure the continued confidentiality of these Declarations.

This is hardly a revolutionary bill. Rather, it is one discrete, rational measure that is needed to improve our defense against the spread of nuclear, chemical or biological weapons to countries or groups that could otherwise rain chaos and destruction upon our country and the whole world.

We simply must take this step, along with others recommended by the

Deutch Commission. For our own sake and for our children's sake as well, we absolutely must respond to the challenge of proliferation.

By Mr. FEINGOLD:

S. 1373. A bill to increase monitoring of the use of offsets in international defense trade; to the Committee on Foreign Relations.

DEFENSE OFFSETS DISCLOSURE ACT OF 1999

Mr. FEINGOLD. Mr. President, I rise today to introduce a bill that will help clarify the difficult subject of the use of offsets in international defense trade. This little known practice has a potentially tremendous impact on our domestic industry, international trade, and national security, yet is barely understood by either the public or private sectors. My bill, the ''Defense Offsets Disclosure Act of 1999'' seeks to expand the monitoring and reporting of offsets use so that policy makers and the public can better understand the impact on our economy.

Mr. President, what are offsets? Offsets are the entire range of industrial and commercial benefits that are provided to foreign governments as inducements, or conditions, for the purchase of military goods and services. Among techniques used to meet offset requirements are co-production, subcontracting, technology transfers, in-country procurement, marketing and financial assistance, and joint ventures. In other words, they are largely non-cash ''sweeteners'' attached to export sales of large military [and occasionally civilian] products, typically set forth in side agreements and provided to the purchasing country over a period of time.

My legislation would offer several measures to get a handle on the whole range of issues involved in the use of offsets:

First, my bill declares that it is the policy of the United States to pursue better monitoring of offsets, to promote fairness in international trade; and to ensure an appropriate level of foreign participation in the production of United States weapons systems. To fully understand the implications of offsets and the extent of their impact, we must have more information on offset agreements, particularly the indirect offset obligations that are otherwise invisible. While many of my colleagues can cite anecdotal evidence of companies harmed or jobs lost, we must develop a more effective mechanism to accurately quantify the impact of offsets.

Second, my bill expresses the sense of Congress that the Executive Branch should seek trade fairness through transparency and standardization of the use of offsets in international defense trade. In particular, the Secretaries of State and Commerce and the U.S. Trade Representative should raise the issues of transparency and standardization bilaterally at all suitable venues, and our government should initiate discussions on standards for use of offsets through appropriate multilateral fora. While some believe that offsets are a business practice best left to business to handle, the nature of the problem calls out for government-to-government discussion to ensure that an even playing field exists for all stakeholders in the international defense trade.

Third, the bill establishes a new requirement for more detailed information on offsets in Congressional notifications of government-to-government and commercial sales. Current law only requires notification of the existence of an offset agreement, with no details or follow up description of the measures used to fulfill the offset obligation. My bill will require a description of the offset agreement and its dollar value. It also calls for an additional report upon completion of an offset obligation which would identify all measures taken to fulfill the offset agreement identified earlier in its pre-sale Congressional notification. At least one defense contractor already has been willing to provide this information as part of its regular license application and has provided the size of the offset, its direct and indirect components, and a rough estimate of the likely measures it would use to fulfill its offset obligations. My bill should elicit similar useful information on all offset agreements.

Fourth, the bill expands a prohibition on incentive payments that I authored in 1993. That earlier provision prohibited the use of third party incentive payments to secure offset agreements in any sale subject to the Arms Export Control Act. My new bill expands the prohibition to include items ''exported'' or ''licensed''. The previous language addressed only ''sales''. The incentive payments provision in my bill should close any loopholes and clarify that incentive payments are not an acceptable component of any type of offset transaction.

Fifth, the bill requires the Administration to initiate a review to determine the feasibility, and the most effective means, of negotiating multilateral agreements on standards for the use of offsets. It also mandates a report on the Administration's activities in the area. Through international dialogue and coordination we can arrive at multilateral standards for the use of offsets in defense trade agreements. Whether you believe that offsets are merely an annoying, but ordinary, business practice, or hold the view that they pose a major long term threat to our labor force, our industries, and our national security, I believe it is both possible and necessary to develop some common ground for business practices worldwide.

Sixth, the bill requires the President to establish a high-level, nonpartisan commission to review the full range of current practices; the impact of the use of offsets; and the role of offsets in domestic industry, trade competitiveness, national security, and the globalization of the weapons industry. There needs to be broader public awareness and national debate by a range of concerned parties on the implications of offsets. A June 29 hearing on offsets in the House Subcommittee on Criminal Justice, Drug Policy, and Human Resources, at which I testified, was a good start, but more still must be done.

Mr. President, I first discovered the murky world of offsets in 1993 when I learned that the Wisconsin-based Beloit Corporation, a subsidiary of Harnischfeger Industries Inc., had been negatively affected by an apparent indirect offset arrangement between the Northrop Corporation and the government of Finland. Beloit was one of only three companies in the world that produced a particular type of large papermaking machine. In its efforts to sell one of these machines to the International Paper Company, Beloit became aware that Northrop had offered International Paper an incentive payment to select instead the machine offered by a Finnish company, Valmet. Northrop was promoting the purchase of the Valmet machinery as part of an agreement that would provide dollar-for-dollar offset credit on a deal with Finland to purchase sixty-four F–18 aircraft. This type of payment had the flavor of a kickback, distorted the practice of free enterprise, and threatened U.S. jobs. By lowering its bid—barely breaking even on the contract—to take into account the incentive payment offered by Northrop, Beloit did succeed in winning the contract. Nevertheless, the incident demonstrated to me the potential for offset obligations to have an impact on apparently unrelated domestic U.S. industries.

To address some of the immediate concerns raised by Beloit's experience, as I mentioned earlier, in 1993 I offered an amendment (which passed into law in 1994), to the Arms Export Control Act to prohibit incentive payments in the provision of offset credit. I wanted to clarify the Congress' disapproval of an activity that appeared to fall through the cracks of various existing acts. Neither the Anti-Kickback Act nor the Foreign Corrupt Practices Act seemed clearly to address issues raised by the payment being offered to International Paper in the Beloit case. The measure also expanded the requirements for Congressional notification of the existence, and to the extent possible, information on any offset agreement at the time of Congressional notification of a pending arms sale under the Arms Export Control Act. Last year, I offered additional language to expand further the prohibition on incentive payments and enhance the reporting requirement on offsets to include a description of the offset with dollar amounts. While my provisions were incorporated in the Security Assistance Act of 1998 as passed by the Senate Foreign Relations Committee, the legislation never made it to the floor.

Unfortunately, Mr. President, while Congress has tried to address specific problems encountered by companies in our states and districts, efforts to date have barely scratched the surface of the difficult subject of offsets. In fact, neither the legislative nor the executive branches has a full grasp of the breadth and complexity of the issue, although I know many are concerned about the potential impact of the use of offsets. From what we do know, it appears that there are several key areas affected by the practice of using offsets:

The domestic labor force and defense industrial base, particularly in the aerospace industry, impacted by the increasing role of overseas production in the defense industry;

The non-defense industrial sectors unintentionally harmed, as in the Beloit case, when defense contractors engage in indirect offset obligations;

The breadth of the U.S. economy potentially influenced by the growing globalization of the defense industry; and

The national security possibly threatened by joint ventures and growing reliance on foreign defense contractors, a concern recently highlighted in the Cox report on China's technology acquisition.

Mr. President, I believe my bill will allow us to collect better information on the use of offsets, to engage in an informed discussion on both the problem and viable policy options, and to encourage multilateral efforts to find common standards and solutions that will benefit us all. Only through these efforts can we hope to get a clear picture of the complex offset issue and ensure that their use does not produce negative consequences for the American labor force, the domestic industrial base, or our national security.

Mr. President, I ask that the bill be printed in the RECORD.

The bill follows:

S. 1373

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Defense Offsets Disclosure Act of 1999''.

SEC. 2. FINDINGS AND DECLARATION OF POLICY.

(a) FINDINGS.—Congress makes the following findings:

(1) A fair business environment is necessary to advance international trade, economic stability, and development worldwide, is beneficial for American workers and businesses, and is in the United States national interest.

(2) Mandated offset requirements can cause economic distortions in international defense trade and sabotage fairness and competitiveness, and may cause particular harm to small- and medium-sized businesses.

(3) The stated goal of supporting the national security needs of allied countries by assisting their defense industries through the use of offsets may no longer be sufficient justification for the practice.

(4) The use of offsets may lead to increasing dependence on foreign suppliers for the production of United States weapons systems.

(5) The offset demands required by some purchasing countries, including some of the United States closest allies, equal or exceed the value of the base contract they are intended to offset, mitigating much of the potential economic benefit of the exports.

(6) Offset demands often unduly inflate the prices of defense contracts.

(7) In some cases, United States contractors are required to provide indirect offsets which can negatively impact nondefense industrial sectors.

(8) Unilateral efforts by the United States to prohibit offsets may be impractical in the current era of globalization and would severely hinder the competitiveness of the United States defense industry in the global market.

(9) The development of global standards to manage and restrict demands for offsets would enhance United States efforts to mitigate the negative impact of offsets.

(b) DECLARATION OF POLICY.—Congress declares that the United States policy is to develop a workable system to monitor the use of offsets in the defense industry, to promote fairness in international trade, and to ensure an appropriate level of foreign participation in production of United States weapons systems.

SEC. 3. SENSE OF CONGRESS.

It is the sense of Congress that—

(1) the executive branch should pursue efforts to address trade fairness by making transparent and establishing standards for the use of offsets in international business transactions among United States trading partners and competitors;

(2) the Secretary of State, the Secretary of Commerce, and the United States Trade Representative, or their designees, should raise the need for transparency and other standards bilaterally with other industrialized nations at every suitable venue; and

(3) the United States Government should enter into discussions regarding the establishment of multilateral standards for the control of the use of offsets in international defense trade through the appropriate multilateral fora, including such organizations as the Transatlantic Economic Partnership, the Wassenaar Arrangement, the G-8, and the World Trade Organization.

SEC. 4. DEFINITIONS.

In this Act:

(1) APPROPRIATE CONGRESSIONAL COMMITTEES.—The term ''appropriate congressional committees'' means—

(A) the Committee on Foreign Relations of the Senate;

(B) the Committee on International Relations of the House of Representatives;

(C) the Committees on Commerce of the Senate and the House of Representatives; and

(D) the Committees on Armed Services of the Senate and the House of Representatives.

(2) G–8.—The term ''G–8'' means the group consisting of France, Germany, Japan, the United Kingdom, the United States, Canada, Italy, and Russia established to facilitate economic cooperation among the eight major economic powers.

(3) OFFSET.—The term ''offset'' means the entire range of industrial and commercial benefits provided to foreign governments as an inducement or condition to purchase military goods or services, including benefits such as coproduction, licensed production, subcontracting, technology transfer, in-country procurement, marketing and financial assistance, and joint ventures.

(4) TRANSATLANTIC ECONOMIC PARTNERSHIP.—The term ''Transatlantic Economic Partnership'' means the joint commitment made by the United States and the European Union to reinforce their close relationship through an initiative involving the intensification and extension of multilateral and bilateral cooperation and common actions in the areas of trade and investment.

(5) WASSENAAR ARRANGEMENT.—The term ''Wassenaar Arrangement'' means the multilateral export control regime in which the United States participates that seeks to promote transparency and responsibility with regard to transfers of conventional armaments and sensitive dual-use items.

(6) WORLD TRADE ORGANIZATION.—The term ''World Trade Organization'' means the organization established pursuant to the WTO Agreement.

(7) WTO AGREEMENT.—The term ''WTO Agreement'' means the Agreement Establishing The World Trade Organization entered into on April 15, 1994.

SEC. 5. REPORTING OF OFFSET AGREEMENTS.

(a) INITIAL REPORTING OF OFFSET AGREEMENTS.—

(1) GOVERNMENT-TO-GOVERNMENT SALES.—Section 36(b)(1) of the Arms Export Control Act (22 U.S.C. 2776(b)(1)) is amended—

(A) in the fourth sentence, by striking ''(if known on the date of transmittal of such certification)'' and inserting ''and a description of any offset agreement, including the dollar amount of the agreement''; and

(B) by inserting after the fourth sentence the following: ''Such description shall to the extent possible be available to the public.''.

(2) COMMERCIAL SALES.—Section 36(c)(1) of the Arms Export Control Act (22 U.S.C. 2776(c)(1)) is amended—

(A) in the second sentence, by striking ''(if known on the date of transmittal of such certification)'' and inserting ''and a description of any offset agreement, including the dollar amount of the agreement''; and

(B) by inserting after the fourth sentence the following: ''Such description shall to the extent possible be available to the public.''.

(b) REPORTING UPON COMPLETION OF OFFSET OBLIGATIONS.—Not later than 90 days after the fulfillment of an offset obligation made in conjunction with transactions reported in section 36 (b) or (c) of the Arms Export Control Act, the President shall submit a report to Congress identifying all measures taken to fulfill the offset obligations related to the sale. The report shall contain all the information required in section 36 (b) and (c) of the Arms Export Control Act, as well as any additional information that may not have been available at the time of the initial notification.

SEC. 6. EXPANDED PROHIBITION ON INCENTIVE PAYMENTS.

(a) IN GENERAL.—Section 39A(a) of the Arms Export Control Act (22 U.S.C. 2779a(a)) is amended—

(1) by inserting ''or licensed'' after ''sold''; and

(2) by inserting ''or export'' after ''sale''.

(b) DEFINITION OF UNITED STATES PERSON.—Section 39A(d)(3)(B)(ii) of the Arms Export Control Act (22 U.S.C. 2779a(d)(3)(B)(ii)) is amended by inserting ''or by an entity described in clause (i)'' after ''subparagraph (A)''.

SEC. 7. MULTILATERAL STRATEGY TO COMBAT OFFSETS.

(a) IN GENERAL.—The President shall initiate a review to determine the feasibility of establishing, and the most effective means of negotiating, multilateral agreements on standards for the use of offsets in international defense trade, with a goal of limiting all offset transactions.

(b) REPORT REQUIRED.—Not later than 90 days after the date of enactment of this Act, the President shall submit to the appropriate congressional committees a report containing a strategy for United States negotiations of multilateral agreements with

designated foreign countries that provide standards for the use of offsets with respect to the sale or licensing of defense articles or defense services under the Arms Export Control Act (22 U.S.C. 2751 et seq.), and a timetable for entering into such multilateral agreements. One year after the date the report is submitted under the preceding sentence, and annually thereafter for 5 years, the President shall submit to the appropriate congressional committees a report detailing the progress toward reaching such multilateral agreements.

(c) REQUIRED INFORMATION.—The report required by subsection (b) shall include—

(1) a description of the United States efforts to pursue multilateral negotiations on standards for the use of offsets in international defense trade;

(2) an evaluation of existing multilateral fora as appropriate venues for establishing such negotiations;

(3) a description on a country-by-country basis of United States efforts to engage in negotiations to establish bilateral agreements with respect to the use of offsets in international defense trade; and

(4) an evaluation on a country-by-country basis of foreign government efforts to address the use of offsets in international defense trade.

(d) COMPTROLLER GENERAL REVIEW.—The Comptroller General of the United States shall monitor and periodically report to Congress on the progress in reaching a multilateral agreement.

SEC. 8. ESTABLISHMENT OF REVIEW COMMISSION.

(a) IN GENERAL.—There is established a National Commission on the Use of Offsets in Defense Trade (in this section referred to as the ''Commission'') to address all aspects of the use of offsets in international defense trade.

(b) COMMISSION MEMBERSHIP.—Not later than 60 days after the date of enactment of this Act, the President, in consultation with Congress, shall appoint 10 people to serve as members of the Commission. Commission membership shall include four representatives from the private sector, including one each from a labor organization, the defense manufacturing sector, academia, and an organization devoted to arms control; four from the executive branch, including one each from the Office of Management and budget, and the Departments of Commerce, Defense, and State; and two from the legislative branch, one each from among members of the Senate and the House of Representatives. The member designated from Office of Management and Budget will serve as Chairperson of the Commission. The President shall ensure that the Commission is nonpartisan and that the full range of perspectives on the subject of offsets in the defense industry is adequately represented.

(c) DUTIES.—The Commission shall be responsible for reviewing and reporting on—

(1) the full range of current practices by foreign governments requiring offsets in purchasing agreements and the extent and nature of offsets offered by United States and foreign defense industry contractors;

(2) the impact of the use of offsets on defense subcontractors and nondefense industrial sectors affected by indirect offsets; and

(3) the role of offsets, both direct and indirect, on domestic industry stability, United States trade competitiveness, national security, and the globalization of the weapons industry.

(d) COMMISSION REPORT.—Not later than 12 months after the Commission is established, the Commission shall submit a report to the appropriate congressional committees. The report shall include—

(1) an analysis of—

(A) the collateral impact of offsets on industry sectors that may be different than those of the contractor providing the offsets, including estimates of contracts and jobs lost as well as an assessment of damage to industrial sectors;

(B) the role of offsets with respect to competitiveness of the United States defense industry in international trade and the potential damage to the ability of United States contractors to compete if offsets were prohibited;

(C) the impact on United States national security of the use of coproduction, subcontracting, and technology transfer with foreign governments or companies that result from fulfilling offset requirements; and

(D) the potential negative effects of the increasing globalization of the weapons industry through the use of offsets and the resultant implications for the United States ability to limit the proliferation of weapons and weapons technology;

(2) proposals for unilateral, bilateral, or multilateral measures aimed at reducing the detrimental effects of offsets; and

(3) an identification of the appropriate executive branch agencies to be responsible for monitoring the use of offsets in international defense trade.

(e) TERMINATION.—The Commission shall terminate not later than the date that is 3 years after the date of enactment of this Act.●

By Mr. THOMAS (for himself and Mr. ENZI):

S. 1374. A bill to authorize the development and maintenance of a multi-agency campus project in the town of Jackson, Wyoming; to the Committee on Energy and Natural Resources.

MULTI-AGENCY VISITOR CAMPUS IN JACKSON, WYOMING

Mr. THOMAS. Mr. President, I am pleased to introduce a bill today to authorize the development and maintenance of a multi-agency campus in the town of Jackson, Wyoming.

The management of our public lands and natural resources is often complicated and requires the coordination of many individuals to accomplish desired objectives. When western folks discuss federal land issues, we do not often have an opportunity to identify proposals that capture this type of consensus and enjoy the support from a wide array of interests; however, the multi-agency campus offers just such a unique prospect. As local, state and federal officials attempt to provide services to the public, they have identified a need to develop a campus in Jackson, Wyoming that offers visitors ''one stop shopping'' service for wildlife, tourism and resource issues.

The multi-agency campus includes a wildlife interpretive center, facilities for public programs, walkways, bike paths, museum space, and office locations for Wyoming Game and Fish, U.S. Forest Service and the local chamber of commerce. There are several entities involved with this effort—U.S. Department of Agriculture, U.S. Forest Service, Wyoming Game and Fish, National Park Service, U.S. Fish and Wildlife, U.S. Department of Interior, Teton County, Town of Jackson, Jackson Chamber of Commerce and the Jackson Hole Historical Society. Project coordinators and involved parties have spent a great deal of time incorporating the concerns of various individuals through public meetings and by presenting their plans to agency and congressional representatives.

This legislation is needed to improve communication between the federal agencies and related entities, and reduce costs to federal, state and local governments as they attempt to address public needs. Specifically, the bill would allow the U.S. Forest Service to transfer a small parcel of their land within the proposed campus boundaries to the Town of Jackson in exchange for the Town constructing a new administrative facility for the agency.

Mr. President, this bill enjoys the support of many different groups including federal agencies, state organizations and officials, as well as the local community. It is my hope that the Senate will seize this opportunity to improve upon efforts to provide services to the American public.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1374

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Jackson Multi-Agency Campus Act of 1999''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) the management of public land and natural resources and the service of the public in the area of Jackson, Wyoming, are responsibilities shared by—

(A) the Department of Agriculture;

(B) the Forest Service;

(C) the Department of the Interior, including—

(i) the National Park Service; and

(ii) the United States Fish and Wildlife Service;

(D) the Game and Fish Commission of the State of Wyoming;

(E) Teton County, Wyoming;

(F) the town of Jackson, Wyoming;

(G) the Jackson Chamber of Commerce; and

(H) the Jackson Hole Historical Society; and

(2) it is desirable to locate the administrative offices of several of the agencies and entities specified in paragraph (1) on 1 site to—

(A) facilitate communication between the agencies and entities;

(B) reduce costs to the Federal, State, and local governments; and

(C) better serve the public.

(b) PURPOSES.—The purposes of this Act are to—

(1) authorize the Federal agencies specified in subsection (a) to—

(A) develop and maintain the Project in Jackson, Wyoming, in cooperation with the other agencies and entities specified in subsection (a); and

(B) provide resources and enter into such agreements as are necessary for the planning, design, construction, operation, maintenance, and fixture modifications of all elements of the Project;

(2) direct the Secretary to convey to the town of Jackson, Wyoming, certain parcels

of federally owned land located in Teton County, Wyoming, in exchange for construction of facilities for the Bridger-Teton National Forest by the town of Jackson;

(3) direct the Secretary to convey to the Game and Fish Commission of the State of Wyoming certain parcels of federally owned land in the town of Jackson, Wyoming, in exchange for approximately 1.35 acres of land, also located in the town of Jackson, to be used in the construction of the Project; and

(4) relinquish certain reversionary interests of the United States in order to facilitate the transactions described in paragraphs (1) through (4).

SEC. 3. DEFINITIONS.

In this Act:

(1) COMMISSION.—The term ''Commission'' means the Game and Fish Commission of the State of Wyoming.

(2) CONSTRUCTION COST.—The term ''construction cost'' means any cost that is—

(A) associated with building improvements to Federal standards and guidelines; and

(B) open to a competitive bidding process approved by the Secretary.

(3) FEDERAL PARCEL.—The term ''Federal parcel'' means the parcel of land, and all appurtenances to the land, comprising approximately 15.3 acres, depicted as ''Bridger-Teton National Forest'' on the Map.

(4) MAP.—The term ''Map'' means the map entitled ''Multi-Agency Campus Project Site'', dated March 31, 1999, and on file in the offices of—

(A) the Bridger-Teton National Forest, in the State of Wyoming; and

(B) the Chief of the Forest Service.

(5) MASTER PLAN.—The term ''master plan'' means the document entitled ''Conceptual Master Plan'', dated July 14, 1998, and on file at the offices of—

(A) the Bridger-Teton National Forest, in the State of Wyoming; and

(B) the Chief of the Forest Service.

(6) PROJECT.—The term ''Project'' means the proposed project for construction of a multi-agency campus, to be carried out by the town of Jackson in cooperation with the other agencies and entities described in section 2(a)(1), to provide, in accordance with the master plan—

(A) administrative facilities for various agencies and entities; and

(B) interpretive, educational, and other facilities for visitors to the greater Yellowstone area.

(7) SECRETARY.—The term ''Secretary'' means the Secretary of Agriculture (including a designee of the Secretary).

(8) STATE PARCEL.—The term ''State parcel'' means the parcel of land comprising approximately 3 acres, depicted as ''Wyoming Game and Fish'' on the Map.

(9) TOWN.—The term ''town'' means the town of Jackson, Wyoming.

SEC. 4. MULTI-AGENCY CAMPUS PROJECT, JACKSON, WYOMING.

(a) CONSTRUCTION OFFERS FOR EXCHANGE OF PROPERTY.—

(1) IN GENERAL.—The town may offer to construct, as part of the Project, an administrative facility for the Bridger-Teton National Forest.

(2) CONVEYANCE.—If the offer described in paragraph (2) is made not later than 5 years after the date of enactment of this Act, the Secretary shall convey the Federal land described in section 5(a)(1) to the town, in exchange for the completed administrative facility described in this paragraph, in accordance with this Act.

(b) OFFER TO CONVEY STATE PARCEL.—

(1) IN GENERAL.—The Commission may offer to convey a portion of the State parcel, depicted on the Map as ''Parcel Three'', to the United States to be used for construction of an administrative facility for the Bridger-Teton National Forest.

(2) CONVEYANCE.—If the offer described in paragraph (2) is made not later than 5 years after the date of enactment of this Act, the Secretary shall convey, through a simultaneous conveyance, the Federal land described in section 5(a)(2) to the Commission, in exchange for the portion of the State parcel described in paragraph (2), in accordance with this Act.

SEC. 5. CONVEYANCE OF FEDERAL LAND.

(a) IN GENERAL.—In exchange for the consideration described in section 3, the Secretary shall convey—

(1) to the town, a portion of the Federal parcel, comprising approximately 9.3 acres, depicted on the Map as ''Parcel Two''; and

(2) to the Commission, a portion of the Federal parcel comprising approximately 3.2 acres, depicted on the Map as ''Parcel One''.

(b) REVERSIONARY INTERESTS.—As additional consideration for acceptance by the United States of any offer described in section 4, the United States shall relinquish all reversionary interests in the State parcel, as set forth in the deed between the United States and the State of Wyoming, dated February 19, 1957, and recorded on October 2, 1967, in Book 14 of Deeds, Page 382, in the records of Teton County, Wyoming.

SEC. 6. EQUAL VALUE OF INTERESTS EXCHANGED.

(a) VALUATION OF LAND TO BE CONVEYED.—

(1) IN GENERAL.—The fair market and improvement values of the land to be exchanged under this Act shall be determined—

(A) by appraisals acceptable to the Secretary, utilizing nationally recognized appraisal standards; and

(B) in accordance with section 206 of the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1716).

(2) APPRAISAL REPORT.—Each appraisal report shall be written to Federal standards, as defined in the Uniform Appraisal Standards for Federal Land Acquisitions developed by the Interagency Land Acquisition Conference.

(3) NO EFFECT ON VALUE OF REVERSIONARY INTERESTS.—An appraisal of the State parcel shall not take into consideration any reversionary interest held by the United States in the State parcel as of the date on which the appraisal is conducted.

(b) VALUE OF FEDERAL LAND GREATER THAN CONSTRUCTION COSTS.—If the value of the Federal land to be conveyed to the town under section 5(a)(1) is greater than the construction costs to be paid by the town for the administrative facility described in section 4(a), the Secretary shall reduce the acreage of the Federal land conveyed so that the value of the Federal land conveyed to the town closely approximates the construction costs.

(c) VALUE OF FEDERAL LAND LESS THAN CONSTRUCTION COSTS.—If the value of the Federal land to be conveyed to the town under section 5(a)(1) is less than the construction costs to be paid by the town for the administrative facility described in section 4(a), the Secretary may convey to the town additional Federal land administered by the Secretary for national forest administrative site purposes in Teton County, Wyoming, so that the total value of the Federal land conveyed to the town closely approximates the construction costs.

(d) VALUE OF FEDERAL LAND EQUAL TO VALUE OF STATE PARCEL.—

(1) IN GENERAL.—The value of any Federal land conveyed to the Commission under section 5(a)(2) shall be equal to the value of the State parcel conveyed to the United States under section 4(b).

(2) BOUNDARIES.—The boundaries of the Federal land and the State parcel may be adjusted to equalize values.

(e) PAYMENT OF CASH EQUALIZATION.—Notwithstanding subsections (b) through (d), the values of Federal land and the State parcel may be equalized by payment of cash to the Secretary, the Commission, or the town, as appropriate, in accordance with section 206(b) of the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1716(b)), if the values cannot be equalized by adjusting the size of parcels to be conveyed or by conveying additional land, without compromising the design of the Project.

SEC. 7. ADDITIONAL PROVISIONS.

(a) CONSTRUCTION OF FEDERAL FACILITIES.—The construction of facilities on Federal land within the boundaries of the Project shall be—

(1) supervised and managed by the town; and

(2) carried out to standards and specifications approved by the Secretary.

(b) ACCESS.—The town (including contractors and subcontractors of the town) shall have access to the Federal land until completion of construction for all purposes related to construction of facilities under this Act.

(c) ADMINISTRATION OF LAND ACQUIRED BY UNITED STATES.—Land acquired by the United States under this Act shall be governed by all laws applicable to the administration of national forest sites.

(d) WETLAND.—

(1) IN GENERAL.—There shall be no construction of any facility after the date of conveyance of Federal land under this Act within any portion of the Federal parcel delineated on the map as ''wetlands''.

(2) DEEDS AND CONVEYANCE DOCUMENTS.—A deed or other conveyance document executed by the Secretary in carrying out this Act shall contain such reservations as are necessary to preclude development of wetland on any portion of the Federal parcel.

By Mr. LEAHY (for himself and Mr. KOHL):

S. 1375. A bill to amend the Immigration and Nationality Act to provide that aliens who commit act of torture abroad are inadmissible and removable and to establish within the Criminal Division of the Department of Justice an Office of Special Investigations having responsibilities under that Act with respect to all alien participants in act of genocide and torture abroad; to the Committee on the Judiciary.

THE ANTI-ATROCITY ALIEN DEPORTATION ACT

Mr. LEAHY. Mr. President, the recent events in Kosovo have been a graphic reminder that crimes against humanity did not end with the Second World War. Our treatment of those persecuted by the Nazis has long been regarded as a travesty. Blatant American anti-Semitism led to post-war immigration quotas that virtually shut out Jews coming from concentration camps while embracing German sympathizers.

In contrast to this country's dismal record in accepting Jewish refugees following the last world war, the United States has tried harder and done better in recent years to provide refuge to those persons fleeing homelands that have been ravaged by violence. For example, over the past five years, approximately 83,247 Bosnian refugees have been admitted to this country. During the latest hostilities in Kosovo, the Clinton Administration provided leadership to other nations by pledging

to take in as many as 20,000 Kosovar refugees.

Unfortunately, criminals who wielded machetes and guns against innocent civilians in countries like Haiti, Yugoslavia and Rwanda have been able to gain entry to the United States through the same doors that we have opened to deserving refugees. We need to lock that door to those war criminals who seek a safe haven in the United States. And to those war criminals who are already here, we should promptly show them the door out.

Our country has long provided the template and moral leadership for dealing with Nazi war criminals. The Justice Department has a specialized unit, the Offfice of Special Investigations (OSI), which was created to hunt down, prosecute and remove Nazi war criminals who had slipped into the United States among their victims under the Displaced Persons Act. Since the OSI's inception in 1979, 61 Nazi persecutors have been stripped of U.S. citizenship, 49 such individuals have been removed from the United States, and more than 150 have been denied entry.

OSI was created almost 35 years after the end of World War II and it remains authorized only to track Nazi war criminals. Little is being done about the new generation of international war criminals living among us, and these delays are costly. As any prosecutor—or, in my case, former prosecutor—knows instinctively, such delays make documentary and testimonial evidence more difficult to obtain. Stale cases are the hardest to make.

We should not repeat the mistake of waiting decades before tracking down war criminals and human rights abusers who have settled in this country. War criminals should find no sanctuary in loopholes in our current immigration policies and enforcement. No war criminal should ever come to believe that he is going to find safe harbor in the United States.

Too often, once war criminals slip through the immigration nets, they remain in the United States, unpunished for their crimes. In Vermont, news reports indicate that a Bosnian-Muslim man suspected of participating in ethnic cleansing during the Serbian war now is in Burlington. He has been identified by many people, including his own relatives, as a member of a Serbian paramilitary group responsible for the torture, rape, and murder of countless innocent people. We see the possibility that refugees now may encounter their persecutors thousands of miles away from their homeland, walking the streets of America.

This is not an isolated occurrence. The center for Justice and Accountability, a San Francisco human rights group, has identified approximately sixty suspected human rights violators now living in the United States. We have unwittingly sheltered the oppressors along with the oppressed for too long. We should not let this situation continue. We waited too long after the last world war to focus prosecutorial resources and attention on Nazi war criminals who entered this country on false pretenses. We should not repeat that mistake for other aliens who engaged in human rights abuses before coming to the United States. We need to focus the attention of our law enforcement investigators to prosecute and deport those who have committed atrocities abroad and who now enjoy safe harbor in the United States.

Despite U.S. ratification of the United Nations' ''Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,'' current immigration law provides that those who participated in Nazi war crimes and genocide are inadmissible to and are removable from the United States, yet those who have committed the criminal act of torture are not. This leads to cases like that of Kelbessa Negewo, a member of the military dictatorship ruling Ethiopia in the 1970s, who has been found guilty of torture in a private civil action by an American court but who remains in the United States nonetheless because the Immigration and Naturalization Act does not provide explicit authority to investigate, denaturalize or remove him. The Leahy ''Anti-Atrocity Alien Deportation Act'' would close this loophole and make those who commit torture abroad inadmissible to and deportable from our country.

The ''Anti-Atrocity Alien Deportation Act,'' which I introduce today with Senator KOHL, would amend the Immigration and Nationality Act to expand the grounds for inadmissibility and deportation to cover aliens who have engaged in acts of torture abroad. ''Torture'' is already defined in the Federal criminal code, 18 U.S.C. §2340, in a law passed as part of the implementing legislation for the ''Convention Against Torture.'' Under this Convention, the United States has an affirmative duty to prosecute torturers within its boundaries regardless of their respective nationalities. 18 U.S.C. §2340A (1994).

This legislation would also provide statutory authorization for OSI, which currently owes its existence to an Attorney General order, and would expand its jurisdiction to authorize investigations, prosecutions, and removal of any alien who participated in torture and genocide abroad—not just Nazis. The success of OSI is hunting Nazi war criminals demonstrates the effectiveness of centralized resources and expertise in these cases. OSI has worked, and it is time to update its mission.

The knowledge of the people, politics and pathologies of particular regimes engaged in genocide and human rights abuses is often necessary for effective prosecutions of these cases and may best be accomplished by the concentrated efforts of a single office, rather than in piecemeal litigation around the country or in offices that have more diverse missions.

Unquestionably, the need to bring Nazi war criminals to justice remains a matter of great importance. Funds would not be derived from the OSI's current mission. Additional resources are authorized in the bill for OSI's expanded duties.

I have for many years sought to advance the search for war criminals who have clandestinely immigrated to our country. In 1996, the moving testimony of esteemed individuals like Rabbi Marvin Hier (the dean and founder of the Simon Wisenthal Center) led me to work closely on the drafting of the Nazi War Crimes Disclosure Act. More recently, I helped to ensure that the OSI would be able to further its efforts in investigating and denaturalizing Nazi war criminals with a budget increase of two million dollars for 1999, and I am attempting to do the same for the Year 2000.

I have also supported a strong and effective War Crimes Tribunal—with the necessary funds and authority to fully apprehend and prosecute war criminals. Expanding the mission of OSI, combined with a vigorous War Crimes Tribunal, represents a full-scale, two-prong assault on war criminals, wherever they may hide.

We must honor and respect the unique experiences of those who were victims in the darkest moment in world history. The Anti-Defamation League has expressed its support for my bill. We may help honor the memories of the victims of the Holocaust by pursuing all war criminals who enter our country. By so doing, the United States can provide moral leadership and show that we will not tolerate perpetrators of genocide and torture, least of all here.

In sum, the Anti-Atrocity Alien Deportation Act would:

Bar admission into the United States and authorize the deportation of aliens who have engaged in acts of torture abroad.

Provide statutory authorization for and expand the jurisdiction of the Office of Special Investigations (so-called ''Nazi war criminal hunters'') with the Department of Justice to investigate, prosecute and remove any alien who participated in torture and genocide abroad—not just Nazis; and

Authorize additional funding to ensure that OSI has adequate resources to fulfill its current mission of hunting Nazi war criminals.

I ask unanimous consent that the text of the bill and a sectional analysis be printed in the RECORD.

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

S. 1375

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Anti-Atrocity Alien Deportation Act''.

SEC. 2. INADMISSIBILITY AND REMOVABILITY OF ALIENS WHO HAVE COMMITTED ACTS OF TORTURE ABROAD.

(a) INADMISSIBILITY.—Section 212(a)(3)(E) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(3)(E)) is amended by adding at the end the following:

''(iii) COMMISSION OF ACTS OF TORTURE.—Any alien who, outside the United States, has committed any act of torture, as defined in section 2340 of title 18, United States Code, is inadmissible.''.

(b) REMOVABILITY.—Section 237(a)(4)(D) of that Act (8 U.S.C. 1227(a)(4)(D)) is amended by striking ''clause (i) or (ii)'' and inserting ''clause (i), (ii), or (iii)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to offenses committed before, on, or after the date of enactment of this Act.

SEC. 3. ESTABLISHMENT OF THE OFFICE OF SPECIAL INVESTIGATIONS.

(a) AMENDMENT OF THE IMMIGRATION AND NATIONALITY ACT.—Section 103 of the Immigration and Nationality Act (8 U.S.C. 1103) is amended by adding at the end the following:

''(g) The Attorney General shall establish within the Criminal Division of the Department of Justice an Office of Special Investigations with the authority of investigating, and, where appropriate, taking legal action to remove, denaturalize, or prosecute any alien found to be in violation of clause (i), (ii), or (iii) of section 212(a)(3)(E).''.

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to the Department of Justice for the fiscal year 2000 such sums as may be necessary to carry out the additional duties established under section 103(g) of the Immigration and Nationality Act (as added by this Act) in order to ensure that the Office of Special Investigations fulfills its continuing obligations regarding Nazi war criminals.

(2) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to paragraph (1) are authorized to remain available until expended.

SECTIONAL ANALYSIS OF LEAHY ANTI-ATROCITY ALIEN DEPORTATION ACT

Summary: This bill would make two significant changes in our country's enforcement capability against those who have committed atrocities abroad and then entered the United States. First, the bill would amend the Immigration and Nationality Act to expand the grounds for inadmissibility and deportation to cover aliens who have engaged in acts of torture, as defined in 18 U.S.C. §2340, abroad. Second, the bill would direct the Attorney General to establish the Office of Special Investigations (OSI) within the Criminal Division and expand the current OSI's authority to investigate, prosecute, and remove any alien who participated in torture and genocide abroad, not just Nazi war criminals.

Sec. 1. Short Title. The Act may be cited as the ''Anti-Atrocity Alien Deportation Act.''

Sec. 2. Admissibility and Removability of Aliens Who Have Committed Acts of Torture Abroad. Currently, the Immigration and Nationality Act provides that (i) participants in Nazi persecutions during the time period from March 23, 1933 to May 8, 1945, and (ii) aliens who engaged in genocide, are inadmissable to the United States and deportable. *See* 8 U.S.C. §1182(a)(3)(E)(i) and §1227(a)(4)(D). The bill would amend these sections of the Immigration and Nationality Act by expanding the grounds for inadmissibility and deportation to cover aliens who have engaged in acts of torture abroad. The United Nations' ''Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment'' entered into force with respect to the United States on November 20, 1994. This Convention, and the implementing legislation, the Torture Victims Protection Act, 18 U.S.C. §§2340 *et seq.*, includes the definition of ''torture'' incorporated in the bill and imposed an affirmative duty on the United States to prosecute tortures within its jurisdiction.

Sec. 3. Establishment of the Office of Special Investigations. Attorney General Civiletti established OSI in 1979 within the Criminal Division of the Department of Justice, consolidating within it all ''investigative and litigation activities involving individuals, who prior to and during World War II, under the supervision of or in association with the Nazi government of Germany, its allies, and other affiliatated [sic] governments, are alleged to have ordered, incited, assisted, or otherwise participated in the persecution of any person because of race, religion, national origin, or political opinion.'' (Att'y Gen. Order No. 851–79). The OSI's mission continues to be limited by that Attorney General Order.

This section would amend the Immigration and Nationality Act, 8 U.S.C. §1103, by directing the Attorney General to establish an Office of Special Investigations within the Department of Justice with authorization to investigate, remove, denaturalize, or prosecute any alien who has participated in torture or genocide abroad. This would expand OSI's current authorized mission. Additional funds are authorized for these expanded duties to ensure that OSI fulfills its continuing obligations regarding Nazi war criminals.

By Mr. HOLLINGS:

S. 1376. A bill to amend the Internal Revenue Code of 1986 to impose a value added tax and to use the receipts from the tax to reduce Federal debt and to ensure the solvency of the Social Security System; to the Committee on Finance.

DEFICIT AND DEBT REDUCTION AND SOCIAL SECURITY SOLVENCY ACT OF 1999

● Mr. HOLLINGS. Mr. President, this charade has gone far enough. The economy gives indications of overheating causing the Federal Reserve to increase interest rates, and now both the President and the Congress are in a foot race to cut taxes to make sure the economy catches fire. Rather than a surplus, the President's OMB Mid-Session Review on page 42 projects an increase in the debt each year for five years, and on page 43, by computation, an increase in the debt of $1.883.4 trillion over fifteen years. Some suggest cutting spending; others downsizing the government. The Democrats did both in 1993 and lost the Congress in 1994. Now, neither Republicans nor Democrats will vote to make substantial cuts and what's really needed is a tax increase. When Lyndon Johnson last balanced the budget the national debt was less than $1 trillion and interest costs of $16 billion. Now, CBO projects a deficit this year of $5.6 trillion with interest costs of $356 billion. We have increased spending since President Johnson's time $340 billion each year for nothing. A fiscal cancer. To excise this fiscal cancer, to put government on a pay-as-you-go basis, spending cuts and a tax increase will be necessary. A value added tax of 5 percent dedicated to eliminating the debt and stabilizing Social Security is in order. It would promote a very much needed paradigm of saving. More than that, it would eliminate a substantial disadvantage in international trade. The deficit in the balance of trade nears $300 billion this year. Every industrial country except the United States has a VAT which is rebated at the port of departure. Articles produced in Europe enter the United States market with a 15 percent rebated advantage, and from Korea 25 percent. All this talk of surpluses and tax cuts misleads the American public. What we really should be doing in good times is paying down the National Debt. This bill that I am introducing today will do the trick.●

By Mr. BENNETT:

S. 1377. A bill to amend the Central Utah Project Completion Act regarding the use of funds for water development for the Bonneville Unit, and for other purposes; to the Committee on Energy and Natural Resources.

CENTRAL UTAH PROJECT COMPLETION AMENDMENT OF 1999

Mr. BENNETT. Mr. President, I am pleased to introduce legislation which amends the Central Utah Project Completion Act. This is a simple bill and I hope my colleagues will support it.

My father was elected to the Senate in 1950 and it was during that time that legislation was passed that created the Central Utah Project. During his 24 years in the Senate, my father fought to win the initial authorizations as well as provide the annual appropriations for the various projects. Were it not for the foresight of planners in the 1950s, Utah would be grappling with severe water shortages for both agricultural and municipal purposes today.

In 1992, the Central Utah Project was reauthorized with the passage of the Central Utah Project Completion Act of 1992 (CUPCA). As part of the 1992 Act, CUPCA provided strict authorization levels for each project and program. Seven years after the passage of the reauthorization bill, planning has neared completion on these projects. During that time, we have learned several things. First, we are pleased that the District and the Bureau have saved money on other projects authorized under CUPCA. At the same time, many of us were surprised how successful the water conservation activities have been. They have been so successful that it appears we are on track to reach the authorized funding in the near future. We have also learned that the acquisition of water rights and instream flows are inadequate in other areas.

Recognizing that there are shortfalls in some areas and significant savings achieved in other areas, this legislation simply amends the current law to permit the use of savings achieved in certain areas to be spent on other projects and programs where needed. By doing so, we can ensure that the projects can be completed in a timely and cost-effective manner.

By passing this legislation we can continue the progress made in completing the Central Utah Project. I hope my colleagues will support this bill and I look forward to working with the members of the Energy Committee to bring it to the floor for consideration.

By Mr. VOINOVICH (for himself and Mrs. LINCOLN):

S. 1378. A bill to amend chapter 35 of title 44, United States Code, for the purposes of facilitating compliance by small businesses with certain Federal paperwork requirements, to establish a task force to examine the feasibility of streamlining paperwork requirements applicable to small businesses, and for other purposes; to the Committee on Governmental Affairs.

THE SMALL BUSINESS PAPERWORK REDUCTION ACT

Mr. VOINOVICH. Mr. President, I rise today to introduce the Small Business Paperwork Reduction Act, legislation that will give small businesses across the nation the time they need to correct first-time paperwork violations before federal fines are assessed When enacted, the provisions of this law would apply as long as the violations do not cause serious harm or threaten public health or safety. I am pleased to be joined in this effort by my colleague from Arkansas, Senator BLANCHE LAMBERT-LINCOLN.

To own one's business is, for many, the epitome of the American dream, knowing that you are your own boss and that you alone are responsible for the success of your business. It's what motivates thousands of individuals each week to take that initial leap of faith and it is their effort and their perseverance to succeed that constitute the economic and entrepreneurial backbone of this country.

Small business owners are reponsible for the employment of millions of individuals, providing the roots for families to settle in small towns and large cities all across America. Through their payroll contributions and their tax base, small businesses—whether it's a shoe store in Cleveland, Ohio or a diner in Arkadelphia, Arkansas—make up the final nucleus of many a community.

However, even with their many contributions, small business owners face a number of obstacles to success. One of the larger obstacles they face is the daunting task of meeting federal paperwork requirements. Small business owners spend an inordinate amount of their time filling out various forms to comply with a myriad of government requirements. In fact, small business owners spend about $229 billion per year on compliance costs and some 6.7 billion hours are used annually to fill out the expected paperwork.

In addition, according to the National Federation of Independent Business (NFIB), small business owners are subjected to 63% of the nation's regulatory burden, and the paperwork regulations they are subjected to cost more than $2,000 per employee.

I believe whatever we can do to relieve the burden on the small business men and women of our nation will help increase productivity, save money and create more jobs. Obviously, to obtain these benefits necessitates a review of our paperwork requirements on our nation's small businesses.

When Congress passed the Paperwork Reduction Act of 1995, many small business owners believed they would finally obtain relief from the blizzard of paper to which they are subjected. Unfortunately, it has done too little to stem the tide of Federal paperwork requirements. In 1996, the Act was supposed to reduce the amount of paper by 10%. Instead, it was only a 2.6% * * * .

When Congress passed the Paperwork Reduction Act of 1995, many small business owners believed they would finally obtain relief from the blizzard of paper to which they are subjected. Unfortunately, it has done too little to stem the tide of federal paperwork requirements. In 1996, the Act was supposed to reduce the amount of paper by 10%. Instead, it was only 2.6% reduction. In 1997, the Act was supposed to provide another 10% reduction in the amount of paper. Instead, there was a 2.3% increase. In 1998, the Act was supposed to provide another 5% reduction in the amount of paper. Instead, there was another 1% increase.

In addition, under the Small Business Regulatory Enforcement Fairness Act (SBREFA) of 1996, federal agencies were required to submit plans to Congress by March of 1998 for waiving and/or reducing fines as deemed appropriate for small business. However, a large majority of federal agencies, including at least half-a-dozen cabinet departments, did not even submit their plans by the March 1998 deadline. In addition, of the plans submitted, most are settlement policies, which force small businesses into negotiations to reduce or eliminate penalties rather than to help small businesses comply with paperwork reductions.

Mr. President, even with all the forms that they are required to fill out, and all the time it takes to complete them, small business owners want to comply with the laws of our nation. Their biggest concern, though, is the Sword of Damocles that hangs over them should they send in an incorrect form, or worse, not send one in at all. In the latter instance, it is almost always because they didn't know that they were supposed to fill out any paperwork, and unfortunately, it is such situations that generally bring about hefty fines for small business owners.

Clearly, we have an opportunity to help these business owners, and, in turn, help continue the growth of our strong U.S. economy, maintain stable and productive jobs and create new jobs and opportunities.

The legislation that Senator LINCOLN and I are introducing, the Small Business Paperwork Reduction Act, is a companion bill to H.R. 391, which passed the House on February 11, 1999 by a vote of 274–151. Like the House-passed bill, our legislation will give small business owners a ''grace period'' to make amends for first-time paperwork violations before fines are assessed. The only exceptions would be for violations that cause harm, affect internal revenue laws or involve criminal activity. If a violation threatens public health or safety, each affected agency of jurisdiction would have the discretion to levy a fine as usual, or provide a 24-hour window to correct the infraction.

In addition, our bill would establish a multi-agency task force to study how to streamline reporting requirements for small business; establish a point of contact at each federal agency that small businesses could contact regarding paperwork requirements; and require an annual comprehensive list of all federal paperwork requirements for small business to be placed on the Internet.

So there is no confusion—our bill does not give small business owners carte blanch to skip their record keeping and reporting requirements. Thus, firefighters will not be threatened with injury on the job because a business doesn't have records of the toxic substances it has on its premises, or an elderly patient in a nursing home will be secure in the knowledge that their medical records will be maintained.

As I stated earlier, the men and women of America who own small businesses do not embark on a course of flagrantly violating the laws of our nation. If they did, they would soon be out of business and probably in jail. They just want an opportunity to make up what they didn't do or correct what they've done wrong.

Mr. President, compliance through cooperation should be the way our federal agencies do business, however, in many instances, federal agencies are all too eager to ''fine first, ask questions later.'' This legislation will give our nation's small business owners the time they need to correct small, non-threatening paperwork mistakes without having to pay a penalty that could jeopardize their very business.

Our legislation is a sensible approach that has the support of the National Federation of Independent Business (NFIB), the voice of small business owners across the country, who have written to me in support of this legislation. I urge my colleagues to co-sponsor our bill and I encourage the Senate to act expeditiously.

I ask unanimous consent that the letter from the NFIB in support of this legislation be inserted into the RECORD.

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

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
Washington, DC, July 15, 1999.

Hon. GEORGE VOINOVICH,
U.S. Senate, Washington, DC.

DEAR SENATOR VOINOVICH: On behalf of the 600,000 members of the National Federation of Independent Business (NFIB), I want to thank you and Senator Lincoln for your leadership in introducing the Small Business Paperwork Reduction Act Amendments of 1999.

The federal paperwork burden consistently ranks among the top small business concerns in the NFIB ''Small Business Problems and Priorities'' survey. In fact, the burden of regulatory compliance is as much as 50 percent more for small businesses than their larger counterparts. In addition, it is estimated that paperwork alone accounts for one-third of regulatory compliance costs. Small businesses spent approximately 7 billion hours filling out federal paperwork in 1998, with the total paperwork burden estimated at $229 billion. It is clear that the burden of government paperwork hinders the ability of small businesses to grow and create new jobs.

The Voinovich-Lincoln bill will provide small businesses with a penalty waiver for a first-time paperwork violation, provided that it does not threaten public health, safety or the environment. This waiver is only applicable if the business owner corrects the violation in a reasonable time period. The bill would also establish a task force of agency representatives to study streamlining reporting requirements for small businesses.

We believe that this incremental and responsible bill can be signed into law this year. A similar bill was passed by a bipartisan majority in the House, laying the groundwork for Senate action. We look forward to working with you for Senate passage and enactment of this bill.

Sincerely,

DAN DANNER,
Vice President, Federal Public Policy.

Mrs. LINCOLN. Would my colleague from Ohio kindly answer a few questions regarding this bill?

Mr. VOINOVICH. I would be happy to discuss the bill with my distinguished colleague.

Mrs. LINCOLN. Thank you. I have heard some concerns voiced about this bill, namely how it could impact nursing homes and fire fighters. I hope you can clarify for me how regulations applicable to these groups would be impacted by the Small Business Paperwork Reduction Act, if at all.

Mr. VOINOVICH. Certainly, I would be happy to clear up the misconceptions that this bill might endanger firefighters and nursing home patients.

Some have claimed that this bill would encourage fraud or abuse of elderly nursing home patients by allowing a penalty waiver for those who violate rules regulating their care. Still others have claimed that the bill would threaten the lives of firefighters by allowing a waiver for businesses that violate rules regulating hazardous substances in the workplace. Neither of these claims is substantiated.

Like the Senator from Arkansas, I care very much about the health and safety of all Americans and would not dream of putting seniors or firefighters in obvious jeopardy. Clearly, this is not the kind of negligent misbehavior this bill aims to reward with a civil penalty waiver for a first-time paperwork violation. And this is not the kind of violation covered by this bill.

Mrs. LINCOLN. How can my colleague be certain that this kind of tragedy is not protected from civil penalty under this bill?

Mr. VOINOVICH. Allow me to explain. Nursing homes that do not keep proper medical and treatment records for their patients are clearly endangering human health and safety. Small businesses that do not keep the required records of hazardous chemicals are also endangering human health and safety. As such, neither is covered by this bill.

Mrs. LINCOLN. So what my colleague is saying is that any violation that causes actual danger to human health and safety is exempted from coverage by this bill.

Mr. VOINOVICH. This bill goes even further than that. The language states that any violation that has ''the potential to cause serious harm to the public interest'' is exempt from this bill and cannot receive a penalty waiver. Where there is a potential to cause serious harm to the public, the agencies will be able to impose, in addition to all of their other remedies, an appropriate civil fine.

Mrs. LINCOLN. As the Senator from Ohio knows, he and I are working together on another piece of legislation that would protect the powers of states and impose accountability for Federal preemption of state and local laws. Does this bill preempt state laws?

Mr. VOINOVICH. My colleague raises a good point. This bill does not preempt state laws regarding collection of information. What it does say is that states my not impose a civil penalty on small businesses for a first-time violation under Federal laws that the State may administer.

Again—I want to make clear—this bill does not preempt state laws. Instead it provides consistency that a small business will not be fined under Federal laws whether the laws are being carried out by Federal or State government.

Mrs. LINCOLN. I thank my colleague for these clarifications. I am pleased to hear that this bill will help reduce the paperwork burden from our nation's small businesses while protecting the health and safety of our nursing home and firefighter communities, and I look forward to working with him to pass this bill.

By Mr. DOMENICI:

S. 1379. A bill to amend the Internal Revenue Code of 1986 to provide broad based tax relief for all taxpaying families, to mitigate the marriage penalty, to expand retirement savings, to phase out gift and estate taxes, and for other purposes; to the Committee on Finance.

Mr. DOMENICI. Mr. President, I am going to send to the desk a tax reduction bill. Everybody has ideas around here. I thought I would work with some people who think like I think and put together what I choose to call the Share the Surplus Tax Reduction and Simplification Act. It uses up the $780 billion over 10 years. I am introducing it tonight, and tomorrow I will speak on it. I hope some Senators will look at it from the standpoint of a balanced approach to moving toward some simplification and, at the same time, doing some of the things that will be fair, equitable, and good for our economy.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1379

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Share the Surplus Tax Reduction and Simplification Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—TAX RELIEF

Sec. 11. Broad based tax relief for all taxpaying families.
Sec. 12. Marriage penalty mitigation and tax burden reduction.

TITLE II—SAVING AND INVESTMENT PROVISIONS

Sec. 21. Dividend and interest tax relief.
Sec. 22. Long-term capital gains deduction for individuals.
Sec. 23. Increase in contribution limits for traditional IRAs.

TITLE III—BUSINESS INVESTMENT PROVISIONS

Sec. 31. Repeal of alternative minimum tax on corporations.
Sec. 32. Increase in limit for expensing certain business assets.

TITLE IV—ESTATE AND GIFT TAX RELIEF

Sec. 41. Phaseout of estate and gift taxes.

TITLE V—RESEARCH CREDIT EXTENSION AND MODIFICATION

Sec. 51. Purpose.
Sec. 52. Permanent extension of research credit.
Sec. 53. Improved alternative incremental credit.
Sec. 54. Modifications to credit for basic research.
Sec. 55. Credit for expenses attributable to certain collaborative research consortia.
Sec. 56. Improvement to credit for small businesses and research partnerships.

TITLE VI—ENERGY INDEPENDENCE

Sec. 61. Purposes.
Sec. 62. Tax credit for marginal domestic oil and natural gas well production.
Sec. 63. 10-year carryback for unused minimum tax credit.
Sec. 64. 10-year net operating loss carryback for losses attributable to oil servicing companies and mineral interests of oil and gas producers.
Sec. 65. Waiver of limitations.
Sec. 66. Election to expense geological and geophysical expenditures and delay rental payments.

TITLE VII—REVENUE PROVISION

Sec. 71. 4-year averaging for conversion of traditional IRA to Roth IRA.

TITLE I—TAX RELIEF

SEC. 11. BROAD BASED TAX RELIEF FOR ALL TAXPAYING FAMILIES.

(a) PURPOSE.—The purpose of this section is to cut taxes for 120,000,000 taxpaying families by lowering the 15 percent tax rate.

(b) IN GENERAL.—Section 1 of the Internal Revenue Code of 1986 (relating to tax imposed) is amended—

(1) by striking ''15%'' each place it appears in the tables in subsections (a) through (e) and inserting ''The applicable rate'', and

(2) by adding at the end the following:

''(i) APPLICABLE RATE.—For purposes of this section, the applicable rate for any taxable year shall be determined in accordance with the following table:

"In the case of any taxable year beginning in—	The applicable rate is:
	Percent
2002	14.9
2003	14.8
2004	14.7
2005	14.1
2006 and thereafter	13.5.''

(b) CONFORMING AMENDMENTS.—

(1) Section 1(f)(2) of the Internal Revenue Code of 1986 is amended—

(A) by inserting ''except as provided in subsection (i),'' before ''by not changing'' in subparagraph (B), and

(B) by inserting ''and the adjustment in rates under subsection (i)'' after ''rate brackets'' in subparagraph (C).

(2) Section 1(g)(7)(B)(ii)(II) of such Code is amended by striking ''15 percent'' and inserting ''the applicable rate''.

(3) Section 3402(p)(2) of such Code is amended by striking ''15 percent'' and inserting ''the applicable rate in effect under section 1(i) for the taxable year''.

(c) NEW TABLES.—Not later than 15 days after the date of enactment of this Act, the Secretary of the Treasury—

(1) shall prescribe tables for taxable years beginning in 2002 which shall reflect the amendments made by this section and which shall apply in lieu of the tables prescribed under sections 1(f)(1) and 3(a) of the Internal Revenue Code of 1986 for such taxable years, and

(2) shall modify the withholding tables and procedures for such taxable years under section 3402(a)(1) of such Code to take effect as if the reduction in the rate of tax under section 1 of such Code (as amended by this section) was attributable to such a reduction effective on such date of enactment.

(d) SECTION 15 NOT TO APPLY.—No amendment made by this section shall be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 12. MARRIAGE PENALTY MITIGATION AND TAX BURDEN REDUCTION.

(a) PURPOSE.—The purposes of this section are to return 7,000,000 taxpaying families to the 15 percent tax bracket and to cut taxes for 35,000,000 taxpaying families who will benefit from a tax cut of up to $1,300 per family by eliminating or mitigating the marriage penalty for many middle class taxpaying families.

(b) IN GENERAL.—Section 1(f) of the Internal Revenue Code of 1986 (relating to adjustments in tax tables so that inflation will not result in tax increases) is amended—

(1) in paragraph (2)—

(A) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D),

(B) by inserting after subparagraph (A) the following:

''(B) in the case of the tables contained in subsections (a), (b), (c), and (d), by increasing the maximum taxable income level for the lowest rate bracket and the minimum taxable income level for the 28 percent rate bracket otherwise determined under subparagraph (A) for taxable years beginning in any calendar year after 2001, by the applicable dollar amount for such calendar year,'', and

(C) by striking ''subparagraph (A)'' in subparagraph (C) (as so redesignated) and inserting ''subparagraphs (A) and (B)'', and

(2) by adding at the end the following:

''(8) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (2)(B), the applicable dollar amount for any calendar year shall be determined as follows:

''(A) JOINT RETURNS AND SURVIVING SPOUSES.—In the case of the table contained in subsection (a)—

"Calendar year:	Applicable Dollar Amount:
2002	$2,000
2003	$4,000
2004	$6,000
2005	$8,000
2006 and thereafter	$10,000.

''(B) OTHER TABLES.—In the case of the table contained in subsection (b), (c), or (d)—

"Calendar year:	Applicable Dollar Amount:
2002	$1,000
2003	$2,000
2004	$3,000
2005	$4,000
2006 and thereafter	$5,000.''.

SEC. 13. REPEAL OF ALTERNATIVE MINIMUM TAX ON INDIVIDUALS.

(a) PURPOSES.—The purposes of this section are—

(1) to simplify the tax code so that millions of Americans will no longer be required to calculate their income taxes under 2 systems; and

(2) to recognize that tax credits should not be denied to individuals who are eligible for such credit.

(b) IN GENERAL.—Subsection (a) of section 55 of the Internal Revenue Code of 1986 is amended by adding at the end the following new flush sentence:

''For purposes of this title, the tentative minimum tax on any taxpayer other than a corporation for any taxable year beginning after December 31, 2009, shall be zero.''

(c) REDUCTION OF TAX ON INDIVIDUALS PRIOR TO REPEAL.—Section 55 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) PHASEOUT OF TAX ON INDIVIDUALS.—

''(1) IN GENERAL.—The tax imposed by this section on a taxpayer other than a corporation for any taxable year beginning after December 31, 2004, and before January 1, 2010, shall be the applicable percentage of the tax which would be imposed but for this subsection.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage shall be determined in accordance with the following table:

"For taxable years beginning in calendar year—	The applicable percentage is—
2005	80
2006	70
2007	60
2008 or 2009	50.''

(d) NONREFUNDABLE PERSONAL CREDITS FULLY ALLOWED AGAINST REGULAR TAX LIABILITY.—

(1) IN GENERAL.—Subsection (a) of section 26 of the Internal Revenue Code of 1986 (relating to limitation based on amount of tax) is amended to read as follows:

''(a) LIMITATION BASED ON AMOUNT OF TAX.—The aggregate amount of credits allowed by this subpart for the taxable year shall not exceed the taxpayer's regular tax liability for the taxable year.''

(2) CHILD CREDIT.—Subsection (d) of section 24 of such Code is amended by striking paragraph (2) and by redesignating paragraph (3) as paragraph (2).

(e) LIMITATION ON USE OF CREDIT FOR PRIOR YEAR MINIMUM TAX LIABILITY.—Subsection (c) of section 53 of the Internal Revenue Code of 1986 is amended to read as follows:

''(c) LIMITATION.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the credit allowable under subsection (a) for any taxable year shall not exceed the excess (if any) of—

''(A) the regular tax liability of the taxpayer for such taxable year reduced by the sum of the credits allowable under subparts A, B, D, E, and F of this part, over

''(B) the tentative minimum tax for the taxable year.

''(2) TAXABLE YEARS BEGINNING AFTER 2009.—In the case of any taxable year beginning after 2009, the credit allowable under subsection (a) to a taxpayer other than a corporation for any taxable year shall not exceed 90 percent of the excess (if any) of—

''(A) regular tax liability of the taxpayer for such taxable year, over

''(B) the sum of the credits allowable under subparts A, B, D, E, and F of this part.''

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

TITLE II—SAVING AND INVESTMENT PROVISIONS

SEC. 21. DIVIDEND AND INTEREST TAX RELIEF.

(a) PURPOSES.—The purposes of this section are—

(1) to provide an incremental step toward taxing income that is consumed rather than income that is earned and saved;

(2) to simplify the tax code by eliminating 67,000,000 hours spent on tax preparation;

(3) to eliminate all income tax on savings for more than 30,000,000 middle class families;

(4) to reduce income taxes on savings for 37,000,000 individuals; and

(5) to allow a $10,000 nest egg to grow tax-free and let individuals experience the miracle of compound interest.

(b) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to amounts specifically excluded from gross income) is amended by inserting after section 115 the following new section:

"SEC. 116. PARTIAL EXCLUSION OF DIVIDENDS AND INTEREST RECEIVED BY INDIVIDUALS.

''(a) EXCLUSION FROM GROSS INCOME.—Gross income does not include the sum of the amounts received during the taxable year by an individual as—

''(1) dividends from domestic corporations, or

''(2) interest.

''(b) LIMITATIONS.—

''(1) MAXIMUM AMOUNT.—The aggregate amount excluded under subsection (a) for any taxable year shall not exceed $250 ($500 in the case of a joint return).

''(2) CERTAIN DIVIDENDS EXCLUDED.—Subsection (a)(1) shall not apply to any dividend from a corporation which, for the taxable year of the corporation in which the distribution is made, or for the next preceding

taxable year of the corporation, is a corporation exempt from tax under section 501 (relating to certain charitable, etc., organization) or section 521 (relating to farmers' cooperative associations).

''(c) INTEREST.—For purposes of this section, the term 'interest' means—

''(1) interest on deposits with a bank (as defined in section 581),

''(2) amounts (whether or not designated as interest) paid in respect of deposits, investment certificates, or withdrawable or repurchasable shares, by—

''(A) a mutual savings bank, cooperative bank, domestic building and loan association, industrial loan association or bank, or credit union, or

''(B) any other savings or thrift institution which is chartered and supervised under Federal or State law,

the deposits or accounts in which are insured under Federal or State law or which are protected and guaranteed under State law,

''(3) interest on—

''(A) evidences of indebtedness (including bonds, debentures, notes, and certificates) issued by a domestic corporation in registered form, and

''(B) to the extent provided in regulations prescribed by the Secretary, other evidences of indebtedness issued by a domestic corporation of a type offered by corporations to the public,

''(4) interest on obligations of the United States, a State, or a political subdivision of a State (not excluded from gross income of the taxpayer under any other provision of law), and

''(5) interest attributable to participation shares in a trust established and maintained by a corporation established pursuant to Federal law.

''(d) SPECIAL RULES.—For purposes of this section—

''(1) DISTRIBUTIONS FROM REGULATED INVESTMENT COMPANIES AND REAL ESTATE INVESTMENT TRUSTS.—Subsection (a) shall apply with respect to distributions by—

''(A) regulated investment companies to the extent provided in section 854(c), and

''(B) real estate investment trusts to the extent provided in section 857(c).

''(2) DISTRIBUTIONS BY A TRUST.—For purposes of subsection (a), the amount of dividends and interest properly allocable to a beneficiary under section 652 or 662 shall be deemed to have been received by the beneficiary ratably on the same date that the dividends and interest were received by the estate or trust.

''(3) CERTAIN NONRESIDENT ALIENS INELIGIBLE FOR EXCLUSION.—In the case of a nonresident alien individual, subsection (a) shall apply only—

''(A) in determining the tax imposed for the taxable year pursuant to section 871(b)(1) and only in respect of dividends and interest which are effectively connected with the conduct of a trade or business within the United States, or

''(B) in determining the tax imposed for the taxable year pursuant to section 877(b).''.

(c) CONFORMING AMENDMENTS.—

(1) The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 115 the following:

''Sec. 116. Partial exclusion of dividends and interest received by individuals.''.

(2) Paragraph (2) of section 265(a) of such Code is amended by inserting before the period at the end the following: '', or to purchase or carry obligations or shares, or to make deposits, to the extent the interest thereon is excludable from gross income under section 116''.

(3) Subsection (c) of section 584 of such Code is amended by adding at the end the following new flush sentence:

''The proportionate share of each participant in the amount of dividends or interest received by the common trust fund and to which section 116 applies shall be considered for purposes of such section as having been received by such participant.''.

(4) Subsection (a) of section 643 of such Code is amended by redesignating paragraph (7) as paragraph (8) and by inserting after paragraph (6) the following:

''(7) DIVIDENDS OR INTEREST.—There shall be included the amount of any dividends or interest excluded from gross income pursuant to section 116.''.

(5) Section 854 of such Code is amended by adding at the end the following:

''(c) TREATMENT UNDER SECTION 116.—

''(1) IN GENERAL.—For purposes of section 116, in the case of any dividend (other than a dividend described in subsection (a)) received from a regulated investment company which meets the requirements of section 852 for the taxable year in which it paid the dividend—

''(A) the entire amount of such dividend shall be treated as a dividend if the sum of the aggregate dividends and the aggregate interest received by such company during the taxable year equals or exceeds 75 percent of its gross income, or

''(B) if subparagraph (A) does not apply, there shall be taken into account under section 116 only the portion of such dividend which bears the same ratio to the amount of such dividend as the sum of the aggregate dividends received and aggregate interest received bears to gross income.

For purposes of the preceding sentence, gross income and aggregate interest received shall each be reduced by so much of the deduction allowable by section 163 for the taxable year as does not exceed aggregate interest received for the taxable year.

''(2) NOTICE TO SHAREHOLDERS.—The amount of any distribution by a regulated investment company which may be taken into account as a dividend for purposes of the exclusion under section 116 shall not exceed the amount so designated by the company in a written notice to its shareholders mailed not later than 60 days after the close of its taxable year.

''(3) DEFINITIONS.—For purposes of this subsection—

''(A) GROSS INCOME.—The term 'gross income' does not include gain from the sale or other disposition of stock or securities.

''(B) AGGREGATE DIVIDENDS.—The term 'aggregate dividends' includes only dividends received from domestic corporations other than dividends described in section 116(b)(2). In determining the amount of any dividend for purposes of this subparagraph, the rules provided in section 116(d)(1) (relating to certain distributions) shall apply.

''(C) INTEREST.—The term 'interest' has the meaning given such term by section 116(c).''.

(6) Subsection (c) of section 857 of such Code is amended to read as follows:

''(c) LIMITATIONS APPLICABLE TO DIVIDENDS RECEIVED FROM REAL ESTATE INVESTMENT TRUSTS.—

''(1) IN GENERAL.—For purposes of section 116 (relating to an exclusion for dividends and interest received by individuals) and section 243 (relating to deductions for dividends received by corporations), a dividend received from a real estate investment trust which meets the requirements of this part shall not be considered as a dividend.

''(2) TREATMENT AS INTEREST.—For purposes of section 116, in the case of a dividend (other than a capital gain dividend, as defined in subsection (b)(3)(C)) received from a real estate investment trust which meets the requirements of this part for the taxable year in which it paid the dividend—

''(A) such dividend shall be treated as interest if the aggregate interest received by the real estate investment trust for the taxable year equals or exceeds 75 percent of its gross income, or

''(B) if subparagraph (A) does not apply, the portion of such dividend which bears the same ratio to the amount of such dividend as the aggregate interest received bears to gross income shall be treated as interest.

''(3) ADJUSTMENTS TO GROSS INCOME AND AGGREGATE INTEREST RECEIVED.—For purposes of paragraph (2)—

''(A) gross income does not include the net capital gain,

''(B) gross income and aggregate interest received shall each be reduced by so much of the deduction allowable by section 163 for the taxable year (other than for interest on mortgages on real property owned by the real estate investment trust) as does not exceed aggregate interest received by the taxable year, and

''(C) gross income shall be reduced by the sum of the taxes imposed by paragraphs (4), (5), and (6) of section 857(b).

''(4) INTEREST.—The term 'interest' has the meaning given such term by section 116(c).

''(5) NOTICE TO SHAREHOLDERS.—The amount of any distribution by a real estate investment trust which may be taken into account as interest for purposes of the exclusion under section 116 shall not exceed the amount so designated by the trust in a written notice to its shareholders mailed not later than 60 days after the close of its taxable year.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 22. LONG-TERM CAPITAL GAINS DEDUCTION FOR INDIVIDUALS.

(a) PURPOSES.—The purposes of this section are—

(1) to provide an incremental step toward shifting the Internal Revenue Code away from taxing savings and investment,

(2) to lower the cost of capital so that prosperity, better paying jobs, and innovation will continue in the United States,

(3) to eliminate capital gain taxes for 10,000,000 families, 75 percent of whom have annual incomes of $75,000 or less, and

(4) to simplify the tax code and thereby eliminate 70,000,000 hours of tax preparation.

(b) GENERAL RULE.—Part I of subchapter P of chapter 1 of the Internal Revenue Code of 1986 (relating to treatment of capital gains) is amended by redesignating section 1202 as section 1203 and by inserting after section 1201 the following:

''SEC. 1202. CAPITAL GAINS DEDUCTION FOR INDIVIDUALS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction for the taxable year an amount equal to the lesser of—

''(1) the net capital gain of the taxpayer for the taxable year, or

''(2) $5,000.

''(b) SALES BETWEEN RELATED PARTIES.—Gains from sales and exchanges to any related person (within the meaning of section 267(b) or 707(b)(1)) shall not be taken into account in determining net capital gain.

''(c) SPECIAL RULE FOR SECTION 1250 PROPERTY.—Solely for purposes of this section, in applying section 1250 to any disposition of section 1250 property, all depreciation adjustments in respect of the property shall be treated as additional depreciation.

''(d) SECTION NOT TO APPLY TO CERTAIN TAXPAYERS.—No deduction shall be allowed under this section to—

''(1) an individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins,

''(2) a married individual (within the meaning of section 7703) filing a separate return for the taxable year, or

''(3) an estate or trust.

''(e) SPECIAL RULE FOR PASS-THRU ENTITIES.—

''(1) IN GENERAL.—In applying this section with respect to any pass-thru entity, the determination of when the sale or exchange occurs shall be made at the entity level.

''(2) PASS-THRU ENTITY DEFINED.—For purposes of paragraph (1), the term 'pass-thru entity' means—

''(A) a regulated investment company,

''(B) a real estate investment trust,

''(C) an S corporation,

''(D) a partnership,

''(E) an estate or trust, and

''(F) a common trust fund.''.

(c) COORDINATION WITH MAXIMUM CAPITAL GAINS RATE.—Paragraph (3) of section 1(h) of the Internal Revenue Code of 1986 (relating to maximum capital gains rate) is amended to read as follows:

''(3) COORDINATION WITH OTHER PROVISIONS.—For purposes of this subsection, the amount of the net capital gain shall be reduced (but not below zero) by the sum of—

''(A) the amount of the net capital gain taken into account under section 1202(a) for the taxable year, plus

''(B) the amount which the taxpayer elects to take into account as investment income for the taxable year under section 163(d)(4)(B)(iii).''.

(d) DEDUCTION ALLOWABLE IN COMPUTING ADJUSTED GROSS INCOME.—Subsection (a) of section 62 of the Internal Revenue Code of 1986 (defining adjusted gross income) is amended by inserting after paragraph (17) the following:

''(18) LONG-TERM CAPITAL GAINS.—The deduction allowed by section 1202.''.

(e) TREATMENT OF COLLECTIBLES.—

(1) IN GENERAL.—Section 1222 of the Internal Revenue Code of 1986 (relating to other terms relating to capital gains and losses) is amended by inserting after paragraph (11) the following:

''(12) SPECIAL RULE FOR COLLECTIBLES.—

''(A) IN GENERAL.—Any gain or loss from the sale or exchange of a collectible shall be treated as a short-term capital gain or loss (as the case may be), without regard to the period such asset was held. The preceding sentence shall apply only to the extent the gain or loss is taken into account in computing taxable income.

''(B) TREATMENT OF CERTAIN SALES OF INTEREST IN PARTNERSHIP, ETC.—For purposes of subparagraph (A), any gain from the sale or exchange of an interest in a partnership, S corporation, or trust which is attributable to unrealized appreciation in the value of collectibles held by such entity shall be treated as gain from the sale or exchange of a collectible. Rules similar to the rules of section 751(f) shall apply for purposes of the preceding sentence.

''(C) COLLECTIBLE.—For purposes of this paragraph, the term 'collectible' means any capital asset which is a collectible (as defined in section 408(m) without regard to paragraph (3) thereof).''.

(2) CHARITABLE DEDUCTION NOT AFFECTED.—

(A) Paragraph (1) of section 170(e) of such Code is amended by adding at the end the following: ''For purposes of this paragraph, section 1222 shall be applied without regard to paragraph (12) thereof (relating to special rule for collectibles).''.

(B) Clause (iv) of section 170(b)(1)(C) of such Code is amended by inserting before the period at the end the following: ''and section 1222 shall be applied without regard to paragraph (12) thereof (relating to special rule for collectibles)''.

(f) CONFORMING AMENDMENTS.—

(1) Section 57(a)(7) of the Internal Revenue Code of 1986 is amended by striking ''1202'' and inserting ''1203''.

(2) Clause (iii) of section 163(d)(4)(B) of such Code is amended to read as follows:

''(iii) the sum of—

''(I) the portion of the net capital gain referred to in clause (ii)(II) (or, if lesser, the net capital gain referred to in clause (ii)(I)) taken into account under section 1202, reduced by the amount of the deduction allowed with respect to such gain under section 1202, plus

''(II) so much of the gain described in subclause (I) which is not taken into account under section 1202 and which the taxpayer elects to take into account under this clause.''.

(3) Subparagraph (B) of section 172(d)(2) of such Code is amended to read as follows:

''(B) the deduction under section 1202 and the exclusion under section 1203 shall not be allowed.''.

(4) Section 642(c)(4) of such Code is amended by striking ''1202'' and inserting ''1203''.

(5) Section 643(a)(3) of such Code is amended by striking ''1202'' and inserting ''1203''.

(6) Paragraph (4) of section 691(c) of such Code is amended inserting ''1203,'' after ''1202,''.

(7) The second sentence of section 871(a)(2) of such Code is amended by inserting ''or 1203'' after ''section 1202''.

(8) The last sentence of section 1044(d) of such Code is amended by striking ''1202'' and inserting ''1203''.

(9) Paragraph (1) of section 1402(i) of such Code is amended by inserting '', and the deduction provided by section 1202 and the exclusion provided by section 1203 shall not apply'' before the period at the end.

(10) Section 121 of such Code is amended by adding at the end the following:

''(h) CROSS REFERENCE.—

''For treatment of eligible gain not excluded under subsection (a), see section 1202.''.

(11) Section 1203 of such Code, as redesignated by subsection (a), is amended by adding at the end the following:

''(l) CROSS REFERENCE.—

''For treatment of eligible gain not excluded under subsection (a), see section 1202.''.

(12) The table of sections for part I of subchapter P of chapter 1 of such Code is amended by striking the item relating to section 1202 and by inserting after the item relating to section 1201 the following:

''Sec. 1202. Capital gains deduction.

''Sec. 1203. 50-percent exclusion for gain from certain small business stock.''.

(g) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2000.

(2) COLLECTIBLES.—The amendments made by subsection (d) shall apply to sales and exchanges after December 31, 2000.

SEC. 23. INCREASE IN CONTRIBUTION LIMITS FOR TRADITIONAL IRAS.

(a) PURPOSES.—The purposes of this section are—

(1) to increase the savings rate for all Americans by reforming the tax system to favorably treat income that is invested for retirement, and

(2) to provide targeted incentives to middle class families to increase their retirement savings in a traditional IRA by $1,000 per working member of the family per taxable year.

(b) INCREASE IN CONTRIBUTION LIMIT.—Paragraph (1)(A) of section 219(b) of the Internal Revenue Code of 1986 (relating to maximum amount of deduction) is amended by striking ''$2,000'' and inserting ''$3,000''.

(c) INFLATION ADJUSTMENT.—Section 219 of the Internal Revenue Code of 1986 (relating to deduction for retirement savings) is amended by redesignating subsection (h) as subsection (i) and by inserting after subsection (g) the following:

''(h) COST-OF-LIVING ADJUSTMENT.—

''(1) DEDUCTIBLE AMOUNTS.—In the case of any taxable year beginning in a calendar year after 2009, the $3,000 amount under subsection (b)(1)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2008' for 'calendar year 1992' in subparagraph (B) thereof.

''(2) ROUNDING RULES.—If any amount after adjustment under paragraph (1) is not a multiple of $100, such amount shall be rounded to the next lower multiple of $100.''.

(d) CONFORMING AMENDMENTS.—

(1) Section 408(a)(1) of the Internal Revenue Code of 1986 is amended by striking ''in excess of $2,000 on behalf of any individual'' and inserting ''on behalf of any individual in excess of the amount in effect for such taxable year under section 219(b)(1)(A)''.

(2) Section 408(b)(2)(B) of such Code is amended by striking ''$2,000'' and inserting ''the dollar amount in effect under section 219(b)(1)(A)''.

(3) Section 408(b) of such Code is amended by striking ''$2,000'' in the matter following paragraph (4) and inserting ''the dollar amount in effect under section 219(b)(1)(A)''.

(4) Section 408(j) of such Code is amended by striking ''$2,000''.

(5) Section 408(p)(8) of such Code is amended by striking ''$2,000'' and inserting ''the dollar amount in effect under section 219(b)(1)(A)''.

(6) Section 408A(c)(2)(A) of such Code is amended to read as follows:

''(A) $2,000, over''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

TITLE III—BUSINESS INVESTMENT PROVISIONS

SEC. 31. REPEAL OF ALTERNATIVE MINIMUM TAX ON CORPORATIONS.

(a) PURPOSE.—The purpose of this section is to eliminate one of the most misguided, anti-growth, anti-investment tax schemes ever devised.

(b) IN GENERAL.—The last sentence of section 55(a) of the Internal Revenue Code of 1986, as amended by section 13, is amended by striking ''on any taxpayer other than a corporation''.

(c) REPEAL OF 90 PERCENT LIMITATION ON FOREIGN TAX CREDIT.—

(1) IN GENERAL.—Section 59(a) of the Internal Revenue Code of 1986 (relating to alternative minimum tax foreign tax credit) is amended by striking paragraph (2) and by redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(2) CONFORMING AMENDMENT.—Section 53(d)(1)(B)(i)(II) of such Code is amended by striking ''and if section 59(a)(2) did not apply''.

(d) LIMITATION ON USE OF CREDIT FOR PRIOR YEAR MINIMUM TAX LIABILITY.—

(1) IN GENERAL.—Subsection (c) of section 53 of the Internal Revenue Code of 1986, as

amended by section 13, is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

''(2) CORPORATIONS FOR TAXABLE YEARS BEGINNING AFTER 2004.—In the case of corporation for any taxable year beginning after 2004 and before 2010, the limitation under paragraph (1) shall be increased by the applicable percentage (determined in accordance with the following table) of the tentative minimum tax for the taxable year.

''For taxable years beginning in calendar year—	**The applicable percentage is—**
2005	20
2006	30
2007	40
2008 or 2009	50.

In no event shall the limitation determined under this paragraph be greater than the sum of the tax imposed by section 55 and the regular tax reduced by the sum of the credits allowed under subparts A, B, D, E, and F of this part.''

(2) CONFORMING AMENDMENTS.—

(A) Section 55(e) of such Code is amended by striking paragraph (5).

(B) Paragraph (3) of section 53(c) of such Code, as redesignated by paragraph (1), is amended by striking ''to a taxpayer other than a corporation''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after December 31, 2004.

(2) REPEAL OF 90 PERCENT LIMITATION ON FOREIGN TAX CREDIT.—The amendments made by subsection (c) shall apply to taxable years beginning after December 31, 2003.

(3) SUBSECTION (d)(2)(A).—The amendment made by subsection (d)(2)(A) shall apply to taxable years beginning after December 31, 2009.

SEC. 32. INCREASE IN LIMIT FOR ELECTION TO EXPENSE CERTAIN BUSINESS ASSETS.

(a) IN GENERAL.—Section 179(b)(1) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking the last item in the table and inserting the following new items:

''2003 or 2004 25,000
''2005 or thereafter .....250,000.''

(b) INDEX.—Section 179(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(5) INFLATION ADJUSTMENT.—In the case of a taxable year beginning after 2005, the $25,000 amount under paragraph (1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2004' for 'calendar year 1992' in subparagraph (B) thereof.''

(c) INCREASE IN LIMITATION ON COST OF PROPERTY PLACED IN SERVICE.—Section 179(b)(2) of the Internal Revenue Code of 1986 (relating to reduction in limitation) is amended by striking ''$200,000'' and inserting ''$4,000,000''.

TITLE IV—ESTATE AND GIFT TAX RELIEF

SEC. 41. PHASEOUT OF ESTATE AND GIFT TAXES.

(a) PURPOSE.—The purpose of this section is to begin phasing out the confiscatory gift and estate tax by reducing the rate of tax.

(b) REPEAL OF ESTATE AND GIFT TAXES.—Subtitle B of the Internal Revenue Code of 1986 (relating to estate and gift taxes) is repealed effective with respect to estates of decedents dying, and gifts made, after December 31, 2009.

(c) PHASEOUT OF TAX.—Subsection (c) of section 2001 of the Internal Revenue Code of 1986 (relating to imposition and rate of tax) is amended by adding at the end the following:

''(3) PHASEOUT OF TAX.—In the case of estates of decedents dying, and gifts made, during any calendar year after 1999 and before 2010—

''(A) IN GENERAL.—The tentative tax under this subsection shall be determined by using a table prescribed by the Secretary (in lieu of using the table contained in paragraph (1)) which is the same as such table; except that—

''(i) each of the rates of tax shall be reduced (but not below zero) by the number of percentage points determined under subparagraph (B), and

''(ii) the amounts setting forth the tax shall be adjusted to the extent necessary to reflect the adjustments under clause (i).

''(B) PERCENTAGE POINTS OF REDUCTION.—

''For calendar year:	**The number of percentage points is:**
2001	1
2002	2
2003	3
2004	4
2005	5
2006	7
2007	9
2008	11
2009	15.

''(C) COORDINATION WITH PARAGRAPH (2).—Paragraph (2) shall be applied by reducing the 55 percent percentage contained therein by the number of percentage points determined for such calendar year under subparagraph (B).

''(D) COORDINATION WITH CREDIT FOR STATE DEATH TAXES.—Rules similar to the rules of subparagraph (A) shall apply to the table contained in section 2011(b) except that the number of percentage points referred to in subparagraph (A)(i) shall be determined under the following table:

''For calendar year:	**The number of percentage points is:**
2001	1
2002	2
2003	3
2004	4
2005	5
2006	7
2007	9
2008	11
2009	15.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to estates of decedents dying, and gifts made, after December 31, 2000.

TITLE V—RESEARCH CREDIT EXTENSION AND MODIFICATION

SEC. 51. PURPOSE.

The purpose of this title is to make the research credit permanent and make certain modifications to the credit.

SEC. 52. PERMANENT EXTENSION OF RESEARCH CREDIT.

(a) IN GENERAL.—Section 41 of the Internal Revenue Code of 1986 (relating to credit for increasing research activities) is amended by striking subsection (h).

(b) CONFORMING AMENDMENT.—Section 45C(b)(1) of the Internal Revenue Code of 1986 is amended by striking subparagraph (D).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred after December 31, 2000.

SEC. 53. IMPROVED ALTERNATIVE INCREMENTAL CREDIT.

(a) IN GENERAL.—Section 41 of the Internal Revenue Code of 1986 (relating to credit for increasing research activities), as amended by section 52, is amended by adding at the end the following:

''(h) ELECTION OF ALTERNATIVE INCREMENTAL CREDIT.—

''(1) IN GENERAL.—At the election of the taxpayer, the credit under subsection (a)(1) shall be determined under this section by taking into account the modifications provided by this subsection.

''(2) DETERMINATION OF BASE AMOUNT.—

''(A) IN GENERAL.—In computing the base amount under subsection (c)—

''(i) notwithstanding subsection (c)(3), the fixed-base percentage shall be equal to 80 percent of the percentage which the aggregate qualified research expenses of the taxpayer for the base period is of the aggregate gross receipts of the taxpayer for the base period, and

''(ii) the minimum base amount under subsection (c)(2) shall not apply.

''(B) START-UP AND SMALL TAXPAYERS.—In computing the base amount under subsection (c), the gross receipts of a taxpayer for any taxable year in the base period shall be treated as at least equal to $1,000,000.

''(C) BASE PERIOD.—For purposes of this subsection, the base period is the 8-taxable year period preceding the taxable year (or, if shorter, the period the taxpayer (and any predecessor) has been in existence).

''(3) ELECTION.—An election under this subsection shall apply to the taxable year for which made and all succeeding taxable years unless revoked with the consent of the Secretary.''.

(b) CONFORMING AMENDMENT.—Section 41(c) of the Internal Revenue Code of 1986 is amended by striking paragraph (4) and by redesignating paragraphs (5) and (6) as paragraphs (4) and (5), respectively.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2004.

SEC. 54. MODIFICATIONS TO CREDIT FOR BASIC RESEARCH.

(a) ELIMINATION OF INCREMENTAL REQUIREMENT.—

(1) IN GENERAL.—Paragraph (1) of section 41(e) of the Internal Revenue Code of 1986 (relating to credit allowable with respect to certain payments to qualified organizations for basic research) is amended to read as follows:

''(1) IN GENERAL.—The amount of basic research payments taken into account under subsection (a)(2) shall be determined in accordance with this subsection.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 41(a)(2) of the Internal Revenue Code of 1986 is amended by striking ''determined under subsection (e)(1)(A)'' and inserting ''for the taxable year''.

(B) Section 41(e) of such Code is amended by striking paragraphs (3), (4), and (5) and by redesignating paragraphs (6) and (7) as paragraphs (3) and (4), respectively.

(C) Section 41(e)(4) of such Code, as redesignated by subparagraph (B), is amended by striking subparagraph (B) and by redesignating subparagraphs (C), (D), and (E) as subparagraphs (B), (C), and (D), respectively.

(D) Clause (i) of section 170(e)(4)(B) of such Code is amended by striking ''section 41(e)(6)'' and inserting ''section 41(e)(3)''.

(b) BASIC RESEARCH.—

(1) SPECIFIC COMMERCIAL OBJECTIVE.—Section 41(e)(4) of the Internal Revenue Code of 1986 (relating to definitions and special rules), as redesignated by subsection (a)(2)(B), is amended by adding at the end the following:

''(E) SPECIFIC COMMERCIAL OBJECTIVE.—For purposes of subparagraph (A), research shall not be treated as having a specific commercial objective if the results of such research are to be published in a timely manner as to be available to the general public prior to their use for a commercial purpose.''.

(2) EXCLUSIONS FROM BASIC RESEARCH.—Clause (ii) of section 41(e)(4)(A) of such Code (relating to definitions and special rules), as redesignated by subsection (a), is amended to read as follows:

''(ii) basic research in the arts and humanities.''.

(c) EXPANSION OF CREDIT TO RESEARCH DONE AT FEDERAL LABORATORIES.—Section 41(e)(3) of the Internal Revenue Code of 1986, as redesignated by subsection (a), is amended by adding at the end the following new subparagraph:

''(E) FEDERAL LABORATORIES.—Any organization which is a Federal laboratory (as defined in section 4(6) of the Stevenson-Wydler Technology Innovation Act of 1980 (15 U.S.C. 3703(6)).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2004.

SEC. 55. CREDIT FOR EXPENSES ATTRIBUTABLE TO CERTAIN COLLABORATIVE RESEARCH CONSORTIA.

(a) CREDIT FOR EXPENSES ATTRIBUTABLE TO CERTAIN COLLABORATIVE RESEARCH CONSORTIA.—Subsection (a) of section 41 of the Internal Revenue Code of 1986 (relating to credit for increasing research activities) is amended by striking ''and'' at the end of paragraph (1), striking the period at the end of paragraph (2) and inserting '', and '', and by adding at the end the following:

''(3) 20 percent of the amounts paid or incurred by the taxpayer in carrying on any trade or business of the taxpayer during the taxable year (including as contributions) to a qualified research consortium.''.

(b) QUALIFIED RESEARCH CONSORTIUM DEFINED.—Subsection (f) of section 41 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(6) QUALIFIED RESEARCH CONSORTIUM.—The term 'qualified research consortium' means any organization—

''(A) which is—

''(i) described in section 501(c)(3) and is exempt from tax under section 501(a) and is organized and operated primarily to conduct scientific or engineering research, or

''(ii) organized and operated primarily to conduct scientific or engineering research in the public interest (within the meaning of section 501(c)(3)),

''(B) which is not a private foundation,

''(C) to which at least 5 unrelated persons paid or incurred during the calendar year in which the taxable year of the organization begins amounts (including as contributions) to such organization for scientific or engineering research, and

''(D) to which no single person paid or incurred (including as contributions) during such calendar year an amount equal to more than 50 percent of the total amounts received by such organization during such calendar year for scientific or engineering research.

All persons treated as a single employer under subsection (a) or (b) of section 52 shall be treated as related persons for purposes of subparagraph (C) and as a single person for purposes of subparagraph (D).''.

(c) CONFORMING AMENDMENT.—Paragraph (3) of section 41(b) of the Internal Revenue Code of 1986 is amended by striking subparagraph (C).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2004.

SEC. 56. IMPROVEMENT TO CREDIT FOR SMALL BUSINESSES AND RESEARCH PARTNERSHIPS.

(a) ASSISTANCE TO SMALL AND START-UP BUSINESSES.—The Secretary of the Treasury or the Secretary's delegate shall take such actions as are appropriate to—

(1) provide assistance to small and start-up businesses in complying with the requirements of section 41 of the Internal Revenue Code of 1986, and

(2) reduce the costs of such compliance.

(b) REPEAL OF LIMITATION ON CONTRACT RESEARCH EXPENSES PAID TO SMALL BUSINESSES, UNIVERSITIES, AND FEDERAL LABORATORIES.—Section 41(b)(3) of the Internal Revenue Code of 1986, as amended by section 55(c), is amended by adding at the end the following:

''(C) AMOUNTS PAID TO ELIGIBLE SMALL BUSINESSES, UNIVERSITIES, AND FEDERAL LABORATORIES.—

''(i) IN GENERAL.—In the case of amounts paid by the taxpayer to an eligible small business, an institution of higher education (as defined in section 3304(f)), or an organization which is a Federal laboratory (as defined in subsection (e)(3)(E)), subparagraph (A) shall be applied by substituting '100 percent' for '65 percent'.

''(ii) ELIGIBLE SMALL BUSINESS.—For purposes of this subparagraph, the term 'eligible small business' means a small business with respect to which the taxpayer does not own (within the meaning of section 318) 50 percent or more of—

''(I) in the case of a corporation, the outstanding stock of the corporation (either by vote or value), and

''(II) in the case of a small business which is not a corporation, the capital and profits interests of the small business.

''(iii) SMALL BUSINESS.—For purposes of this subparagraph—

''(I) IN GENERAL.—The term 'small business' means, with respect to any calendar year, any person if the annual average number of employees employed by such person during either of the 2 preceding calendar years was 500 or fewer. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the person was in existence throughout the year.

''(II) STARTUPS, CONTROLLED GROUPS, AND PREDECESSORS.—Rules similar to the rules of subparagraphs (B) and (D) of section 220(c)(4) shall apply for purposes of this clause.''.

(c) CREDIT FOR PATENT FILING FEES.—Section 41(a) of the Internal Revenue Code of 1986, as amended by section 55(a), is amended by striking ''and'' at the end of paragraph (2), by striking the period at the end of paragraph (3) and inserting '', and'', and by adding at the end the following:

''(4) 20 percent of the patent filing fees paid or incurred by a small business (as defined in subsection (b)(3)(C)(iii)) to the United States or to any foreign government in carrying on any trade or business.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2004.

TITLE VI—ENERGY INDEPENDENCE

SEC. 61. PURPOSES.

The purposes of this title are—

(1) to prevent the abandonment of marginal oil and gas wells owned and operated by independent oil and gas producers, which are responsible for half of the United States' domestic production, and

(2) to transform earned tax credits and other benefits into working capital for the cash-strapped domestic oil and gas producers and service companies.

SEC. 62. TAX CREDIT FOR MARGINAL DOMESTIC OIL AND NATURAL GAS WELL PRODUCTION.

(a) CREDIT FOR PRODUCING OIL AND GAS FROM MARGINAL WELLS.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business credits) is amended by adding at the end the following:

''SEC. 45D. CREDIT FOR PRODUCING OIL AND GAS FROM MARGINAL WELLS.

''(a) GENERAL RULE.—For purposes of section 38, the marginal well production credit for any taxable year is an amount equal to the product of—

''(1) the credit amount, and

''(2) the qualified crude oil production and the qualified natural gas production which is attributable to the taxpayer.

''(b) CREDIT AMOUNT.—For purposes of this section—

''(1) IN GENERAL.—The credit amount is—

''(A) $3 per barrel of qualified crude oil production, and

''(B) 50 cents per 1,000 cubic feet of qualified natural gas production.

''(2) REDUCTION AS OIL AND GAS PRICES INCREASE.—

''(A) IN GENERAL.—The $3 and 50 cents amounts under paragraph (1) shall each be reduced (but not below zero) by an amount which bears the same ratio to such amount (determined without regard to this paragraph) as—

''(i) the excess (if any) of the applicable reference price over $14 ($1.56 for qualified natural gas production), bears to

''(ii) $3 ($0.33 for qualified natural gas production).

The applicable reference price for a taxable year is the reference price for the calendar year preceding the calendar year in which the taxable year begins.

''(B) INFLATION ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 2000, each of the dollar amounts contained in subparagraph (A) shall be increased to an amount equal to such dollar amount multiplied by the inflation adjustment factor for such calendar year (determined under section 43(b)(3)(B) by substituting '1999' for '1990').

''(C) REFERENCE PRICE.—For purposes of this paragraph, the term 'reference price' means, with respect to any calendar year—

''(i) in the case of qualified crude oil production, the reference price determined under section 29(d)(2)(C), and

''(ii) in the case of qualified natural gas production, the Secretary's estimate of the annual average wellhead price per 1,000 cubic feet for all domestic natural gas.

''(c) QUALIFIED CRUDE OIL AND NATURAL GAS PRODUCTION.—For purposes of this section—

''(1) IN GENERAL.—The terms 'qualified crude oil production' and 'qualified natural gas production' mean domestic crude oil or natural gas which is produced from a marginal well.

''(2) LIMITATION ON AMOUNT OF PRODUCTION WHICH MAY QUALIFY.—

''(A) IN GENERAL.—Crude oil or natural gas produced during any taxable year from any well shall not be treated as qualified crude oil production or qualified natural gas production to the extent production from the well during the taxable year exceeds 1,095 barrels or barrel equivalents.

''(B) PROPORTIONATE REDUCTIONS.—

''(i) SHORT TAXABLE YEARS.—In the case of a short taxable year, the limitations under this paragraph shall be proportionately reduced to reflect the ratio which the number of days in such taxable year bears to 365.

''(ii) WELLS NOT IN PRODUCTION ENTIRE YEAR.—In the case of a well which is not capable of production during each day of a taxable year, the limitations under this paragraph applicable to the well shall be proportionately reduced to reflect the ratio which the number of days of production bears to the total number of days in the taxable year.

''(3) DEFINITIONS.—

''(A) MARGINAL WELL.—The term 'marginal well' means a domestic well—

''(i) the production from which during the taxable year is treated as marginal production under section 613A(c)(6), or

''(ii) which, during the taxable year—

''(I) has average daily production of not more than 25 barrel equivalents, and

''(II) produces water at a rate not less than 95 percent of total well effluent.

''(B) CRUDE OIL, ETC.—The terms 'crude oil', 'natural gas', 'domestic', and 'barrel' have the meanings given such terms by section 613A(e).

''(C) BARREL EQUIVALENT.—The term 'barrel equivalent' means, with respect to natural gas, a conversion ratio of 6,000 cubic feet of natural gas to 1 barrel of crude oil.

''(d) OTHER RULES.—

''(1) PRODUCTION ATTRIBUTABLE TO THE TAXPAYER.—In the case of a marginal well in which there is more than one owner of operating interests in the well and the crude oil or natural gas production exceeds the limitation under subsection (c)(2), qualifying crude oil production or qualifying natural gas production attributable to the taxpayer shall be determined on the basis of the ratio which taxpayer's revenue interest in the production bears to the aggregate of the revenue interests of all operating interest owners in the production.

''(2) OPERATING INTEREST REQUIRED.—Any credit under this section may be claimed only on production which is attributable to the holder of an operating interest.

''(3) PRODUCTION FROM NONCONVENTIONAL SOURCES EXCLUDED.—In the case of production from a marginal well which is eligible for the credit allowed under section 29 for the taxable year, no credit shall be allowable under this section unless the taxpayer elects not to claim the credit under section 29 with respect to the well.''.

(b) CREDIT TREATED AS BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 is amended by striking ''plus'' at the end of paragraph (11), by striking the period at the end of paragraph (12) and inserting '', plus'', and by adding at the end the following:

''(13) the marginal oil and gas well production credit determined under section 45D(a).''.

(c) CREDIT ALLOWED AGAINST REGULAR AND MINIMUM TAX.—

(1) IN GENERAL.—Subsection (c) of section 38 of the Internal Revenue Code of 1986 (relating to limitation based on amount of tax) is amended by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following:

''(3) SPECIAL RULES FOR MARGINAL OIL AND GAS WELL PRODUCTION CREDIT.—

''(A) IN GENERAL.—In the case of the marginal oil and gas well production credit—

''(i) this section and section 39 shall be applied separately with respect to the credit, and

''(ii) in applying paragraph (1) to the credit—

''(I) subparagraphs (A) and (B) thereof shall not apply, and

''(II) the limitation under paragraph (1) (as modified by subclause (I)) shall be reduced by the credit allowed under subsection (a) for the taxable year (other than the marginal oil and gas well production credit).

''(B) MARGINAL OIL AND GAS WELL PRODUCTION CREDIT.—For purposes of this subsection, the term 'marginal oil and gas well production credit' means the credit allowable under subsection (a) by reason of section 45D(a).''.

(2) CONFORMING AMENDMENT.—Subclause (II) of section 38(c)(2)(A)(ii) of such Code is amended by inserting ''or the marginal oil and gas well production credit'' after ''employment credit''.

(d) CARRYBACK.—Subsection (a) of section 39 of the Internal Revenue Code of 1986 (relating to carryback and carryforward of unused credits generally) is amended by adding at the end the following:

''(3) 10-YEAR CARRYBACK FOR MARGINAL OIL AND GAS WELL PRODUCTION CREDIT.—In the case of the marginal oil and gas well production credit—

''(A) this section shall be applied separately from the business credit (other than the marginal oil and gas well production credit),

''(B) paragraph (1) shall be applied by substituting '10 taxable years' for '1 taxable years' in subparagraph (A) thereof, and

''(C) paragraph (2) shall be applied—

''(i) by substituting '31 taxable years' for '21 taxable years' in subparagraph (A) thereof, and

''(ii) by substituting '30 taxable years' for '20 taxable years' in subparagraph (B) thereof.''.

(e) COORDINATION WITH SECTION 29.—Section 29(a) of the Internal Revenue Code of 1986 is amended by striking ''There'' and inserting ''At the election of the taxpayer, there''.

(f) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''45D. Credit for producing oil and gas from marginal wells.''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to production after December 31, 2000.

SEC. 63. 10-YEAR CARRYBACK FOR UNUSED MINIMUM TAX CREDIT.

(a) IN GENERAL.—Section 53(c) of the Internal Revenue Code of 1986 (relating to limitation) is amended by adding at the end the following:

''(2) SPECIAL RULE FOR TAXPAYERS WITH UNUSED ENERGY MINIMUM TAX CREDITS.—

''(A) IN GENERAL.—If, during the 10-taxable year period ending with the current taxable year, a taxpayer has an unused energy minimum tax credit for any taxable year in such period (determined without regard to the application of this paragraph to the current taxable year)—

''(i) paragraph (1) shall not apply to each of the taxable years in such period for which the taxpayer has an unused energy minimum tax credit (as so determined), and

''(ii) the credit allowable under subsection (a) for each of such taxable years shall be equal to the excess (if any) of—

''(I) the sum of the regular tax liability and the net minimum tax for such taxable year, over

''(II) the sum of the credits allowable under subparts A, B, D, E, and F of this part.

''(B) ENERGY MINIMUM TAX CREDIT.—For purposes of this paragraph, the term 'energy minimum tax credit' means the minimum tax credit which would be computed with respect to any taxable year if the adjusted net minimum tax were computed by only taking into account items attributable to—

''(i) the taxpayer's mineral interests in oil and gas property, and

''(ii) the taxpayer's active conduct of a trade or business of providing tools, products, personnel, and technical solutions on a contractual basis to persons engaged in oil and gas exploration and production.''.

(b) CONFORMING AMENDMENTS.—Section 53(c) of the Internal Revenue Code of 1986 (as in effect before the amendment made by subsection (a)) is amended—

(1) by striking ''The'' and inserting:

''(1) IN GENERAL.—Except as provided in paragraph (2), the '', and

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000, and to any taxable year beginning on or before such date to the extent necessary to apply section 53(c)(2) of the Internal Revenue Code of 1986 (as added by subsection (a)).

SEC. 64. 10-YEAR NET OPERATING LOSS CARRYBACK FOR LOSSES ATTRIBUTABLE TO OIL SERVICING COMPANIES AND MINERAL INTERESTS OF OIL AND GAS PRODUCERS.

(a) IN GENERAL.—Paragraph (1) of section 172(b) of the Internal Revenue Code of 1986 (relating to years to which loss may be carried) is amended by adding at the end the following:

''(H) LOSSES ON OPERATING MINERAL INTERESTS OF OIL AND GAS PRODUCERS AND OILFIELD SERVICING COMPANIES.—In the case of a taxpayer which has an eligible oil and gas loss (as defined in subsection (j)) for a taxable year, such eligible oil and gas loss shall be a net operating loss carryback to each of the 10 taxable years preceding the taxable year of such loss.''.

(b) ELIGIBLE OIL AND GAS LOSS.—Section 172 of the Internal Revenue Code of 1986 is amended by redesignating subsection (j) as subsection (k) and by inserting after subsection (i) the following:

''(j) ELIGIBLE OIL AND GAS LOSS.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible oil and gas loss' means the lesser of—

''(A) the amount which would be the net operating loss for the taxable year if only income and deductions attributable to—

''(i) mineral interests in oil and gas wells, and

''(ii) the active conduct of a trade or business of providing tools, products, personnel, and technical solutions on a contractual basis to persons engaged in oil and gas exploration and production,

are taken into account, and

''(B) the amount of the net operating loss for such taxable year.

''(2) COORDINATION WITH SUBSECTION (b)(2).—For purposes of applying subsection (b)(2), an eligible oil and gas loss for any taxable year shall be treated in a manner similar to the manner in which a specified liability loss is treated.

''(3) ELECTION.—Any taxpayer entitled to a 10-year carryback under subsection (b)(1)(H) from any loss year may elect to have the carryback period with respect to such loss year determined without regard to subsection (b)(1)(H). Such election shall be made in such manner as may be prescribed by the Secretary and shall be made by the due date (including extensions of time) for filing the taxpayer's return for the taxable year of the net operating loss. Such election, once made for any taxable year, shall be irrevocable for such taxable year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to net operating losses for taxable years beginning after December 31, 1999, and to any taxable year beginning on or before such date to the extent necessary to apply section 172(b)(1)(H) of the Internal Revenue Code of 1986 (as added by subsection (a)).

SEC. 65. WAIVER OF LIMITATIONS.

If refund or credit of any overpayment of tax resulting from the application of the amendments made by sections 63 and 64 is prevented at any time before the close of the 1-year period beginning on the date of the enactment of this Act by the operation of any law or rule of law (including res judicata), such refund or credit may nevertheless be made or allowed if claim therefor is filed before the close of such period.

SEC. 66. ELECTION TO EXPENSE GEOLOGICAL AND GEOPHYSICAL EXPENDITURES AND DELAY RENTAL PAYMENTS.

(a) PURPOSE.—The purpose of this section is to recognize that geological and geophysical expenditures and delay rentals are ordinary and necessary business expenses that should be deducted in the year the expense is incurred.

(b) ELECTION TO EXPENSE GEOLOGICAL AND GEOPHYSICAL EXPENDITURES.—

(1) IN GENERAL.—Section 263 of the Internal Revenue Code of 1986 (relating to capital expenditures) is amended by adding at the end the following:

''(j) GEOLOGICAL AND GEOPHYSICAL EXPENDITURES FOR DOMESTIC OIL AND GAS WELLS.—Notwithstanding subsection (a), a taxpayer may elect to treat geological and geophysical expenses incurred in connection with the exploration for, or development of, oil or gas within the United States (as defined in section 638) as expenses which are not chargeable to capital account. Any expenses so treated shall be allowed as a deduction in the taxable year in which paid or incurred.''.

(2) CONFORMING AMENDMENT.—Section 263A(c)(3) of such Code is amended by inserting ''263(j),'' after ''263(i),''.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendments made by this subsection shall apply to expenses paid or incurred after December 31, 2000.

(B) TRANSITION RULE.—In the case of any expenses described in section 263(j) of the Internal Revenue Code of 1986, as added by this subsection, which were paid or incurred on or before December 31, 2000, the taxpayer may elect, at such time and in such manner as the Secretary of the Treasury may prescribe, to amortize the unamortized portion of such expenses over the 36-month period beginning with the month of January, 2001. For purposes of this subparagraph, the unamortized portion of any expense is the amount remaining unamortized as of the first day of the 36-month period.

(c) ELECTION TO EXPENSE DELAY RENTAL PAYMENTS.—

(1) IN GENERAL.—Section 263 of the Internal Revenue Code of 1986 (relating to capital expenditures), as amended by subsection (b)(1), is amended by adding at the end the following:

''(k) DELAY RENTAL PAYMENTS FOR DOMESTIC OIL AND GAS WELLS.—

''(1) IN GENERAL.—Notwithstanding subsection (a), a taxpayer may elect to treat delay rental payments incurred in connection with the development of oil or gas within the United States (as defined in section 638) as payments which are not chargeable to capital account. Any payments so treated shall be allowed as a deduction in the taxable year in which paid or incurred.

''(2) DELAY RENTAL PAYMENTS.—For purposes of paragraph (1), the term 'delay rental payment' means an amount paid for the privilege of deferring development of an oil or gas well.''.

(2) CONFORMING AMENDMENT.—Section 263A(c)(3) of the Internal Revenue Code of 1986, as amended by subsection (b)(2), is amended by inserting ''263(k),'' after ''263(j),''.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendments made by this subsection shall apply to payments made or incurred after December 31, 2000.

(B) TRANSITION RULE.—In the case of any payments described in section 263(k) of the Internal Revenue Code of 1986, as added by this subsection, which were made or incurred on or before December 31, 2000, the taxpayer may elect, at such time and in such manner as the Secretary of the Treasury may prescribe, to amortize the unamortized portion of such payments over the 36-month period beginning with the month of January, 2001. For purposes of this subparagraph, the unamortized portion of any payment is the amount remaining unamortized as of the first day of the 36-month period.

TITLE VII—REVENUE PROVISION

SEC. 71. 4-YEAR AVERAGING FOR CONVERSION OF TRADITIONAL IRA TO ROTH IRA.

(a) IN GENERAL.—Section 408A(d)(3)(A)(iii) of the Internal Revenue Code of 1986 is amended by striking ''January 1, 1999,'' and inserting ''January 1, 2004,''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to distributions made after December 31, 2000.

ADDITIONAL COSPONSORS

S. 253

At the request of Mr. MURKOWSKI, the name of the Senator from Idaho (Mr. CRAIG) was withdrawn as a cosponsor of S. 253, a bill to provide for the reorganization of the Ninth Circuit Court of Appeals, and for other purposes.

S. 309

At the request of Mr. MCCAIN, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 309, a bill to amend the Internal Revenue Code of 1986 to provide that a member of the uniformed services shall be treated as using a principal residence while away from home on qualified official extended duty in determining the exclusion of gain from the sale of such residence.

S. 409

At the request of Mr. KENNEDY, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. 409, a bill to authorize qualified organizations to provide technical assistance and capacity building services to microenterprise development organizations and programs and to disadvantaged entrepreneurs using funds from the Community Development Financial Institutions Fund, and for other purposes.

S. 424

At the request of Mr. COVERDELL, the name of the Senator from Utah (Mr. BENNETT) was added as a cosponsor of S. 424, a bill to preserve and protect the free choice of individuals and employees to form, join, or assist labor organizations, or to refrain from such activities.

S. 514

At the request of Mr. COCHRAN, the names of the Senator from Maryland (Mr. SARBANES) and the Senator from Indiana (Mr. LUGAR) were added as cosponsors of S. 514, a bill to improve the National Writing Project.

S. 632

At the request of Mr. DEWINE, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 632, a bill to provide assistance for poison prevention and to stabilize the funding of regional poison control centers.

S. 800

At the request of Mr. BURNS, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 800, a bill to promote and enhance public safety through the use of 9–1–1 as the universal emergency assistance number, further deployment of wireless 9–1–1 service, support of States in upgrading 9–1–1 capabilities and related functions, encouragement of construction and operation of seamless, ubiquitous, and reliable networks for personal wireless services, and for other purposes.

S. 820

At the request of Mr. BREAUX, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 820, a bill to amend the Internal Revenue Code of 1986 to repeal the 4.3-cent motor fuel excise taxes on railroads and inland waterway transportation which remain in the general fund of the Treasury.

S. 872

At the request of Mr. VOINOVICH, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 872, a bill to impose certain limits on the receipt of out-of-State municipal solid waste, to authorize State and local controls over the flow of municipal solid waste, and for other purposes.

S. 882

At the request of Mr. MURKOWSKI, the names of the Senator from Mississippi (Mr. COCHRAN), and the Senator from Colorado (Mr. CAMPBELL) were added as cosponsors of S. 882, a bill to strengthen provisions in the Energy Policy Act of 1992 and the Federal Nonnuclear Energy Research and Development Act of 1974 with respect to potential Climate Change.

S. 984

At the request of Ms. COLLINS, the name of the Senator from Idaho (Mr. CRAPO) was added as a cosponsor of S. 984, a bill to amend the Internal Revenue Code of 1986 to modify the tax credit for electricity produced from certain renewable resources.

S. 1029

At the request of Mr. COCHRAN, the name of the Senator from South Dakota (Mr. DASCHLE) was added as a cosponsor of S. 1029, a bill to amend title III of the Elementary and Secondary Education Act of 1965 to provide for digital education partnerships.

S. 1038

At the request of Mr. GRASSLEY, the name of the Senator from Minnesota (Mr. GRAMS) was added as a cosponsor of S. 1038, a bill to amend the Internal Revenue Code of 1986 to exempt small issue bonds for agriculture from the State volume cap.

S. 1053

At the request of Mr. BOND, the names of the Senator from Oklahoma (Mr. INHOFE) and the Senator from Texas (Mrs. HUTCHISON) were added as cosponsors of S. 1053, a bill to amend the Clean Air Act to incorporate certain provisions of the transportation conformity regulations, as in effect on March 1, 1999.

S. 1070

At the request of Mr. BOND, the name of the Senator from South Carolina (Mr. THURMOND) was added as a cosponsor of S. 1070, a bill to require the Secretary of Labor to wait for completion of a National Academy of Sciences study before promulgating a standard, regulation or guideline on ergonomics.

S. 1139

At the request of Mr. REID, the name of the Senator from New York (Mr. MOYNIHAN) was added as a cosponsor of S. 1139, a bill to amend title 49, United States Code, relating to civil penalties for unruly passengers of air carriers and to provide for the protection of employees providing air safety information, and for other purposes.

S. 1193

At the request of Mr. LAUTENBERG, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 1193, a bill to improve the safety of animals transported on aircraft, and for other purposes.

S. 1196

At the request of Mr. COVERDELL, the name of the Senator from Georgia (Mr. CLELAND) was added as a cosponsor of S. 1196, a bill to improve the quality, timeliness, and credibility of forensic science services for criminal justice purposes.

S. 1266

At the request of Mr. GORTON, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 1266, a bill to allow a State to combine certain funds to improve the academic achievement of all its students.

S. 1318

At the request of Mr. JEFFORDS, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1318, a bill to authorize the Secretary of Housing and Urban Development to award grants to States to supplement State and local assistance for the preservation and promotion of affordable housing opportunities for low-income families.

S. 1345

At the request of Mr. LAUTENBERG, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 1345, a bill to amend title 18, United States Code, to prohibit certain interstate conduct relating to exotic animals.

SENATE CONCURRENT RESOLUTION 9

At the request of Ms. SNOWE, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of Senate Concurrent Resolution 9, a concurrent resolution calling for a United States effort to end restrictions on the freedoms and human rights of the enclaved people in the occupied area of Cyprus.

SENATE RESOLUTION 128

At the request of Mr. COCHRAN, the name of the Senator from Indiana (Mr. LUGAR) was added as a cosponsor of Senate Resolution 128, a resolution designating March 2000, as ''Arts Education Month.''

SENATE RESOLUTION 141—TO CONGRATULATE THE UNITED STATES WOMEN'S SOCCER TEAM ON WINNING THE 1999 WOMEN'S WORLD CUP CHAMPIONSHIP

Ms. SNOWE (for herself, Mr. REID, Mrs. MURRAY, Ms. MIKULSKI, Ms. COLLINS, Ms. LANDRIEU, Mrs. FEINSTEIN, Mrs. BOXER, Mrs. HUTCHISON, Mrs. LINCOLN, and Mr. DASCHLE) submitted the following resolution; which was considered and agreed to:

S. RES. 141

Whereas the Americans blanked Germany in the second half of the quarter finals, before winning 3 to 2, shut out Brazil in the semifinals, 2 to 0, and then stymied China for 120 minutes Saturday, July 10, 1999;

Whereas the Americans, after playing the final match through heat, exhaustion, and tension throughout regulation play and two sudden-death 15-minute overtime periods, out-shot China 5–4 on penalty kicks;

Whereas the Team has brought excitement and pride to the United States with its outstanding play and selfless teamwork throughout the entire World Cup tournament;

Whereas the Americans inspired young women throughout the country to participate in soccer and other competitive sports that can enhance self-esteem and physical fitness;

Whereas the Team has helped to highlight the importance and positive results of title IX of the Education Amendments of 1972 (20 U.S.C. 1681), a law enacted to eliminate sex discrimination in education in the United States and to expand sports participation by girls and women;

Whereas the Team became the first team representing a country hosting the Women's World Cup tournament to win the tournament;

Whereas the popularity of the Team is evidenced by the facts that more fans watched the United States defeat Denmark in the World Cup opener held at Giants Stadium in New Jersey on June 19, 1999, than have ever watched a Giants or Jets National Football League game at that stadium, and over 90,000 people attended the final match in Pasadena, California, the largest attendance ever for a sporting event in which the only competitors were women;

Whereas the United States becomes the first women's team to simultaneously reign as both Olympic and World Cup champions;

Whereas five Americans, forward Mia Hamm, midfielder Michelle Akers, goalkeeper Briana Scurry, and defenders Brandi Chastain and Carla Overbeck, were chosen for the elite 1999 Women's World Cup All-Star team;

Whereas all the members of the 1999 U.S. women's World Cup team—defenders Brandi Chastain, Christie Pearce, Lorrie Fair, Joy Fawcett, Carla Overbeck, and Kate Sobrero; forwards Danielle Fotopoulos, Mia Hamm, Shannon MacMillian, Cindy Parlow, Kristine Lilly, and Tiffeny Milbrett; goalkeepers Tracy Ducar, Briana Scurry, and Saskia Webber; and midfielders Michelle Akers, Julie Foudy, Tiffany Roberts, Tisha Venturini, and Sara Whalen; and coach Tony DiCicco—both on the playing field and on the practice field, demonstrated their devotion to the team and played an important part in the team's success; and

Whereas the Americans will now set their sights on defending their Olympic title in Sydney 2000: Now, therefore, be it

Resolved, That the Senate congratulates the United States Women's Soccer Team on winning the 1999 Women's World Cup Championship.

Mrs. MURRAY. Mr. President, I am very pleased to join Senators SNOWE and REID as a cosponsor of the resolution congratulating the U.S. Women's Soccer Team on their wonderful performance in the 1999 World Cup tournament. Through hard work and dedication, they have achieved the ultimate goal and placed first in the world. This is truly a feat that will inspire women throughout our country to strive to their highest aspirations.

The U.S. Women's Soccer Team will surely have an impact on America's already rising numbers of young women and girls playing sports. They have created a wave of excitement and pride throughout the country, in men and women, boys and girls. All of the women who participated in the World Cup tournament are inspirations throughout the world, to women in their own countries and to women worldwide. Many young women share the dreams the women on the U.S. Women's Soccer Team had. The fact that they were able to accomplish their dreams is an inspiration to all of us. Their win shows that if girls truly believe in themselves and their abilities, their dreams too can come true.

This U.S. Women's Soccer Team also embodies the success of Title IX, a law enacted in 1972 to eliminate sexual discrimination in American education and expand sports participation by girls and women. Without Title IX, it is possible that such a success would never have occurred. It is possible that these women would never have had the chance to play soccer. It is possible that their talent would never have been realized. Title IX gave them a chance. The success of Title IX was made especially vivid in our team's victory.

Young women need positive role models as they are growing up. The U.S. Women's Soccer Team embodies such positive role models. They are women who do not work just for themselves but rather for each other and for their team. Their success shows that women can achieve anything they sincerely put their hearts and minds into. The U.S. Women's Soccer Team has proven to young women that they can prevail not only in athletics, but in anything and everything through hard work and dedication. Such role models are invaluable.

So, yes, the 1999 U.S. Women's Soccer Team joins the ranks of the landmark role models. They will go down in history as the first U.S. women's soccer team to win the World Cup. They will be remembered in the same light as other women who have had a tremendous impact on our society. Their success will not be forgotten, but will live on in its inspiration of many young women and girls throughout our country and world.

I am honored to recognize the U.S. Women's Soccer Team for its glorious victory. These talented, strong, and committed women have done a wonderful job and set a very positive example

for all people, but especially for girls and women of all ages.

SENATE RESOLUTION 142—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON SMALL BUSINESS

Mr. BOND, from the Committee on Small Business, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 142

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on Small Business is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or non-reimbursable basis the services of personnel of any such department or agency.

SEC. 2. The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $1,330,794, of which amount (1) not to exceed $20,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $10,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

(b) For the period of October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $567,472, of which amount (1) not to exceed $10,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $5,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required (1) for the disbursement of salaries of employees paid at an annual rate, or (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment of stationery supplies purchased through the Keeper of the Stationery, United States Senate, or (4) for payments to the Postmaster, United States Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services or (7) for payment of franked mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000 through February 28, 2001, to be paid from the Appropriations account for ''Expenses of Inquiries and Investigations.''

SENATE RESOLUTION 143—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON ARMED SERVICES

Mr. WARNER, from the Committee on Armed Services, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 143

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on Armed Services is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or non-reimbursable basis the services of personnel of any such department or agency.

SEC. 2. The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $3,796,030, of which amount (1) not to exceed $75,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $10,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

(b) For the period October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $1,568,418, of which amount (1) not to exceed $30,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $5,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required (1) for the disbursement of salaries of employees paid at an annual rate, or (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment of stationery supplies purchased through the Keeper of the Stationery, United States Senate, or (4) for payments to the Postmaster, United States Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services, or (7) for payment of franked and mass mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from the Appropriations account for ''Expenses of Inquiries and Investigations.''

SENATE RESOLUTION 144—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON THE JUDICIARY

Mr. HATCH, from the Committee on the Judiciary, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 144

Resolved, That, in carrying out its powers, duties and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on the Judiciary is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or non-reimbursable basis the services of personnel of any such department or agency.

SEC. 2. The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $4,845,263.00 of which amount (1) not to exceed $60,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $20,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946.)

(b) For the period of October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $2,068,258.00 of which amount (1) not to exceed $60,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $20,000.00 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946.)

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the

Senate at the earliest practicable date, but not later than February 29, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required for the disbursement of salaries of employees paid at an annual rate, or (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment of stationery supplies purchased through the Keeper of Stationery, U.S. Senate, or (4) for payments to the Postmaster, United States Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services, or (7) for payment of franked and mass mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from Appropriations account for ''Expenses of Inquiries and Investigations.''

SENATE RESOLUTION 145—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. MCCAIN, from the Committee on Commerce, Science, and Transportation, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 145

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on Commerce, Science, and Transportation is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or non-reimbursable basis the services of personnel of any such department or agency.

SEC. 2. (a) The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $3,823,318, of which amount (1) not to exceed $14,572 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $15,600 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

(b) For the period October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $1,631,426, of which amount (1) not to exceed $14,572 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $15,600 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required (1) for the disbursement of salaries of employees paid at an annual rate, or (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment of stationery supplies purchased through the Keeper of the Stationery, United States Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services, or (7) for payment of franked and mass mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from the Appropriations account for ''Expenses of Inquiries and Investigations''.

SENATE RESOLUTION 146—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Mr. CHAFEE, from the Committee on Environment and Public Works, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 146

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on Environment and Public Works is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or nonreimbursable basis the services of personnel of any such department or agency.

SEC. 2. (a) The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $2,688,097, of which amount (1) not to exceed $8,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $2,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

(b) For the period October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $1,146,192, of which amount (1) not to exceed $3,333 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $833 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required (1) for the disbursement of salaries of employees paid at an annual rate, or (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment of stationery supplies purchased through the Keeper of the Stationery, United States Senate, or (4) for payments to the Postmaster, United States Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services, or (7) for payment of franked and mass mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from the appropriations account for ''Expenses of Inquiries and Investigations''.

SENATE RESOLUTION 147—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIR

Mr. GRAMM from the Committee on Banking, Housing, and Urban Affairs, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 147

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on Banking, Housing, and Urban Affairs is authorize from October 1, 1999 through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or non-reimbursable basis the services of personnel of any such department or agency.

SEC. 2. The expenses of the committee for the period of October 1, 1999, through September 30, 2000, under this resolution shall not exceed $3,160,739 of which amount (1) not to exceed $20,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $850 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

(b) For the period of October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $1,348,349 of which amount (1) not to exceed $8,333 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $354 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required (1) for the disbursement of salaries of employees paid at an annual rate, or (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment of stationery supplies purchased through the keeper of the Stationery, United States Senate, or (4) for payments to the Postmaster, United Stats Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services, or (7) for payment of franked and mass mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from the Appropriations account for ''Expenses of Inquiries and Investigations.''

SENATE RESOLUTION 148—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON FOREIGN RELATIONS

Mr. HELMS, from the Committee on Foreign Relations, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 148

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on Foreign Relations, is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or non-reimbursable basis the services of personnel of any such department or agency.

SEC. 2. The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $3,158,449, of which amount (1) not to exceed $45,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

(b) For the period October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $1,347,981, of which amount (1) not to exceed $45,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

SEC. 3. The Committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required (1) for the disbursement of salaries of employees paid at an annual rate, or (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment of stationery supplies purchased through the Keeper of the Stationery, United States Senate, or (4) for payments to the Postmaster, United States Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services, or (7) for payment of franked and mass mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from the Appropriations account for ''Expenses of Inquiries and Investigations.''

SENATE RESOLUTION 149—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON THE BUDGET

Mr. DOMENICI, from the Committee on the Judiciary, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 149

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on the Budget is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or nonreimbursable basis the services of personnel of any such department or agency.

SEC. 2. (a) The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $3,449,315, of which amount (1) not to exceed $20,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $2,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

(b) For the period October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $1,472,442, of which amount (1) not to exceed $20,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $2,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required (1) for the disbursement of salaries of employees paid at an annual rate, or (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment of stationery supplies purchased through the Keeper of the Stationery, United States Senate, or (4) for payments to the Postmaster, United States Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services, or (7) for payment of franked and mass mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from the appropriations account for ''Expenses of Inquiries and Investigations''.

SENATE RESOLUTION 150—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON FINANCE

Mr. ROTH, from the Committee on Finance, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 150

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on Finance is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or non-reimbursable, basis the services of personnel of any such department or agency.

SEC. 2. The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $3,762,517, of which amount not to exceed $30,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and not to exceed $10,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

(b) For the period October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $1,604,978, of which amount not to exceed $30,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $10,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than September 30, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required (1) for the disbursement of salaries of employees paid at an annual rate, (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, (3) for the payment of stationery supplies purchased through the Keeper of the Stationery, United States Senate, or (4) for payments to the Postmaster, United States Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from the Appropriations account for ''Expenses of Inquiries and Investigations.''

SENATE RESOLUTION 151—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON VETERANS' AFFAIRS

Mr. SPECTER, from the Committee on Veterans' Affairs, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 151

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel of any such department or agency.

SEC. 2. (a) The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $1,246,174, of which amount (1) not to exceed $50,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(I) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $5,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

(b) For the period October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $531,794, of which amount (1) not to exceed $21,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(I) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $2,100 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

SEC. 3. The committee shall report its findings, together with such recommendation for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be requried for (1) the disbursement of salaries of employees paid at an annual rate, or (2) the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment stationery supplies purchased through the Keeper of Stationery, United States Senate, or (4) for payments to the Postmaster, United States Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services, or (7) for payment of franked and mass mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from the appropriations account for ''Expenses of Inquiries and Investigations.''

SENATE RESOLUTION 152—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON RULES AND ADMINISTRATION

Mr. MCCONNELL, from the Committee on Rules and Administration, reported the following original resolution:

S. RES. 152

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on Rules and Administration is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or non-reimbursable basis the services of personnel of any such department or agency.

SEC. 2. The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $1,647,719, of which amount (1) not to exceed $50,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $10,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

(b) For the period October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $703,526, of which amount (1) not to exceed $21,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $4,200 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

SEC. 3. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required (1) for the disbursement of salaries of employees paid at an annual rate, or (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment of stationery supplies purchased through the Keeper of the Stationery, United States Senate, or (4) for payments to the Postmaster, United States Senate, or (5) for the payment of metered charges on copying

equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services, or (7) for payment of franked and mass mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 4. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from the Appropriations account for ''Expenses of Inquiries and Investigations.''

SENATE RESOLUTION 153—URGING THE PARLIAMENT OF KUWAIT WHEN IT SITS ON JULY 17 TO GRANT WOMEN THE RIGHT TO HOLD OFFICE AND THE RIGHT TO VOTE

Mr. WELLSTONE submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 153

Whereas, His Highness, Sheikh Jaber al-Sabah, the Amir of Kuwait, issued a decree in May granting Kuwaiti women the right to vote and to hold office in 2003;

Whereas, Amiri decrees in Kuwait must be approved by the fifty member Kuwaiti national Parliament;

Whereas, the Kuwaiti people elected a new Parliament on July 3;

Whereas, the new Parliament will convene on July 17 and consider legislation to grant women the right to hold office and the right to vote;

Whereas, the United States of America embraces democratic principles and the importance of women's rights;

Whereas, the United States is strongly committed to advancing the political rights of women, and democratic principles throughout the Middle East; Now therefore, be it

Resolved by the Senate, that the Congress—

(1) comments His Highness, Sheikh Jaber al-Sabah, for issuing his decree granting suffrage and the right to hold office to Kuwaiti women,

(2) commends the women of Kuwait for their great strides and continuing struggle toward political equality; and

(3) calls on the Kuwaiti Parliament to affirm women's suffrage and the right to hold office of women in Kuwait.

● Mr. WELLSTONE. Mr. President, I rise to submit a resolution that urges the Parliament of Kuwait, sometime during its upcoming session, to grant women the right to hold office and the right to vote. Real progress has been made in support of the democratic ideal of fuller participation for women in the political process there. The women of Kuwait enjoy many social and economic benefits, but have historically lacked one fundamental right: the right of political participation in their own country's emerging democracy.

I am proud to commend the Amir of Kuwait, His Highness, Sheikh Jaber al-Sabah, for his historic decision to issue a decree on May 16 to grant Kuwait women the right to vote and to hold office starting in 2003. Today in Kuwait, women lack the right to vote and to hold public office. All of this could change in the coming weeks when a newly-elected Parliament will vote to confirm or reject the Amir's decision.

Mr. President, the decision of the Amir, though it will be granted great weight by the Parliament, is not final. Such royal decrees must be confirmed by a parliamentary vote. Recently, the Amir dismissed Parliament in Kuwait for inactivity and on July 3 Kuwait voted for new leaders. Now the men Parliament will vote on whether to confirm the right to vote and to hold office for Kuwaiti women in the coming weeks.

I am also proud to say that a woman named Fatima al-Abdali, a courageous and passionate champion for women's rights in Kuwait, recently became one of the first women to announce that she is running for office in 2003. She is now one of at least seven women there who have announced that they will run for office for the first time. She has spent the last decade of her life fighting for the right to hold office and to vote. Her efforts have finally paid off with the Amir's recognition, as he has remarked, of ''the role played by Kuwaiti women in building and developing Kuwait society.''

This is a truly historic moment in the Middle East.

It is only fitting, Mr. President, that Americans should be moved by the struggle of Kuwaiti women. The United States has been defined by great struggles for basic political rights: for the freedoms embodied in the Declaration of Independence and the Emancipation Proclamation; the freedom central to the major civil rights legislation of this century, and to the struggle of women in our own country to achieve the right to vote and the right to hold public office. Sojourner Truth and Susan B. Anthony were great heroines of this nation. They fought the fight in this country that is currently being waged in Kuwait. In memory of these crusaders for justice, I stand in strong support of Kuwaiti women. I know I speak for my home state of Minnesota and the entire country when I support the struggle being waged by the women of Kuwait.

Some people in the region are arguing that under Islamic tradition women should not have such political rights. Contrary to this opinion, many experts believe that Islam does not prohibit the right for women to vote and to hold public office. In fact, Islamic history is filled with prominent female figures.

Women in Kuwait are making great strides in business, government, education, and the media. A woman is the Rector of Kuwait University. The Under Secretary for Higher Education is a woman. A woman is the head of the Kuwait news agency.

Now we are seeing women move forward and make significant political strides as well. Armed with this Amiri decree, the women in Kuwait are becoming prepared to seize the opportunity they have fought for. They are announcing campaigns for office in 2003. I ask that the members of the new Parliament not turn their backs on history and vote against the Amiri decree allowing voting rights and the right to hold office.

I join the with leaders from across the world, including Egypt, Iran, Pakistan, and Indonesia in my admiration and respect for the importance of this development. I hope Kuwait's new Parliament will have the courage to take the historic step of affirming this decree.●

SENATE RESOLUTION 154—AUTHORIZING EXPENDITURES BY THE COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. THOMPSON, from the Committee on Governmental Affairs, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 154

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Committee on Governmental Affairs is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate; (2) to employ personnel; and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration to use, on a reimbursable or nonreimbursable basis, the services of personnel of any such department or agency.

SEC. 2. The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $5,026,582, of which amount (1) not to exceed $75,000, may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended; and (2) not to exceed $20,000, may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

(b) For the period October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $2,144,819, of which amount (1) not to exceed $75,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $20,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of the Legislative Reorganization Act of 1946).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee,

except that vouchers shall not be required (1) for the disbursement of salaries of employees paid at an annual rate, or (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment of stationery supplies purchased through the Keeper of the Stationery, United States Senate, or (4) for payments to the Postmaster, United States Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services, or (7) for payment of franked and mass mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from the Appropriations account for ''Expenses of Inquiries and Investigations.''

INVESTIGATIONS

SEC. 6. (1) IN GENERAL.—The committee, or any duly authorized subcommittee of the committee, is authorized to study or investigate

(a) the efficiency and economy of operations of all branches of the Government, including the possible existence of fraud, misfeasance, malfeasance, collusion, mismanagement, incompetence, corruption, or unethical practices, waste, extravagance, conflicts of interest, and the improper expenditure of Government funds in transactions, contracts, and activities of the Government or of Government officials and employees and any and all such improper practices between Government personnel and corporations, individuals, companies, or persons affiliated therewith, doing business with the Government; and the compliance or noncompliance of such corporations, companies, or individuals or other entities with the rules, regulations, and laws governing the various governmental agencies and its relationships with the public;

(b) the extent to which criminal or other improper practices or activities are, or have been, engaged in the field of labor-management relations or in groups or organizations of employees or employers, to the detriment of interests of the public, employers, or employees, and to determine whether any changes are required in the laws of the United States in order to protect such interests against the occurrence of such practices or activities;

(c) organized criminal activity which may operate in or otherwise utilize the facilities of interstate or international commerce in furtherance of any transactions and the manner and extent to which, and the identity of the persons, firms, or corporations, or other entities by whom such utilization is being made, and further, to study and investigate the manner in which and the extent to which persons engaged in organized criminal activity have infiltrated lawful business enterprise, and to study the adequacy of Federal laws to prevent the operations of organized crime in interstate or international commerce; and to determine whether any changes are required in the laws of the United States in order to protect the public against such practices or activities;

(d) all other aspects of crime and lawlessness within the United States which have an impact upon or affect the national health, welfare, and safety; including but not limited to investment fraud schemes, commodity and security fraud, computer fraud, and the use of offshore banking and corporate facilities to carry out criminal objectives;

(e) the efficiency and economy of operations of all branches and functions of the Government with particular reference to

(i) the effectiveness of present national security methods, staffing, and processes as tested against the requirements imposed by the rapidly mounting complexity of national security problems;

(ii) the capacity of present national security staffing, methods, and processes to make full use of the Nation's resources of knowledge and talents;

(iii) the adequacy of present intergovernmental relations between the United States and international organizations principally concerned with national security of which the United States is a memeber; and

(iv) legislative and other proposals to improve these methods, processes, and relationships;

(f) the efficiency, economy, and effectiveness of all agencies and departments of the Government involved in the control and management of energy shortages including, but not limited to, their performance with respect to

(i) the collection and dissemination of accurate statistics on fuel demand and supply;

(ii) the implementation of effective energy conservation measures;

(iii) the pricing of energy in all forms;

(iv) coordination of energy programs with State and local government;

(v) control of exports of scarce fuels;

(vi) the management of tax, import, pricing, and other policies affecting energy supplies;

(vii) maintenance of the independent sector of the petroleum industry as a strong competitive force;

(viii) the allocation of fuels in short supply by public and private entities;

(ix) the management of energy supplies owned or controlled by the Government;

(x) relations with other oil producing and consuming countries;

(xi) the monitoring of compliance by governments, corporations, or individuals with the laws and regulations governing the allocation, conservation, or pricing of energy supplies; and

(xii) research into the discovery and development of alternative energy supplies; and

(g) the efficiency and economy of all branches and functions of Government with particular references to the operations and management of Federal regulatory policies and programs.

(2) EXTENT OF INQUIRIES.—In carrying out the duties provided in paragraph (1), the inquiries of this committee or any subcommittee of the committee shall not be construed to be limited to the records, functions, and operations of any particular branch of the Government and may extend to the records and activities of any persons, corporation, or other entity.

(3) SPECIAL COMMITTEE AUTHORITY.—For the purposes of this subsection, the committee, or any duly authorized subcommittee of the committee, or its chairman, or any other member of the committee or subcommittee designated by the chairman, from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, is authorized, in its, his, or their discretion.

(a) to require by subpoena or otherwise the attendance of witnesses and production of correspondence, books, papers, and documents;

(b) to hold hearings;

(c) to sit and act at any time or place during the sessions, recess, and adjournment periods of the Senate;

(d) to administer oaths; and

(e) to take testimony, either orally or by sworn statement, or, in the case of staff members of the Committee and the Permanent Subcommittee on Investigations, by deposition in accordance with the Committee Rules of Procedure.

(4) AUTHORITY OF OTHER COMMITTEES.—Nothing in this subsection shall affect or impair the exercise of any other standing committee of the Senate of any power, or the discharge by such committee of any duty, conferred or imposed upon it by the Standing Rules of the Senate or by the Legislative Reorganization Act of 1946.

(5) SUBPOENA AUTHORITY.—All subpoenas and related legal processes of the committee and its subcommittees authorized under S. Res. 49, agreed to February 24, 1999 (106th Congress) are authorized to continue.

SENATE RESOLUTION 155—AUTHORIZING EXPENDITURES BY THE SPECIAL COMMITTEE ON AGING

Mr. GRASSLEY, from the Special Committee on Aging, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 155

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Special Committee on Aging is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion—

(1) to make expenditures from the contingent fund of the Senate,

(2) to employ personnel, and

(3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or nonreimbursable basis the services of personnel of any such department or agency.

SEC. 2. (a) The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $1,459,827, of which amount not to exceed $50,000 may be expended for the procurement of the services of individual consultants or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended).

(b) For the period October 1, 2000, through February 28, 2001, expenses of the committee under this resolution shall not exceed $622,709, of which amount not to exceed $50,000 may be expended for the procurement of the services of individual consultants or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 2000, and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required—

(1) for the disbursement of salaries of employees paid at an annual rate,

(2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate,

(3) for the payment of stationery supplies purchased through the Keeper of the Stationery, United States Senate,

(4) for payments to the Postmaster, United States Senate,

(5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate,

(6) for the payment of Senate Recording and Photographic Services, or

(7) for the payment of franked and mass mail costs by the Office of the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, to be paid from the Appropriations account for ''Expenses of Inquiries and Investigations.''.

AMENDMENTS SUBMITTED

PATIENTS' BILL OF RIGHTS ACT OF 1999

GREGG AMENDMENT NO. 1250

Mr. GREGG proposed an amendment to amendment No. 1243 proposed by Ms. COLLINS to the 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; as follows:

At the end of the amendment add the following:

SEC. . PROTECTING PATIENTS AND ACCELERATING THEIR TREATMENT AND CARE.

(a) FINDINGS.—The Senate makes the following findings with respect to the expansion of medical malpractice liability lawsuits in Senate bill 6 (106th Congress):

(1) The expansion of liability in S. 6 (106th Congress) would not benefit patients and will not improve health care quality.

(2) Expanding the scope of medical malpractice liability to health plans and employers will force higher costs on American families and their employers as a result of increased litigation, attorneys' fees, administrative costs, the costs of defensive coverage determinations, liability insurance premium increases, and unlimited jury verdicts.

(3) Legal liability for health plans and employers is the largest expansion of medical malpractice in history and the most expensive provision of S. 6 (106th Congress), and would increase costs ''on average, about 1.4 percent of the premiums of all employer-sponsored plans,'' according to the Congressional Budget Office.

(4) The expansion of medical malpractice lawsuits would force employers to drop health coverage altogether, rather than take the risk of jeopardizing the solvency of their companies over lawsuits involving health claims.

(5) Seven out of 10 employers in the United States have less than 10 employees, and only 26 percent of employees in these small businesses have health insurance. Such businesses already struggle to provide this coverage, and would be devastated by one lawsuit, and thus, would be discouraged from offering health insurance altogether.

(6) According to a Chamber of Commerce survey in July of 1998, 57 percent of small employers would be likely to drop coverage if exposed to increased lawsuits. Other studies have indicated that for every 1 percent real increase in premiums, small business sponsorship of health insurance drops by 2.6 percent.

(7) There are currently 43,000,000 Americans who are uninsured, and the expansion of medical malpractice lawsuits for health plans and employers would result in millions of additional Americans losing their health insurance coverage and being unable to provide health insurance for their families.

(8) Exposing health plans and employers to greater liability would increase defensive medicine and the delivery of unnecessary services that do not benefit patients, and result in decisions being based not on best practice protocols but on the latest jury verdicts and court decisions.

(9) In order to minimize their liability risk and the liability risk for the actions of providers, health plans and employers would constrict their provider networks, and micro manage hospitals and doctors. This result is the opposite of the very goal sought by S. 6 (106th Congress).

(10) The expansion of medical malpractice liability also would reduce consumer choice because it would drive from the marketplace many of the innovative and hybrid care delivery systems that are popular today with American families.

(11) The provisions of S. 6 (106th Congress) that greatly increase medical malpractice lawsuits against private health programs and employers are an ineffective means of compensating for injury or loss given that patients ultimately receive less than one-half of the total award and the rest goes to trial lawyers and court costs.

(12) Medical malpractice claims will not help patients get timely access to the care that they need because such claims take years to resolve and the payout is usually made over multiple years. Trial lawyers usually receive their fees up front and which can be between one-third and one-half of any total award.

(13) Expanding liability lawsuits is inconsistent with the recommendations of President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which specifically rejected expanded lawsuits for health plans and employers because they believed it would have serious consequences on the entire health industry.

(14) At the State level, legislatures in 24 States have rejected the expansion of medical malpractice lawsuits against health plans and employers, and instead 26 States have adopted external grievance and appeals laws to protect patients.

(15) At a time when the tort system of the United States has been criticized as inefficient, expensive and of little benefit to the injured, S. 6 (106th Congress) would be bad medicine for American families, workers and employers, driving up premiums and rewarding more lawyers than patients.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that—

(1) Americans families want and deserve quality health care;

(2) patients need health care before they are harmed rather than compensation provided long after an injury has occurred;

(3) the expansion of medical malpractice liability lawsuits would divert precious resources away from patient care and into the pockets of trial lawyers;

(4) health care reform should not result in higher costs for health insurance and fewer insured Americans; and

(5) providing a fast, fair, efficient, and independent grievances and appeals process will improve quality of care, patient access to care, and is the key to an efficient and innovative health care system in the 21st Century.

(c) NULLIFICATION OF PROVISION.—Notwithstanding any other provision of this Act, Section 302 of this Act shall be null, void, and have no effect.

WYDEN (AND OTHERS) AMENDMENT NO. 1251

Mr. WYDEN (for himself, Mr. REED, Mr. HARKIN, Mr. WELLSTONE, and Mr. BINGAMAN) proposed an amendment to amendment No. 1232 proposed by Mr. DASCHLE to the bill, S. 1344, supra; as follows:

At the appropriate place, insert the following:

SEC. . PROTECTING THE RELATIONSHIP BETWEEN HEALTH CARE PROFESSIONALS AND THEIR PATIENTS.

(a) ERISA.—Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as added by section 101(a)(2) of this Act, is amended by adding at the end the following:

''SEC. 730A. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

''(a) PROHIBITION.—

''(1) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan, or a health insurance issuer in connection with group health insurance coverage, (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or restrict the provider from engaging in medical communications with the provider's patient.

''(2) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of paragraph (1) shall be null and void.

''(b) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) to prohibit the enforcement, as part of a contract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by a group health plan, or a health insurance issuer in connection with group health insurance coverage, to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider) but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers and their patients; or

''(2) to permit a health care provider to misrepresent the scope of benefits covered under the group health plan or health insurance coverage or to otherwise require a group health plan or health insurance issuer to reimburse providers for benefits not covered under the plan or coverage.

''(c) MEDICAL COMMUNICATION DEFINED.—In this section:

''(1) IN GENERAL.—The term 'medical communication' means any communication made by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) with respect to—

''(A) the patient's health status, medical care, or treatment options;

''(B) any utilization review requirements that may affect treatment options for the patient; or

''(C) any financial incentives that may affect the treatment of the patient.

''(2) MISREPRESENTATION.—The term 'medical communication' does not include a communication by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) if the communication involves a knowing or willful misrepresentation by such provider.

''SEC. 730B. PROHIBITION AGAINST TRANSFER OF INDEMNIFICATION OR IMPROPER INCENTIVE ARRANGEMENTS.

''(a) PROHIBITION OF TRANSFER OF INDEMNIFICATION.—

''(1) IN GENERAL.—No contract or agreement between a group health plan or health insurance issuer (or any agent acting on behalf of such a plan or issuer) and a health care provider shall contain any provision purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions, or omissions of the plan, issuer, or agent (as opposed to the provider).

''(2) NULLIFICATION.—Any contract or agreement provision described in paragraph (1) shall be null and void.

''(b) PROHIBITION OF IMPROPER PHYSICIAN INCENTIVE PLANS.—

''(1) IN GENERAL.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in subparagraph (A) of such section are met with respect to such a plan.

''(2) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority or a group health plan, or a health insurance issuer in connection with group health insurance coverage, respectively, and a participant or beneficiary with the plan or enrollee with the issuer respectively.

''(c) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS IN UTILIZATION REVIEW PROGRAMS.—A utilization review program maintained by a group health plan, or a health insurance issuer in connection with group health insurance coverage, shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that—

''(1) provides incentives, direct or indirect, for such persons to make inappropriate review decisions, or

''(2) is based, directly or indirectly, on the quantity or type of adverse determinations rendered.

''(d) PROHIBITION OF CONFLICTS.—A program described in subsection (c) shall not permit a health care professional who provides health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

''SEC. 730C. ADDITIONAL RULES REGARDING PARTICIPATION OF HEALTH CARE PROFESSIONALS.

''(a) PROCEDURES.—Insofar as a group health plan, or a health insurance issuer in connection with group health insurance coverage, provides benefits through participating health care professionals, the plan or issuer shall establish reasonable procedures relating to the participation (under an agreement between a professional and the plan or issuer) of such professionals under the plan or coverage. Such procedures shall include—

''(1) providing notice of the rules regarding participation;

''(2) providing written notice of participation decisions that are adverse to professionals; and

''(3) providing a process within the plan or issuer for appealing such adverse decisions, including the presentation of information and views of the professional regarding such decision.

''(b) CONSULTATION IN MEDICAL POLICIES.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, shall consult with participating physicians (if any) regarding the plan's or issuer's medical policy, quality, and medical management procedures.

''SEC. 730D. PROTECTION FOR PATIENT ADVOCACY.

''(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's, or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this part.

''(b) PROTECTION FOR QUALITY ADVOCACY BY HEALTH CARE PROFESSIONALS.—

''(1) IN GENERAL.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, may not retaliate or discriminate against a protected health care professional because the professional in good faith—

''(A) discloses information relating to the care, services, or conditions affecting one or more participants or beneficiaries of the plan or enrollees under health insurance coverage to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

''(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

''(2) GOOD FAITH ACTION.—For purposes of paragraph (1), a protected health care professional is considered to be acting in good faith with respect to disclosure of information or participation if, with respect to the information disclosed as part of the action—

''(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with the same licensure or certification and the same experience;

''(B) the professional reasonably believes the information to be true;

''(C) the information evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

''(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan or issuer or institutional health care provider established for the purpose of addressing quality concerns before making the disclosure.

''(3) EXCEPTION AND SPECIAL RULE.—

''(A) GENERAL EXCEPTION.—Paragraph (1) does not protect disclosures that would violate Federal or State law or diminish or impair the rights of any person to the continued protection of confidentiality of communications provided by such law.

''(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

''(C) INTERNAL PROCEDURE EXCEPTION.—Subparagraph (D) of paragraph (2) also shall not apply if—

''(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

''(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

''(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

''(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan or issuer or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

''(5) NOTICE.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

''(6) CONSTRUCTIONS.—

''(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

''(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan or issuer or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

''(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees and protected health care professionals under other applicable Federal or State laws.

''(7) PROTECTED HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term 'protected health care professional' means an individual who is a licensed or certified health care professional and who—

''(A) with respect to a group health plan or health insurance issuer, is an employee of the plan or issuer or has a contract with the plan or issuer for provision of services for which benefits are available under the plan or coverage; or

''(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the provider respecting the provision of health care services.

''SEC. 730E. PROCESS FOR SELECTION OF PROVIDERS.

''(a) IN GENERAL.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, shall, if it provides benefits through participating health care professionals, have a written process for the selection of participating health care professionals, including minimum professional requirements.

''(b) VERIFICATION OF BACKGROUND.—Such process shall include verification of a health care provider's license and a history of suspension or revocation.

''(c) RESTRICTION.—Such process shall not use a high-risk patient base or location of a provider in an area with residents with poorer health status as a basis for excluding providers from participation.

''(d) NONDISCRIMINATION BASED ON LICENSURE.—

''(1) IN GENERAL.—Such process shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

''(2) CONSTRUCTION.—Paragraph (1) shall not be construed—

''(A) as requiring the coverage under a plan or coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan issuer; or

''(B) to override any State licensure or scope-of-practice law.

''(e) GENERAL NONDISCRIMINATION.—

''(1) IN GENERAL.—Subject to paragraph (2), such process shall not discriminate with respect to selection of a health care professional to be a participating health care provider, or with respect to the terms and conditions of such participation, based on the professional's race, color, religion, sex, national origin, age, sexual orientation, or disability (consistent with the Americans with Disabilities Act of 1990).

''(2) RULES.—The appropriate Secretary may establish such definitions, rules, and exceptions as may be appropriate to carry out paragraph (1), taking into account comparable definitions, rules, and exceptions in effect under employment-based nondiscrimination laws and regulations that relate to each of the particular bases for discrimination described in such paragraph.

''SEC. 730F. OFFERING OF CHOICE OF COVERAGE OPTIONS UNDER GROUP HEALTH PLANS.

''(a) REQUIREMENT.—

''(1) OFFERING OF POINT-OF-SERVICE COVERAGE OPTION.—Except as provided in paragraph (2), if a group health plan, or a health insurance issuer in connection with group health insurance coverage, provides benefits only through participating health care providers, the plan or issuer shall offer the participant the option to purchase point-of-service coverage (as defined in subsection (b)) for all such benefits for which coverage is otherwise so limited. Such option shall be made available to the participant at the time of enrollment under the plan or coverage and at such other times as the plan or issuer offers the participant a choice of coverage options.

''(2) EXCEPTION.—Paragraph (1) shall not apply with respect to a participant in a group health plan, or enrollee under health insurance coverage, if the plan or issuer offers the participant or enrollee—

''(A) a choice of health insurance coverage; and

''(B) one or more coverage options that do not provide benefits only through participating health care providers.

''(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term 'point-of-service coverage' means, with respect to benefits covered under a group health plan, or health insurance coverage, coverage of such benefits when provided by a nonparticipating health care provider. Such coverage need not include coverage of providers that the plan or issuer excludes because of fraud, quality, or similar reasons.

''(c) CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring coverage for benefits for a particular type of health care provider;

''(2) as requiring an employer to pay any costs as a result of this section or to make equal contributions with respect to different health coverage options; or

''(3) as preventing a group health plan or health insurance issuer from imposing higher premiums or cost-sharing on a participant for the exercise of a point-of-service coverage option.

''(d) NO REQUIREMENT FOR GUARANTEED AVAILABILITY.—If a health insurance issuer offers group health insurance coverage that includes point-of-service coverage with respect to an employer solely in order to meet the requirement of subsection (a), nothing in section 2711(a)(1)(A) of the Public Health Service Act shall be construed as requiring the offering of such coverage with respect to another employer.

''(e) APPLICATION OF SECTION.—This section and sections 730A, 730B, 730C, 730D, and 730E shall supersede any provision of this subpart that conflicts with a provision of this section or section 730A, 730B, 730C, 730D, or 730E.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any provision of this subchapter, the group health plan shall not be liable for such violation unless the plan caused such violation.

''(g) APPLICABILITY.—The provisions of this section and sections 730A, 730B, 730C, 730D, and 730E shall apply to group health plans and health insurance issuers as if included in—

''(1) subpart 2 of part A of title XXVII of the Public Health Service Act;

''(2) the first subpart 3 of part B of title XXVII of the Public Health Service Act (relating to other requirements); and

''(3) subchapter B of chapter 100 of the Internal Revenue Code of 1986.

''(h) NONAPPLICATION OF CERTAIN PROVISION.—Only for purposes of applying the requirements of this section and sections 730A, 730B, 730C, 730D, and 730E under section 714 of the Employee Retirement Income Security Act of 1974 (as added by section 301 of this Act), sections 2707 and 2753 of the Public Health Service Act (as added by sections 201 and 202 of this Act), and section 9813 of the Internal Revenue Code of 1986 (as added by section 401 of this Act)—

''(1) section 2721(b)(2) of the Public Health Service Act and section 9831(a)(1) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section and sections 730A, 730B, 730C, 730D, and 730E; and

''(2) with respect to limited scope dental benefits, subparagraph (A) of section 733(c)(2) of the Employee Retirement Income Security Act of 1974, subparagraph (A) of section 2791(c)(2) of the Public Health Service Act, and subparagraph (A) of section 9832(c)(2) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section and sections 730A, 730B, 730C, 730D, and 730E.

''(i) LIMITATION ON ACTIONS.—

''(1) IN GENERAL.—Except as provided for in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 by a participant or beneficiary seeking relief based on the application of any provision in this section.

''(2) PERMISSIBLE ACTIONS.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 by a participant or beneficiary seeking relief based on the application of this section to the individual circumstances of that participant or beneficiary; except that—

''(A) such an action may not be brought or maintained as a class action; and

''(B) in such an action relief may only provide for the provision of (or payment for) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.''.

(b) NO IMPACT ON SOCIAL SECURITY TRUST FUND.—

(1) IN GENERAL.—Nothing in this section shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(2) TRANSFERS.—

(A) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this section has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(B) TRANSFER OF FUNDS.—If, under subparagraph (A), the Secretary of the Treasury estimates that the enactment of this section has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such section.

(c) EFFECTIVE DATE.—The provisions of this section shall apply to group health plans for plan years beginning after, and to health insurance issuers for coverage offered or sold after, October 1, 2000.''.

SEC. . HEALTH INSURANCE OMBUDSMEN.

(a) IN GENERAL.—Each State that obtains a grant under subsection (c) shall provide for creation and operation of a Health Insurance Ombudsman through a contract with a not-for-profit organization that operates independent of group health plans and health insurance issuers. Such Ombudsman shall be responsible for at least the following:

(1) To assist consumers in the State in choosing among health insurance coverage or among coverage options offered within group health plans.

(2)To provide counseling and assistance to enrollees dissatisfied with their treatment by health insurance issuers and group health plans in regard to such coverage or plans and with respect to grievances and appeals regarding determinations under such coverage or plans.

(b) FEDERAL ROLE.—In the case of any State that does not provide for such an Ombudsman under subsection (a), the Secretary of Health and Human Services shall provide for the creation and operation of a Health Insurance Ombudsman through a contract with a not-for-profit organization that operates independent of group health plans and health insurance issuers and that is responsible for carrying out with respect to that State the functions otherwise provided under subsection (a) by a Health Insurance Ombudsman.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Health and Human Services such amounts as may be necessary to provide for grants to States for contracts for Health Insurance Ombudsmen under subsection (a) or contracts for such Ombudsmen under subsection (b).

(d) Construction.—Nothing in this section shall be construed to prevent the use of other forms of enrollee assistance.

(e) DEFINITIONS.—The definitions in section 2791 of the Public Health Services Act (42 U.S.C. 300gg–91) shall apply to this section.

SEC. . INFORMATION REQUIREMENTS.

(a) INFORMATION FROM GROUP HEALTH PLANS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following:

''(7) INFORMATION FROM GROUP HEALTH PLANS.—

''(A) PROVISION OF INFORMATION BY GROUP HEALTH PLANS.—The administrator of a group health plan subject to the requirements of paragraph (1) shall provide to the Secretary such of the information elements described in subparagraph (C) as the Secretary specifies, and in such manner and at such times as the Secretary may specify (but not more frequently than 4 times per year), with respect to each individual covered under the plan who is entitled to any benefits under this title.

''(B) PROVISION OF INFORMATION BY EMPLOYERS AND EMPLOYEE ORGANIZATIONS.—An employer (or employee organization) that maintains or participates in a group health plan subject to the requirements of paragraph (1) shall provide to the administrator of the plan such of the information elements required to be provided under subparagraph (A), and in such manner and at such times as the Secretary may specify, at a frequency consistent with that required under subparagraph (A) with respect to each individual described in subparagraph (A) who is covered under the plan by reason of employment with that employer or membership in the organization.

''(C) INFORMATION ELEMENTS.—The information elements described in this subparagraph are the following:

''(i) ELEMENTS CONCERNING THE INDIVIDUAL.—

''(I) The individual's name.

''(II) The individual's date of birth.

''(III) The individual's sex.

''(IV) The individual's social security insurance number.

''(V) The number assigned by the Secretary to the individual for claims under this title.

''(VI) The family relationship of the individual to the person who has or had current or employment status with the employer.

''(ii) ELEMENTS CONCERNING THE FAMILY MEMBER WITH CURRENT OR FORMER EMPLOYMENT STATUS.—

''(I) The name of the person in the individual's family who has current or former employment status with the employer.

''(II) That person's social security insurance number.

''(III) The number or other identifier assigned by the plan to that person.

''(IV) The periods of coverage for that person under the plan.

''(V) The employment status of that person (current or former) during those periods of coverage.

''(VI) The classes (of that person's family members) covered under the plan.

''(iii) PLAN ELEMENTS.—

''(I) The items and services covered under the plan.

''(II) The name and address to which claims under the plan are to be sent.

''(iv) ELEMENTS CONCERNING THE EMPLOYER.—

''(I) The employer's name.

''(II) The employer's address.

''(III) The employer identification number of the employer.

''(D) USE OF IDENTIFIERS.—The administrator of a group health plan shall utilize a unique identifier for the plan in providing information under subparagraph (A) and in other transactions, as may be specified by the Secretary, related to the provisions of this subsection. The Secretary may provide to the administrator the unique identifier described in the preceding sentence.

''(E) PENALTY FOR NONCOMPLIANCE.—Any entity that knowingly and willfully fails to comply with a requirement imposed by the previous subparagraphs shall be subject to a civil money penalty not to exceed $1,000 for each incident of such failure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as those provisions apply to a penalty or proceeding under section 1128A(a).''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect 180 days after the date of the enactment of this Act.

SEC. . MODIFICATION OF INSTALLMENT METHOD AND REPEAL OF INSTALLMENT METHOD FOR ACCRUAL METHOD TAXPAYERS.

(a) REPEAL OF INSTALLMENT METHOD FOR ACCRUAL BASIS TAXPAYERS.—

(1) IN GENERAL.—Subsection (a) of section 453 (relating to installment method) is amended to read as follows:

''(a) USE OF INSTALLMENT METHOD.—

''(1) IN GENERAL.—Except as otherwise provided in this section, income from an installment sale shall be taken into account for purposes of this title under the installment method.

''(2) ACCRUAL METHOD TAXPAYER.—The installment method shall not apply to income from an installment sale if such income would be reported under an accrual method of accounting without regard to this section. The preceding sentence shall not apply to a disposition described in subparagraph (A) or (B) of subsection (l)(2).''

(2) CONFORMING AMENDMENTS.—Sections 453(d)(1), 453(i)(1), and 453(k) are each amended by striking ''(a)'' each place it appears and inserting ''(a)(1)''.

(b) MODIFICATION OF PLEDGE RULES.—Paragraph (4) of section 453A(d) (relating to pledges, etc., of installment obligations) is amended by adding at the end the following: ''A payment shall be treated as directly secured by an interest in an installment obligation to the extent an arrangement allows the taxpayer to satisfy all or a portion of the indebtedness with the installment obligation.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to sales or other dispositions occurring on or after the date of the enactment of this Act.

ASHCROFT (AND OTHERS) AMENDMENT NO. 1252

Mr. FRIST (for Mr. ASHCROFT (for himself, Mr. KYL, Mr. MACK, Mr. FRIST, Mr. SESSIONS, Ms. COLLINS, Mr. CRAPO, Mr. ABRAHAM, Mr. JEFFORDS, Mr. ENZI, Mr. DEWINE, Mr. GRASSLEY, Mr. HATCH, and Mr. HELMS) proposed an amendment to amendment No. 1251 proposed by Mr. WYDEN to the bill, S. 1344, supra; as follows:

Strike section 121 of the amendment, and insert the following:

SEC. . AMENDMENT TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended to read as follows:

''SEC. 503. CLAIMS PROCEDURE, COVERAGE DETERMINATION, GRIEVANCES AND APPEALS.

''(a) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every employee benefit plan shall—

''(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant; and

''(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

''(b) COVERAGE DETERMINATIONS UNDER GROUP HEALTH PLANS.—

''(1) PROCEDURES.—

''(A) IN GENERAL.—A group health plan or health insurance issuer conducting utilization review shall ensure that procedures are in place for—

''(i) making determinations regarding whether a participant or beneficiary is eligible to receive a payment or coverage for health services under the plan or coverage involved and any cost-sharing amount that the participant or beneficiary is required to pay with respect to such service;

''(ii) notifying a covered participant or beneficiary (or the authorized representative of such participant or beneficiary) and the treating health care professionals involved regarding determinations made under the plan or issuer and any additional payments that the participant or beneficiary may be required to make with respect to such service; and

''(iii) responding to requests, either written or oral, for coverage determinations or for internal appeals from a participant or beneficiary (or the authorized representative of such participant or beneficiary) or the treating health care professional with the consent of the participant or beneficiary.

''(B) ORAL REQUESTS.—With respect to an oral request described in subparagraph (A)(iii), a group health plan or health insurance issuer may require that the requesting individual provide written evidence of such request.

''(2) TIMELINE FOR MAKING DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—A group health plan or a health insurance issuer shall maintain procedures to ensure that prior authorization determinations concerning the provision of non-emergency items or services are made within 30 days from the date on which the request for a determination is submitted, except that such period may be extended where certain circumstances exist that are determined by the Secretary to be beyond control of the plan or issuer.

''(B) EXPEDITED DETERMINATION.—

''(i) IN GENERAL.—A prior authorization determination under this subsection shall be made within 72 hours, in accordance with the

medical exigencies of the case, after a request is received by the plan or issuer under clause (ii) or (iii).

''(ii) REQUEST BY PARTICIPANT OR BENEFICIARY.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of a participant or beneficiary if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the participant or beneficiary.

''(iii) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if the request involved indicates that the treating health care professional has reasonably documented, based on the medical exigencies, that a determination under the procedures described in subparagraph (A) could seriously jeopardize the life or health of the participant or beneficiary.

''(C) CONCURRENT DETERMINATIONS.—A plan or issuer shall maintain procedures to certify or deny coverage of an extended stay or additional services.

''(D) RETROSPECTIVE DETERMINATION.—A plan or issuer shall maintain procedures to ensure that, with respect to the retrospective review of a determination made under paragraph (1), the determination shall be made within 30 working days of the date on which the plan or issuer receives necessary information.

''(3) NOTICE OF DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(A), the plan or issuer shall issue notice of such determination to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and, consistent with the medical exigencies of the case, to the treating health care professional involved not later than 2 working days after the date on which the determination is made.

''(B) EXPEDITED DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(B), the plan or issuer shall issue notice of such determination to the participant or beneficiary (or the authorized representative of the participant or beneficiary), and consistent with the medical exigencies of the case, to the treating health care professional involved within the 72 hour period described in paragraph (2)(B).

''(C) CONCURRENT REVIEWS.—With respect to the determination under a plan or issuer under paragraph (2)(C) to certify or deny coverage of an extended stay or additional services, the plan or issuer shall issue notice of such determination to the treating health care professional and to the participant or beneficiary involved (or the authorized representative of the participant or beneficiary) within 1 working day of the determination.

''(D) RETROSPECTIVE REVIEWS.—With respect to the retrospective review under a plan or issuer of a determination made under paragraph (2)(D), the plan or issuer shall issue written notice of an approval or disapproval of a determination under this subparagraph to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and health care provider involved within 5 working days of the date on which such determination is made.

''(E) REQUIREMENTS OF NOTICE OF ADVERSE COVERAGE DETERMINATIONS.—A written notice of an adverse coverage determination under this subsection, or of an expedited adverse coverage determination under paragraph (2)(B), shall be provided to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and treating health care professional (if any) involved and shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average participant or beneficiary;

''(ii) the procedures for obtaining additional information concerning the determination; and

''(iii) notification of the right to appeal the determination and instructions on how to initiate an appeal in accordance with subsection (d).

''(c) GRIEVANCES.—A group health plan or a health insurance issuer shall have written procedures for addressing grievances between the plan or issuer offering health insurance coverage in connection with a group health plan and a participant or beneficiary. Determinations under such procedures shall be non-appealable.

''(d) INTERNAL APPEAL OF COVERAGE DETERMINATIONS.—

''(1) RIGHT TO APPEAL.—

''(A) IN GENERAL.—A participant or beneficiary (or the authorized representative of the participant or beneficiary) or the treating health care professional with the consent of the participant or beneficiary (or the authorized representative of the participant or beneficiary), may appeal any adverse coverage determination under subsection (b) under the procedures described in this subsection.

''(B) TIME FOR APPEAL.—A plan or issuer shall ensure that a participant or beneficiary has a period of not less than 180 days beginning on the date of an adverse coverage determination under subsection (b) in which to appeal such determination under this subsection.

''(C) FAILURE TO ACT.—The failure of a plan or issuer to issue a determination under subsection (b) within the applicable timeline established for such a determination under such subsection shall be treated as an adverse coverage determination for purposes of proceeding to internal review under this subsection.

''(2) RECORDS.—A group health plan and a health insurance issuer shall maintain written records, for at least 6 years, with respect to any appeal under this subsection for purposes of internal quality assurance and improvement. Nothing in the preceding sentence shall be construed as preventing a plan and issuer from entering into an agreement under which the issuer agrees to assume responsibility for compliance with the requirements of this section and the plan is released from liability for such compliance.

''(3) ROUTINE DETERMINATIONS.—A group health plan or a health insurance issuer shall complete the consideration of an appeal of an adverse routine determination under this subsection not later than 30 working days after the date on which a request for such appeal is received.

''(4) EXPEDITED DETERMINATION.—

''(A) IN GENERAL.—An expedited determination with respect to an appeal under this subsection shall be made in accordance with the medical exigencies of the case, but in no case more than 72 hours after the request for such appeal is received by the plan or issuer under subparagraph (B) or (C).

''(B) REQUEST BY PARTICIPANT OR BENEFICIARY.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of a participant or beneficiary if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the participant or beneficiary.

''(C) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if the request involved indicates that the treating health care professional has reasonably documented, based on the medical exigencies of the case that a determination under the procedures described in paragraph (2) could seriously jeopardize the life or health of the participant or beneficiary.

''(5) CONDUCT OF REVIEW.—A review of an adverse coverage determination under this subsection shall be conducted by an individual with appropriate expertise who was not directly involved in the initial determination.

''(6) LACK OF MEDICAL NECESSITY.—A review of an appeal under this subsection relating to a determination to deny coverage based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, shall be made only by a physician with appropriate expertise, including age-appropriate expertise, who was not involved in the initial determination.

''(7) NOTICE.—

''(A) IN GENERAL.—Written notice of a determination made under an internal review process shall be issued to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and the treating health care professional not later than 2 working days after the completion of the review (or within the 72-hour period referred to in paragraph (4) if applicable).

''(B) ADVERSE COVERAGE DETERMINATIONS.—With respect to an adverse coverage determination made under this subsection, the notice described in subparagraph (A) shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average participant or beneficiary;

''(ii) the procedures for obtaining additional information concerning the determination; and

''(iii) notification of the right to an independent external review under subsection (e) and instructions on how to initiate such a review.

''(e) INDEPENDENT EXTERNAL REVIEW.—

''(1) ACCESS TO REVIEW.—

''(A) IN GENERAL.—A group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan shall have written procedures to permit a participant or beneficiary (or the authorized representative of the participant or beneficiary) access to an independent external review with respect to an adverse coverage determination concerning a particular item or service (including a circumstance treated as an adverse coverage determination under subparagraph (B)) where—

''(i) the particular item or service involved—

''(I)(aa) would be a covered benefit, when medically necessary and appropriate under the terms and conditions of the plan, and the item or service has been determined not to be medically necessary and appropriate under the internal appeals process required under subsection (d) or there has been a failure to issue a coverage determination as described in subparagraph (B); and

''(bb)(AA) the amount of such item or service involved exceeds a significant financial threshold; or

''(BB) there is a significant risk of placing the life or health of the participant or beneficiary in jeopardy; or

''(II) would be a covered benefit, when not considered experimental or investigational

under the terms and conditions of the plan, and the item or service has been determined to be experimental or investigational under the internal appeals process required under subsection (d) or there has been a failure to issue a coverage determination as described in subparagraph (B); and

''(ii) the participant or beneficiary has completed the internal appeals process under subsection (d) with respect to such determination.

''(B) FAILURE TO ACT.—The failure of a plan or issuer to issue a coverage determination under subsection (d)(6) within the applicable timeline established for such a determination under such subsection shall be treated as an adverse coverage determination for purposes of proceeding to independent external review under this subsection.

''(2) INITIATION OF THE INDEPENDENT EXTERNAL REVIEW PROCESS.—

''(A) FILING OF REQUEST.—A participant or beneficiary (or the authorized representative of the participant or beneficiary) who desires to have an independent external review conducted under this subsection shall file a written request for such a review with the plan or issuer involved not later than 30 working days after the receipt of a final denial of a claim under subsection (d). Any such request shall include the consent of the participant or beneficiary (or the authorized representative of the participant or beneficiary) for the release of medical information and records to independent external reviewers regarding the participant or beneficiary.

''(B) TIMEFRAME FOR SELECTION OF APPEALS ENTITY.—Not later than 5 working days after the receipt of a request under subparagraph (A), or earlier in accordance with the medical exigencies of the case, the plan or issuer involved shall—

''(i) select an external appeals entity under paragraph (3)(A) that shall be responsible for designating an independent external reviewer under paragraph (3)(B); and

''(ii) provide notice of such selection to the participant or beneficiary (which shall include the name and address of the entity).

''(C) PROVISION OF INFORMATION.—Not later than 5 working days after the plan or issuer provides the notice required under subparagraph (B)(ii), or earlier in accordance with the medical exigencies of the case, the plan, issuer, participant, beneficiary or physician (of the participant or beneficiary) involved shall forward necessary information (including, only in the case of a plan or issuer, medical records, any relevant review criteria, the clinical rationale consistent with the terms and conditions of the contract between the plan or issuer and the participant or beneficiary for the coverage denial, and evidence of the coverage of the participant or beneficiary) to the qualified external appeals entity designated under paragraph (3)(A).

''(D) FOLLOW-UP WRITTEN NOTIFICATION.—The plan or issuer involved shall send a follow-up written notification, in a timely manner, to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and the plan administrator, indicating that an independent external review has been initiated.

''(3) CONDUCT OF INDEPENDENT EXTERNAL REVIEW.—

''(A) DESIGNATION OF EXTERNAL APPEALS ENTITY BY PLAN OR ISSUER.—

''(i) IN GENERAL.—A plan or issuer that receives a request for an independent external review under paragraph (2)(A) shall designate a qualified entity described in clause (ii), in a manner designed to ensure that the entity so designated will make a decision in an unbiased manner, to serve as the external appeals entity.

''(ii) QUALIFIED ENTITIES.—A qualified entity shall be—

''(I) an independent external review entity licensed or credentialed by a State;

''(II) a State agency established for the purpose of conducting independent external reviews;

''(III) any entity under contract with the Federal Government to provide independent external review services;

''(IV) any entity accredited as an independent external review entity by an accrediting body recognized by the Secretary for such purpose; or

''(V) any other entity meeting criteria established by the Secretary for purposes of this subparagraph.

''(B) DESIGNATION OF INDEPENDENT EXTERNAL REVIEWER BY EXTERNAL APPEALS ENTITY.—The external appeals entity designated under subparagraph (A) shall, not later than 30 days after the date on which such entity is designated under subparagraph (A), or earlier in accordance with the medical exigencies of the case, designate one or more individuals to serve as independent external reviewers with respect to a request received under paragraph (2)(A). Such reviewers shall be independent medical experts who shall—

''(i) be appropriately credentialed or licensed in any State to deliver health care services;

''(ii) not have any material, professional, familial, or financial affiliation with the case under review, the participant or beneficiary involved, the treating health care professional, the institution where the treatment would take place, or the manufacturer of any drug, device, procedure, or other therapy proposed for the participant or beneficiary whose treatment is under review;

''(iii) have expertise (including age-appropriate expertise) in the diagnosis or treatment under review and be a physician of the same specialty, when reasonably available, as the physician treating the participant or beneficiary or recommending or prescribing the treatment in question;

''(iv) receive only reasonable and customary compensation from the group health plan or health insurance issuer in connection with the independent external review that is not contingent on the decision rendered by the reviewer; and

''(v) not be held liable for decisions regarding medical determinations (but may be held liable for actions that are arbitrary and capricious).

''(4) STANDARD OF REVIEW.—

''(A) IN GENERAL.—An independent external reviewer shall—

''(i) make an independent determination based on the valid, relevant, scientific and clinical evidence to determine the medical necessity, appropriateness, experimental or investigational nature of the proposed treatment; and

''(ii) take into consideration appropriate and available information, including any evidence-based decision making or clinical practice guidelines used by the group health plan or health insurance issuer; timely evidence or information submitted by the plan, issuer, patient or patient's physician; the patient's medical record; expert consensus including both generally accepted medical practice and recognized best practice; medical literature as defined in section 556(5) of the Federal Food, Drug, and Cosmetic Act; the following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information; and findings, studies, or research conducted by or under the auspices of Federal Government agencies and nationally recognized Federal research institutes including the Agency for Healthcare Research and Quality, National Institutes of Health, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purposes of evaluating the medical value of health services.

''(B) NOTICE.—The plan or issuer involved shall ensure that the participant or beneficiary receives notice, within 30 days after the determination of the independent medical expert, regarding the actions of the plan or issuer with respect to the determination of such expert under the independent external review.

''(5) TIMEFRAME FOR REVIEW.—

''(A) IN GENERAL.—The independent external reviewer shall complete a review of an adverse coverage determination in accordance with the medical exigencies of the case.

''(B) EXPEDITED REVIEW.—Notwithstanding subparagraph (A), a review described in such subparagraph shall be completed not later than 72 hours after the later of—

''(i) the date on which such reviewer is designated; or

''(ii) the date on which all information necessary to completing such review is received;

if the completion of such review in a period of time in excess of 72 hours would seriously jeopardize the life or health of the participant or beneficiary.

''(C) LIMITATION.—Notwithstanding subparagraph (A), and except as provided in subparagraph (B), a review described in subparagraph (A) shall be completed not later than 30 working days after the later of—

''(i) the date on which such reviewer is designated; or

''(ii) the date on which all information necessary to completing such review is received.

''(6) BINDING DETERMINATION AND ACCESS TO CARE.—

''(A) IN GENERAL.—The determination of an independent external reviewer under this subsection shall be binding upon the plan or issuer if the provisions of this subsection or the procedures implemented under such provisions were complied with by the independent external reviewer.

''(B) TIMETABLE FOR COMMENCEMENT OF CARE.—Where an independent external reviewer determines that the participant or beneficiary is entitled to coverage of the items or services that were the subject of the review, the reviewer shall establish a timeframe, in accordance with the medical exigencies of the case, during which the plan or issuer shall begin providing for the coverage of such items or services.

''(C) FAILURE TO COMPLY.—If a plan or issuer fails to comply with the timeframe established under subparagraph (B) with respect to a participant or beneficiary, the participant or beneficiary may obtain the items or services involved (in a manner consistent with the determination of the independent external reviewer) from any provider regardless of whether such provider is a participating provider under the plan or coverage.

''(D) REIMBURSEMENT.—

''(i) IN GENERAL.—Where a participant or beneficiary obtains items or services in accordance with subparagraph (C), the plan or issuer involved shall provide for reimbursement of the costs of such items of services. Such reimbursement shall be made to the treating provider or to the participant or beneficiary (in the case of a participant or beneficiary who pays for the costs of such items or services).

''(ii) AMOUNT.—The plan or issuer shall fully reimburse a provider, participant or beneficiary under clause (i) for the total costs of the items or services provided (regardless of any plan limitations that may apply to the coverage of such items of services) so long as—

''(I) the items or services would have been covered under the terms of the plan or coverage if provided by the plan or issuer; and

''(II) the items or services were provided in a manner consistent with the determination of the independent external reviewer.

''(E) FAILURE TO REIMBURSE.—Where a plan or issuer fails to provide reimbursement to a provider, participant or beneficiary in accordance with this paragraph, the provider, participant or beneficiary may commence a civil action (or utilize other remedies available under law) to recover only the amount of any such reimbursement that is unpaid and any necessary legal costs or expenses (including attorneys' fees) incurred in recovering such reimbursement.

''(7) STUDY.—Not later than 2 years after the date of enactment of this section, the General Accounting Office shall conduct a study of a statistically appropriate sample of completed independent external reviews. Such study shall include an assessment of the process involved during an independent external review and the basis of decision-making by the independent external reviewer. The results of such study shall be submitted to the appropriate committees of Congress.

''(8) EFFECT ON CERTAIN PROVISIONS.—Nothing in this section shall be construed as affecting or modifying section 514 of this Act with respect to a group health plan.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a plan administrator or plan fiduciary or health plan medical director from requesting an independent external review by an independent external reviewer without first completing the internal review process.

''(g) DEFINITIONS.—In this section:

''(1) ADVERSE COVERAGE DETERMINATION.—The term 'adverse coverage determination' means a coverage determination under the plan which results in a denial of coverage or reimbursement.

''(2) COVERAGE DETERMINATION.—The term 'coverage determination' means with respect to items and services for which coverage may be provided under a health plan, a determination of whether or not such items and services are covered or reimbursable under the coverage and terms of the contract.

''(3) GRIEVANCE.—The term 'grievance' means any complaint made by a participant or beneficiary that does not involve a coverage determination.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' shall have the meaning given such term in section 733(a). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 733(b)(1). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 733(b)(2).

''(7) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means a coverage determination prior to the provision of the items and services as a condition of coverage of the items and services under the coverage.

''(8) TREATING HEALTH CARE PROFESSIONAL.—The term 'treating health care professional' with respect to a group health plan, health insurance issuer or provider sponsored organization means a physician (medical doctor or doctor of osteopathy) or other health care practitioner who is acting within the scope of his or her State licensure or certification for the delivery of health care services and who is primarily responsible for delivering those services to the participant or beneficiary.

''(9) UTILIZATION REVIEW.—The term 'utilization review' with respect to a group health plan or health insurance coverage means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.''

(b) ENFORCEMENT.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) is amended by adding at the end the following:

''(8) The Secretary may assess a civil penalty against any plan of up to $10,000 for the plan's failure or refusal to comply with any timeline applicable under section 503(e) or any determination under such section, except that in any case in which treatment was not commenced by the plan in accordance with the determination of an independent external reviewer, the Secretary shall assess a civil penalty of $10,000 against the plan and the plan shall pay such penalty to the participant or beneficiary involved.''.

(c) CONFORMING AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the item relating to section 503 and inserting the following new item:

''Sec. 503. Claims procedures, coverage determination, grievances and appeals.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after 1 year after the date of enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

SEC. ___. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan (other than a fully insured group health plan) provides coverage to a qualified individual (as defined in subsection (b)), the plan—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsections (b), (c), and (d) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the participant's or beneficiaries participation in such trial.

(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

(1)(A) The individual has been diagnosed with cancer for which no standard treatment is effective.

(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

(2) Either—

(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) PAYMENT.—

(1) IN GENERAL.—Under this section a group health plan (other than a fully insured group health plan) shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

(2) STANDARDS FOR DETERMINING ROUTINE PATIENT COSTS ASSOCIATED WITH CLINICAL TRIAL PARTICIPATION.—

(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards relating to the coverage of routine patient costs for individuals participating in clinical trials that group health plans must meet under this section.

(B) FACTORS.—In establishing routine patient cost standards under subparagraph (A), the Secretary shall consult with interested parties and take into account —

(i) quality of patient care;

(ii) routine patient care costs versus costs associated with the conduct of clinical trials, including unanticipated patient care costs as a result of participation in clinical trials; and

(iii) previous and on-going studies relating to patient care costs associated with participation in clinical trials.

(C) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this paragraph, the Secretary, after consultation with organizations representing cancer patients, health care practitioners, medical researchers, employers, group health plans, manufacturers of drugs, biologics and medical devices, medical economists, hospitals, and other interested parties, shall publish notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

(D) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subparagraph (C), and for purposes of this paragraph, the ''target date for publication'' (referred to in section 564(a)(5) of such title 5) shall be June 30, 2000.

(E) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title 5 under this paragraph, ''15 days'' shall be substituted for ''30 days''.

(F) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

(i) the appointment of a negotiated rulemaking committee under section 565(a) of such title 5 by not later than 30 days after the end of the comment period provided for under section 564(c) of such title 5 (as shortened under subparagraph (E)), and

(ii) the nomination of a facilitator under section 566(c) of such title 5 by not later than

10 days after the date of appointment of the committee.

(G) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subparagraph (F) shall report to the Secretary, by not later than March 29, 2000, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this paragraph through such other methods as the Secretary may provide.

(H) FINAL COMMITTEE REPORT.—If the committee is not terminated under subparagraph (G), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

(I) FINAL EFFECT.—The Secretary shall publish a rule under this paragraph in the Federal Register by not later than the target date of publication.

(J) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

(K) EFFECTIVE DATE.—The provisions of this paragraph shall apply to group health plans (other than a fully insured group health plan) for plan years beginning on or after January 1, 2001.

(3) PAYMENT RATE.—In the case of covered items and services provided by—

(A) a participating provider, the payment rate shall be at the agreed upon rate, or

(B) a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable services under subparagraph (A).

(d) APPROVED CLINICAL TRIAL DEFINED.—

(1) IN GENERAL.—In this section, the term ''approved clinical trial'' means a cancer clinical research study or cancer clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

(A) The National Institutes of Health.

(B) A cooperative group or center of the National Institutes of Health.

(C) Either of the following if the conditions described in paragraph (2) are met:

(i) The Department of Veterans Affairs.

(ii) The Department of Defense.

(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's coverage with respect to clinical trials.

(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

(1) IN GENERAL.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

(2) CONSTRUCTION.—Nothing in this section shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

(g) STUDY AND REPORT.—

(1) STUDY.—The Secretary shall study the impact on group health plans for covering routine patient care costs for individuals who are entitled to benefits under this section and who are enrolled in an approved cancer clinical trial program.

(2) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains an assessment of—

(A) any incremental cost to group health plans resulting from the provisions of this section;

(B) a projection of expenditures to such plans resulting from this section; and

(C) any impact on premiums resulting from this section.

(h) APPLICATION OF PROVISIONS.—

(1) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the provisions of this section shall only apply to group health plans (other than fully insured group health plans).

(2) FULLY INSURED GROUP HEALTH PLAN.—In this section, the term ''fully insured group health plan'' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.

SEC. ___. OFFERING OF CHOICE OF COVERAGE OPTIONS.

(a) REQUIREMENT.—

(1) OFFERING OF POINT-OF-SERVICE COVERAGE OPTION.—Except as provided in paragraph (2), if a group health plan (other than a fully insured group health plan) provides coverage for benefits only through a defined set of participating health care professionals, the plan shall offer the participant the option to purchase point-of-service coverage (as defined in subsection (b)) for all such benefits for which coverage is otherwise so limited. Such option shall be made available to the participant at the time of enrollment under the plan and at such other times as the plan offers the participant a choice of coverage options.

(2) EXCEPTION IN CASE OF LACK OF AVAILABILITY.—Paragraph (1) shall not apply with respect to a group health plan (other than a fully insured group health plan) if care relating to the point-of-service coverage would not be available and accessible to the participant with reasonable promptness (consistent with section 1301(b)(4) of the Public Health Service Act (42 U.S.C. 300e(b)(4))).

(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term ''point-of-service coverage'' means, with respect to benefits covered under a group health plan (other than a fully insured group health plan), coverage of such benefits when provided by a nonparticipating health care professional.

(c) SMALL EMPLOYER EXEMPTION.—

(1) IN GENERAL.—This section shall not apply to any group health plan (other than a fully insured group health plan) of a small employer.

(2) SMALL EMPLOYER.—For purposes of paragraph (1), the term ''small employer'' means, in connection with a group health plan (other than a fully insured group health plan) with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of this paragraph, the provisions of subparagraph (C) of section 712(c)(1) of the Employee Retirement Income Security Act of 1974 shall apply in determining employer size.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

(1) as requiring coverage for benefits for a particular type of health care professional;

(2) as requiring an employer to pay any costs as a result of this section or to make equal contributions with respect to different health coverage options;

(3) as preventing a group health plan (other than a fully insured group health plan) from imposing higher premiums or cost-sharing on a participant for the exercise of a point-of-service coverage option; or

(4) to require that a group health plan (other than a fully insured group health plan) include coverage of health care professionals that the plan excludes because of fraud, quality of care, or other similar reasons with respect to such professionals.

(e) APPLICATION OF PROVISIONS.—

(1) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the provisions of this section shall only apply to group health plans (other than fully insured group health plans).

(2) FULLY INSURED GROUP HEALTH PLAN.—In this section, the term ''fully insured group health plan'' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.

SEC. ___. CONTINUITY OF CARE.

(a) IN GENERAL.—

(1) TERMINATION OF PROVIDER.—If a contract between a group health plan (other than a fully insured group health plan) and a health care provider is terminated (as defined in paragraph (2)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such group health plan, and an individual who is a participant or beneficiary in the plan is undergoing a course of treatment from the provider at the time of such termination, the plan shall—

(A) notify the individual on a timely basis of such termination;

(B) provide the individual with an opportunity to notify the plan of a need for transitional care; and

(C) in the case of termination described in paragraph (2), (3), or (4) of subsection (b), and subject to subsection (c), permit the individual to continue or be covered with respect to the course of treatment with the provider's consent during a transitional period (as provided under subsection (b)).

(2) TERMINATED.—In this section, the term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract by the group health plan, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

(3) CONTRACTS.—For purposes of this section, the term ''contract between a group health plan (other than a fully insured group health plan) and a health care provider'' shall include a contract between such a plan and an organized network of providers.

(b) TRANSITIONAL PERIOD.—

(1) GENERAL RULE.—Except as provided in paragraph (3), the transitional period under this subsection shall permit the participant

or beneficiary to extend the coverage involved for up to 90 days from the date of the notice described in subsection (a)(1)(A) of the provider's termination.

(2) INSTITUTIONAL CARE.—Subject to paragraph (1), the transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status if the care was scheduled before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such care.

(3) PREGNANCY.—Notwithstanding paragraph (1), if—

(A) a participant or beneficiary has entered the second trimester of pregnancy at the time of a provider's termination of participation; and

(B) the provider was treating the pregnancy before the date of the termination;

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

(4) TERMINAL ILLNESS.—Subject to paragraph (1), if—

(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) prior to a provider's termination of participation; and

(B) the provider was treating the terminal illness before the date of termination;

the transitional period under this subsection shall be for care directly related to the treatment of the terminal illness and shall extend for the remainder of the individual's life for such care.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan (other than a fully insured group health plan) may condition coverage of continued treatment by a provider under subsection (a)(1)(C) upon the provider agreeing to the following terms and conditions:

(1) The provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or at the rates applicable under the replacement plan after the date of the termination of the contract with the group health plan) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the plan responsible for payment under paragraph (1) and to provide to such plan necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to such plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

(e) DEFINITION.—In this section, the term ''health care provider'' or ''provider'' means—

(1) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

(2) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(f) APPLICATION OF PROVISIONS.—

(1) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the provisions of this section shall only apply to group health plans (other than fully insured group health plans).

(2) FULLY INSURED GROUP HEALTH PLAN.—In this section, the term ''fully insured group health plan'' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.

(g) COMPREHENSIVE STUDY OF COST, QUALITY AND COORDINATION OF COVERAGE FOR PATIENTS AT THE END OF LIFE.—

(1) STUDY BY THE MEDICARE PAYMENT ADVISORY COMMISSION.—The Medicare Payment Advisory Commission shall conduct a study of the costs and patterns of care for persons with serious and complex conditions and the possibilities of improving upon that care to the degree it is triggered by the current category of terminally ill as such term is used for purposes of section 1861(dd) of the Social Security Act (relating to hospice benefits) or of utilizing care in other payment settings in Medicare.

(2) AGENCY FOR HEALTH CARE POLICY AND RESEARCH.—The Agency for Health Care Policy and Research shall conduct studies of the possible thresholds for major conditions causing serious and complex illness, their administrative parameters and feasibility, and their impact upon costs and quality.

(3) HEALTH CARE FINANCING ADMINISTRATION.—The Health Care Financing Administration shall conduct studies of the merits of applying similar thresholds in Medicare+Choice programs, including adapting risk adjustment methods to account for this category.

(4) INITIAL REPORT.—

(A) IN GENERAL.—Not later than 12 months after the date of enactment of this Act, the Medicare Payment Advisory Commission and the Agency for Health Care Policy and Research shall each prepare and submit to the Committee on Health, Education, Labor and Pensions of the Senate a report concerning the results of the studies conducted under paragraphs (1) and (2), respectively.

(B) COPY TO SECRETARY.—Concurrent with the submission of the reports under subparagraph (A), the Medicare Payment Advisory Commission and the Agency for health Care Policy and Research shall transmit a copy of the reports under such subparagraph to the Secretary.

(5) FINAL REPORT.—

(A) CONTRACT WITH INSTITUTE OF MEDICINE.—Not later than 1 year after the submission of the reports under paragraph (4), the Secretary of Health and Human Services shall contract with the Institute of Medicine to conduct a study of the practices and their effects arising from the utilization of the category ''serious and complex'' illness.

(B) REPORT.—Not later than 1 year after the date of the execution of the contract referred to in subparagraph (A), the Institute of Medicine shall prepare and submit to the Committee on Health, Education, Labor and Pensions of the Senate a report concerning the study conducted pursuant to such contract.

(6) FUNDING.—From funds appropriated to the Department of Health and Human Services, the Secretary of Health and Human Services shall make available such funds as the Secretary determines is necessary to carry out this subsection.

SEC. ___. PROHIBITING DISCRIMINATION AGAINST PROVIDERS.

(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This subsection shall not be construed as requiring the coverage under a plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants and beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

(b) NO REQUIREMENT FOR ANY WILLING PROVIDER.—Nothing in this section shall be construed as requiring a group health plan that offers network coverage to include for participation every willing provider or health professional who meets the terms and conditions of the plan.

(c) APPLICATION OF PROVISIONS.—

(1) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the provisions of this section shall only apply to group health plans (other than fully insured group health plans).

(2) FULLY INSURED GROUP HEALTH PLAN.—In this section, the term ''fully insured group health plan'' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.

KERREY (AND OTHERS) AMENDMENT NO. 1253

Mr. KERREY (for himself, Ms. MIKULSKI, Mr. SCHUMER, Mr. GRAHAM, Mr. KENNEDY, Mrs. MURRAY, Mr. DASCHLE, Mr. DURBIN, Mr. ROCKEFELLER, and Mr. TORRICELLI) proposed an amendment to amendment No. 1251 proposed by Mr. WYDEN to the bill, S. 1344, supra; as follows:

At the appropriate place insert the following:

SEC. ___. CONTINUITY OF CARE.

(a) ERISA.—Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as added by section 101(a)(2) of this Act, is amended by adding at the end the following:

''SEC. 730A. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with group health insurance coverage, and a health care provider is terminated (as defined in paragraph (2)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan or health insurance coverage, and an individual who is a participant, beneficiary or enrollee in the plan or coverage is undergoing a course of treatment from the provider at the time of such termination, the plan or issuer shall—

''(A) notify the individual on a timely basis of such termination, and

''(B) subject to subsection (c), permit the individual to continue or be covered with respect to the course of treatment with the provider during a transitional period (provided under subsection (b)).

''(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

''(3) TERMINATION.—In this section, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

''(b) TRANSITIONAL PERIOD.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend for at least 90 days from the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) INSTITUTIONAL CARE.—The transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status if the care was scheduled before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such care.

''(3) PREGNANCY.—If—

''(A) a participant, beneficiary or enrollee has entered the second trimester of pregnancy at the time of a provider's termination of participation, and

''(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—If—

''(A) a participant, beneficiary or enrollee was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

''(B) the provider was treating the terminal illness before the date of termination, the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

''(2) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

''(d) CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

''(e) APPLICATION OF SECTION.—This section shall supersede the provisions of section 726 and section 726 shall have no effect.

''(f) REVIEW.—Failure to meet the requirements of this section shall constitute an appealable decision under this Act.

''(g) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any provision of this subchapter, the group health plan shall not be liable for such violation unless the plan caused such violation.

''(h) APPLICABILITY.—The provisions of this section shall apply to group health plans and health insurance issuers as if included in—

''(1) subpart 2 of part A of title XXVII of the Public Health Service Act;

''(2) the first subpart 3 of part B of title XXVII of the Public Health Service Act (relating to other requirements); and

''(3) subchapter B of chapter 100 of the Internal Revenue Code of 1986.

''(i) NONAPPLICATION OF CERTAIN PROVISION.—Only for purposes of applying the requirements of this section under section 714 of the Employee Retirement Income Security Act of 1974 (as added by section 301 of this Act), sections 2707 and 2753 of the Public Health Service Act (as added by sections 201 and 202 of this Act), and section 9813 of the Internal Revenue Code of 1986 (as added by section 401 of this Act)—

''(1) section 2721(b)(2) of the Public Health Service Act and section 9831(a)(1) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section; and

''(2) with respect to limited scope dental benefits, subparagraph (A) of section 733(c)(2) of the Employee Retirement Income Security Act of 1974, subparagraph (A) of section 2791(c)(2) of the Public Health Service Act, and subparagraph (A) of section 9832(c)(2) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section.

''(j) LIMITATION ON ACTIONS.—

''(1) IN GENERAL.—Except as provided for in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 by a participant or beneficiary seeking relief based on the application of any provision in this section.

''(2) PERMISSIBLE ACTIONS.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 by a participant or beneficiary seeking relief based on the application of this section to the individual circumstances of that participant or beneficiary; except that—

''(A) such an action may not be brought or maintained as a class action; and

''(B) in such an action relief may only provide for the provision of (or payment for) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.

''(k) EFFECTIVE DATE.—The provisions of this section shall apply to group health plans for plan years beginning after, and to health insurance issuers for coverage offered or sold after, October 1, 2000.''.

(b) INFORMATION REQUIREMENTS.—

(1) INFORMATION FROM GROUP HEALTH PLANS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following:

''(7) INFORMATION FROM GROUP HEALTH PLANS.—

''(A) PROVISION OF INFORMATION BY GROUP HEALTH PLANS.—The administrator of a group health plan subject to the requirements of paragraph (1) shall provide to the Secretary such of the information elements described in subparagraph (C) as the Secretary specifies, and in such manner and at such times as the Secretary may specify (but not more frequently than 4 times per year), with respect to each individual covered under the plan who is entitled to any benefits under this title.

''(B) PROVISION OF INFORMATION BY EMPLOYERS AND EMPLOYEE ORGANIZATIONS.—An employer (or employee organization) that maintains or participates in a group health plan subject to the requirements of paragraph (1) shall provide to the administrator of the plan such of the information elements required to be provided under subparagraph (A), and in such manner and at such times as the Secretary may specify, at a frequency consistent with that required under subparagraph (A) with respect to each individual described in subparagraph (A) who is covered under the plan by reason of employment with that employer or membership in the organization.

''(C) INFORMATION ELEMENTS.—The information elements described in this subparagraph are the following:

''(i) ELEMENTS CONCERNING THE INDIVIDUAL.—

''(I) The individual's name.

''(II) The individual's date of birth.

''(III) The individual's sex.

''(IV) The individual's social security insurance number.

''(V) The number assigned by the Secretary to the individual for claims under this title.

''(VI) The family relationship of the individual to the person who has or had current or employment status with the employer.

''(ii) ELEMENTS CONCERNING THE FAMILY MEMBER WITH CURRENT OR FORMER EMPLOYMENT STATUS.—

''(I) The name of the person in the individual's family who has current or former employment status with the employer.

''(II) That person's social security insurance number.

''(III) The number or other identifier assigned by the plan to that person.

''(IV) The periods of coverage for that person under the plan.

''(V) The employment status of that person (current or former) during those periods of coverage.

''(VI) The classes (of that person's family members) covered under the plan.

''(iii) PLAN ELEMENTS.—

''(I) The items and services covered under the plan.

''(II) The name and address to which claims under the plan are to be sent.

''(iv) ELEMENTS CONCERNING THE EMPLOYER.—

''(I) The employer's name.

''(II) The employer's address.

''(III) The employer identification number of the employer.

''(D) USE OF IDENTIFIERS.—The administrator of a group health plan shall utilize a unique identifier for the plan in providing information under subparagraph (A) and in other transactions, as may be specified by the Secretary, related to the provisions of this subsection. The Secretary may provide to the administrator the unique identifier described in the preceding sentence.

''(E) PENALTY FOR NONCOMPLIANCE.—Any entity that knowingly and willfully fails to comply with a requirement imposed by the previous subparagraphs shall be subject to a civil money penalty not to exceed $1,000 for each incident of such failure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as those provisions apply to a penalty or proceeding under section 1128A(a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect 180 days after the date of the enactment of this Act.

(c) LIMITATIONS ON WELFARE BENEFIT FUNDS OF 10 OR MORE EMPLOYER PLANS.—

(1) BENEFITS TO WHICH EXCEPTION APPLIES.—Section 419A(f)(6)(A) of the Internal Revenue Code of 1986 (relating to exception for 10 or more employer plans) is amended to read as follows:

''(A) IN GENERAL.—This subpart shall not apply to a welfare benefit fund which is part of a 10 or more employer plan if the only benefits provided through the fund are 1 or more of the following:

''(i) Medical benefits.

''(ii) Disability benefits.

''(iii) Group term life insurance benefits which do not provide for any cash surrender value or other money that can be paid, assigned, borrowed, or pledged for collateral for a loan.

The preceding sentence shall not apply to any plan which maintains experience-rating arrangements with respect to individual employers.''

(2) LIMITATION ON USE OF AMOUNTS FOR OTHER PURPOSES.—Section 4976(b) of such Act (defining disqualified benefit) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR 10 OR MORE EMPLOYER PLANS EXEMPTED FROM PREFUNDING LIMITS.—For purposes of paragraph (1)(C), if—

''(A) subpart D of part I of subchapter D of chapter 1 does not apply by reason of section 419A(f)(6) to contributions to provide 1 or more welfare benefits through a welfare benefit fund under a 10 or more employer plan, and

''(B) any portion of the welfare benefit fund attributable to such contributions is used for a purpose other than that for which the contributions were made,

then such portion shall be treated as reverting to the benefit of the employers maintaining the fund.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

LOTT (AND NICKLES) AMENDMENT NO. 1254

Mr. LOTT (for himself and Mr. NICKLES) proposed an amendment to amendment No. 1232 proposed by Mr. DASCHLE to the bill, S. 1344, supra; as follows:

Strike all after the enacting clause, and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patients' Bill of Rights Plus Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—PATIENTS' BILL OF RIGHTS

Subtitle A—Right to Advice and Care

Sec. 101. Patient right to medical advice and care.

''SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

''Sec. 721. Patient access to emergency medical care.
''Sec. 722. Offering of choice of coverage options.
''Sec. 723. Patient access to obstetric and gynecological care.
''Sec. 724. Patient access to pediatric care.
''Sec. 725. Timely access to specialists.
''Sec. 726. Continuity of care.
''Sec. 727. Protection of patient-provider communications.
''Sec. 728. Patient's right to prescription drugs.
''Sec. 729. Self-payment for behavioral health care services.
''Sec. 730. Coverage for individuals participating in approved cancer clinical trials.
''Sec. 730A. Prohibiting discrimination against providers.
''Sec. 730B. Generally applicable provision.

Sec. 102. Conforming amendment to the Internal Revenue Code of 1986.
''Sec. 9821. Patient access to emergency medical care.
''Sec. 9822. Offering of choice of coverage options.
''Sec. 9823. Patient access to obstetric and gynecological care.
''Sec. 9824. Patient access to pediatric care.
''Sec. 9825. Timely access to specialists.
''Sec. 9826. Continuity of care.
''Sec. 9827. Protection of patient-provider communications.
''Sec. 9828. Patient's right to prescription drugs.
''Sec. 9829. Self-payment for behavioral health care services.
''Sec. 9830. Coverage for individuals participating in approved cancer clinical trials.
''Sec. 9830A. Prohibiting discrimination against providers.
''Sec. 9830B. Generally applicable provision.

Sec. 103. Effective date and related rules.

Subtitle B—Right to Information About Plans and Providers

Sec. 111. Information about plans.
Sec. 112. Information about providers.

Subtitle C—Right to Hold Health Plans Accountable

Sec. 121. Amendment to Employee Retirement Income Security Act of 1974.

TITLE II—WOMEN'S HEALTH AND CANCER RIGHTS

Sec. 201. Women's health and cancer rights.

TITLE III—GENETIC INFORMATION AND SERVICES

Sec. 301. Short title.
Sec. 302. Amendments to Employee Retirement Income Security Act of 1974.
Sec. 303. Amendments to the Public Health Service Act.
Sec. 304. Amendments to the Internal Revenue Code of 1986.

TITLE IV—HEALTHCARE RESEARCH AND QUALITY

Sec. 401. Short title.
Sec. 402. Amendment to the Public Health Service Act.

''TITLE IX—AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

''PART A—ESTABLISHMENT AND GENERAL DUTIES

''Sec. 901. Mission and duties.
''Sec. 902. General authorities.

''PART B—HEALTHCARE IMPROVEMENT RESEARCH

''Sec. 911. Healthcare outcome improvement research.
''Sec. 912. Private-public partnerships to improve organization and delivery.
''Sec. 913. Information on quality and cost of care.
''Sec. 914. Information systems for healthcare improvement.
''Sec. 915. Research supporting primary care and access in underserved areas.
''Sec. 916. Clinical practice and technology innovation.
''Sec. 917. Coordination of Federal government quality improvement efforts.

''PART C—GENERAL PROVISIONS

''Sec. 921. Advisory Council for Healthcare Research and Quality.
''Sec. 922. Peer review with respect to grants and contracts.
''Sec. 923. Certain provisions with respect to development, collection, and dissemination of data.
''Sec. 924. Dissemination of information.
''Sec. 925. Additional provisions with respect to grants and contracts.
''Sec. 926. Certain administrative authorities.
''Sec. 927. Funding.
''Sec. 928. Definitions.

Sec. 403. References.

TITLE V—ENHANCED ACCESS TO HEALTH INSURANCE COVERAGE

Sec. 501. Full deduction of health insurance costs for self-employed individuals.
Sec. 502. Full availability of medical savings accounts.
Sec. 503. Permitting contribution towards medical savings account through Federal employees health benefits program (FEHBP).
Sec. 504. Carryover of unused benefits from cafeteria plans, flexible spending arrangements, and health flexible spending accounts.

TITLE VI—PROVISIONS RELATING TO LONG-TERM CARE INSURANCE

Sec. 601. Inclusion of qualified long-term care insurance contracts in cafeteria plans, flexible spending arrangements, and health flexible spending accounts.
Sec. 602. Deduction for premiums for long-term care insurance.
Sec. 603. Study of long-term care needs in the 21st century.

TITLE VII—INDIVIDUAL RETIREMENT PLANS

Sec. 701. Modification of income limits on contributions and rollovers to Roth IRAs.

TITLE VIII—REVENUE PROVISIONS

Sec. 801. Modification to foreign tax credit carryback and carryover periods.
Sec. 802. Limitation on use of non-accrual experience method of accounting.
Sec. 803. Returns relating to cancellations of indebtedness by organizations lending money.

Sec. 804. Extension of Internal Revenue Service user fees.
Sec. 805. Property subject to a liability treated in same manner as assumption of liability.
Sec. 806. Charitable split-dollar life insurance, annuity, and endowment contracts.
Sec. 807. Transfer of excess defined benefit plan assets for retiree health benefits.
Sec. 808. Limitations on welfare benefit funds of 10 or more employer plans.
Sec. 809. Modification of installment method and repeal of installment method for accrual method taxpayers.
Sec. 810. Inclusion of certain vaccines against streptococcus pneumoniae to list of taxable vaccines.
TITLE IX—MISCELLANEOUS PROVISIONS
Sec. 901. Medicare competitive pricing demonstration project.

TITLE I—PATIENTS' BILL OF RIGHTS

Subtitle A—Right to Advice and Care

SEC. 101. PATIENT RIGHT TO MEDICAL ADVICE AND CARE.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is amended—

(1) by redesignating subpart C as subpart D; and

(2) by inserting after subpart B the following:

"Subpart C—Patient Right to Medical Advice and Care

"SEC. 721. PATIENT ACCESS TO EMERGENCY MEDICAL CARE.

''(a) COVERAGE OF EMERGENCY CARE.—

''(1) IN GENERAL.—To the extent that the group health plan (other than a fully insured group health plan) provides coverage for benefits consisting of emergency medical care (as defined in subsection (c)) or emergency ambulance services, except for items or services specifically excluded—

''(A) the plan shall provide coverage for benefits, without requiring preauthorization, for emergency medical screening examinations or emergency ambulance services, to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations or emergency ambulance services to be necessary to determine whether emergency medical care (as so defined) is necessary; and

''(B) the plan shall provide coverage for benefits, without requiring preauthorization, for additional emergency medical care to stabilize an emergency medical condition following an emergency medical screening examination (if determined necessary under subparagraph (A)), pursuant to the definition of stabilize under section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

''(2) REIMBURSEMENT FOR CARE TO MAINTAIN MEDICAL STABILITY.—

''(A) IN GENERAL.—In the case of services provided to a participant or beneficiary by a nonparticipating provider in order to maintain the medical stability of the participant or beneficiary, the group health plan involved shall provide for reimbursement with respect to such services if—

''(i) coverage for services of the type furnished is available under the group health plan;

''(ii) the services were provided for care related to an emergency medical condition and in an emergency department in order to maintain the medical stability of the participant or beneficiary; and

''(iii) the nonparticipating provider contacted the plan regarding approval for such services.

''(B) FAILURE TO RESPOND.—If a group health plan fails to respond within 1 hours of being contacted in accordance with subparagraph (A)(iii), then the plan shall be liable for the cost of services provided by the nonparticipating provider in order to maintain the stability of the participant or beneficiary.

''(C) LIMITATION.—The liability of a group health plan to provide reimbursement under subparagraph (A) shall terminate when the plan has contacted the nonparticipating provider to arrange for discharge or transfer.

''(D) LIABILITY OF PARTICIPANT.—A participant or beneficiary shall not be liable for the costs of services to which subparagraph (A) in an amount that exceeds the amount of liability that would be incurred if the services were provided by a participating health care provider with prior authorization by the plan.

''(b) IN-NETWORK UNIFORM COSTS-SHARING AND OUT-OF-NETWORK CARE.—

''(1) IN-NETWORK UNIFORM COST-SHARING.—Nothing in this section shall be construed as preventing a group health plan (other than a fully insured group health plan) from imposing any form of cost-sharing applicable to any participant or beneficiary (including co-insurance, copayments, deductibles, and any other charges) in relation to coverage for benefits described in subsection (a), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in subsection (c)) provided to such similarly situated participants and beneficiaries under the plan, and such cost-sharing is disclosed in accordance with section 714.

''(2) OUT-OF-NETWORK CARE.—If a group health plan (other than a fully insured group health plan) provides any benefits with respect to emergency medical care (as defined in subsection (c)), the plan shall cover emergency medical care under the plan in a manner so that, if such care is provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed any form of cost-sharing (including co-insurance, co-payments, deductibles, and any other charges) that would be incurred if the services were provided by a participating provider.

''(c) DEFINITION OF EMERGENCY MEDICAL CARE.—In this section:

''(1) IN GENERAL.—The term 'emergency medical care' means, with respect to a participant or beneficiary under a group health plan (other than a fully insured group health plan), covered inpatient and outpatient services that—

''(A) are furnished by any provider, including a nonparticipating provider, that is qualified to furnish such services; and

''(B) are needed to evaluate or stabilize (as such term is defined in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd)(e)(3)) an emergency medical condition (as defined in paragraph (2)).

''(2) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(A) placing the health of the participant or beneficiary (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(B) serious impairment to bodily functions, or

''(C) serious dysfunction of any bodily organ or part.

"SEC. 722. OFFERING OF CHOICE OF COVERAGE OPTIONS.

''(a) REQUIREMENT.—

''(1) OFFERING OF POINT-OF-SERVICE COVERAGE OPTION.—Except as provided in paragraph (2), if a group health plan (other than a fully insured group health plan) provides coverage for benefits only through a defined set of participating health care professionals, the plan shall offer the participant the option to purchase point-of-service coverage (as defined in subsection (b)) for all such benefits for which coverage is otherwise so limited. Such option shall be made available to the participant at the time of enrollment under the plan and at such other times as the plan offers the participant a choice of coverage options.

''(2) EXCEPTION IN CASE OF LACK OF AVAILABILITY.—Paragraph (1) shall not apply with respect to a group health plan (other than a fully insured group health plan) if care relating to the point-of-service coverage would not be available and accessible to the participant with reasonable promptness (consistent with section 1301(b)(4) of the Public Health Service Act (42 U.S.C. 300e(b)(4))).

''(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term 'point-of-service coverage' means, with respect to benefits covered under a group health plan (other than a fully insured group health plan), coverage of such benefits when provided by a nonparticipating health care professional.

''(c) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan (other than a fully insured group health plan) of a small employer.

''(2) SMALL EMPLOYER.—For purposes of paragraph (1), the term 'small employer' means, in connection with a group health plan (other than a fully insured group health plan) with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of this paragraph, the provisions of subparagraph (C) of section 712(c)(1) shall apply in determining employer size.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring coverage for benefits for a particular type of health care professional;

''(2) as requiring an employer to pay any costs as a result of this section or to make equal contributions with respect to different health coverage options;

''(3) as preventing a group health plan (other than a fully insured group health plan) from imposing higher premiums or cost-sharing on a participant for the exercise of a point-of-service coverage option; or

''(4) to require that a group health plan (other than a fully insured group health plan) include coverage of health care professionals that the plan excludes because of fraud, quality of care, or other similar reasons with respect to such professionals.

"SEC. 723. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(a) GENERAL RIGHTS.—

''(1) WAIVER OF PLAN REFERRAL REQUIREMENT.—If a group health plan described in subsection (b) requires a referral to obtain coverage for specialty care, the plan shall waive the referral requirement in the case of a female participant or beneficiary who seeks coverage for obstetrical care and related follow-up obstetrical care or routine

gynecological care (such as preventive gynecological care).

''(2) RELATED ROUTINE CARE.—With respect to a participant or beneficiary described in paragraph (1), a group health plan described in subsection (b) shall treat the ordering of other routine care that is related to routine gynecologic care, by a physician who specializes in obstetrics and gynecology as the authorization of the primary care provider for such other care.

''(b) APPLICATION OF SECTION.—A group health plan described in this subsection is a group health plan (other than a fully insured group health plan), that—

''(1) provides coverage for obstetric care (such as pregnancy-related services) or routine gynecologic care (such as preventive women's health examinations); and

''(2) requires the designation by a participant or beneficiary of a participating primary care provider who is not a physician who specializes in obstetrics or gynecology.

''(c) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of obstetric or gynecologic care described in subsection (a);

''(2) to preclude the plan from requiring that the physician who specializes in obstetrics or gynecology notify the designated primary care provider or the plan of treatment decisions;

''(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine obstetric or routine gynecologic care; or

''(4) to preclude a group health plan from permitting a physician who specializes in obstetrics and gynecology from being a primary care provider under the plan.

''SEC. 724. PATIENT ACCESS TO PEDIATRIC CARE.

''(a) IN GENERAL.—In the case of a group health plan (other than a fully insured group health plan) that provides coverage for routine pediatric care and that requires the designation by a participant or beneficiary of a participating primary care provider, if the designated primary care provider is not a physician who specializes in pediatrics—

''(1) the plan may not require authorization or referral by the primary care provider in order for a participant or beneficiary to obtain coverage for routine pediatric care; and

''(2) the plan shall treat the ordering of other routine care related to routine pediatric care by such a specialist as having been authorized by the designated primary care provider.

''(b) RULES OF CONSTRUCTION.—Nothing in subsection (a) shall be construed—

''(1) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of any pediatric care provided to, or ordered for, a participant or beneficiary;

''(2) to preclude a group health plan from requiring that a specialist described in subsection (a) notify the designated primary care provider or the plan of treatment decisions; or

''(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine pediatric care.

''SEC. 725. TIMELY ACCESS TO SPECIALISTS.

''(a) TIMELY ACCESS.—

''(1) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall ensure that participants and beneficiaries have timely, in accordance with the medical exigencies of the case, access to primary and specialty health care professionals who are appropriate to the condition of the participant or beneficiary, when such care is covered under the plan. Such access may be provided through contractual arrangements with specialized providers outside of the network of the plan.

''(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

''(A) to require the coverage under a group health plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants or beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan; or

''(B) to override any State licensure or scope-of-practice law.

''(b) TREATMENT PLANS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to prohibit a group health plan (other than a fully insured group health plan) from requiring that specialty care be provided pursuant to a treatment plan so long as the treatment plan is—

''(A) developed by the specialist, in consultation with the case manager or primary care provider, and the participant or beneficiary;

''(B) approved by the plan in a timely manner in accordance with the medical exigencies of the case; and

''(C) in accordance with the applicable quality assurance and utilization review standards of the plan.

''(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan from requiring the specialist to provide the case manager or primary care provider with regular updates on the specialty care provided, as well as all other necessary medical information.

''(c) REFERRALS.—Nothing in this section shall be construed to prohibit a plan from requiring an authorization by the case manager or primary care provider of the participant or beneficiary in order to obtain coverage for specialty services so long as such authorization is for an adequate number of referrals.

''(d) SPECIALTY CARE DEFINED.—For purposes of this subsection, the term 'specialty care' means, with respect to a condition, care and treatment provided by a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise (including age-appropriate expertise) through appropriate training and experience.

''SEC. 726. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan (other than a fully insured group health plan) and a health care provider is terminated (as defined in paragraph (2)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such group health plan, and an individual who is a participant or beneficiary in the plan is undergoing a course of treatment from the provider at the time of such termination, the plan shall—

''(A) notify the individual on a timely basis of such termination;

''(B) provide the individual with an opportunity to notify the plan of a need for transitional care; and

''(C) in the case of termination described in paragraph (2), (3), or (4) of subsection (b), and subject to subsection (c), permit the individual to continue or be covered with respect to the course of treatment with the provider's consent during a transitional period (as provided under subsection (b)).

''(2) TERMINATED.—In this section, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract by the group health plan, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

''(3) CONTRACTS.—For purposes of this section, the term 'contract between a group health plan (other than a fully insured group health plan) and a health care provider' shall include a contract between such a plan and an organized network of providers.

''(b) TRANSITIONAL PERIOD.—

''(1) GENERAL RULE.—Except as provided in paragraph (3), the transitional period under this subsection shall permit the participant or beneficiary to extend the coverage involved for up to 90 days from the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) INSTITUTIONAL CARE.—Subject to paragraph (1), the transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status if the care was scheduled before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such care.

''(3) PREGNANCY.—Notwithstanding paragraph (1), if—

''(A) a participant or beneficiary has entered the second trimester of pregnancy at the time of a provider's termination of participation; and

''(B) the provider was treating the pregnancy before the date of the termination;

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—Notwithstanding paragraph (1), if—

''(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) prior to a provider's termination of participation; and

''(B) the provider was treating the terminal illness before the date of termination;

the transitional period under this subsection shall be for care directly related to the treatment of the terminal illness and shall extend for the remainder of the individual's life for such care.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan (other than a fully insured group health plan) may condition coverage of continued treatment by a provider under subsection (a)(1)(C) upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or at the rates applicable under the replacement plan after the date of the termination of the contract with the group health plan) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

''(2) The provider agrees to adhere to the quality assurance standards of the plan responsible for payment under paragraph (1) and to provide to such plan necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan's policies and procedures,

including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

''(e) DEFINITION.—In this section, the term 'health care provider' or 'provider' means—

''(1) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

''(2) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

''(f) COMPREHENSIVE STUDY OF COST, QUALITY AND COORDINATION OF COVERAGE FOR PATIENTS AT THE END OF LIFE.—

''(1) STUDY BY THE MEDICARE PAYMENT ADVISORY COMMISSION.—The Medicare Payment Advisory Commission shall conduct a study of the costs and patterns of care for persons with serious and complex conditions and the possibilities of improving upon that care to the degree it is triggered by the current category of terminally ill as such term is used for purposes of section 1861(dd) of the Social Security Act (relating to hospice benefits) or of utilizing care in other payment settings in Medicare.

''(2) AGENCY FOR HEALTH CARE POLICY AND RESEARCH.—The Agency for Health Care Policy and Research shall conduct studies of the possible thresholds for major conditions causing serious and complex illness, their administrative parameters and feasibility, and their impact upon costs and quality.

''(3) HEALTH CARE FINANCING ADMINISTRATION.—The Health Care Financing Administration shall conduct studies of the merits of applying similar thresholds in Medicare+Choice programs, including adapting risk adjustment methods to account for this category.

''(4) INITIAL REPORT.—

''(A) IN GENERAL.—Not later than 12 months after the date of enactment of this section, the Medicare Payment Advisory Commission and the Agency for Health Care Policy and Research shall each prepare and submit to the Committee on Health, Education, Labor and Pensions of the Senate a report concerning the results of the studies conducted under paragraphs (1) and (2), respectively.

''(B) COPY TO SECRETARY.—Concurrent with the submission of the reports under subparagraph (A), the Medicare Payment Advisory Commission and the Agency for health Care Policy and Research shall transmit a copy of the reports under such subparagraph to the Secretary.

''(5) FINAL REPORT.—

''(A) CONTRACT WITH INSTITUTE OF MEDICINE.—Not later than 1 year after the submission of the reports under paragraph (4), the Secretary of Health and Human Services shall contract with the Institute of Medicine to conduct a study of the practices and their effects arising from the utilization of the category ''serious and complex'' illness.

''(B) REPORT.—Not later than 1 year after the date of the execution of the contract referred to in subparagraph (A), the Institute of Medicine shall prepare and submit to the Committee on Health, Education, Labor and Pensions of the Senate a report concerning the study conducted pursuant to such contract.

''(6) FUNDING.—From funds appropriated to the Department of Health and Human Services, the Secretary of Health and Human Services shall make available such funds as the Secretary determines is necessary to carry out this subsection.

''SEC. 727. PROTECTION OF PATIENT-PROVIDER COMMUNICATIONS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (other than a fully insured group health plan and in relation to a participant or beneficiary) shall not prohibit or otherwise restrict a health care professional from advising such a participant or beneficiary who is a patient of the professional about the health status of the participant or beneficiary or medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether coverage for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan (other than a fully insured group health plan) to provide specific benefits under the terms of such plan.

''SEC. 728. PATIENT'S RIGHT TO PRESCRIPTION DRUGS.

''To the extent that a group health plan (other than a fully insured group health plan) provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan shall—

''(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary; and

''(2) in accordance with the applicable quality assurance and utilization review standards of the plan, provide for exceptions from the formulary limitation when a nonformulary alternative is medically necessary and appropriate.

''SEC. 729. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE SERVICES.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) may not—

''(1) prohibit or otherwise discourage a participant or beneficiary from self-paying for behavioral health care services once the plan has denied coverage for such services; or

''(2) terminate a health care provider because such provider permits participants or beneficiaries to self-pay for behavioral health care services—

''(A) that are not otherwise covered under the plan; or

''(B) for which the group health plan provides limited coverage, to the extent that the group health plan denies coverage of the services.

''(b) RULE OF CONSTRUCTION.—Nothing in subsection (a)(2)(B) shall be construed as prohibiting a group health plan from terminating a contract with a health care provider for failure to meet applicable quality standards or for fraud.

''SEC. 730. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan (other than a fully insured group health plan) provides coverage to a qualified individual (as defined in subsection (b)), the plan—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsections (b), (c), and (d) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(C) may not discriminate against the individual on the basis of the participant's or beneficiaries participation in such trial.

''(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(1)(A) The individual has been diagnosed with cancer for which no standard treatment is effective.

''(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

''(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(2) Either—

''(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

''(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

''(c) PAYMENT.—

''(1) IN GENERAL.—Under this section a group health plan (other than a fully insured group health plan) shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(2) STANDARDS FOR DETERMINING ROUTINE PATIENT COSTS ASSOCIATED WITH CLINICAL TRIAL PARTICIPATION.—

''(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards relating to the coverage of routine patient costs for individuals participating in clinical trials that group health plans must meet under this section.

''(B) FACTORS.—In establishing routine patient cost standards under subparagraph (A), the Secretary shall consult with interested parties and take into account —

''(i) quality of patient care;

''(ii) routine patient care costs versus costs associated with the conduct of clinical trials, including unanticipated patient care costs as a result of participation in clinical trials; and

''(iii) previous and on-going studies relating to patient care costs associated with participation in clinical trials.

''(C) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this paragraph, the Secretary, after consultation with organizations representing cancer patients, health care practitioners, medical researchers, employers, group health plans, manufacturers of drugs, biologics and medical devices, medical economists, hospitals, and other interested parties, shall publish notice provided for under section 564(a) of title 5,

United States Code, by not later than 45 days after the date of the enactment of this section.

''(D) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subparagraph (C), and for purposes of this paragraph, the 'target date for publication' (referred to in section 564(a)(5) of such title 5) shall be June 30, 2000.

''(E) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title 5 under this paragraph, '15 days' shall be substituted for '30 days'.

''(F) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(i) the appointment of a negotiated rulemaking committee under section 565(a) of such title 5 by not later than 30 days after the end of the comment period provided for under section 564(c) of such title 5 (as shortened under subparagraph (E)), and

''(ii) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

''(G) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subparagraph (F) shall report to the Secretary, by not later than March 29, 2000, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this paragraph through such other methods as the Secretary may provide.

''(H) FINAL COMMITTEE REPORT.—If the committee is not terminated under subparagraph (G), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

''(I) FINAL EFFECT.—The Secretary shall publish a rule under this paragraph in the Federal Register by not later than the target date of publication.

''(J) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

''(K) EFFECTIVE DATE.—The provisions of this paragraph shall apply to group health plans (other than a fully insured group health plan) for plan years beginning on or after January 1, 2001.

''(3) PAYMENT RATE.—In the case of covered items and services provided by—

''(A) a participating provider, the payment rate shall be at the agreed upon rate, or

''(B) a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—

''(1) IN GENERAL.—In this section, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

''(A) The National Institutes of Health.

''(B) A cooperative group or center of the National Institutes of Health.

''(C) Either of the following if the conditions described in paragraph (2) are met:

''(i) The Department of Veterans Affairs.

''(ii) The Department of Defense.

''(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

''(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's coverage with respect to clinical trials.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(1) IN GENERAL.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(2) CONSTRUCTION.—Nothing in this section shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(g) STUDY AND REPORT.—

''(1) STUDY.—The Secretary shall study the impact on group health plans for covering routine patient care costs for individuals who are entitled to benefits under this section and who are enrolled in an approved cancer clinical trial program.

''(2) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains an assessment of—

''(A) any incremental cost to group health plans resulting from the provisions of this section;

''(B) a projection of expenditures to such plans resulting from this section; and

''(C) any impact on premiums resulting from this section.

''SEC. 730A. PROHIBITING DISCRIMINATION AGAINST PROVIDERS.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This subsection shall not be construed as requiring the coverage under a plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants and beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

''(b) NO REQUIREMENT FOR ANY WILLING PROVIDER.—Nothing in this section shall be construed as requiring a group health plan that offers network coverage to include for participation every willing provider or health professional who meets the terms and conditions of the plan.

''SEC. 730B. GENERALLY APPLICABLE PROVISION.

''In the case of a group health plan that provides benefits under 2 or more coverage options, the requirements of this subpart shall apply separately with respect to each coverage option.''.

(b) RULE WITH RESPECT TO CERTAIN PLANS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, health insurance issuers may offer, and eligible individuals may purchase, high deductible health plans described in section 220(c)(2)(A) of the Internal Revenue Code of 1986. Effective for the 4-year period beginning on the date of the enactment of this Act, such health plans shall not be required to provide payment for any health care items or services that are exempt from the plan's deductible.

(2) EXISTING STATE LAWS.—A State law relating to payment for health care items and services in effect on the date of enactment of this Act that is preempted under paragraph (1), shall not apply to high deductible health plans after the expiration of the 4-year period described in such paragraph unless the State reenacts such law after such period.

(c) DEFINITION.—Section 733(a) of the Employee Retirement Income Security Act of 1974 (42 U.S.C. 1191(a)) is amended by adding at the end the following:

''(3) FULLY INSURED GROUP HEALTH PLAN.—The term 'fully insured group health plan' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.''.

(d) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended—

(1) in the item relating to subpart C, by striking ''Subpart C'' and inserting ''Subpart D''; and

(2) by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new items:

''SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

''Sec. 721. Patient access to emergency medical care.
''Sec. 722. Offering of choice of coverage options.
''Sec. 723. Patient access to obstetric and gynecological care.
''Sec. 724. Patient access to pediatric care.
''Sec. 725. Timely access to specialists.
''Sec. 726. Continuity of care.
''Sec. 727. Protection of patient-provider communications.
''Sec. 728. Patient's right to prescription drugs.
''Sec. 729. Self-payment for behavioral health care services.
''Sec. 730. Coverage for individuals participating in approved cancer clinical trials.
''Sec. 730A. Prohibiting discrimination against providers.
''Sec. 730B. Generally applicable provision.

SEC. 102. CONFORMING AMENDMENT TO THE INTERNAL REVENUE CODE OF 1986.

(a) IN GENERAL.—Chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subchapter C as subchapter D; and

(2) by inserting after subchapter B the following:

''Subchapter C—Patient Right to Medical Advice and Care

''Sec. 9821. Patient access to emergency medical care.
''Sec. 9822. Offering of choice of coverage options.
''Sec. 9823. Patient access to obstetric and gynecological care.
''Sec. 9824. Patient access to pediatric care.
''Sec. 9825. Timely access to specialists.
''Sec. 9826. Continuity of care.
''Sec. 9827. Protection of patient-provider communications.
''Sec. 9828. Patient's right to prescription drugs.
''Sec. 9829. Self-payment for behavioral health care services.

''Sec. 9830. Coverage for individuals participating in approved cancer clinical trials.
''Sec. 9830A. Prohibiting discrimination against providers.
''Sec. 9830B. Generally applicable provision.

''SEC. 9821. PATIENT ACCESS TO EMERGENCY MEDICAL CARE.

''(a) COVERAGE OF EMERGENCY CARE.—

''(1) IN GENERAL.—To the extent that the group health plan (other than a fully insured group health plan) provides coverage for benefits consisting of emergency medical care (as defined in subsection (c)) or emergency ambulance services, except for items or services specifically excluded—

''(A) the plan shall provide coverage for benefits, without requiring preauthorization, for emergency medical screening examinations or emergency ambulance services, to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations or emergency ambulance services to be necessary to determine whether emergency medical care (as so defined) is necessary; and

''(B) the plan shall provide coverage for benefits, without requiring preauthorization, for additional emergency medical care to stabilize an emergency medical condition following an emergency medical screening examination (if determined necessary under subparagraph (A)), pursuant to the definition of stabilize under section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

''(2) REIMBURSEMENT FOR CARE TO MAINTAIN MEDICAL STABILITY.—

''(A) IN GENERAL.—In the case of services provided to a participant or beneficiary by a nonparticipating provider in order to maintain the medical stability of the participant or beneficiary, the group health plan involved shall provide for reimbursement with respect to such services if—

''(i) coverage for services of the type furnished is available under the group health plan;

''(ii) the services were provided for care related to an emergency medical condition and in an emergency department in order to maintain the medical stability of the participant or beneficiary; and

''(iii) the nonparticipating provider contacted the plan regarding approval for such services.

''(B) FAILURE TO RESPOND.—If a group health plan fails to respond within 1 hours of being contacted in accordance with subparagraph (A)(iii), then the plan shall be liable for the cost of services provided by the nonparticipating provider in order to maintain the stability of the participant or beneficiary.

''(C) LIMITATION.—The liability of a group health plan to provide reimbursement under subparagraph (A) shall terminate when the plan has contacted the nonparticipating provider to arrange for discharge or transfer.

''(D) LIABILITY OF PARTICIPANT.—A participant or beneficiary shall not be liable for the costs of services to which subparagraph (A) in an amount that exceeds the amount of liability that would be incurred if the services were provided by a participating health care provider with prior authorization by the plan.

''(b) IN-NETWORK UNIFORM COSTS-SHARING AND OUT-OF-NETWORK CARE.—

''(1) IN-NETWORK UNIFORM COST-SHARING.—Nothing in this section shall be construed as preventing a group health plan (other than a fully insured group health plan) from imposing any form of cost-sharing applicable to any participant or beneficiary (including co-insurance, copayments, deductibles, and any other charges) in relation to coverage for benefits described in subsection (a), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in subsection (c)) provided to such similarly situated participants and beneficiaries under the plan, and such cost-sharing is disclosed in accordance with section 9814.

''(2) OUT-OF-NETWORK CARE.—If a group health plan (other than a fully insured group health plan) provides any benefits with respect to emergency medical care (as defined in subsection (c)), the plan shall cover emergency medical care under the plan in a manner so that, if such care is provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed any form of cost-sharing (including co-insurance, co-payments, deductibles, and any other charges) that would be incurred if the services were provided by a participating provider.

''(c) DEFINITION OF EMERGENCY MEDICAL CARE.—In this section:

''(1) IN GENERAL.—The term 'emergency medical care' means, with respect to a participant or beneficiary under a group health plan (other than a fully insured group health plan), covered inpatient and outpatient services that—

''(A) are furnished by any provider, including a nonparticipating provider, that is qualified to furnish such services; and

''(B) are needed to evaluate or stabilize (as such term is defined in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd)(e)(3)) an emergency medical condition (as defined in paragraph (2)).

''(2) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(A) placing the health of the participant or beneficiary (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(B) serious impairment to bodily functions, or

''(C) serious dysfunction of any bodily organ or part.

''SEC. 9822. OFFERING OF CHOICE OF COVERAGE OPTIONS.

''(a) REQUIREMENT.—

''(1) OFFERING OF POINT-OF-SERVICE COVERAGE OPTION.—Except as provided in paragraph (2), if a group health plan (other than a fully insured group health plan) provides coverage for benefits only through a defined set of participating health care professionals, the plan shall offer the participant the option to purchase point-of-service coverage (as defined in subsection (b)) for all such benefits for which coverage is otherwise so limited. Such option shall be made available to the participant at the time of enrollment under the plan and at such other times as the plan offers the participant a choice of coverage options.

''(2) EXCEPTION IN CASE OF LACK OF AVAILABILITY.—Paragraph (1) shall not apply with respect to a group health plan (other than a fully insured group health plan) if care relating to the point-of-service coverage would not be available and accessible to the participant with reasonable promptness (consistent with section 1301(b)(4) of the Public Health Service Act (42 U.S.C. 300e(b)(4))).

''(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term 'point-of-service coverage' means, with respect to benefits covered under a group health plan (other than a fully insured group health plan), coverage of such benefits when provided by a nonparticipating health care professional.

''(c) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan (other than a fully insured group health plan) of a small employer.

''(2) SMALL EMPLOYER.—For purposes of paragraph (1), the term 'small employer' means, in connection with a group health plan (other than a fully insured group health plan) with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of this paragraph, the provisions of subparagraph (C) of section 4980D(d)(2) shall apply in determining employer size.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring coverage for benefits for a particular type of health care professional;

''(2) as requiring an employer to pay any costs as a result of this section or to make equal contributions with respect to different health coverage options;

''(3) as preventing a group health plan (other than a fully insured group health plan) from imposing higher premiums or cost-sharing on a participant for the exercise of a point-of-service coverage option; or

''(4) to require that a group health plan (other than a fully insured group health plan) include coverage of health care professionals that the plan excludes because of fraud, quality of care, or other similar reasons with respect to such professionals.

''SEC. 9823. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(a) GENERAL RIGHTS.—

''(1) WAIVER OF PLAN REFERRAL REQUIREMENT.—If a group health plan described in subsection (b) requires a referral to obtain coverage for specialty care, the plan shall waive the referral requirement in the case of a female participant or beneficiary who seeks coverage for obstetrical care and related follow-up obstetrical care or routine gynecological care (such as preventive gynecological care).

''(2) RELATED ROUTINE CARE.—With respect to a participant or beneficiary described in paragraph (1), a group health plan described in subsection (b) shall treat the ordering of other routine care that is related to routine gynecologic care, by a physician who specializes in obstetrics and gynecology as the authorization of the primary care provider for such other care.

''(b) APPLICATION OF SECTION.—A group health plan described in this subsection is a group health plan (other than a fully insured group health plan), that—

''(1) provides coverage for obstetric care (such as pregnancy-related services) or routine gynecologic care (such as preventive women's health examinations); and

''(2) requires the designation by a participant or beneficiary of a participating primary care provider who is not a physician who specializes in obstetrics or gynecology.

''(c) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of obstetric or gynecologic care described in subsection (a);

''(2) to preclude the plan from requiring that the physician who specializes in obstetrics or gynecology notify the designated primary care provider or the plan of treatment decisions;

''(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine obstetric or routine gynecologic care; or

''(4) to preclude a group health plan from permitting a physician who specializes in obstetrics and gynecology from being a primary care provider under the plan.

''SEC. 9824. PATIENT ACCESS TO PEDIATRIC CARE.

''(a) IN GENERAL.—In the case of a group health plan (other than a fully insured group health plan) that provides coverage for routine pediatric care and that requires the designation by a participant or beneficiary of a participating primary care provider, if the designated primary care provider is not a physician who specializes in pediatrics—

''(1) the plan may not require authorization or referral by the primary care provider in order for a participant or beneficiary to obtain coverage for routine pediatric care; and

''(2) the plan shall treat the ordering of other routine care related to routine pediatric care by such a specialist as having been authorized by the designated primary care provider.

''(b) RULES OF CONSTRUCTION.—Nothing in subsection (a) shall be construed—

''(1) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of any pediatric care provided to, or ordered for, a participant or beneficiary;

''(2) to preclude a group health plan from requiring that a specialist described in subsection (a) notify the designated primary care provider or the plan of treatment decisions; or

''(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine pediatric care.

''SEC. 9825. TIMELY ACCESS TO SPECIALISTS.

''(a) TIMELY ACCESS.—

''(1) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall ensure that participants and beneficiaries have timely, in accordance with the medical exigencies of the case, access to primary and specialty health care professionals who are appropriate to the condition of the participant or beneficiary, when such care is covered under the plan. Such access may be provided through contractual arrangements with specialized providers outside of the network of the plan.

''(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

''(A) to require the coverage under a group health plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants or beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan; or

''(B) to override any State licensure or scope-of-practice law.

''(b) TREATMENT PLANS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to prohibit a group health plan (other than a fully insured group health plan) from requiring that specialty care be provided pursuant to a treatment plan so long as the treatment plan is—

''(A) developed by the specialist, in consultation with the case manager or primary care provider, and the participant or beneficiary;

''(B) approved by the plan in a timely manner in accordance with the medical exigencies of the case; and

''(C) in accordance with the applicable quality assurance and utilization review standards of the plan.

''(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan from requiring the specialist to provide the case manager or primary care provider with regular updates on the specialty care provided, as well as all other necessary medical information.

''(c) REFERRALS.—Nothing in this section shall be construed to prohibit a plan from requiring an authorization by the case manager or primary care provider of the participant or beneficiary in order to obtain coverage for specialty services so long as such authorization is for an adequate number of referrals.

''(d) SPECIALTY CARE DEFINED.—For purposes of this subsection, the term 'specialty care' means, with respect to a condition, care and treatment provided by a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise (including age-appropriate expertise) through appropriate training and experience.

''SEC. 9826. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan (other than a fully insured group health plan) and a health care provider is terminated (as defined in paragraph (2)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such group health plan, and an individual who is a participant or beneficiary in the plan is undergoing a course of treatment from the provider at the time of such termination, the plan shall—

''(A) notify the individual on a timely basis of such termination;

''(B) provide the individual with an opportunity to notify the plan of a need for transitional care; and

''(C) in the case of termination described in paragraph (2), (3), or (4) of subsection (b), and subject to subsection (c), permit the individual to continue or be covered with respect to the course of treatment with the provider's consent during a transitional period (as provided under subsection (b)).

''(2) TERMINATED.—In this section, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract by the group health plan, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

''(3) CONTRACTS.—For purposes of this section, the term 'contract between a group health plan (other than a fully insured group health plan) and a health care provider' shall include a contract between such a plan and an organized network of providers.

''(b) TRANSITIONAL PERIOD.—

''(1) GENERAL RULE.—Except as provided in paragraph (3), the transitional period under this subsection shall permit the participant or beneficiary to extend the coverage involved for up to 90 days from the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) INSTITUTIONAL CARE.—Subject to paragraph (1), the transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status if the care was scheduled before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such care.

''(3) PREGNANCY.—Notwithstanding paragraph (1), if—

''(A) a participant or beneficiary has entered the second trimester of pregnancy at the time of a provider's termination of participation; and

''(B) the provider was treating the pregnancy before the date of the termination;

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—Notwithstanding paragraph (1), if—

''(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) prior to a provider's termination of participation; and

''(B) the provider was treating the terminal illness before the date of termination; the transitional period under this subsection shall be for care directly related to the treatment of the terminal illness and shall extend for the remainder of the individual's life for such care.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan (other than a fully insured group health plan) may condition coverage of continued treatment by a provider under subsection (a)(1)(C) upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or at the rates applicable under the replacement plan after the date of the termination of the contract with the group health plan) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

''(2) The provider agrees to adhere to the quality assurance standards of the plan responsible for payment under paragraph (1) and to provide to such plan necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

''(e) DEFINITION.—In this section, the term 'health care provider' or 'provider' means—

''(1) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

''(2) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

''(f) COMPREHENSIVE STUDY OF COST, QUALITY AND COORDINATION OF COVERAGE FOR PATIENTS AT THE END OF LIFE.—

''(1) STUDY BY THE MEDICARE PAYMENT ADVISORY COMMISSION.—The Medicare Payment

Advisory Commission shall conduct a study of the costs and patterns of care for persons with serious and complex conditions and the possibilities of improving upon that care to the degree it is triggered by the current category of terminally ill as such term is used for purposes of section 1861(dd) of the Social Security Act (relating to hospice benefits) or of utilizing care in other payment settings in Medicare.

''(2) AGENCY FOR HEALTH CARE POLICY AND RESEARCH.—The Agency for Health Care Policy and Research shall conduct studies of the possible thresholds for major conditions causing serious and complex illness, their administrative parameters and feasibility, and their impact upon costs and quality.

''(3) HEALTH CARE FINANCING ADMINISTRATION.—The Health Care Financing Administration shall conduct studies of the merits of applying similar thresholds in Medicare+Choice programs, including adapting risk adjustment methods to account for this category.

''(4) INITIAL REPORT.—

''(A) IN GENERAL.—Not later than 12 months after the date of enactment of this section, the Medicare Payment Advisory Commission and the Agency for Health Care Policy and Research shall each prepare and submit to the Committee on Health, Education, Labor and Pensions of the Senate a report concerning the results of the studies conducted under paragraphs (1) and (2), respectively.

''(B) COPY TO SECRETARY.—Concurrent with the submission of the reports under subparagraph (A), the Medicare Payment Advisory Commission and the Agency for health Care Policy and Research shall transmit a copy of the reports under such subparagraph to the Secretary.

''(5) FINAL REPORT.—

''(A) CONTRACT WITH INSTITUTE OF MEDICINE.—Not later than 1 year after the submission of the reports under paragraph (4), the Secretary of Health and Human Services shall contract with the Institute of Medicine to conduct a study of the practices and their effects arising from the utilization of the category ''serious and complex'' illness.

''(B) REPORT.—Not later than 1 year after the date of the execution of the contract referred to in subparagraph (A), the Institute of Medicine shall prepare and submit to the Committee on Health, Education, Labor and Pensions of the Senate a report concerning the study conducted pursuant to such contract.

''(6) FUNDING.—From funds appropriated to the Department of Health and Human Services, the Secretary of Health and Human Services shall make available such funds as the Secretary determines is necessary to carry out this subsection.

''SEC. 9827. PROTECTION OF PATIENT-PROVIDER COMMUNICATIONS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (other than a fully insured group health plan and in relation to a participant or beneficiary) shall not prohibit or otherwise restrict a health care professional from advising such a participant or beneficiary who is a patient of the professional about the health status of the participant or beneficiary or medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether coverage for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan (other than a fully insured group health plan) to provide specific benefits under the terms of such plan.

''SEC. 9828. PATIENT'S RIGHT TO PRESCRIPTION DRUGS.

''To the extent that a group health plan (other than a fully insured group health plan) provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan shall—

''(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary; and

''(2) in accordance with the applicable quality assurance and utilization review standards of the plan, provide for exceptions from the formulary limitation when a nonformulary alternative is medically necessary and appropriate.

''SEC. 9829. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE SERVICES.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) may not—

''(1) prohibit or otherwise discourage a participant or beneficiary from self-paying for behavioral health care services once the plan has denied coverage for such services; or

''(2) terminate a health care provider because such provider permits participants or beneficiaries to self-pay for behavioral health care services—

''(A) that are not otherwise covered under the plan; or

''(B) for which the group health plan provides limited coverage, to the extent that the group health plan denies coverage of the services.

''(b) RULE OF CONSTRUCTION.—Nothing in subsection (a)(2)(B) shall be construed as prohibiting a group health plan from terminating a contract with a health care provider for failure to meet applicable quality standards or for fraud.

''SEC. 9830. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan (other than a fully insured group health plan) provides coverage to a qualified individual (as defined in subsection (b)), the plan—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsections (b), (c), and (d) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(C) may not discriminate against the individual on the basis of the participant's or beneficiaries participation in such trial.

''(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(1)(A) The individual has been diagnosed with cancer for which no standard treatment is effective.

''(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

''(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(2) Either—

''(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

''(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

''(c) PAYMENT.—

''(1) IN GENERAL.—Under this section a group health plan (other than a fully insured group health plan) shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(2) STANDARDS FOR DETERMINING ROUTINE PATIENT COSTS ASSOCIATED WITH CLINICAL TRIAL PARTICIPATION.—

''(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards relating to the coverage of routine patient costs for individuals participating in clinical trials that group health plans must meet under this section.

''(B) FACTORS.—In establishing routine patient cost standards under subparagraph (A), the Secretary shall consult with interested parties and take into account —

''(i) quality of patient care;

''(ii) routine patient care costs versus costs associated with the conduct of clinical trials, including unanticipated patient care costs as a result of participation in clinical trials; and

''(iii) previous and on-going studies relating to patient care costs associated with participation in clinical trials.

''(C) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this paragraph, the Secretary, after consultation with organizations representing cancer patients, health care practitioners, medical researchers, employers, group health plans, manufacturers of drugs, biologics and medical devices, medical economists, hospitals, and other interested parties, shall publish notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

''(D) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subparagraph (C), and for purposes of this paragraph, the 'target date for publication' (referred to in section 564(a)(5) of such title 5) shall be June 30, 2000.

''(E) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title 5 under this paragraph, '15 days' shall be substituted for '30 days'.

''(F) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(i) the appointment of a negotiated rulemaking committee under section 565(a) of such title 5 by not later than 30 days after the end of the comment period provided for under section 564(c) of such title 5 (as shortened under subparagraph (E)), and

''(ii) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

''(G) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subparagraph (F) shall report

to the Secretary, by not later than March 29, 2000, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this paragraph through such other methods as the Secretary may provide.

''(H) FINAL COMMITTEE REPORT.—If the committee is not terminated under subparagraph (G), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

''(I) FINAL EFFECT.—The Secretary shall publish a rule under this paragraph in the Federal Register by not later than the target date of publication.

''(J) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

''(K) EFFECTIVE DATE.—The provisions of this paragraph shall apply to group health plans (other than a fully insured group health plan) for plan years beginning on or after January 1, 2001.

''(3) PAYMENT RATE.—In the case of covered items and services provided by—

''(A) a participating provider, the payment rate shall be at the agreed upon rate, or

''(B) a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—

''(1) IN GENERAL.—In this section, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

''(A) The National Institutes of Health.

''(B) A cooperative group or center of the National Institutes of Health.

''(C) Either of the following if the conditions described in paragraph (2) are met:

''(i) The Department of Veterans Affairs.

''(ii) The Department of Defense.

''(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

''(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's coverage with respect to clinical trials.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(1) IN GENERAL.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(2) CONSTRUCTION.—Nothing in this section shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(g) STUDY AND REPORT.—

''(1) STUDY.—The Secretary shall study the impact on group health plans for covering routine patient care costs for individuals who are entitled to benefits under this section and who are enrolled in an approved cancer clinical trial program.

''(2) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains an assessment of—

''(A) any incremental cost to group health plans resulting from the provisions of this section;

''(B) a projection of expenditures to such plans resulting from this section; and

''(C) any impact on premiums resulting from this section.

"SEC. 9830A. PROHIBITING DISCRIMINATION AGAINST PROVIDERS.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This subsection shall not be construed as requiring the coverage under a plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants and beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

''(b) NO REQUIREMENT FOR ANY WILLING PROVIDER.—Nothing in this section shall be construed as requiring a group health plan that offers network coverage to include for participation every willing provider or health professional who meets the terms and conditions of the plan.

"SEC. 9830B. GENERALLY APPLICABLE PROVISION.

''In the case of a group health plan that provides benefits under 2 or more coverage options, the requirements of this subchapter shall apply separately with respect to each coverage option.''.

(b) DEFINITION.—Section 9832(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(4) FULLY INSURED GROUP HEALTH PLAN.—The term 'fully insured group health plan' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.''.

(c) CONFORMING AMENDMENT.—Chapter 98 of the Internal Revenue Code of 1986 is amended in the table of subchapters in the item relating to subchapter C, by striking ''Subchapter C'' and inserting ''Subchapter D''.

SEC. 103. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle B—Right to Information About Plans and Providers

SEC. 111. INFORMATION ABOUT PLANS.

(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

"SEC. 714. HEALTH PLAN COMPARATIVE INFORMATION.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides coverage in connection with group health insurance coverage, shall, not later than 12 months after the date of enactment of this section, and at least annually thereafter, provide for the disclosure, in a clear and accurate form to each participant and each beneficiary who does not reside at the same address as the participant, or upon request to an individual eligible for coverage under the plan, of the information described in subsection (b).

''(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a plan or issuer from entering into any agreement under which the issuer agrees to assume responsibility for compliance with the requirements of this section and the plan is released from liability for such compliance.

''(3) PROVISION OF INFORMATION.—Information shall be provided to participants and beneficiaries under this section at the address maintained by the plan or issuer with respect to such participants or beneficiaries.

''(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each package option available under a group health plan the following:

''(1) A description of the covered items and services under each such plan and any in- and out-of-network features of each such plan, including a summary description of the specific exclusions from coverage under the plan.

''(2) A description of any cost-sharing, including premiums, deductibles, coinsurance, and copayment amounts, for which the participant or beneficiary will be responsible, including any annual or lifetime limits on benefits, for each such plan.

''(3) A description of any optional supplemental benefits offered by each such plan and the terms and conditions (including premiums or cost-sharing) for such supplemental coverage.

''(4) A description of any restrictions on payments for services furnished to a participant or beneficiary by a health care professional that is not a participating professional and the liability of the participant or beneficiary for additional payments for these services.

''(5) A description of the service area of each such plan, including the provision of any out-of-area coverage.

''(6) A description of the extent to which participants and beneficiaries may select the primary care provider of their choice, including providers both within the network and outside the network of each such plan (if the plan permits out-of-network services).

''(7) A description of the procedures for advance directives and organ donation decisions if the plan maintains such procedures.

''(8) A description of the requirements and procedures to be used to obtain

preauthorization for health services (including telephone numbers and mailing addresses), including referrals for specialty care.

''(9) A description of the definition of medical necessity used in making coverage determinations by each such plan.

''(10) A summary of the rules and methods for appealing coverage decisions and filing grievances (including telephone numbers and mailing addresses), as well as other available remedies.

''(11) A summary description of any provisions for obtaining off-formulary medications if the plan utilizes a defined formulary for providing specific prescription medications.

''(12) A summary of the rules for access to emergency room care. Also, any available educational material regarding proper use of emergency services.

''(13) A description of whether or not coverage is provided for experimental treatments, investigational treatments, or clinical trials and the circumstances under which access to such treatments or trials is made available.

''(14) A description of the specific preventative services covered under the plan if such services are covered.

''(15) A statement regarding—

''(A) the manner in which a participant or beneficiary may access an obstetrician, gynecologist, or pediatrician in accordance with section 723 or 724; and

''(B) the manner in which a participant or beneficiary obtains continuity of care as provided for in section 726.

''(16) A statement that the following information, and instructions on obtaining such information (including telephone numbers and, if available, Internet websites), shall be made available upon request:

''(A) The names, addresses, telephone numbers, and State licensure status of the plan's participating health care professionals and participating health care facilities, and, if available, the education, training, specialty qualifications or certifications of such professionals.

''(B) A summary description of the methods used for compensating participating health care professionals, such as capitation, fee-for-service, salary, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(C) A summary description of the methods used for compensating health care facilities, including per diem, fee-for-service, capitation, bundled payments, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(D) A summary description of the procedures used for utilization review.

''(E) The list of the specific prescription medications included in the formulary of the plan, if the plan uses a defined formulary.

''(F) A description of the specific exclusions from coverage under the plan.

''(G) Any available information related to the availability of translation or interpretation services for non-English speakers and people with communication disabilities, including the availability of audio tapes or information in Braille.

''(H) Any information that is made public by accrediting organizations in the process of accreditation if the plan is accredited, or any additional quality indicators that the plan makes available.

''(c) MANNER OF DISTRIBUTION.—The information described in this section shall be distributed in an accessible format that is understandable to an average plan participant or beneficiary.

''(d) RULE OF CONSTRUCTION.—Nothing in this section may be construed to prohibit a group health plan, or health insurance issuer in connection with group health insurance coverage, from distributing any other additional information determined by the plan or issuer to be important or necessary in assisting participants and beneficiaries or upon request potential participants and beneficiaries in the selection of a health plan or from providing information under subsection (b)(15) as part of the required information.

''(e) CONFORMING REGULATIONS.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under part 1, to reduce duplication with respect to any information that is required to be provided under any such requirements.

''(f) HEALTH CARE PROFESSIONAL.—In this section, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the health plan involved for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711, and inserting ''sections 711 and 714''.

(B) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) is amended by inserting after the item relating to section 713, the following:

''Sec. 714. Health plan comparative information.''.

(b) INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Health plan comparative information.''; and

(2) by inserting after section 9812 the following:

''SEC. 9813. HEALTH PLAN COMPARATIVE INFORMATION.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—A group health plan shall, not later than 12 months after the date of enactment of this section, and at least annually thereafter, provide for the disclosure, in a clear and accurate form to each participant and each beneficiary who does not reside at the same address as the participant, or upon request to an individual eligible for coverage under the plan, of the information described in subsection (b).

''(2) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a plan from entering into any agreement under which a health insurance issuer agrees to assume responsibility for compliance with the requirements of this section and the plan is released from liability for such compliance.

''(3) PROVISION OF INFORMATION.—Information shall be provided to participants and beneficiaries under this section at the address maintained by the plan with respect to such participants or beneficiaries.

''(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each package option available under a group health plan the following:

''(1) A description of the covered items and services under each such plan and any in- and out-of-network features of each such plan, including a summary description of the specific exclusions from coverage under the plan.

''(2) A description of any cost-sharing, including premiums, deductibles, coinsurance, and copayment amounts, for which the participant or beneficiary will be responsible, including any annual or lifetime limits on benefits, for each such plan.

''(3) A description of any optional supplemental benefits offered by each such plan and the terms and conditions (including premiums or cost-sharing) for such supplemental coverage.

''(4) A description of any restrictions on payments for services furnished to a participant or beneficiary by a health care professional that is not a participating professional and the liability of the participant or beneficiary for additional payments for these services.

''(5) A description of the service area of each such plan, including the provision of any out-of-area coverage.

''(6) A description of the extent to which participants and beneficiaries may select the primary care provider of their choice, including providers both within the network and outside the network of each such plan (if the plan permits out-of-network services).

''(7) A description of the procedures for advance directives and organ donation decisions if the plan maintains such procedures.

''(8) A description of the requirements and procedures to be used to obtain preauthorization for health services (including telephone numbers and mailing addresses), including referrals for specialty care.

''(9) A description of the definition of medical necessity used in making coverage determinations by each such plan.

''(10) A summary of the rules and methods for appealing coverage decisions and filing grievances (including telephone numbers and mailing addresses), as well as other available remedies.

''(11) A summary description of any provisions for obtaining off-formulary medications if the plan utilizes a defined formulary for providing specific prescription medications.

''(12) A summary of the rules for access to emergency room care. Also, any available educational material regarding proper use of emergency services.

''(13) A description of whether or not coverage is provided for experimental treatments, investigational treatments, or clinical trials and the circumstances under which access to such treatments or trials is made available.

''(14) A description of the specific preventative services covered under the plan if such services are covered.

''(15) A statement regarding—

''(A) the manner in which a participant or beneficiary may access an obstetrician, gynecologist, or pediatrician in accordance with section 723 or 724; and

''(B) the manner in which a participant or beneficiary obtains continuity of care as provided for in section 726.

''(16) A statement that the following information, and instructions on obtaining such information (including telephone numbers and, if available, Internet websites), shall be made available upon request:

''(A) The names, addresses, telephone numbers, and State licensure status of the plan's participating health care professionals and participating health care facilities, and, if available, the education, training, specialty

qualifications or certifications of such professionals.

''(B) A summary description of the methods used for compensating participating health care professionals, such as capitation, fee-for-service, salary, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(C) A summary description of the methods used for compensating health care facilities, including per diem, fee-for-service, capitation, bundled payments, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(D) A summary description of the procedures used for utilization review.

''(E) The list of the specific prescription medications included in the formulary of the plan, if the plan uses a defined formulary.

''(F) A description of the specific exclusions from coverage under the plan.

''(G) Any available information related to the availability of translation or interpretation services for non-English speakers and people with communication disabilities, including the availability of audio tapes or information in Braille.

''(H) Any information that is made public by accrediting organizations in the process of accreditation if the plan is accredited, or any additional quality indicators that the plan makes available.

''(c) MANNER OF DISTRIBUTION.—The information described in this section shall be distributed in an accessible format that is understandable to an average plan participant or beneficiary.

''(d) RULE OF CONSTRUCTION.—Nothing in this section may be construed to prohibit a group health plan from distributing any other additional information determined by the plan to be important or necessary in assisting participants and beneficiaries or upon request potential participants and beneficiaries in the selection of a health plan or from providing information under subsection (b)(15) as part of the required information.

''(e) HEALTH CARE PROFESSIONAL.—In this section, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the health plan involved for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.''.

SEC. 112. INFORMATION ABOUT PROVIDERS.

(a) STUDY.—The Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine for the conduct of a study, and the submission to the Secretary of a report, that includes—

(1) an analysis of information concerning health care professionals that is currently available to patients, consumers, States, and professional societies, nationally and on a State-by-State basis, including patient preferences with respect to information about such professionals and their competencies;

(2) an evaluation of the legal and other barriers to the sharing of information concerning health care professionals; and

(3) recommendations for the disclosure of information on health care professionals, including the competencies and professional qualifications of such practitioners, to better facilitate patient choice, quality improvement, and market competition.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall forward to the appropriate committees of Congress a copy of the report and study conducted under subsection (a).

Subtitle C—Right to Hold Health Plans Accountable

SEC. 121. AMENDMENT TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended to read as follows:

''SEC. 503. CLAIMS PROCEDURE, COVERAGE DETERMINATION, GRIEVANCES AND APPEALS.

''(a) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every employee benefit plan shall—

''(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant; and

''(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

''(b) COVERAGE DETERMINATIONS UNDER GROUP HEALTH PLANS.—

''(1) PROCEDURES.—

''(A) IN GENERAL.—A group health plan or health insurance issuer conducting utilization review shall ensure that procedures are in place for—

''(i) making determinations regarding whether a participant or beneficiary is eligible to receive a payment or coverage for health services under the plan or coverage involved and any cost-sharing amount that the participant or beneficiary is required to pay with respect to such service;

''(ii) notifying a covered participant or beneficiary (or the authorized representative of such participant or beneficiary) and the treating health care professionals involved regarding determinations made under the plan or issuer and any additional payments that the participant or beneficiary may be required to make with respect to such service; and

''(iii) responding to requests, either written or oral, for coverage determinations or for internal appeals from a participant or beneficiary (or the authorized representative of such participant or beneficiary) or the treating health care professional with the consent of the participant or beneficiary.

''(B) ORAL REQUESTS.—With respect to an oral request described in subparagraph (A)(iii), a group health plan or health insurance issuer may require that the requesting individual provide written evidence of such request.

''(2) TIMELINE FOR MAKING DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—A group health plan or a health insurance issuer shall maintain procedures to ensure that prior authorization determinations concerning the provision of non-emergency items or services are made within 30 days from the date on which the request for a determination is submitted, except that such period may be extended where certain circumstances exist that are determined by the Secretary to be beyond control of the plan or issuer.

''(B) EXPEDITED DETERMINATION.—

''(i) IN GENERAL.—A prior authorization determination under this subsection shall be made within 72 hours, in accordance with the medical exigencies of the case, after a request is received by the plan or issuer under clause (ii) or (iii).

''(ii) REQUEST BY PARTICIPANT OR BENEFICIARY.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of a participant or beneficiary if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the participant or beneficiary.

''(iii) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if the request involved indicates that the treating health care professional has reasonably documented, based on the medical exigencies, that a determination under the procedures described in subparagraph (A) could seriously jeopardize the life or health of the participant or beneficiary.

''(C) CONCURRENT DETERMINATIONS.—A plan or issuer shall maintain procedures to certify or deny coverage of an extended stay or additional services.

''(D) RETROSPECTIVE DETERMINATION.—A plan or issuer shall maintain procedures to ensure that, with respect to the retrospective review of a determination made under paragraph (1), the determination shall be made within 30 working days of the date on which the plan or issuer receives necessary information.

''(3) NOTICE OF DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(A), the plan or issuer shall issue notice of such determination to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and, consistent with the medical exigencies of the case, to the treating health care professional involved not later than 2 working days after the date on which the determination is made.

''(B) EXPEDITED DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(B), the plan or issuer shall issue notice of such determination to the participant or beneficiary (or the authorized representative of the participant or beneficiary), and consistent with the medical exigencies of the case, to the treating health care professional involved within the 72 hour period described in paragraph (2)(B).

''(C) CONCURRENT REVIEWS.—With respect to the determination under a plan or issuer under paragraph (2)(C) to certify or deny coverage of an extended stay or additional services, the plan or issuer shall issue notice of such determination to the treating health care professional and to the participant or beneficiary involved (or the authorized representative of the participant or beneficiary) within 1 working day of the determination.

''(D) RETROSPECTIVE REVIEWS.—With respect to the retrospective review under a plan or issuer of a determination made under paragraph (2)(D), the plan or issuer shall issue written notice of an approval or disapproval of a determination under this subparagraph to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and health care provider involved within 5 working days of the date on which such determination is made.

''(E) REQUIREMENTS OF NOTICE OF ADVERSE COVERAGE DETERMINATIONS.—A written notice of an adverse coverage determination under this subsection, or of an expedited adverse coverage determination under paragraph (2)(B), shall be provided to the participant or beneficiary (or the authorized representative of the participant or beneficiary)

and treating health care professional (if any) involved and shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average participant or beneficiary;

''(ii) the procedures for obtaining additional information concerning the determination; and

''(iii) notification of the right to appeal the determination and instructions on how to initiate an appeal in accordance with subsection (d).

''(c) GRIEVANCES.—A group health plan or a health insurance issuer shall have written procedures for addressing grievances between the plan or issuer offering health insurance coverage in connection with a group health plan and a participant or beneficiary. Determinations under such procedures shall be non-appealable.

''(d) INTERNAL APPEAL OF COVERAGE DETERMINATIONS.—

''(1) RIGHT TO APPEAL.—

''(A) IN GENERAL.—A participant or beneficiary (or the authorized representative of the participant or beneficiary) or the treating health care professional with the consent of the participant or beneficiary (or the authorized representative of the participant or beneficiary), may appeal any adverse coverage determination under subsection (b) under the procedures described in this subsection.

''(B) TIME FOR APPEAL.—A plan or issuer shall ensure that a participant or beneficiary has a period of not less than 180 days beginning on the date of an adverse coverage determination under subsection (b) in which to appeal such determination under this subsection.

''(C) FAILURE TO ACT.—The failure of a plan or issuer to issue a determination under subsection (b) within the applicable timeline established for such a determination under such subsection shall be treated as an adverse coverage determination for purposes of proceeding to internal review under this subsection.

''(2) RECORDS.—A group health plan and a health insurance issuer shall maintain written records, for at least 6 years, with respect to any appeal under this subsection for purposes of internal quality assurance and improvement. Nothing in the preceding sentence shall be construed as preventing a plan and issuer from entering into an agreement under which the issuer agrees to assume responsibility for compliance with the requirements of this section and the plan is released from liability for such compliance.

''(3) ROUTINE DETERMINATIONS.—A group health plan or a health insurance issuer shall complete the consideration of an appeal of an adverse routine determination under this subsection not later than 30 working days after the date on which a request for such appeal is received.

''(4) EXPEDITED DETERMINATION.—

''(A) IN GENERAL.—An expedited determination with respect to an appeal under this subsection shall be made in accordance with the medical exigencies of the case, but in no case more than 72 hours after the request for such appeal is received by the plan or issuer under subparagraph (B) or (C).

''(B) REQUEST BY PARTICIPANT OR BENEFICIARY.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of a participant or beneficiary if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the participant or beneficiary.

''(C) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if the request involved indicates that the treating health care professional has reasonably documented, based on the medical exigencies of the case that a determination under the procedures described in paragraph (2) could seriously jeopardize the life or health of the participant or beneficiary.

''(5) CONDUCT OF REVIEW.—A review of an adverse coverage determination under this subsection shall be conducted by an individual with appropriate expertise who was not directly involved in the initial determination.

''(6) LACK OF MEDICAL NECESSITY.—A review of an appeal under this subsection relating to a determination to deny coverage based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, shall be made only by a physician with appropriate expertise, including age-appropriate expertise, who was not involved in the initial determination.

''(7) NOTICE.—

''(A) IN GENERAL.—Written notice of a determination made under an internal review process shall be issued to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and the treating health care professional not later than 2 working days after the completion of the review (or within the 72-hour period referred to in paragraph (4) if applicable).

''(B) ADVERSE COVERAGE DETERMINATIONS.—With respect to an adverse coverage determination made under this subsection, the notice described in subparagraph (A) shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average participant or beneficiary;

''(ii) the procedures for obtaining additional information concerning the determination; and

''(iii) notification of the right to an independent external review under subsection (e) and instructions on how to initiate such a review.

''(e) INDEPENDENT EXTERNAL REVIEW.—

''(1) ACCESS TO REVIEW.—

''(A) IN GENERAL.—A group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan shall have written procedures to permit a participant or beneficiary (or the authorized representative of the participant or beneficiary) access to an independent external review with respect to an adverse coverage determination concerning a particular item or service (including a circumstance treated as an adverse coverage determination under subparagraph (B)) where—

''(i) the particular item or service involved—

''(I)(aa) would be a covered benefit, when medically necessary and appropriate under the terms and conditions of the plan, and the item or service has been determined not to be medically necessary and appropriate under the internal appeals process required under subsection (d) or there has been a failure to issue a coverage determination as described in subparagraph (B); and

''(bb)(AA) the amount of such item or service involved exceeds a significant financial threshold; or

''(BB) there is a significant risk of placing the life or health of the participant or beneficiary in jeopardy; or

''(II) would be a covered benefit, when not considered experimental or investigational under the terms and conditions of the plan, and the item or service has been determined to be experimental or investigational under the internal appeals process required under subsection (d) or there has been a failure to issue a coverage determination as described in subparagraph (B); and

''(ii) the participant or beneficiary has completed the internal appeals process under subsection (d) with respect to such determination.

''(B) FAILURE TO ACT.—The failure of a plan or issuer to issue a coverage determination under subsection (d)(6) within the applicable timeline established for such a determination under such subsection shall be treated as an adverse coverage determination for purposes of proceeding to independent external review under this subsection.

''(2) INITIATION OF THE INDEPENDENT EXTERNAL REVIEW PROCESS.—

''(A) FILING OF REQUEST.—A participant or beneficiary (or the authorized representative of the participant or beneficiary) who desires to have an independent external review conducted under this subsection shall file a written request for such a review with the plan or issuer involved not later than 30 working days after the receipt of a final denial of a claim under subsection (d). Any such request shall include the consent of the participant or beneficiary (or the authorized representative of the participant or beneficiary) for the release of medical information and records to independent external reviewers regarding the participant or beneficiary.

''(B) TIMEFRAME FOR SELECTION OF APPEALS ENTITY.—Not later than 5 working days after the receipt of a request under subparagraph (A), or earlier in accordance with the medical exigencies of the case, the plan or issuer involved shall—

''(i) select an external appeals entity under paragraph (3)(A) that shall be responsible for designating an independent external reviewer under paragraph (3)(B); and

''(ii) provide notice of such selection to the participant or beneficiary (which shall include the name and address of the entity).

''(C) PROVISION OF INFORMATION.—Not later than 5 working days after the plan or issuer provides the notice required under subparagraph (B)(ii), or earlier in accordance with the medical exigencies of the case, the plan, issuer, participant, beneficiary or physician (of the participant or beneficiary) involved shall forward necessary information (including, only in the case of a plan or issuer, medical records, any relevant review criteria, the clinical rationale consistent with the terms and conditions of the contract between the plan or issuer and the participant or beneficiary for the coverage denial, and evidence of the coverage of the participant or beneficiary) to the qualified external appeals entity designated under paragraph (3)(A).

''(D) FOLLOW-UP WRITTEN NOTIFICATION.—The plan or issuer involved shall send a follow-up written notification, in a timely manner, to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and the plan administrator, indicating that an independent external review has been initiated.

''(3) CONDUCT OF INDEPENDENT EXTERNAL REVIEW.—

''(A) DESIGNATION OF EXTERNAL APPEALS ENTITY BY PLAN OR ISSUER.—

''(i) IN GENERAL.—A plan or issuer that receives a request for an independent external review under paragraph (2)(A) shall designate a qualified entity described in clause (ii), in a manner designed to ensure that the entity so designated will make a decision in an unbiased manner, to serve as the external appeals entity.

''(ii) QUALIFIED ENTITIES.—A qualified entity shall be—

''(I) an independent external review entity licensed or credentialed by a State;

''(II) a State agency established for the purpose of conducting independent external reviews;

''(III) any entity under contract with the Federal Government to provide independent external review services;

''(IV) any entity accredited as an independent external review entity by an accrediting body recognized by the Secretary for such purpose; or

''(V) any other entity meeting criteria established by the Secretary for purposes of this subparagraph.

''(B) DESIGNATION OF INDEPENDENT EXTERNAL REVIEWER BY EXTERNAL APPEALS ENTITY.—The external appeals entity designated under subparagraph (A) shall, not later than 30 days after the date on which such entity is designated under subparagraph (A), or earlier in accordance with the medical exigencies of the case, designate one or more individuals to serve as independent external reviewers with respect to a request received under paragraph (2)(A). Such reviewers shall be independent medical experts who shall—

''(i) be appropriately credentialed or licensed in any State to deliver health care services;

''(ii) not have any material, professional, familial, or financial affiliation with the case under review, the participant or beneficiary involved, the treating health care professional, the institution where the treatment would take place, or the manufacturer of any drug, device, procedure, or other therapy proposed for the participant or beneficiary whose treatment is under review;

''(iii) have expertise (including age-appropriate expertise) in the diagnosis or treatment under review and be a physician of the same specialty, when reasonably available, as the physician treating the participant or beneficiary or recommending or prescribing the treatment in question;

''(iv) receive only reasonable and customary compensation from the group health plan or health insurance issuer in connection with the independent external review that is not contingent on the decision rendered by the reviewer; and

''(v) not be held liable for decisions regarding medical determinations (but may be held liable for actions that are arbitrary and capricious).

''(4) STANDARD OF REVIEW.—

''(A) IN GENERAL.—An independent external reviewer shall—

''(i) make an independent determination based on the valid, relevant, scientific and clinical evidence to determine the medical necessity, appropriateness, experimental or investigational nature of the proposed treatment; and

''(ii) take into consideration appropriate and available information, including any evidence-based decision making or clinical practice guidelines used by the group health plan or health insurance issuer; timely evidence or information submitted by the plan, issuer, patient or patient's physician; the patient's medical record; expert consensus including both generally accepted medical practice and recognized best practice; medical literature as defined in section 556(5) of the Federal Food, Drug, and Cosmetic Act; the following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information; and findings, studies, or research conducted by or under the auspices of Federal Government agencies and nationally recognized Federal research institutes including the Agency for Healthcare Research and Quality, National Institutes of Health, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purposes of evaluating the medical value of health services.

''(B) NOTICE.—The plan or issuer involved shall ensure that the participant or beneficiary receives notice, within 30 days after the determination of the independent medical expert, regarding the actions of the plan or issuer with respect to the determination of such expert under the independent external review.

''(5) TIMEFRAME FOR REVIEW.—

''(A) IN GENERAL.—The independent external reviewer shall complete a review of an adverse coverage determination in accordance with the medical exigencies of the case.

''(B) EXPEDITED REVIEW.—Notwithstanding subparagraph (A), a review described in such subparagraph shall be completed not later than 72 hours after the later of—

''(i) the date on which such reviewer is designated; or

''(ii) the date on which all information necessary to completing such review is received;

if the completion of such review in a period of time in excess of 72 hours would seriously jeopardize the life or health of the participant or beneficiary.

''(C) LIMITATION.—Notwithstanding subparagraph (A), and except as provided in subparagraph (B), a review described in subparagraph (A) shall be completed not later than 30 working days after the later of—

''(i) the date on which such reviewer is designated; or

''(ii) the date on which all information necessary to completing such review is received.

''(6) BINDING DETERMINATION AND ACCESS TO CARE.—

''(A) IN GENERAL.—The determination of an independent external reviewer under this subsection shall be binding upon the plan or issuer if the provisions of this subsection or the procedures implemented under such provisions were complied with by the independent external reviewer.

''(B) TIMETABLE FOR COMMENCEMENT OF CARE.—Where an independent external reviewer determines that the participant or beneficiary is entitled to coverage of the items or services that were the subject of the review, the reviewer shall establish a timeframe, in accordance with the medical exigencies of the case, during which the plan or issuer shall comply with the decision of the reviewer with respect to the coverage of such items or services under the terms and conditions of the plan.

''(C) FAILURE TO COMPLY.—If a plan or issuer fails to comply with the timeframe established under subparagraph (B) with respect to a participant or beneficiary, where such failure to comply is caused by the plan or issuer, the participant or beneficiary may obtain the items or services involved (in a manner consistent with the determination of the independent external reviewer) from any provider regardless of whether such provider is a participating provider under the plan or coverage.

''(D) REIMBURSEMENT.—

''(i) IN GENERAL.—Where a participant or beneficiary obtains items or services in accordance with subparagraph (C), the plan or issuer involved shall provide for reimbursement of the costs of such items of services. Such reimbursement shall be made to the treating provider or to the participant or beneficiary (in the case of a participant or beneficiary who pays for the costs of such items or services).

''(ii) AMOUNT.—The plan or issuer shall fully reimburse a provider, participant or beneficiary under clause (i) for the total costs of the items or services provided (regardless of any plan limitations that may apply to the coverage of such items of services) so long as—

''(I) the items or services would have been covered under the terms of the plan or coverage if provided by the plan or issuer; and

''(II) the items or services were provided in a manner consistent with the determination of the independent external reviewer.

''(E) FAILURE TO REIMBURSE.—Where a plan or issuer fails to provide reimbursement to a provider, participant or beneficiary in accordance with this paragraph, the provider, participant or beneficiary may commence a civil action (or utilize other remedies available under law) to recover only the amount of any such reimbursement that is unpaid and any necessary legal costs or expenses (including attorneys' fees) incurred in recovering such reimbursement.

''(7) STUDY.—Not later than 2 years after the date of enactment of this section, the General Accounting Office shall conduct a study of a statistically appropriate sample of completed independent external reviews. Such study shall include an assessment of the process involved during an independent external review and the basis of decision-making by the independent external reviewer. The results of such study shall be submitted to the appropriate committees of Congress.

''(8) EFFECT ON CERTAIN PROVISIONS.—Nothing in this section shall be construed as affecting or modifying section 514 of this Act with respect to a group health plan.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a plan administrator or plan fiduciary or health plan medical director from requesting an independent external review by an independent external reviewer without first completing the internal review process.

''(g) DEFINITIONS.—In this section:

''(1) ADVERSE COVERAGE DETERMINATION.—The term 'adverse coverage determination' means a coverage determination under the plan which results in a denial of coverage or reimbursement.

''(2) COVERAGE DETERMINATION.—The term 'coverage determination' means with respect to items and services for which coverage may be provided under a health plan, a determination of whether or not such items and services are covered or reimbursable under the coverage and terms of the contract.

''(3) GRIEVANCE.—The term 'grievance' means any complaint made by a participant or beneficiary that does not involve a coverage determination.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' shall have the meaning given such term in section 733(a). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 733(b)(1). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 733(b)(2).

''(7) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means a coverage determination prior to the provision of the items and services as a condition of coverage of the items and services under the coverage.

''(8) TREATING HEALTH CARE PROFESSIONAL.—The term 'treating health care professional' with respect to a group health plan, health insurance issuer or provider

sponsored organization means a physician (medical doctor or doctor of osteopathy) or other health care practitioner who is acting within the scope of his or her State licensure or certification for the delivery of health care services and who is primarily responsible for delivering those services to the participant or beneficiary.

''(9) UTILIZATION REVIEW.—The term 'utilization review' with respect to a group health plan or health insurance coverage means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.''

(b) ENFORCEMENT.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) is amended by adding at the end the following:

''(8) The Secretary may assess a civil penalty against any plan of up to $10,000 for the plan's failure or refusal to comply with any timeline applicable under section 503(e) or any determination under such section, except that in any case in which treatment was not commenced by the plan in accordance with the determination of an independent external reviewer, the Secretary shall assess a civil penalty of $10,000 against the plan and the plan shall pay such penalty to the participant or beneficiary involved.''.

(c) CONFORMING AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the item relating to section 503 and inserting the following new item:

''Sec. 503. Claims procedures, coverage determination, grievances and appeals.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after 1 year after the date of enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

TITLE II—WOMEN'S HEALTH AND CANCER RIGHTS

SEC. 201. WOMEN'S HEALTH AND CANCER RIGHTS.

(a) SHORT TITLE.—This section may be cited as the ''Women's Health and Cancer Rights Act of 1999''.

(b) FINDINGS.—Congress finds that—

(1) the offering and operation of health plans affect commerce among the States;

(2) health care providers located in a State serve patients who reside in the State and patients who reside in other States; and

(3) in order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in 1 State as well as health plans operating among the several States.

(c) AMENDMENTS TO ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 111(a), is further amended by adding at the end the following:

''SEC. 715. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000; whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d).''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.''.

(d) AMENDMENTS TO PHSA RELATING TO THE GROUP MARKET.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.) is amended by adding at the end the following new section:

''SEC. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000; whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d).''.

(e) AMENDMENTS TO PHSA RELATING TO THE INDIVIDUAL MARKET.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–51 et seq.) (relating to other requirements) (42 U.S.C. 300gg-51 et seq.) is amended—

(1) by redesignating such subpart as subpart 2; and

(2) by adding at the end the following:

''SEC. 2753. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND SECONDARY CONSULTATIONS.

''The provisions of section 2707 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(f) AMENDMENTS TO THE IRC.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 111(b), is further amended by inserting after section 9813 the following:

''SEC. 9814. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan and shall be transmitted—

''(1) in the next mailing made by the plan to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000; whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES.—A group health plan may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan involved under subsection (d).''.

(2) CLERICAL AMENDMENT.—The table of contents for chapter 100 of such Code is amended by inserting after the item relating to section 9813 the following new item:

''Sec. 9814. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.''.

TITLE III—GENETIC INFORMATION AND SERVICES

SEC. 301. SHORT TITLE.

This title may be cited as the ''Genetic Information Nondiscrimination in Health Insurance Act of 1999''.

SEC. 302. AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 702(a)(1)(F) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(a)(1)(F)) is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by sections 111(a) and 201, is further amended by adding at the end the following:

''SEC. 716. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''A group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).''.

(3) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 702(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)) is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 716.''.

(B) TABLE OF CONTENTS.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974, as amended by sections 111(a) and 201, is further amended by inserting after the item relating to section 715 the following new item:

''Sec. 716. Prohibiting premium discrimination against groups on the basis of predictive genetic information.''.

(b) LIMITATION ON COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Section 702 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182) is amended by adding at the end the following:

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan or issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan or issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan or issuer.''.

(c) DEFINITIONS.—Section 733(d) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(d)) is amended by adding at the end the following:

''(5) FAMILY MEMBER.—The term 'family member' means with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(6) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(7) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(8) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(9) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(d) EFFECTIVE DATE.—Except as provided in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning 1 year after the date of the enactment of this Act.

SEC. 303. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

(a) AMENDMENTS RELATING TO THE GROUP MARKET.—

(1) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION IN THE GROUP MARKET.—

(A) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 2702(a)(1)(F) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(1)(F)) is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(B) NO DISCRIMINATION IN PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by section 201, is further amended by adding at the end the following new section:

''SEC. 2708. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION IN THE GROUP MARKET.

''A group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).''.

(C) CONFORMING AMENDMENT.—Section 2702(b) of the Public Health Service Act (42 U.S.C. 300gg–1(b)) is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 2708.''.

(D) LIMITATION ON COLLECTION AND DISCLOSURE OF PREDICTIVE GENETIC INFORMATION.—Section 2702 of the Public Health Service Act (42 U.S.C. 300gg–1) is amended by adding at the end the following:

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan or issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan or issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan or issuer.''.

(2) DEFINITIONS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg–91(d)) is amended by adding at the end the following:

''(15) FAMILY MEMBER.—The term 'family member' means, with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(16) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(17) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(18) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(19) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(b) AMENDMENT RELATING TO THE INDIVIDUAL MARKET.—Subpart 2 of part B of title XXVII of the Public Health Service Act, as amended by section 201, is further amended by adding at the end the following new section:

''SEC. 2754. PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''(a) PROHIBITION ON PREDICTIVE GENETIC INFORMATION AS A CONDITION OF ELIGIBILITY.—A health insurance issuer offering health insurance coverage in the individual market may not use predictive genetic information as a condition of eligibility of an individual to enroll in individual health insurance coverage (including information about a request for or receipt of genetic services).

''(b) PROHIBITION ON PREDICTIVE GENETIC INFORMATION IN SETTING PREMIUM RATES.—A health insurance issuer offering health insurance coverage in the individual market shall not adjust premium rates for individuals on the basis of predictive genetic information concerning such an individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a health insurance issuer offering health insurance coverage in the individual market shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a health insurance issuer offering health insurance coverage in the individual market that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the health insurance issuer offering health insurance coverage in the individual market shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A health insurance issuer offering health insurance coverage in the individual market shall post or provide, in writing and in a clear and conspicuous manner, notice of the issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A health insurance issuer offering health insurance coverage in the individual market shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such issuer.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to—

(1) group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after 1 year after the date of enactment of this Act; and

(2) health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after 1 year after the date of enactment of this Act.

SEC. 304. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

(a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 9802(a)(1)(F) of the Internal Revenue Code of 1986 is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by sections 111(b) and 201, is further amended by adding at the end the following:

''SEC. 9815. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''A group health plan shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).''.

(B) CONFORMING AMENDMENT.—Section 9802(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or the receipt of genetic services), see section 9815.''.

(C) AMENDMENT TO TABLE OF SECTIONS.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by sections 111(b) and 201, is further amended by adding at the end the following:

''Sec. 9816. Prohibiting premium discrimination against groups on the basis of predictive genetic information.''.

(b) LIMITATION ON COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Section 9802 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(d) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan shall not request or require predictive genetic information concerning any

individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES; DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (e), of such predictive genetic information.

''(e) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan.''.

(c) DEFINITIONS.—Section 9832(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(6) FAMILY MEMBER.—The term 'family member' means, with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(7) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(8) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(9) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(10) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(d) EFFECTIVE DATE.—Except as provided in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning after 1 year after the date of the enactment of this Act.

TITLE IV—HEALTHCARE RESEARCH AND QUALITY

SEC. 401. SHORT TITLE.

This title may be cited as the ''Healthcare Research and Quality Act of 1999''.

SEC. 402. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended to read as follows:

''TITLE IX—AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

''PART A—ESTABLISHMENT AND GENERAL DUTIES

''SEC. 901. MISSION AND DUTIES.

''(a) IN GENERAL.—There is established within the Public Health Service an agency to be known as the Agency for Healthcare Research and Quality. In carrying out this subsection, the Secretary shall redesignate the Agency for Health Care Policy and Research as the Agency for Healthcare Research and Quality.

''(b) MISSION.—The purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of healthcare services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions. The Agency shall promote healthcare quality improvement by—

''(1) conducting and supporting research that develops and presents scientific evidence regarding all aspects of healthcare, including—

''(A) the development and assessment of methods for enhancing patient participation in their own care and for facilitating shared patient-physician decision-making;

''(B) the outcomes, effectiveness, and cost-effectiveness of healthcare practices, including preventive measures and long-term care;

''(C) existing and innovative technologies;

''(D) the costs and utilization of, and access to healthcare;

''(E) the ways in which healthcare services are organized, delivered, and financed and the interaction and impact of these factors on the quality of patient care;

''(F) methods for measuring quality and strategies for improving quality; and

''(G) ways in which patients, consumers, purchasers, and practitioners acquire new information about best practices and health benefits, the determinants and impact of their use of this information;

''(2) synthesizing and disseminating available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and

''(3) advancing private and public efforts to improve healthcare quality.

''(c) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND PRIORITY POPULATIONS.—In carrying out subsection (b), the Director shall undertake and support research, demonstration projects, and evaluations with respect to the delivery of health services—

''(1) in rural areas (including frontier areas);

''(2) for low-income groups, and minority groups;

''(3) for children;

''(4) for elderly; and

''(5) for people with special healthcare needs, including disabilities, chronic care and end-of-life healthcare.

''(d) APPOINTMENT OF DIRECTOR.—There shall be at the head of the Agency an official to be known as the Director for Healthcare Research and Quality. The Director shall be appointed by the Secretary. The Secretary, acting through the Director, shall carry out the authorities and duties established in this title.

''SEC. 902. GENERAL AUTHORITIES.

''(a) IN GENERAL.—In carrying out section 901(b), the Director shall support demonstration projects, conduct and support research, evaluations, training, research networks, multi-disciplinary centers, technical assistance, and the dissemination of information, on healthcare, and on systems for the delivery of such care, including activities with respect to—

''(1) the quality, effectiveness, efficiency, appropriateness and value of healthcare services;

''(2) quality measurement and improvement;

''(3) the outcomes, cost, cost-effectiveness, and use of healthcare services and access to such services;

''(4) clinical practice, including primary care and practice-oriented research;

''(5) healthcare technologies, facilities, and equipment;

''(6) healthcare costs, productivity, organization, and market forces;

''(7) health promotion and disease prevention, including clinical preventive services;

''(8) health statistics, surveys, database development, and epidemiology; and

''(9) medical liability.

''(b) HEALTH SERVICES TRAINING GRANTS.—

''(1) IN GENERAL.—The Director may provide training grants in the field of health services research related to activities authorized under subsection (a), to include pre- and post-doctoral fellowships and training programs, young investigator awards, and other programs and activities as appropriate. In carrying out this subsection, the Director shall make use of funds made available under section 487 as well as other appropriated funds.

''(2) REQUIREMENTS.—In developing priorities for the allocation of training funds under this subsection, the Director shall take into consideration shortages in the number of trained researchers addressing the priority populations.

''(c) MULTIDISCIPLINARY CENTERS.—The Director may provide financial assistance to assist in meeting the costs of planning and establishing new centers, and operating existing and new centers, for multidisciplinary health services research, demonstration projects, evaluations, training, and policy analysis with respect to the matters referred to in subsection (a).

''(d) RELATION TO CERTAIN AUTHORITIES REGARDING SOCIAL SECURITY.—Activities authorized in this section shall be appropriately coordinated with experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Amendments of 1967. Activities under subsection (a)(2) of this section that affect the programs under titles XVIII, XIX and XXI of the Social Security Act shall be carried out consistent with section 1142 of such Act.

''(e) DISCLAIMER.—The Agency shall not mandate national standards of clinical practice or quality healthcare standards. Recommendations resulting from projects funded and published by the Agency shall include a corresponding disclaimer.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to imply that the Agency's role is to mandate a national standard or specific approach to quality measurement and reporting. In research and quality improvement activities, the Agency shall consider a wide range of choices, providers, healthcare delivery systems, and individual preferences.

"PART B—HEALTHCARE IMPROVEMENT RESEARCH

"SEC. 911. HEALTHCARE OUTCOME IMPROVEMENT RESEARCH.

''(a) EVIDENCE RATING SYSTEMS.—In collaboration with experts from the public and private sector, the Agency shall identify and disseminate methods or systems that it uses to assess healthcare research results, particularly methods or systems that it uses to rate the strength of the scientific evidence behind healthcare practice, recommendations in the research literature, and technology assessments. The Agency shall make methods and systems for evidence rating widely available. Agency publications containing healthcare recommendations shall indicate the level of substantiating evidence using such methods or systems.

''(b) HEALTHCARE IMPROVEMENT RESEARCH CENTERS AND PROVIDER-BASED RESEARCH NETWORKS.—In order to address the full continuum of care and outcomes research, to link research to practice improvement, and to speed the dissemination of research findings to community practice settings, the Agency shall employ research strategies and mechanisms that will link research directly with clinical practice in geographically diverse locations throughout the United States, including—

''(1) Healthcare Improvement Research Centers that combine demonstrated multidisciplinary expertise in outcomes or quality improvement research with linkages to relevant sites of care;

''(2) Provider-based Research Networks, including plan, facility, or delivery system sites of care (especially primary care), that can evaluate and promote quality improvement; and

''(3) other innovative mechanisms or strategies to link research with clinical practice.

"SEC. 912. PRIVATE-PUBLIC PARTNERSHIPS TO IMPROVE ORGANIZATION AND DELIVERY.

''(a) SUPPORT FOR EFFORTS TO DEVELOP INFORMATION ON QUALITY.—

''(1) SCIENTIFIC AND TECHNICAL SUPPORT.—In its role as the principal agency for healthcare research and quality, the Agency may provide scientific and technical support for private and public efforts to improve healthcare quality, including the activities of accrediting organizations.

''(2) ROLE OF THE AGENCY.—With respect to paragraph (1), the role of the Agency shall include—

''(A) the identification and assessment of methods for the evaluation of the health of—

''(i) enrollees in health plans by type of plan, provider, and provider arrangements; and

''(ii) other populations, including those receiving long-term care services;

''(B) the ongoing development, testing, and dissemination of quality measures, including measures of health and functional outcomes;

''(C) the compilation and dissemination of healthcare quality measures developed in the private and public sector;

''(D) assistance in the development of improved healthcare information systems;

''(E) the development of survey tools for the purpose of measuring participant and beneficiary assessments of their healthcare; and

''(F) identifying and disseminating information on mechanisms for the integration of information on quality into purchaser and consumer decision-making processes.

''(b) CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS.—

''(1) IN GENERAL.—The Secretary, acting through the Director and in consultation with the Commissioner of Food and Drugs, shall establish a program for the purpose of making one or more grants for the establishment and operation of one or more centers to carry out the activities specified in paragraph (2).

''(2) REQUIRED ACTIVITIES.—The activities referred to in this paragraph are the following:

''(A) The conduct of state-of-the-art clinical, laboratory, or health services research for the following purposes:

''(i) To increase awareness of—

''(I) new uses of drugs, biological products, and devices;

''(II) ways to improve the effective use of drugs, biological products, and devices; and

''(III) risks of new uses and risks of combinations of drugs and biological products.

''(ii) To provide objective clinical information to the following individuals and entities:

''(I) Healthcare practitioners and other providers of healthcare goods or services.

''(II) Pharmacists, pharmacy benefit managers and purchasers.

''(III) Health maintenance organizations and other managed healthcare organizations.

''(IV) Healthcare insurers and governmental agencies.

''(V) Patients and consumers.

''(iii) To improve the quality of healthcare while reducing the cost of Healthcare through—

''(I) an increase in the appropriate use of drugs, biological products, or devices; and

''(II) the prevention of adverse effects of drugs, biological products, and devices and the consequences of such effects, such as unnecessary hospitalizations.

''(B) The conduct of research on the comparative effectiveness, cost-effectiveness, and safety of drugs, biological products, and devices.

''(C) Such other activities as the Secretary determines to be appropriate, except that grant funds may not be used by the Secretary in conducting regulatory review of new drugs.

''(c) REDUCING ERRORS IN MEDICINE.—The Director shall conduct and support research and build private-public partnerships to—

''(1) identify the causes of preventable healthcare errors and patient injury in healthcare delivery;

''(2) develop, demonstrate, and evaluate strategies for reducing errors and improving patient safety; and

''(3) promote the implementation of effective strategies throughout the healthcare industry.

"SEC. 913. INFORMATION ON QUALITY AND COST OF CARE.

''(a) IN GENERAL.—In carrying out 902(a), the Director shall—

''(1) conduct a survey to collect data on a nationally representative sample of the population on the cost, use and, for fiscal year 2001 and subsequent fiscal years, quality of healthcare, including the types of healthcare services Americans use, their access to healthcare services, frequency of use, how much is paid for the services used, the source of those payments, the types and costs of private health insurance, access, satisfaction, and quality of care for the general population including rural residents and for the populations identified in section 901(c); and

''(2) develop databases and tools that provide information to States on the quality, access, and use of healthcare services provided to their residents.

''(b) QUALITY AND OUTCOMES INFORMATION.—

''(1) IN GENERAL.—Beginning in fiscal year 2001, the Director shall ensure that the survey conducted under subsection (a)(1) will—

''(A) identify determinants of health outcomes and functional status, and their relationships to healthcare access and use, determine the ways and extent to which the priority populations enumerated in section 901(c) differ from the general population with respect to such variables, measure changes over time with respect to such variable, and monitor the overall national impact of changes in Federal and State policy on healthcare;

''(B) provide information on the quality of care and patient outcomes for frequently occurring clinical conditions for a nationally representative sample of the population including rural residents; and

''(C) provide reliable national estimates for children and persons with special healthcare needs through the use of supplements or periodic expansions of the survey.

In expanding the Medical Expenditure Panel Survey, as in existence on the date of enactment of this title, in fiscal year 2001 to collect information on the quality of care, the Director shall take into account any outcomes measurements generally collected by private sector accreditation organizations.

''(2) ANNUAL REPORT.—Beginning in fiscal year 2003, the Secretary, acting through the Director, shall submit to Congress an annual report on national trends in the quality of healthcare provided to the American people.

"SEC. 914. INFORMATION SYSTEMS FOR HEALTHCARE IMPROVEMENT.

''(a) IN GENERAL.—In order to foster a range of innovative approaches to the management and communication of health information, the Agency shall support research, evaluations and initiatives to advance—

''(1) the use of information systems for the study of healthcare quality, including the generation of both individual provider and plan-level comparative performance data;

''(2) training for healthcare practitioners and researchers in the use of information systems;

''(3) the creation of effective linkages between various sources of health information, including the development of information networks;

''(4) the delivery and coordination of evidence-based healthcare services, including

the use of real-time healthcare decision-support programs;

''(5) the utility and comparability of health information data and medical vocabularies by addressing issues related to the content, structure, definitions and coding of such information and data in consultation with appropriate Federal, State and private entities;

''(6) the use of computer-based health records in all settings for the development of personal health records for individual health assessment and maintenance, and for monitoring public health and outcomes of care within populations; and

''(7) the protection of individually identifiable information in health services research and healthcare quality improvement.

''(b) DEMONSTRATION.—The Agency shall support demonstrations into the use of new information tools aimed at improving shared decision-making between patients and their care-givers.

''SEC. 915. RESEARCH SUPPORTING PRIMARY CARE AND ACCESS IN UNDERSERVED AREAS.

''(a) PREVENTIVE SERVICES TASK FORCE.—

''(1) ESTABLISHMENT AND PURPOSE.—The Director may periodically convene a Preventive Services Task Force to be composed of individuals with appropriate expertise. Such a task force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the healthcare community, and updating previous clinical preventive recommendations.

''(2) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operations of the Preventive Services Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

''(3) OPERATION.—In carrying out its responsibilities under paragraph (1), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

''(b) PRIMARY CARE RESEARCH.—

''(1) IN GENERAL.—There is established within the Agency a Center for Primary Care Research (referred to in this subsection as the 'Center') that shall serve as the principal source of funding for primary care practice research in the Department of Health and Human Services. For purposes of this paragraph, primary care research focuses on the first contact when illness or health concerns arise, the diagnosis, treatment or referral to specialty care, preventive care, and the relationship between the clinician and the patient in the context of the family and community.

''(2) RESEARCH.—In carrying out this section, the Center shall conduct and support research concerning—

''(A) the nature and characteristics of primary care practice;

''(B) the management of commonly occurring clinical problems;

''(C) the management of undifferentiated clinical problems; and

''(D) the continuity and coordination of health services.

''SEC. 916. CLINICAL PRACTICE AND TECHNOLOGY INNOVATION.

''(a) IN GENERAL.—The Director shall promote innovation in evidence-based clinical practice and healthcare technologies by—

''(1) conducting and supporting research on the development, diffusion, and use of healthcare technology;

''(2) developing, evaluating, and disseminating methodologies for assessments of healthcare practices and healthcare technologies;

''(3) conducting intramural and supporting extramural assessments of existing and new healthcare practices and technologies;

''(4) promoting education, training, and providing technical assistance in the use of healthcare practice and healthcare technology assessment methodologies and results; and

''(5) working with the National Library of Medicine and the public and private sector to develop an electronic clearinghouse of currently available assessments and those in progress.

''(b) SPECIFICATION OF PROCESS.—

''(1) IN GENERAL.—Not later than December 31, 2000, the Director shall develop and publish a description of the methodology used by the Agency and its contractors in conducting practice and technology assessment.

''(2) CONSULTATIONS.—In carrying out this subsection, the Director shall cooperate and consult with the Assistant Secretary for Health, the Administrator of the Health Care Financing Administration, the Director of the National Institutes of Health, the Commissioner of Food and Drugs, and the heads of any other interested Federal department or agency, and shall seek input, where appropriate, from professional societies and other private and public entities.

''(3) METHODOLOGY.—The Director, in developing assessment methodology, shall consider—

''(A) safety, efficacy, and effectiveness;

''(B) legal, social, and ethical implications;

''(C) costs, benefits, and cost-effectiveness;

''(D) comparisons to alternate technologies and practices; and

''(E) requirements of Food and Drug Administration approval to avoid duplication.

''(c) SPECIFIC ASSESSMENTS.—

''(1) IN GENERAL.—The Director shall conduct or support specific assessments of healthcare technologies and practices.

''(2) REQUESTS FOR ASSESSMENTS.—The Director is authorized to conduct or support assessments, on a reimbursable basis, for the Health Care Financing Administration, the Department of Defense, the Department of Veterans Affairs, the Office of Personnel Management, and other public or private entities.

''(3) GRANTS AND CONTRACTS.—In addition to conducting assessments, the Director may make grants to, or enter into cooperative agreements or contracts with, entities described in paragraph (4) for the purpose of conducting assessments of experimental, emerging, existing, or potentially outmoded healthcare technologies, and for related activities.

''(4) ELIGIBLE ENTITIES.—An entity described in this paragraph is an entity that is determined to be appropriate by the Director, including academic medical centers, research institutions and organizations, professional organizations, third party payers, governmental agencies, and consortia of appropriate research entities established for the purpose of conducting technology assessments.

''SEC. 917. COORDINATION OF FEDERAL GOVERNMENT QUALITY IMPROVEMENT EFFORTS.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—To avoid duplication and ensure that Federal resources are used efficiently and effectively, the Secretary, acting through the Director, shall coordinate all research, evaluations, and demonstrations related to health services research, quality measurement and quality improvement activities undertaken and supported by the Federal Government.

''(2) SPECIFIC ACTIVITIES.—The Director, in collaboration with the appropriate Federal officials representing all concerned executive agencies and departments, shall develop and manage a process to—

''(A) improve interagency coordination, priority setting, and the use and sharing of research findings and data pertaining to Federal quality improvement programs, technology assessment, and health services research;

''(B) strengthen the research information infrastructure, including databases, pertaining to Federal health services research and healthcare quality improvement initiatives;

''(C) set specific goals for participating agencies and departments to further health services research and healthcare quality improvement; and

''(D) strengthen the management of Federal healthcare quality improvement programs.

''(b) STUDY BY THE INSTITUTE OF MEDICINE.—

''(1) IN GENERAL.—To provide Congress, the Department of Health and Human Services, and other relevant departments with an independent, external review of their quality oversight, quality improvement and quality research programs, the Secretary shall enter into a contract with the Institute of Medicine—

''(A) to describe and evaluate current quality improvement, quality research and quality monitoring processes through—

''(i) an overview of pertinent health services research activities and quality improvement efforts conducted by all Federal programs, with particular attention paid to those under titles XVIII, XIX, and XXI of the Social Security Act; and

''(ii) a summary of the partnerships that the Department of Health and Human Services has pursued with private accreditation, quality measurement and improvement organizations; and

''(B) to identify options and make recommendations to improve the efficiency and effectiveness of quality improvement programs through—

''(i) the improved coordination of activities across the medicare, medicaid and child health insurance programs under titles XVIII, XIX and XXI of the Social Security Act and health services research programs;

''(ii) the strengthening of patient choice and participation by incorporating state-of-the-art quality monitoring tools and making information on quality available; and

''(iii) the enhancement of the most effective programs, consolidation as appropriate, and elimination of duplicative activities within various federal agencies.

''(2) REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall enter into a contract with the Institute of Medicine for the preparation—

''(i) not later than 12 months after the date of enactment of this title, of a report providing an overview of the quality improvement programs of the Department of Health and Human Services for the medicare, medicaid, and CHIP programs under titles XVIII, XIX, and XXI of the Social Security Act; and

''(ii) not later than 24 months after the date of enactment of this title, of a final report containing recommendations.

''(B) REPORTS.—The Secretary shall submit the reports described in subparagraph (A) to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Commerce of the House of Representatives.

"PART C—GENERAL PROVISIONS

"SEC. 921. ADVISORY COUNCIL FOR HEALTHCARE RESEARCH AND QUALITY.

''(a) ESTABLISHMENT.—There is established an advisory council to be known as the Advisory Council for Healthcare Research and Quality.

''(b) DUTIES.—

''(1) IN GENERAL.—The Advisory Council shall advise the Secretary and the Director with respect to activities proposed or undertaken to carry out the purpose of the Agency under section 901(b).

''(2) CERTAIN RECOMMENDATIONS.—Activities of the Advisory Council under paragraph (1) shall include making recommendations to the Director regarding—

''(A) priorities regarding healthcare research, especially studies related to quality, outcomes, cost and the utilization of, and access to, healthcare services;

''(B) the field of healthcare research and related disciplines, especially issues related to training needs, and dissemination of information pertaining to healthcare quality; and

''(C) the appropriate role of the Agency in each of these areas in light of private sector activity and identification of opportunities for public-private sector partnerships.

''(c) MEMBERSHIP.—

''(1) IN GENERAL.—The Advisory Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Advisory Council shall be voting members other than the individuals designated under paragraph (3)(B) as ex officio members.

''(2) APPOINTED MEMBERS.—The Secretary shall appoint to the Advisory Council 21 appropriately qualified individuals. At least 17 members of the Advisory Council shall be representatives of the public who are not officers or employees of the United States. The Secretary shall ensure that the appointed members of the Council, as a group, are representative of professions and entities concerned with, or affected by, activities under this title and under section 1142 of the Social Security Act. Of such members—

''(A) 4 shall be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to healthcare;

''(B) 4 shall be individuals distinguished in the practice of medicine of which at least 1 shall be a primary care practitioner;

''(C) 3 shall be individuals distinguished in the other health professions;

''(D) 4 shall be individuals either representing the private healthcare sector, including health plans, providers, and purchasers or individuals distinguished as administrators of healthcare delivery systems;

''(E) 4 shall be individuals distinguished in the fields of healthcare quality improvement, economics, information systems, law, ethics, business, or public policy, including at least 1 individual specializing in rural aspects in 1 or more of these fields; and

''(F) 2 shall be individuals representing the interests of patients and consumers of healthcare.

''(3) EX OFFICIO MEMBERS.—The Secretary shall designate as ex officio members of the Advisory Council—

''(A) the Assistant Secretary for Health, the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Care Financing Administration, the Assistant Secretary of Defense (Health Affairs), and the Under Secretary for Health of the Department of Veterans Affairs; and

''(B) such other Federal officials as the Secretary may consider appropriate.

''(d) TERMS.—Members of the Advisory Council appointed under subsection (c)(2) shall serve for a term of 3 years. A member of the Council appointed under such subsection may continue to serve after the expiration of the term of the members until a successor is appointed.

''(e) VACANCIES.—If a member of the Advisory Council appointed under subsection (c)(2) does not serve the full term applicable under subsection (d), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

''(f) CHAIR.—The Director shall, from among the members of the Advisory Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Advisory Council.

''(g) MEETINGS.—The Advisory Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the Director or the chair.

''(h) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—

''(1) APPOINTED MEMBERS.—Members of the Advisory Council appointed under subsection (c)(2) shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Advisory Council unless declined by the member. Such compensation may not be in an amount in excess of the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day during which such member is engaged in the performance of the duties of the Advisory Council.

''(2) EX OFFICIO MEMBERS.—Officials designated under subsection (c)(3) as ex officio members of the Advisory Council may not receive compensation for service on the Advisory Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

''(i) STAFF.—The Director shall provide to the Advisory Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

"SEC. 922. PEER REVIEW WITH RESPECT TO GRANTS AND CONTRACTS.

''(a) REQUIREMENT OF REVIEW.—

''(1) IN GENERAL.—Appropriate technical and scientific peer review shall be conducted with respect to each application for a grant, cooperative agreement, or contract under this title.

''(2) REPORTS TO DIRECTOR.—Each peer review group to which an application is submitted pursuant to paragraph (1) shall report its finding and recommendations respecting the application to the Director in such form and in such manner as the Director shall require.

''(b) APPROVAL AS PRECONDITION OF AWARDS.—The Director may not approve an application described in subsection (a)(1) unless the application is recommended for approval by a peer review group established under subsection (c).

''(c) ESTABLISHMENT OF PEER REVIEW GROUPS.—

''(1) IN GENERAL.—The Director shall establish such technical and scientific peer review groups as may be necessary to carry out this section. Such groups shall be established without regard to the provisions of title 5, United States Code, that govern appointments in the competitive service, and without regard to the provisions of chapter 51, and subchapter III of chapter 53, of such title that relate to classification and pay rates under the General Schedule.

''(2) MEMBERSHIP.—The members of any peer review group established under this section shall be appointed from among individuals who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group. Officers and employees of the United States may not constitute more than 25 percent of the membership of any such group. Such officers and employees may not receive compensation for service on such groups in addition to the compensation otherwise received for these duties carried out as such officers and employees.

''(3) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, peer review groups established under this section may continue in existence until otherwise provided by law.

''(4) QUALIFICATIONS.—Members of any peer-review group shall, at a minimum, meet the following requirements:

''(A) Such members shall agree in writing to treat information received, pursuant to their work for the group, as confidential information, except that this subparagraph shall not apply to public records and public information.

''(B) Such members shall agree in writing to recuse themselves from participation in the peer-review of specific applications which present a potential personal conflict of interest or appearance of such conflict, including employment in a directly affected organization, stock ownership, or any financial or other arrangement that might introduce bias in the process of peer-review.

''(d) AUTHORITY FOR PROCEDURAL ADJUSTMENTS IN CERTAIN CASES.—In the case of applications for financial assistance whose direct costs will not exceed $100,000, the Director may make appropriate adjustments in the procedures otherwise established by the Director for the conduct of peer review under this section. Such adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented or provider-based research, and for such other purposes as the Director may determine to be appropriate.

''(e) REGULATIONS.—The Director shall issue regulations for the conduct of peer review under this section.

"SEC. 923. CERTAIN PROVISIONS WITH RESPECT TO DEVELOPMENT, COLLECTION, AND DISSEMINATION OF DATA.

''(a) STANDARDS WITH RESPECT TO UTILITY OF DATA.—

''(1) IN GENERAL.—To ensure the utility, accuracy, and sufficiency of data collected by or for the Agency for the purpose described in section 901(b), the Director shall establish standard methods for developing and collecting such data, taking into consideration—

''(A) other Federal health data collection standards; and

''(B) the differences between types of healthcare plans, delivery systems, healthcare providers, and provider arrangements.

''(2) RELATIONSHIP WITH OTHER DEPARTMENT PROGRAMS.—In any case where standards under paragraph (1) may affect the administration of other programs carried out by the Department of Health and Human Services, including the programs under title XVIII, XIX or XXI of the Social Security Act, or may affect health information that is subject to a standard developed under part C of title XI of the Social Security Act, they shall be in the form of recommendations to the Secretary for such program.

''(b) STATISTICS AND ANALYSES.—The Director shall—

''(1) take appropriate action to ensure that statistics and analyses developed under this title are of high quality, timely, and duly comprehensive, and that the statistics are specific, standardized, and adequately analyzed and indexed; and

''(2) publish, make available, and disseminate such statistics and analyses on as wide a basis as is practicable.

''(c) AUTHORITY REGARDING CERTAIN REQUESTS.—Upon request of a public or private entity, the Director may conduct or support research or analyses otherwise authorized by this title pursuant to arrangements under which such entity will pay the cost of the services provided. Amounts received by the Director under such arrangements shall be available to the Director for obligation until expended.

''SEC. 924. DISSEMINATION OF INFORMATION.

''(a) IN GENERAL.—The Director shall—

''(1) without regard to section 501 of title 44, United States Code, promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title;

''(2) ensure that information disseminated by the Agency is science-based and objective and undertakes consultation as necessary to assess the appropriateness and usefulness of the presentation of information that is targeted to specific audiences;

''(3) promptly make available to the public data developed in such research, demonstration projects, and evaluations;

''(4) provide, in collaboration with the National Library of Medicine where appropriate, indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to healthcare to public and private entities and individuals engaged in the improvement of healthcare delivery and the general public, and undertake programs to develop new or improved methods for making such information available; and

''(5) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

''(b) PROHIBITION AGAINST RESTRICTIONS.—Except as provided in subsection (c), the Director may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

''(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Director) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Director) to its publication or release in other form.

''(d) PENALTY.—Any person who violates subsection (c) shall be subject to a civil monetary penalty of not more than $10,000 for each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act are imposed and collected.

''SEC. 925. ADDITIONAL PROVISIONS WITH RESPECT TO GRANTS AND CONTRACTS.

''(a) FINANCIAL CONFLICTS OF INTEREST.—With respect to projects for which awards of grants, cooperative agreements, or contracts are authorized to be made under this title, the Director shall by regulation define—

''(1) the specific circumstances that constitute financial interests in such projects that will, or may be reasonably expected to, create a bias in favor of obtaining results in the projects that are consistent with such interests; and

''(2) the actions that will be taken by the Director in response to any such interests identified by the Director.

''(b) REQUIREMENT OF APPLICATION.—The Director may not, with respect to any program under this title authorizing the provision of grants, cooperative agreements, or contracts, provide any such financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Director determines to be necessary to carry out the program in involved.

''(c) PROVISION OF SUPPLIES AND SERVICES IN LIEU OF FUNDS.—

''(1) IN GENERAL.—Upon the request of an entity receiving a grant, cooperative agreement, or contract under this title, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of the Department of Health and Human Services.

''(2) CORRESPONDING REDUCTION IN FUNDS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of the financial assistance involved by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Director. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

''(d) APPLICABILITY OF CERTAIN PROVISIONS WITH RESPECT TO CONTRACTS.—Contracts may be entered into under this part without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

''SEC. 926. CERTAIN ADMINISTRATIVE AUTHORITIES.

''(a) DEPUTY DIRECTOR AND OTHER OFFICERS AND EMPLOYEES.—

''(1) DEPUTY DIRECTOR.—The Director may appoint a deputy director for the Agency.

''(2) OTHER OFFICERS AND EMPLOYEES.—The Director may appoint and fix the compensation of such officers and employees as may be necessary to carry out this title. Except as otherwise provided by law, such officers and employees shall be appointed in accordance with the civil service laws and their compensation fixed in accordance with title 5, United States Code.

''(b) FACILITIES.—The Secretary, in carrying out this title—

''(1) may acquire, without regard to the Act of March 3, 1877 (40 U.S.C. 34), by lease or otherwise through the Director of General Services, buildings or portions of buildings in the District of Columbia or communities located adjacent to the District of Columbia for use for a period not to exceed 10 years; and

''(2) may acquire, construct, improve, repair, operate, and maintain laboratory, research, and other necessary facilities and equipment, and such other real or personal property (including patents) as the Secretary deems necessary.

''(c) PROVISION OF FINANCIAL ASSISTANCE.—The Director, in carrying out this title, may make grants to public and nonprofit entities and individuals, and may enter into cooperative agreements or contracts with public and private entities and individuals.

''(d) UTILIZATION OF CERTAIN PERSONNEL AND RESOURCES.—

''(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Director, in carrying out this title, may utilize personnel and equipment, facilities, and other physical resources of the Department of Health and Human Services, permit appropriate (as determined by the Secretary) entities and individuals to utilize the physical resources of such Department, and provide technical assistance and advice.

''(2) OTHER AGENCIES.—The Director, in carrying out this title, may use, with their consent, the services, equipment, personnel, information, and facilities of other Federal, State, or local public agencies, or of any foreign government, with or without reimbursement of such agencies.

''(e) CONSULTANTS.—The Secretary, in carrying out this title, may secure, from time to time and for such periods as the Director deems advisable but in accordance with section 3109 of title 5, United States Code, the assistance and advice of consultants from the United States or abroad.

''(f) EXPERTS.—

''(1) IN GENERAL.—The Secretary may, in carrying out this title, obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Such experts or consultants shall be obtained in accordance with section 3109 of title 5, United States Code, except that the limitation in such section on the duration of service shall not apply.

''(2) TRAVEL EXPENSES.—

''(A) IN GENERAL.—Experts and consultants whose services are obtained under paragraph (1) shall be paid or reimbursed for their expenses associated with traveling to and from their assignment location in accordance with sections 5724, 5724a(a), 5724a(c), and 5726(C) of title 5, United States Code.

''(B) LIMITATION.—Expenses specified in subparagraph (A) may not be allowed in connection with the assignment of an expert or consultant whose services are obtained under paragraph (1) unless and until the expert agrees in writing to complete the entire period of assignment, or 1 year, whichever is shorter, unless separated or reassigned for reasons that are beyond the control of the expert or consultant and that are acceptable to the Secretary. If the expert or consultant violates the agreement, the money spent by the United States for the expenses specified in subparagraph (A) is recoverable from the expert or consultant as a statutory obligation owed to the United States. The Secretary may waive in whole or in part a right of recovery under this subparagraph.

''(g) VOLUNTARY AND UNCOMPENSATED SERVICES.—The Director, in carrying out this title, may accept voluntary and uncompensated services.

''SEC. 927. FUNDING.

''(a) INTENT.—To ensure that the United States's investment in biomedical research is rapidly translated into improvements in the quality of patient care, there must be a corresponding investment in research on the most effective clinical and organizational strategies for use of these findings in daily practice. The authorization levels in subsection (b) provide for a proportionate increase in healthcare research as the United States investment in biomedical research increases.

''(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this title, there are authorized to be appropriated $250,000,000 for fiscal year 2000, and such sums as may be necessary for each of the fiscal years 2001 through 2006.

''(c) EVALUATIONS.—In addition to amounts available pursuant to subsection (b) for carrying out this title, there shall be made available for such purpose, from the amounts made available pursuant to section 241 (relating to evaluations), an amount equal to 40

percent of the maximum amount authorized in such section 241 to be made available for a fiscal year.

"SEC. 928. DEFINITIONS.

''In this title:

''(1) ADVISORY COUNCIL.—The term 'Advisory Council' means the Advisory Council on Healthcare Research and Quality established under section 921.

''(2) AGENCY.—The term 'Agency' means the Agency for Healthcare Research and Quality.

''(3) DIRECTOR.—The term 'Director' means the Director for the Agency for Healthcare Research and Quality.''.

SEC. 403. REFERENCES.

Effective upon the date of enactment of this Act, any reference in law to the ''Agency for Health Care Policy and Research'' shall be deemed to be a reference to the ''Agency for Healthcare Research and Quality''.

TITLE V—ENHANCED ACCESS TO HEALTH INSURANCE COVERAGE

SEC. 501. FULL DEDUCTION OF HEALTH INSURANCE COSTS FOR SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Section 162(l)(1) of the Internal Revenue Code of 1986 (relating to allowance of deductions) 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, his spouse, and his dependents.''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 502. FULL AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Section 220(c)(1)(A) of the Internal Revenue Code of 1986 (relating to eligible individual) is amended to read as follows:

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

''(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

''(I) which is not a high deductible health plan, and

''(II) which provides coverage for any benefit which is covered under the high deductible health plan.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 220(c)(1) of such Code is amended by striking subparagraphs (C) and (D).

(B) Section 220(c) of such Code is amended by striking paragraph (4) (defining small employer) and by redesignating paragraph (5) as paragraph (4).

(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(b) REMOVAL OF LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Section 220 of the Internal Revenue Code of 1986 (relating to medical savings accounts) is amended by striking subsections (i) and (j).

(2) MEDICARE+CHOICE.—Section 138 of such Code (relating to Medicare+Choice MSA) is amended by striking subsection (f).

(c) REDUCTION IN HIGH DEDUCTIBLE PLAN MINIMUM ANNUAL DEDUCTIBLE.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking ''$1,500'' and inserting ''$1,000'', and

(B) by striking ''$3,000'' in clause (ii) and inserting ''$2,000''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended—

(A) by striking ''1998'' and inserting ''1999''; and

(B) by striking ''1997'' and inserting ''1998''.

(d) INCREASE IN CONTRIBUTION LIMIT TO 100 PERCENT OF ANNUAL DEDUCTIBLE.—

(1) IN GENERAL.—Section 220(b)(2) of the Internal Revenue Code of 1986 (relating to monthly limitation) is amended to read as follows:

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible of the high deductible health plan of the individual.''

(2) CONFORMING AMENDMENT.—Section 220(d)(1)(A) of such Code is amended by striking ''75 percent of''.

(e) LIMITATION ON ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Section 220(f)(4) of the Internal Revenue Code of 1986 (relating to additional tax on distributions not used for qualified medical expenses) is amended by adding at the end the following:

''(D) EXCEPTION IN CASE OF SUFFICIENT ACCOUNT BALANCE.—Subparagraph (A) shall not apply to any payment or distribution in any taxable year, but only to the extent such payment or distribution does not reduce the fair market value of the assets of the medical savings account to an amount less than the annual deductible for the high deductible health plan of the account holder (determined as of January 1 of the calendar year in which the taxable year begins).''.

(f) TREATMENT OF NETWORK-BASED MANAGED CARE PLANS.—Section 220(c)(2)(B) of the Internal Revenue Code of 1986 (relating to special rules for high deductible health plans) is amended by adding at the end the following:

''(iii) TREATMENT OF NETWORK-BASED MANAGED CARE PLANS.—A plan that provides health care services through a network of contracted or affiliated health care providers, if the benefits provided when services are obtained through network providers meet the requirements of subparagraph (A), shall not fail to be treated as a high deductible health plan by reason of providing benefits for services rendered by providers who are not members of the network, so long as the annual deductible and annual limit on out-of-pocket expenses applicable to services received from non-network providers are not lower than those applicable to services received from the network providers.''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 503. PERMITTING CONTRIBUTION TOWARDS MEDICAL SAVINGS ACCOUNT THROUGH FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP).

(a) AUTHORITY TO CONTRACT FOR CATASTROPHIC PLANS.—Section 8902 of title 5, United States Code, is amended by adding at the end the following:

''(p)(1) The Office shall contract under this chapter for a catastrophic plan with any qualified carrier that—

''(A) offers such a plan; and

''(B) as of the date of enactment of the Patients' Bill of Rights Plus Act, offers a health benefits plan under this chapter.

''(2) The Office may contract under this chapter for a catastrophic plan with any qualified carrier that—

''(A) offers such a plan; but

''(B) does not satisfy the requirement under paragraph (1)(B).''.

(b) GOVERNMENT CONTRIBUTION TO MEDICAL SAVINGS ACCOUNT.—

(1) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by adding at the end the following:

''(j)(1) In the case of an employee or annuitant who is enrolled in a catastrophic plan described by section 8903(5), there shall be a Government contribution under this subsection to a medical savings account established or maintained for the benefit of the individual. The contribution under this subsection shall be in addition to the Government contribution under subsection (b).

''(2) The amount of the Government contribution under this subsection with respect to an individual is equal to the amount by which—

''(A) the maximum contribution allowed under subsection (b)(1) with respect to any employee or annuitant, exceeds

''(B) the amount of the Government contribution actually made with respect to the individual under subsection (b) for coverage under the catastrophic plan.

''(3) The Government contributions under this subsection shall be paid into a medical savings account (designated by the individual involved) in a manner that is specified by the Office and consistent with the timing of contributions under subsection (b).

''(4) Subsections (f) and (g) shall apply to contributions under this section in the same manner as they apply to contributions under subsection (b).

''(5) For the purpose of this subsection, the term 'medical savings account' has the meaning given such term by section 220(d) of the Internal Revenue Code of 1986.''.

(2) ALLOWING PAYMENT OF FULL AMOUNT OF CHARGE FOR CATASTROPHIC PLAN.—Section 8906(b)(2) of such title is amended by inserting ''(or 100 percent of the subscription charge in the case of a catastrophic plan)'' after ''75 percent of the subscription charge''.

(c) OFFERING OF CATASTROPHIC PLANS.—

(1) IN GENERAL.—Section 8903 of title 5, United States Code, is amended by adding at the end the following:

''(5) CATASTROPHIC PLANS.—(A) One or more plans described in paragraph (1), (2), or (3), but which provide benefits of the types referred to by paragraph (5) of section 8904(a), instead of the types referred to in paragraphs (1), (2), and (3) of such section.

''(B) Nothing in this section shall be considered—

''(i) to prevent a carrier from simultaneously offering a plan described by subparagraph (A) and a plan described by paragraph (1) or (2);

''(ii) to require that a catastrophic plan offer two levels of benefits; or

''(iii) to allow, in any contract year, for—

''(I) more than one plan to be offered which satisfies both subparagraph (A) and paragraph (1) (subject to clause (ii)); and

''(II) more than one plan which satisfies both subparagraph (A) and paragraph (2) (subject to clause (ii)).''.

(2) TYPES OF BENEFITS.—Section 8904(a) of such title is amended by inserting after paragraph (4) the following new paragraph:

''(5) CATASTROPHIC PLANS.—Benefits of the types named under paragraph (1) or (2) of this subsection or both, except that the plan shall meet the annual deductible and annual out-of-pocket expenses requirements under section 220(c)(2) of the Internal Revenue Code of 1986.''.

(3) DETERMINING LEVEL OF GOVERNMENT CONTRIBUTIONS.—Section 8906(b) of such title

is amended by adding at the end the following: ''Subscription charges for medical savings accounts shall be deemed to be the amount of Government contributions made under subsection (j)(2).''.

(d) CONFORMING AMENDMENTS.—

(1) ADDITIONAL HEALTH BENEFITS PLANS.—Section 8903a of title 5, United States Code, is amended by redesignating subsection (d) as subsection (e) and by inserting after subsection (c) the following:

''(d) The plans under this section may include one or more plans, otherwise allowable under this section, that satisfy the requirements of clauses (i) and (ii) of section 8903(5)(A).''.

(2) REFERENCE.—Section 8909(d) of title 5, United States Code, is amended by striking ''8903a(d)'' and inserting ''8903a(e)''.

(e) REFERENCES.—Section 8903 of title 5, United States Code, is amended by adding at the end (as a flush left sentence) the following:

''The Office shall prescribe regulations under which the requirements of section 8902(c), 8902(n), 8909(e), and any other provision of this chapter that applies with respect to a plan described by paragraph (1), (2), (3), or (4) of this section shall apply with respect to the corresponding plan under paragraph (5) of this section. Similar regulations shall be prescribed with respect to any plan under section 8903a(d).''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to contract terms beginning on or after January 1, 2000.

SEC. 504. CARRYOVER OF UNUSED BENEFITS FROM CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsections (h) and (i) as subsections (i) and (j) and by inserting after subsection (g) the following new subsection:

''(h) ALLOWANCE OF CARRYOVERS OF UNUSED BENEFITS TO LATER TAXABLE YEARS.—

''(1) IN GENERAL.—For purposes of this title—

''(A) notwithstanding subsection (d)(2), a plan or other arrangement shall not fail to be treated as a cafeteria plan or flexible spending or similar arrangement, and

''(B) no amount shall be required to be included in gross income by reason of this section or any other provision of this chapter,

solely because under such plan or other arrangement any nontaxable benefit which is unused as of the close of a taxable year may be carried forward to 1 or more succeeding taxable years.

''(2) LIMITATION.—Paragraph (1) shall not apply to amounts carried from a plan to the extent such amounts exceed $500 (applied on an annual basis). For purposes of this paragraph, all plans and arrangements maintained by an employer or any related person shall be treated as 1 plan.

''(3) ALLOWANCE OF ROLLOVER.—

''(A) IN GENERAL.—In the case of any unused benefit described in paragraph (1) which consists of amounts in a health flexible spending account or dependent care flexible spending account, the plan or arrangement shall provide that a participant may elect, in lieu of such carryover, to have such amounts distributed to the participant.

''(B) AMOUNTS NOT INCLUDED IN INCOME.—Any distribution under subparagraph (A) shall not be included in gross income to the extent that such amount is transferred in a trustee-to-trustee transfer, or is contributed within 60 days of the date of the distribution, to—

''(i) a qualified cash or deferred arrangement described in section 401(k),

''(ii) a plan under which amounts are contributed by an individual's employer for an annuity contract described in section 403(b),

''(iii) an eligible deferred compensation plan described in section 457, or

''(iv) a medical savings account (within the meaning of section 220).

Any amount rolled over under this subparagraph shall be treated as a rollover contribution for the taxable year from which the unused amount would otherwise be carried.

''(C) TREATMENT OF ROLLOVER.—Any amount rolled over under subparagraph (B) shall be treated as an eligible rollover under section 220, 401(k), 403(b), or 457, whichever is applicable, and shall be taken into account in applying any limitation (or participation requirement) on employer or employee contributions under such section or any other provision of this chapter for the taxable year of the rollover.

''(4) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 1999, the $500 amount under paragraph (2) shall be adjusted at the same time and in the same manner as under section 415(d)(2), except that the base period taken into account shall be the calendar quarter beginning October 1, 1998, and any increase which is not a multiple of $50 shall be rounded to the next lowest multiple of $50.''

''(5) APPLICABILITY.—This subsection shall apply to taxable years beginning after December 31, 1999.''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

TITLE VI—PROVISIONS RELATING TO LONG-TERM CARE INSURANCE

SEC. 601. INCLUSION OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS IN CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125(f) of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by striking the last sentence and inserting the following: ''Such term includes any qualified long-term care insurance contract.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 602. DEDUCTION FOR PREMIUMS FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 222 as section 223 and by inserting after section 221 the following:

''SEC. 222. PREMIUMS FOR LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a deduction an amount equal to 100 percent of the amount paid during the taxable year for any coverage for qualified long-term care services (as defined in section 7702B(c)) or any qualified long-term care insurance contract (as defined in section 7702B(b)) which constitutes medical care for the taxpayer, his spouse, and dependents.

''(b) LIMITATIONS.—

''(1) DEDUCTION NOT AVAILABLE TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), subsection (a) shall not apply to any taxpayer for any calendar month for which the taxpayer is eligible to participate in any plan which includes coverage for qualified long-term care services (as so defined) or is a qualified long-term care insurance contract (as so defined) maintained by any employer (or former employer) of the taxpayer or of the spouse of the taxpayer.

''(B) CONTINUATION COVERAGE.—Coverage shall not be treated as subsidized for purposes of this paragraph if—

''(i) such coverage is continuation coverage (within the meaning of section 4980B(f)) required to be provided by the employer, and

''(ii) the taxpayer or the taxpayer's spouse is required to pay a premium for such coverage in an amount not less than 100 percent of the applicable premium (within the meaning of section 4980B(f)(4)) for the period of such coverage.

''(2) LIMITATION ON LONG-TERM CARE PREMIUMS.—In the case of a qualified long-term care insurance contract (as so defined), only eligible long-term care premiums (as defined in section 213(d)(10)) shall be taken into account under subsection (a)(2).

''(c) SPECIAL RULES.—For purposes of this section—

''(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).

''(2) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this section shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.''

(b) CONFORMING AMENDMENTS.—

(1) Subsection (a) of section 62 of the Internal Revenue Code of 1986 is amended by inserting after paragraph (17) the following:

''(18) LONG-TERM CARE INSURANCE COSTS OF CERTAIN INDIVIDUALS.—The deduction allowed by section 222.''

(2) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

''Sec. 222. Premiums for long-term care insurance.

''Sec. 223. Cross reference.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 603. STUDY OF LONG-TERM CARE NEEDS IN THE 21ST CENTURY.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall provide, in accordance with this section, for a study in order to determine—

(1) future demand for long-term health care services (including institutional and home and community-based services) in the United States in order to meet the needs in the 21st century; and

(2) long-term options to finance the provision of such services.

(b) DETAILS.—The study conducted under subsection (a) shall include the following:

(1) An identification of the relevant demographic characteristics affecting demand for long-term health care services, at least through the year 2030.

(2) The viability and capacity of community-based and other long-term health care services under different federal programs, including through the medicare and medicaid programs, grants to States, housing services, and changes in tax policy.

(3) How to improve the quality of long-term health care services.

(4) The integration of long-term health care services for individuals between different classes of health care providers (such as hospitals, nursing facilities, and home care agencies) and different Federal programs (such as the medicare and medicaid programs).

(5) The possibility of expanding private sector initiatives, including long-term care insurance, to meet the need to finance such services.

(6) An examination of the effect of enactment of the Health Insurance Portability and Accountability Act of 1996 on the provision and financing of long-term health care services, including on portability and affordability of private long-term care insurance, the impact of insurance options on low-income older Americans, and the options for eligibility to improve access to such insurance.

(7) The financial impact of the provision of long-term health care services on caregivers and other family members.

(c) REPORT AND RECOMMENDATIONS.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall provide for a report on the study under this section.

(2) RECOMMENDATIONS.—The report under paragraph (1) shall include findings and recommendations regarding each of the following:

(A) The most effective and efficient manner that the Federal government may use its resources to educate the public on planning for needs for long-term health care services.

(B) The public, private, and joint public-private strategies for meeting identified needs for long-term health care services.

(C) The role of States and local communities in the financing of long-term health care services.

(3) INCLUSION OF COST ESTIMATES.—The report under paragraph (1) shall include cost estimates of the various options for which recommendations are made.

(d) CONDUCT OF STUDY.—

(1) USE OF INSTITUTE OF MEDICINE.—The Secretary of Health and Human Services shall seek to enter into an appropriate arrangement with the Institute of Medicine of the National Academy of Sciences to conduct the study under this section. If such an arrangement cannot be made, the Secretary may provide for the conduct of the study by any other qualified non-governmental entity.

(2) CONSULTATION.—The study should be conducted under this section in consultation with experts from a wide-range of groups from the public and private sectors.

TITLE VII—INDIVIDUAL RETIREMENT PLANS

SEC. 701. MODIFICATION OF INCOME LIMITS ON CONTRIBUTIONS AND ROLLOVERS TO ROTH IRAS.

(a) INCREASE IN AGI LIMIT FOR ROLLOVER CONTRIBUTIONS.—Clause (i) of section 408A(c)(3)(A) of the Internal Revenue Code of 1986 (relating to rollover from IRA), as redesignated by subsection (a), is amended by striking ''$100,000'' and inserting ''$1,000,000''.

(b) CONFORMING AMENDMENTS.—

(1)(A) Subparagraph (B) of section 408A(c)(3) of the Internal Revenue Code of 1986, as redesignated by subsection (a), is amended to read as follows:

''(B) DEFINITION OF ADJUSTED GROSS INCOME.—For purposes of subparagraph (A), adjusted gross income shall be determined—

''(i) after application of sections 86 and 469, and

''(ii) without regard to sections 135, 137, 221, and 911, the deduction allowable under section 219, or any amount included in gross income under subsection (d)(3).''

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 1999.

(2)(A) Subparagraph (B) of section 408A(c)(3) of such Code, as amended by paragraph (1), is amended to read as follows:

''(B) DEFINITION OF ADJUSTED GROSS INCOME.—For purposes of subparagraph (A), adjusted gross income shall be determined—

''(i) after application of sections 86 and 469, and

''(ii) without regard to sections 135, 137, 221, and 911, the deduction allowable under section 219, or any amount included in gross income under subsection (d)(3) or by reason of a required distribution under a provision described in paragraph (5).''

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 2004.

(c) EFFECTIVE DATE.—Except as otherwise provided in this section, the amendments made by this section shall apply to taxable years beginning after December 31, 1999.

TITLE VIII—REVENUE PROVISIONS

SEC. 801. MODIFICATION TO FOREIGN TAX CREDIT CARRYBACK AND CARRYOVER PERIODS.

(a) IN GENERAL.—Section 904(c) of the Internal Revenue Code of 1986 (relating to limitation on credit) is amended—

(1) by striking ''in the second preceding taxable year,'', and

(2) by striking ''or fifth'' and inserting ''fifth, sixth, or seventh''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to credits arising in taxable years beginning after December 31, 2001.

SEC. 802. LIMITATION ON USE OF NON-ACCRUAL EXPERIENCE METHOD OF ACCOUNTING.

(a) IN GENERAL.—Section 448(d)(5) of the Internal Revenue Code of 1986 (relating to special rule for services) is amended—

(1) by inserting ''in fields described in paragraph (2)(A)'' after ''services by such person'', and

(2) by inserting ''CERTAIN PERSONAL'' before ''SERVICES'' in the heading.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

(2) CHANGE IN METHOD OF ACCOUNTING.—In the case of any taxpayer required by the amendments made by this section to change its method of accounting for its first taxable year ending after the date of the enactment of this Act—

(A) such change shall be treated as initiated by the taxpayer,

(B) such change shall be treated as made with the consent of the Secretary of the Treasury, and

(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481 of the Internal Revenue Code of 1986 shall be taken into account over a period (not greater than 4 taxable years) beginning with such first taxable year.

SEC. 803. RETURNS RELATING TO CANCELLATIONS OF INDEBTEDNESS BY ORGANIZATIONS LENDING MONEY.

(a) IN GENERAL.—Paragraph (2) of section 6050P(c) of the Internal Revenue Code of 1986 (relating to definitions and special rules) is amended by striking ''and'' at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting '', and'', and by inserting after subparagraph (C) the following new subparagraph:

''(D) any organization a significant trade or business of which is the lending of money.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges of indebtedness after December 31, 1999.

SEC. 804. EXTENSION OF INTERNAL REVENUE SERVICE USER FEES.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following new section:

''SEC. 7527. INTERNAL REVENUE SERVICE USER FEES.

''(a) GENERAL RULE.—The Secretary shall establish a program requiring the payment of user fees for—

''(1) requests to the Internal Revenue Service for ruling letters, opinion letters, and determination letters, and

''(2) other similar requests.

''(b) PROGRAM CRITERIA.—

''(1) IN GENERAL.—The fees charged under the program required by subsection (a)—

''(A) shall vary according to categories (or subcategories) established by the Secretary,

''(B) shall be determined after taking into account the average time for (and difficulty of) complying with requests in each category (and subcategory), and

''(C) shall be payable in advance.

''(2) EXEMPTIONS, ETC.—The Secretary shall provide for such exemptions (and reduced fees) under such program as the Secretary determines to be appropriate.

''(3) AVERAGE FEE REQUIREMENT.—The average fee charged under the program required by subsection (a) shall not be less than the amount determined under the following table:

''Category	Average Fee
Employee plan ruling and opinion ..	$250
Exempt organization ruling	$350
Employee plan determination	$300
Exempt organization determination.	$275
Chief counsel ruling	$200.

''(c) TERMINATION.—No fee shall be imposed under this section with respect to requests made after September 30, 2009.''

(b) CONFORMING AMENDMENTS.—

(1) The table of sections for chapter 77 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 7527. Internal Revenue Service user fees.''

(2) Section 10511 of the Revenue Act of 1987 is repealed.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to requests made after the date of the enactment of this Act.

SEC. 805. PROPERTY SUBJECT TO A LIABILITY TREATED IN SAME MANNER AS ASSUMPTION OF LIABILITY.

(a) REPEAL OF PROPERTY SUBJECT TO A LIABILITY TEST.—

(1) SECTION 357.—Section 357(a)(2) of the Internal Revenue Code of 1986 (relating to assumption of liability) is amended by striking '', or acquires from the taxpayer property subject to a liability''.

(2) SECTION 358.—Section 358(d)(1) of such Code (relating to assumption of liability) is amended by striking ''or acquired from the taxpayer property subject to a liability''.

(3) SECTION 368.—

(A) Section 368(a)(1)(C) of such Code is amended by striking '', or the fact that property acquired is subject to a liability,''.

(B) The last sentence of section 368(a)(2)(B) of such Code is amended by striking '', and the amount of any liability to which any property acquired from the acquiring corporation is subject,''.

(b) CLARIFICATION OF ASSUMPTION OF LIABILITY.—

(1) IN GENERAL.—Section 357 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(d) DETERMINATION OF AMOUNT OF LIABILITY ASSUMED.—

''(1) IN GENERAL.—For purposes of this section, section 358(d), section 362(d), section 368(a)(1)(C), and section 368(a)(2)(B), except as provided in regulations—

''(A) a recourse liability (or portion thereof) shall be treated as having been assumed

if, as determined on the basis of all facts and circumstances, the transferee has agreed to, and is expected to, satisfy such liability (or portion), whether or not the transferor has been relieved of such liability, and

''(B) except to the extent provided in paragraph (2), a nonrecourse liability shall be treated as having been assumed by the transferee of any asset subject to such liability.

''(2) EXCEPTION FOR NONRECOURSE LIABILITY.—The amount of the nonrecourse liability treated as described in paragraph (1)(B) shall be reduced by the lesser of—

''(A) the amount of such liability which an owner of other assets not transferred to the transferee and also subject to such liability has agreed with the transferee to, and is expected to, satisfy, or

''(B) the fair market value of such other assets (determined without regard to section 7701(g)).

''(3) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this subsection and section 362(d). The Secretary may also prescribe regulations which provide that the manner in which a liability is treated as assumed under this subsection is applied, where appropriate, elsewhere in this title.''

(2) LIMITATION ON BASIS INCREASE ATTRIBUTABLE TO ASSUMPTION OF LIABILITY.—Section 362 of such Code is amended by adding at the end the following new subsection:

''(d) LIMITATION ON BASIS INCREASE ATTRIBUTABLE TO ASSUMPTION OF LIABILITY.—

''(1) IN GENERAL.—In no event shall the basis of any property be increased under subsection (a) or (b) above the fair market value of such property (determined without regard to section 7701(g)) by reason of any gain recognized to the transferor as a result of the assumption of a liability.

''(2) TREATMENT OF GAIN NOT SUBJECT TO TAX.—Except as provided in regulations, if—

''(A) gain is recognized to the transferor as a result of an assumption of a nonrecourse liability by a transferee which is also secured by assets not transferred to such transferee, and

''(B) no person is subject to tax under this title on such gain,

then, for purposes of determining basis under subsections (a) and (b), the amount of gain recognized by the transferor as a result of the assumption of the liability shall be determined as if the liability assumed by the transferee equaled such transferee's ratable portion of such liability determined on the basis of the relative fair market values (determined without regard to section 7701(g)) of all of the assets subject to such liability.''

(c) APPLICATION TO PROVISIONS OTHER THAN SUBCHAPTER C.—

(1) SECTION 584.—Section 584(h)(3) of the Internal Revenue Code of 1986 is amended—

(A) by striking '', and the fact that any property transferred by the common trust fund is subject to a liability,'' in subparagraph (A), and

(B) by striking clause (ii) of subparagraph (B) and inserting:

''(ii) ASSUMED LIABILITIES.—For purposes of clause (i), the term 'assumed liabilities' means any liability of the common trust fund assumed by any regulated investment company in connection with the transfer referred to in paragraph (1)(A).

''(C) ASSUMPTION.—For purposes of this paragraph, in determining the amount of any liability assumed, the rules of section 357(d) shall apply.''

(2) SECTION 1031.—The last sentence of section 1031(d) of such Code is amended—

(A) by striking ''assumed a liability of the taxpayer or acquired from the taxpayer property subject to a liability'' and inserting ''assumed (as determined under section 357(d)) a liability of the taxpayer'', and

(B) by striking ''or acquisition (in the amount of the liability)''.

(d) CONFORMING AMENDMENTS.—

(1) Section 351(h)(1) of the Internal Revenue Code of 1986 is amended by striking '', or acquires property subject to a liability,''.

(2) Section 357 of such Code is amended by striking ''or acquisition'' each place it appears in subsection (a) or (b).

(3) Section 357(b)(1) of such Code is amended by striking ''or acquired''.

(4) Section 357(c)(1) of such Code is amended by striking '', plus the amount of the liabilities to which the property is subject,''.

(5) Section 357(c)(3) of such Code is amended by striking ''or to which the property transferred is subject''.

(6) Section 358(d)(1) of such Code is amended by striking ''or acquisition (in the amount of the liability)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers after October 19, 1998.

SEC. 806. CHARITABLE SPLIT-DOLLAR LIFE INSURANCE, ANNUITY, AND ENDOWMENT CONTRACTS.

(a) IN GENERAL.—Subsection (f) of section 170 of the Internal Revenue Code of 1986 (relating to disallowance of deduction in certain cases and special rules) is amended by adding at the end the following new paragraph:

''(10) SPLIT-DOLLAR LIFE INSURANCE, ANNUITY, AND ENDOWMENT CONTRACTS.—

''(A) IN GENERAL.—Nothing in this section or in section 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522 shall be construed to allow a deduction, and no deduction shall be allowed, for any transfer to or for the use of an organization described in subsection (c) if in connection with such transfer—

''(i) the organization directly or indirectly pays, or has previously paid, any premium on any personal benefit contract with respect to the transferor, or

''(ii) there is an understanding or expectation that any person will directly or indirectly pay any premium on any personal benefit contract with respect to the transferor.

''(B) PERSONAL BENEFIT CONTRACT.—For purposes of subparagraph (A), the term 'personal benefit contract' means, with respect to the transferor, any life insurance, annuity, or endowment contract if any direct or indirect beneficiary under such contract is the transferor, any member of the transferor's family, or any other person (other than an organization described in subsection (c)) designated by the transferor.

''(C) APPLICATION TO CHARITABLE REMAINDER TRUSTS.—In the case of a transfer to a trust referred to in subparagraph (E), references in subparagraphs (A) and (F) to an organization described in subsection (c) shall be treated as a reference to such trust.

''(D) EXCEPTION FOR CERTAIN ANNUITY CONTRACTS.—If, in connection with a transfer to or for the use of an organization described in subsection (c), such organization incurs an obligation to pay a charitable gift annuity (as defined in section 501(m)) and such organization purchases any annuity contract to fund such obligation, persons receiving payments under the charitable gift annuity shall not be treated for purposes of subparagraph (B) as indirect beneficiaries under such contract if—

''(i) such organization possesses all of the incidents of ownership under such contract,

''(ii) such organization is entitled to all the payments under such contract, and

''(iii) the timing and amount of payments under such contract are substantially the same as the timing and amount of payments to each such person under such obligation (as such obligation is in effect at the time of such transfer).

''(E) EXCEPTION FOR CERTAIN CONTRACTS HELD BY CHARITABLE REMAINDER TRUSTS.—A person shall not be treated for purposes of subparagraph (B) as an indirect beneficiary under any life insurance, annuity, or endowment contract held by a charitable remainder annuity trust or a charitable remainder unitrust (as defined in section 664(d)) solely by reason of being entitled to any payment referred to in paragraph (1)(A) or (2)(A) of section 664(d) if—

''(i) such trust possesses all of the incidents of ownership under such contract, and

''(ii) such trust is entitled to all the payments under such contract.

''(F) EXCISE TAX ON PREMIUMS PAID.—

''(i) IN GENERAL.—There is hereby imposed on any organization described in subsection (c) an excise tax equal to the premiums paid by such organization on any life insurance, annuity, or endowment contract if the payment of premiums on such contract is in connection with a transfer for which a deduction is not allowable under subparagraph (A), determined without regard to when such transfer is made.

''(ii) PAYMENTS BY OTHER PERSONS.—For purposes of clause (i), payments made by any other person pursuant to an understanding or expectation referred to in subparagraph (A) shall be treated as made by the organization.

''(iii) REPORTING.—Any organization on which tax is imposed by clause (i) with respect to any premium shall file an annual return which includes—

''(I) the amount of such premiums paid during the year and the name and TIN of each beneficiary under the contract to which the premium relates, and

''(II) such other information as the Secretary may require.

The penalties applicable to returns required under section 6033 shall apply to returns required under this clause. Returns required under this clause shall be furnished at such time and in such manner as the Secretary shall by forms or regulations require.

''(iv) CERTAIN RULES TO APPLY.—The tax imposed by this subparagraph shall be treated as imposed by chapter 42 for purposes of this title other than subchapter B of chapter 42.

''(G) SPECIAL RULE WHERE STATE REQUIRES SPECIFICATION OF CHARITABLE GIFT ANNUITANT IN CONTRACT.—In the case of an obligation to pay a charitable gift annuity referred to in subparagraph (D) which is entered into under the laws of a State which requires, in order for the charitable gift annuity to be exempt from insurance regulation by such State, that each beneficiary under the charitable gift annuity be named as a beneficiary under an annuity contract issued by an insurance company authorized to transact business in such State, the requirements of clauses (i) and (ii) of subparagraph (D) shall be treated as met if—

''(i) such State law requirement was in effect on February 8, 1999,

''(ii) each such beneficiary under the charitable gift annuity is a bona fide resident of such State at the time the obligation to pay a charitable gift annuity is entered into, and

''(iii) the only persons entitled to payments under such contract are persons entitled to payments as beneficiaries under such obligation on the date such obligation is entered into.

''(H) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this paragraph, including regulations to prevent the avoidance of such purposes.''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this section, the amendment made by this section shall apply to transfers made after February 8, 1999.

(2) EXCISE TAX.—Except as provided in paragraph (3) of this subsection, section 170(f)(10)(F) of the Internal Revenue Code of 1986 (as added by this section) shall apply to premiums paid after the date of the enactment of this Act.

(3) REPORTING.—Clause (iii) of such section 170(f)(10)(F) shall apply to premiums paid after February 8, 1999 (determined as if the tax imposed by such section applies to premiums paid after such date).

SEC. 807. TRANSFER OF EXCESS DEFINED BENEFIT PLAN ASSETS FOR RETIREE HEALTH BENEFITS.

(a) EXTENSION.—

(1) IN GENERAL.—Section 420(b)(5) of the Internal Revenue Code of 1986 (relating to expiration) is amended by striking ''in any taxable year beginning after December 31, 2000'' and inserting ''made after September 30, 2009''.

(2) CONFORMING AMENDMENTS.—

(A) Section 101(e)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(e)(3)) is amended by striking ''1995'' and inserting ''2001''.

(B) Section 403(c)(1) of such Act (29 U.S.C. 1103(c)(1)) is amended by striking ''1995'' and inserting ''2001''.

(C) Paragraph (13) of section 408(b) of such Act (29 U.S.C. 1108(b)(13)) is amended—

(i) by striking ''in a taxable year beginning before January 1, 2001'' and inserting ''made before October 1, 2009'', and

(ii) by striking ''1995'' and inserting ''2001''.

(b) APPLICATION OF MINIMUM COST REQUIREMENTS.—

(1) IN GENERAL.—Section 420(c)(3) of the Internal Revenue Code of 1986 is amended to read as follows:

''(3) MINIMUM COST REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met if each group health plan or arrangement under which applicable health benefits are provided provides that the applicable employer cost for each taxable year during the cost maintenance period shall not be less than the higher of the applicable employer costs for each of the 2 taxable years immediately preceding the taxable year of the qualified transfer.

''(B) APPLICABLE EMPLOYER COST.—For purposes of this paragraph, the term 'applicable employer cost' means, with respect to any taxable year, the amount determined by dividing—

''(i) the qualified current retiree health liabilities of the employer for such taxable year determined—

''(I) without regard to any reduction under subsection (e)(1)(B), and

''(II) in the case of a taxable year in which there was no qualified transfer, in the same manner as if there had been such a transfer at the end of the taxable year, by

''(ii) the number of individuals to whom coverage for applicable health benefits was provided during such taxable year.

''(C) ELECTION TO COMPUTE COST SEPARATELY.—An employer may elect to have this paragraph applied separately with respect to individuals eligible for benefits under title XVIII of the Social Security Act at any time during the taxable year and with respect to individuals not so eligible.

''(D) COST MAINTENANCE PERIOD.—For purposes of this paragraph, the term 'cost maintenance period' means the period of 5 taxable years beginning with the taxable year in which the qualified transfer occurs. If a taxable year is in 2 or more overlapping cost maintenance periods, this paragraph shall be applied by taking into account the highest applicable employer cost required to be provided under subparagraph (A) for such taxable year.''

(2) CONFORMING AMENDMENTS.—

(A) Section 420(b)(1)(C)(iii) of such Code is amended by striking ''benefits'' and inserting ''cost''.

(B) Section 420(e)(1)(D) of such Code is amended by striking ''and shall not be subject to the minimum benefit requirements of subsection (c)(3)'' and inserting ''or in calculating applicable employer cost under subsection (c)(3)(B)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to qualified transfers occurring after December 31, 2000, and before October 1, 2009.

SEC. 808. LIMITATIONS ON WELFARE BENEFIT FUNDS OF 10 OR MORE EMPLOYER PLANS.

(a) BENEFITS TO WHICH EXCEPTION APPLIES.—Section 419A(f)(6)(A) of the Internal Revenue Code of 1986 (relating to exception for 10 or more employer plans) is amended to read as follows:

''(A) IN GENERAL.—This subpart shall not apply to a welfare benefit fund which is part of a 10 or more employer plan if the only benefits provided through the fund are 1 or more of the following:

''(i) Medical benefits.

''(ii) Disability benefits.

''(iii) Group term life insurance benefits which do not provide for any cash surrender value or other money that can be paid, assigned, borrowed, or pledged for collateral for a loan.

The preceding sentence shall not apply to any plan which maintains experience-rating arrangements with respect to individual employers.''

(b) LIMITATION ON USE OF AMOUNTS FOR OTHER PURPOSES.—Section 4976(b) of the Internal Revenue Code of 1986 (defining disqualified benefit) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR 10 OR MORE EMPLOYER PLANS EXEMPTED FROM PREFUNDING LIMITS.—For purposes of paragraph (1)(C), if—

''(A) subpart D of part I of subchapter D of chapter 1 does not apply by reason of section 419A(f)(6) to contributions to provide 1 or more welfare benefits through a welfare benefit fund under a 10 or more employer plan, and

''(B) any portion of the welfare benefit fund attributable to such contributions is used for a purpose other than that for which the contributions were made,

then such portion shall be treated as reverting to the benefit of the employers maintaining the fund.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

SEC. 809. MODIFICATION OF INSTALLMENT METHOD AND REPEAL OF INSTALLMENT METHOD FOR ACCRUAL METHOD TAXPAYERS.

(a) REPEAL OF INSTALLMENT METHOD FOR ACCRUAL BASIS TAXPAYERS.—

(1) IN GENERAL.—Subsection (a) of section 453 of the Internal Revenue Code of 1986 (relating to installment method) is amended to read as follows:

''(a) USE OF INSTALLMENT METHOD.—

''(1) IN GENERAL.—Except as otherwise provided in this section, income from an installment sale shall be taken into account for purposes of this title under the installment method.

''(2) ACCRUAL METHOD TAXPAYER.—The installment method shall not apply to income from an installment sale if such income would be reported under an accrual method of accounting without regard to this section. The preceding sentence shall not apply to a disposition described in subparagraph (A) or (B) of subsection (l)(2).''

(2) CONFORMING AMENDMENTS.—Sections 453(d)(1), 453(i)(1), and 453(k) of such Code are each amended by striking ''(a)'' each place it appears and inserting ''(a)(1)''.

(b) MODIFICATION OF PLEDGE RULES.—Paragraph (4) of section 453A(d) of the Internal Revenue Code of 1986 (relating to pledges, etc., of installment obligations) is amended by adding at the end the following: ''A payment shall be treated as directly secured by an interest in an installment obligation to the extent an arrangement allows the taxpayer to satisfy all or a portion of the indebtedness with the installment obligation.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to sales or other dispositions occurring on or after the date of the enactment of this Act.

SEC. 810. INCLUSION OF CERTAIN VACCINES AGAINST STREPTOCOCCUS PNEUMONIAE TO LIST OF TAXABLE VACCINES.

(a) IN GENERAL.—Section 4132(a)(1) of the Internal Revenue Code of 1986 (defining taxable vaccine) is amended by adding at the end the following new subparagraph:

''(L) Any conjugate vaccine against streptococcus pneumoniae.''

(b) EFFECTIVE DATE.—

(1) SALES.—The amendment made by this section shall apply to vaccine sales beginning on the day after the date on which the Centers for Disease Control makes a final recommendation for routine administration to children of any conjugate vaccine against streptococcus pneumoniae.

(2) DELIVERIES.—For purposes of paragraph (1), in the case of sales on or before the date described in such paragraph for which delivery is made after such date, the delivery date shall be considered the sale date.

TITLE IX—MISCELLANEOUS PROVISIONS

SEC. 901. MEDICARE COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) FINDING.—The Senate finds that implementing competitive pricing in the medicare program under title XVIII of the Social Security Act is an important goal.

(b) PROHIBITION ON IMPLEMENTATION OF PROJECT IN CERTAIN AREAS.—Notwithstanding subsection (b) of section 4011 of the Balanced Budget Act of 1997 (Public Law 105–33)), the Secretary of Health and Human Services may not implement the Medicare Competitive Pricing Demonstration Project (operated by the Secretary of Health and Human Services pursuant to such section) in Kansas City, Missouri or Kansas City, Kansas, or in any area in Arizona.

(c) MORATORIUM ON IMPLEMENTATION OF PROJECT IN ANY AREA UNTIL JANUARY, 1, 2001.—Notwithstanding any provision of section 4011 of the Balanced Budget Act of 1997 (Public Law 105–33)), the Secretary of Health and Human Services may not implement the Medicare Competitive Pricing Demonstration Project in any area before January 1, 2001.

(d) STUDY AND REPORT TO CONGRESS.—

(1) STUDY.—The Secretary of Health and Human Services, in conjunction with the Competitive Pricing Advisory Committee, shall conduct a study on the different approaches of implementing the Medicare Competitive Pricing Demonstration Project on a voluntary basis.

(2) REPORT.—Not later than June 30, 2000, the Secretary of Health and Human Services shall submit a report to Congress which shall contain a detailed description of the study conducted under paragraph (1), together with the recommendations of the Secretary and

the Competitive Pricing Advisory Committee regarding the implementation of the Medicare Competitive Pricing Demonstration Project.

NOTICES OF HEARINGS

COMMITTEE ON INDIAN AFFAIRS

Mr. CAMPBELL. Mr. President, I would like to announce that the Senate Committee on Indian Affairs will meet during the session of the Senate on Wednesday, July 21, 1999, at 9:30 a.m. to conduct a hearing on S. 985, the Intergovernmental Gaming Agreement Act of 1999. The hearing will be held in room 106, Dirksen Senate Office Building.

Please direct any inquiries to committee staff at 202/224–2251.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. MURKOWSKI. Mr. President, I would like to announce for the informaiton of the Senate and the public that a full committee hearing has been scheduled before the Committee on Energy and Natural Resources.

The hearing will take place on Thursday, July 22, 1999, at 9:30 a.m. in room SD–366 of the Dirksen Senate Office Building in Washington, DC.

The purpose of this hearing is to consider the nominations of Curt Hebert to be a Member of the Federal Energy Regulatory Commission, and Earl E. DeVaney to be Inspector General of the Department of the Interior.

For further information, please contact David Dye of the Committee staff.

SUBCOMMITTEE ON NATIONAL PARKS, HISTORIC PRESERVATION, AND RECREATION

Mr. THOMAS. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on National Parks, Historic Preservation, and Recreation of the Committee on Energy and Natural Resources, The purpose of this hearing is to receive testimony on S. 710, to authorize a feasibility study on the preservation of certain Civil War battlefields along the Vicksburg Campaign Trail; S. 905, to establish the Lackawanna Valley Heritage Area: S. 1093, to establish the Galisteo Basin Archaeological Protection Sites, to provide for the protection of archaeological sites in the Galisteo Basin of New Mexico, and for other purposes; S. 1117, to establish the Corinth Unit of Shiloh National Military Park, in the vicinity of the city of Corinth, Mississippi, and in the State of Tennessee, and for other purposes; S. 1324, to expand the boundaries of Gettysburg National Military Park to include Wills House, and for other purposes; and S. 1349, to direct the Secretary of the Interior to conduct special resources studies to determine the national significance of specific sites as well as the suitability and feasibility of their inclusion as units of the National Park System.

The hearing will take place on Thursday. July 29, 1999 at 2:15 p.m. in room SD–366 of the Dirksen Senate Office Building in Washington, DC.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Committee on Energy and Natural Resources, United States Senate, SD–364 Dirksen Senate Office Building, Washington, DC 20510–6150.

For further information, please contact Jim O'Toole or Shawn Taylor of the committee staff.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. GREGG. Mr. President, I ask unanimous consent that the Senate Committee on Commerce, Science, and Transportation be authorized to meet on Thursday, July 15, 1999, immediately following the committee executive session at 9:30 a.m. on NTSB reauthorization.

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

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. GREGG. Mr. President, I ask unanimous consent that the Senate Committee on Commerce, Science, and Transportation be authorized to meet on Thursday, July 15, 1999 at 9:30 a.m. on pending committee business.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. GREGG. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be granted permission to meet during the session of the Senate on Thursday, July 15, for purposes of conducting a full committee hearing which is scheduled to begin at 9:30 a.m. The purpose of this hearing is to receive testimony on S. 161, the Power Marketing Administration Reform Act of 1999; S. 282, the Transition to Competition in the Electric Industry Act; S. 516, the Electric Utility Restructuring Empowerment and Competitiveness Act of 1999; S. 1047, the Comprehensive Electricity Competition Act; S. 1273, a bill to amend the Federal Power Act to facilitate the transition to more competitive and efficient electric power markets, and for other purposes; and S. 1284, a bill to amend the Federal Power Act to ensure that no state may establish, maintain or enforce on behalf of any electric utility an exclusive right to sell electric energy or otherwise unduly discriminate against any customer who seeks to purchase electric energy in interstate commerce from any supplier.

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

COMMITTEE ON GOVERNMENT AFFAIRS

Mr. GREGG. Mr. President, I ask unanimous consent that the Government Affairs Committee be permitted to meet on Thursday, July 15, 1999 at 5:00 p.m. for a business meeting to consider pending Committee business.

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

COMMITTEE ON INDIAN AFFAIRS

Mr. GREGG. Mr. President, I ask unanimous consent that the Senate Committee on Indian Affairs be authorized to meet during the session of the Senate on Thursday, July 15, 1999 at 3:30 p.m. to approve the Committee's budget for the 106th Congress. The meeting will be held in room 485, Russell Senate Building.

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

COMMITTEE ON THE JUDICIARY

Mr. GREGG. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet for an executive business meeting, during the session of the Senate on Thursday, July 15, 1999, in S216 of the Capitol.

COMMITTEE ON RULES AND ADMINISTRATION

Mr. GREGG. Mr. President, I ask unanimous consent that the Committee on Rules and Administration be authorized to meet during the session of the Senate on Thursday, July 15, 1999 at 9:30 a.m. to mark-up a Committee funding resolution.

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

COMMITTEE ON SMALL BUSINESS

Mr. GREGG. Mr. President, I ask unanimous consent that the Committee on Small Business be authorized to meet during the session of the Senate on Thursday, July 15, 1999, to consider the Committee's budget and to markup pending legislation. The meeting will begin at 9:00 a.m. in room 428A of the Russell Senate Office Building.

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

COMMITTEE ON INTELLIGENCE

Mr. GREGG. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Thursday, July 15, 1999 at 2:00 p.m. to hold a closed hearing on intelligence matters.

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

SPECIAL COMMITTEE ON THE YEAR 2000 TECHNOLOGY PROBLEM

Mr. GREGG. Mr. President, I ask unanimous consent that the Special Committee on the Year 2000 Technology Problem be permitted to meet on July 15, 1999 at 9:30 a.m. for the purpose of conducting a hearing.

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

SUBCOMMITTEE ON ECONOMIC POLICY, AND INTERNATIONAL TRADE AND FINANCE

Mr. GREGG. Mr. President, I ask unanimous consent that the subcommittees on economic policy, and International Trade and Finance of the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on Thursday, July 15, 1999, to conduct a

hearing on ''Official Dollarization in Latin America.''

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

ADDITIONAL STATEMENTS

THE HIGH-TECH AGENDA

● Mr. ABRAHAM. Mr. President, I rise to address the importance of the high-tech industry for working families in America, and in my state in particular, and to set out what I believe should be the high-tech agenda for this body in the coming months.

Employment in our high-technology sector is vast and growing. According to the American Electronics Association, about 4,825,000 Americans were employed in the high-tech sector during 1998. That reflects a net increase of 852,000 jobs since 1990. And these jobs pay very well. The average high-tech worker in 1997 made over $53,000 per year—a 19% increase over the levels of 1990.

My state of Michigan is playing an important part in the expansion of high-tech industry in America. Ann Arbor has among the largest concentrations of high-technology firms and employees in the nation. The University of Michigan is a leader in this field, and we have integrated cutting edge technology throughout our manufacturing and services sectors.

As of 1997, 96,000 Michiganians were employed in high-tech jobs. The total payroll for these Michigan workers reaches $4.5 billion annually, and the average employee makes an impressive $46,761 per year.

High-tech is of critical importance to my state. In addition to those who are directly employed in this sector, thousands of others depend on the health of our high-tech industry for their livelihood. Just as an example, 21 percent of Michigan's total exports consist of high-tech goods. Clearly, whether in international trade, automobile manufacturing, mining, financial services, or communications, Michigan's workers depend on a healthy high-tech industry in our state.

And the same goes for America, Mr. President. The internet is transforming the way we do business. Electronic or ''E'' commerce between businesses has grown to an estimated $64.8 billion for 1999. 10 million customers shopped for some product using the internet in 1998 alone. International Data Corporation estimates that $31 billion in products will be sold over the Internet in 1999. And 5.3 million households will have access to financial transactions like banking and stock trading by the end of 1999.

All this means that our economy, and its ability to provide high paying jobs for American workers, is increasingly wrapped up in high-tech. Indeed, our nation's competitive edge in the global marketplace rests squarely on our expertise in the high-tech sector. We must maintain a healthy high-tech sector if we are to maintain a healthy, growing economy.

This is not special pleading for one industry, Mr. President. It is a simple recognition of the fact that computer technology is an integral part of numerous industries important to the workers of this country. That being the case, it is in my view critical that we secure the health and vitality of the high-tech sector through policies that encourage investment and competition. In my view it also is critical that we empower more Americans to take part in the economic improvements made possible by high-tech through proper training and education.

Entrepreneurs and workers have made our high-tech sector a success already. That means that Washington's first duty is to do no harm. The federal government must maintain a hands-off policy, refusing to lay extra taxes and regulations on the people creating jobs and wealth through technology.

But in one area in particular decisive action is required. We have all heard, Mr. President, about the impending year 2000 or ''Y2K'' computer problem. Because most computers have been programmed to recognize only the last two digits of a given year, for example assuming the number 69 to refer to 1969, the year 2000 will bring with it many potential problems. Computers that have not been re-programmed to register the new century may assume, come next January 1, that we have entered the year 1900. The results may be minor, or they may include computer malfunctions affecting manufacturing, transportation, water supplies and even medical care.

Clearly such a result would be in no one's interest. Whether large or small, and whether producers or users of computer systems, all businesses have a stake in making the computer transition to the 21st century as smooth as possible. But, as in so many other areas of our lives, progress in dealing with the Y2K problem is being slowed because companies are afraid that acting at this time will simply expose them to big-budget lawsuits. After all, why get involved in a situation that might expose you to expensive litigation?

It was to help prevent these problems that I joined a number of my colleagues to sponsor legislation providing incentives for solving technical issues before failures occur, and by encouraging effective resolution of Y2K problems when they do occur.

This legislation, which the administration has finally signed into law, contains several provisions that would encourage parties to avoid litigation in dealing with the Y2K problem. In addition, Mr. President, this legislation contains provisions to prevent unwarranted, profit-seeking lawsuits from exacerbating any Y2K problem, provisions making sure that only real damages are compensated and only truly responsible parties are made defendants in any Y2K lawsuit.

Quick action is needed, in my view, to prevent the Y2K problem from becoming a disaster. It is a matter of simple common sense that we establish rational legal rules to encourage cooperation and repair rather than conflict and lawsuits in dealing with Y2K. Indeed, for my part, Mr. President, I have made no secret of my desire to apply common sense rules, encouraging cooperation rather than conflict, to our legal system as a whole. I would view our response to the Y2K problem as really an extension of the idea of common sense legal reform to the high-tech arena.

High-technology related commerce, and commerce over the internet in particular, is subject to the same dangers as other forms of commerce. And that means government must make certain that the basic protections needed to make commerce possible are applied to the high-tech sector. In particular, we should keep in mind that commerce is possible only if all parties can be assured that their property will be respected and protected from theft.

I have introduced the Anticybersquatting Consumer Protection Act to combat a new form of fraud that is increasing dangers and costs for people doing business on the internet. The culprit is ''cybersquatting,'' a practice whereby individuals reserve internet domain names similar or identical to companies' trademark names. Some of these sites broadcast pornographic images. Others advertise merchandise and services unrelated to the trademarked name. Still others have been purchased solely for the purpose of forcing the trademark owners to purchase them at highly inflated prices. All of them pollute the internet, undermine consumer confidence and dilute the value of valid trademarks.

Trademark law is based on the recognition that companies and individuals build a property right in brand names because of the reasonable expectations they raise among consumers. If you order a Compaq or a DEC computer, that should mean that you get a computer made by Compaq or DEC, not one built by a fly-by-night company pirating the name. The same goes for trademarks on the Internet. And if it doesn't, if anyone can just come along and take over a brand name, then commerce will suffer. If anyone who wants to steal your product can do so with impunity, then you won't be in business for long. If anyone who wants to steal company trademarks for use on the internet can do so with impunity, then the internet itself will lose its value as a marketplace and people will stop using it for e-commerce. It's really as simple as that.

We must, in my view, extend the basic property rights protections so central to the purpose of government, to the realm of e-commerce.

I have argued, Mr. President, that we must extend the basic, structural rules and protections of commerce to the high-tech arena. To be successful this

effort requires recognition of the need for reasoned innovation. If they are to continue fulfilling their vital function of protecting commerce, pre-existing rules must be modified at times to meet the challenges of new technologies. Nowhere is this more true than in the instance of electronic signatures.

Secure electronic authentication methods, or electronic signatures,'' can allow organizations to enter into contracts without having to drive across town or fly thousands of miles for personal meetings—or wait for papers to make several trips through the mail. They can allow individuals to positively identify the person with whom they are transacting business and to ensure that shared information has not been tampered with.

Electronic signatures are highly controlled and are far more secure than manual signatures. They cannot be forged in the same, relatively easy way as manual signatures. Electronic signatures are verifiable and become invalid if any of the data in the electronic document is altered or deleted. They can make e-commerce the safest as well as the most convenient commerce available.

We made great strides in this Congress toward expanding the use of electronic signatures with the Abraham Government Paperwork Elimination Act. That legislation requires federal agencies to make versions of their forms available online and to allow people to submit those forms with electronic signatures instead of handwritten ones. It also set up a process by which commercially developed electronic signatures can be used in submitting forms to the government, and federal documents could be stored electronically.

By providing individuals and companies with the option of electronic filing and storage, this legislation will reduce the paperwork burden imposed by government on the American people and the American economy. It also will spur electronic innovation. But more must be done, particularly in the area of electronic signatures, to establish a uniform framework within which innovation can be pursued.

More than 40 states have adopted rules governing the use of electronic signatures. But no two states have adopted the same approach. This means that, at present, the greatest barrier to the use of electronic signatures is the lack of a consistent and predictable national framework of rules. Individuals and organizations are not willing to rely on electronic signatures when they cannot be sure that they will be held valid.

I have joined with my colleagues, Senators MCCAIN and WYDEN, to author the Millennium Digital Commerce Act. This legislation, which was recently passed out of the Senate Commerce Committee, will ensure that individuals and organizations in different states are held to their agreements and obligations even if their respective states have different rules concerning electronically signed documents. It provides that electronic records produced in executing a digital contract shall not be denied legal effect solely because they were entered into over the Internet or any other computer network. This will provide uniform treatment of electronic signatures in all the states until such time as they enact uniform legislation on their own.

Our bill also lets the parties who enter into a contract determine, through that contract, what technologies and business methods they will use to execute it. This will give those involved in the transaction the power to decide for themselves how to allocate liability and fees as well as registration and certification requirements. In essence, this legislation empowers individuals and companies involved in e-commerce to decide for themselves whether and how to use the new technology of electronic signatures. It will encourage further growth in this area by extending the power of the contracting parties to define the terms of their own agreements.

And another piece of legislation, the Electronic Securities Transaction Act will remove a specific barrier in the law that is slowing the growth of online commerce in the area of securities trading. As the law now stands, Mr. President, anyone wishing to do business with an online trading company must request or download application materials and physically sign them, then wait for some form of surface mail system to deliver the forms before conducting any trading. Such rules cause unneeded delays and will be eliminated by this legislation.

Control over their agreements is crucial to allowing companies and individuals to conduct commerce in and through the means of high-technology. But we must do more to ensure the continued growth of high-tech commerce. Perhaps most important, we must make certain that companies involved in high-tech can find properly trained people to work for them.

During the last session of Congress I sponsored the American Competitiveness Act. This legislation, since signed into law, provides for a limited increase in the number of highly skilled foreign-born workers who can come to this country on temporary worker visas. It also provides for scholarships to students who elect to study in areas important for the high-tech industry, including computers, math and science.

In my view we should build on the American Competitiveness Act by extending training and educational assistance to the millions of elementary and secondary school children who can and should become the high-tech workers of tomorrow.

It is projected that 60 percent of all jobs will require high-tech computer skills by the year 2000. But 32 percent of our public schools have only one classroom with access to the Internet. The Educational Testing Service reports that, on average, in 1997 there was only one multi-media computer for every 24 students in America. That makes the line to use a school computer five times longer than the Education Department says it should be.

Not only do our classrooms have too few computers, the few computers they do have are so old and outdated that they cannot run the most basic of today's software programs and cannot even access the Internet. One of the more common computers in our schools today is the Apple IIc, a model so archaic it is now on display at the Smithsonian.

The federal government recently attempted to rectify this situation, with little success. The 21st Century Classrooms Act of 1997 allows businesses to take a deduction for donating computer technology, equipment and software. Unfortunately, that deduction was small and businesses had difficulty qualifying for it. Thus the Detwiler Foundation, a leading clearinghouse for computer-to-school donations, reports that they have not witnessed the anticipated increase in donation activity'' since its enactment.

I strongly believe that we must change that. That is why I have joined with Senator RON WYDEN (D-Ore.) to offer the New Millennium Classrooms Act. This legislation will increase the amount of computer technology donated to schools, helping our kids prepare for the high-tech jobs of the future.

The earlier tax deduction failed to produce donations because it was too narrowly drawn. It allowed only a limited deduction (one half the fair market value of the computer). It also applied this deduction only to computers less than two years old. And only the original user of the computer could donate it to the school.

Under the New Millennium Classrooms Act, however, businesses will be able to choose either the old deduction or a tax credit of up to 30 percent of the computer's fair market value, whichever reduces their taxes most. Businesses donating computers to schools located in empowerment zones, enterprise communities and Indian reservations would be eligible for a 50 percent tax credit because they are bringing computers to those who need them most.

In addition, the New Millennium Classrooms Act would eliminate the two year age limit. After all, many computers more than two years old today have Pentium-chip technology and can run programs advanced enough to be extremely useful in the classroom. Finally, the new legislation would let companies that lease computers to other users donate those computers once they are handed in.

These provisions will expand the availability of useful computers to our schools. They will allow our classrooms to become real places of high-tech learning, preparing our children for the

challenges of the future and providing our economy with the skilled workers we need to keep us prosperous and moving ahead. They are an important part of an overall high-tech agenda that emphasizes expanding opportunities for all Americans.

Of course we must do more. We must extend the Research and Development tax credit so important to high-tech innovation. We must extend the 3 year moratorium on any taxing of the internet. We must update our encryption laws so that American companies can compete overseas and provide consumers with state-of-the-art protection for their e-commerce. We must increase high-speed internet access. I will work to support each and every one of these reforms.

Mr. President, these are some of the legislative initiatives a number of my colleagues and I are working on to ensure the future of high-tech growth in this country. It is an important agenda because high-tech is an important sector of our economy. I hope members of both houses of Congress and the Administration will recognize the need to support this agenda so that American workers can continue to prosper.●

TRIBUTE TO COACH GLENN DANIEL

● Mr. SHELBY. Mr. President, I rise today to pay tribute to Coach Glenn Daniel, a dedicated man and an inspirational leader to the many football teams which he has led. The state of Alabama has been blessed with a very rich football heritage. The thought of the sport conjures images of Bear Bryant leading his famed University of Alabama teams to glory on the gridiron. Between interstate colleges and high school rivalries, there is no argument that the State's roots are firmly entrenched in the game of football.

It is from these roots that I pay tribute to the most successful coach in the history of Alabama high school football, Coach Glenn Daniel. With a lifetime record of 302 wins, 167 loses and 16 ties, Coach Daniel has stood the test of time and climbed countless obstacles in his relentless assault on the record books. Coach Daniel's 50-year career, spanning six decades, serves as a inspiration to the young people he coaches and as an example of the internal fortitude and a strength of character which few possess. He is truly the standard bearer for a high school coaching legend and the definition of a man dedicated to the sport of football.

Born on December 2, 1925, in Montgomery, Coach Daniel attended Albert G. Parrish High School in rustic Selma, Alabama. He earned a Bachelor's Degree in Education at Livingston University (now the University of West Alabama) and a Master's Degree from the University of Alabama in 1956. It was in 1947 that Glenn Daniel began his coaching career at the rural Alabama school of Pine Hill High. He was able to successfully resuscitate a football program which had been discontinued for several years due to World War II. Within 5 years of beginning his tenure at Pine Hill, he had established a perennial football powerhouse at the school. During this time, Coach Daniel lead his team to an undefeated season, while outscoring opponents 232–32 and receiving a Birmingham News regional championship.

Following his tenure at Pine Hill, Coach Daniel moved on to coach at Luverne High School in Luverne, Alabama. While coaching at the school for 38 years, Coach Daniel's teams finished with an astonishing 34 winning seasons. In 11 of his last 12 years, his team earned a spot in the state playoffs, including three semi-finals appearances. His remarkable 1991 team reached the ultimate promise land, winning the state 3A championship, the first in Luverne High School's history. Coach Daniel retired in 1993 and did not coach during the 1993 and 1994 seasons. However, he returned as an assistant coach for the 1995 season as Defensive Coordinator and helped his team earn a state championship in 1997.

Coach Daniel was named Alabama's Coach of the Year in 1981, 1987, and 1991 by various major newspapers in the state. In a coach's poll conducted in 1985, he was ranked by his peers as one of the ten best coaches in the state. In addition to these accolades, Coach Daniel served as head coach of the Alabama team in the annual Alabama/Mississippi All-Star Football Classic in 1992, and was named as Alumni Coach of the Year in 1992 by the University of West Alabama. In a fitting honor to cap his distinguished career, Coach Daniel was chosen as a member of the inaugural class of inductees into the Alabama High School Sports Hall of Fame in 1991. Mr. President, if a coaching career has ever proven deserving of these many distinctions, it is Coach Glenn Daniel.●

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. JEFFORDS. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider Executive Calendar No. 164 on today's Executive Calendar.

I further ask unanimous consent the nomination be confirmed, the motion to reconsider be laid upon the table, any statements relating to the nomination appear in the RECORD, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

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

The nomination considered and confirmed is as follows:

DEPARTMENT OF COMMERCE

Johnnie E. Frazier, of Maryland, to be Inspector General, Department of Commerce.

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will resume legislative session.

FEDERAL FINANCIAL ASSISTANCE MANAGEMENT IMPROVEMENT ACT OF 1999

Mr. JEFFORDS. I ask unanimous consent the Senate now proceed to the consideration of Calendar No. 199, S. 468.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

A bill (S. 468) to improve the effectiveness and performance of Federal financial assistance programs, simplify Federal financial assistance application and reporting requirements, and improve the delivery of services to the public.

There being no objection, the Senate proceeded to consider the bill, which had been reported from the Committee on Governmental Affairs, with amendments; as follows:

(The parts of the bill intended to be stricken are shown in boldface brackets and the parts of the bill intended to be inserted are shown in italic.)

S. 468

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Federal Financial Assistance Management Improvement Act of 1999''.

SEC. 2. FINDINGS.

[The**]** Congress finds that—

(1) there are over 600 different Federal financial assistance programs to implement domestic policy;

(2) while the assistance described in paragraph (1) has been directed at critical problems, some Federal administrative requirements may be duplicative, burdensome or conflicting, thus impeding cost-effective delivery of services at the local level;

(3) the Nation's State, local, and tribal governments and private, nonprofit organizations are dealing with increasingly complex problems which require the delivery and coordination of many kinds of services; and

(4) streamlining and simplification of Federal financial assistance administrative procedures and reporting requirements will improve the delivery of services to the public.

SEC. 3. PURPOSES.

The purposes of this Act are to—

(1) improve the effectiveness and performance of Federal financial assistance programs;

(2) simplify Federal financial assistance application and reporting requirements;

(3) improve the delivery of services to the public; and

(4) facilitate greater coordination among those responsible for delivering such services.

SEC. 4. DEFINITIONS.

In this Act:

(1) DIRECTOR.—The term ''Director'' means the Director of the Office of Management and Budget.

(2) FEDERAL AGENCY.—The term ''Federal agency'' means any agency as defined under section 551(1) of title 5, United States Code.

(3) FEDERAL FINANCIAL ASSISTANCE.—The term ''Federal financial assistance'' has

the same meaning as defined in section 7501(a)(5) of title 31, United States Code, under which Federal financial assistance is provided, directly or indirectly, to a non-Federal entity.

(4) LOCAL GOVERNMENT.—The term ''local government'' means a political subdivision of a State that is a unit of general local government (as defined under section 7501(a)(11) of title 31, United States Code);.

(5) NON-FEDERAL ENTITY.—The term ''non-Federal entity'' means a State, local government, or nonprofit organization.

(6) NONPROFIT ORGANIZATION.—The term ''nonprofit organization'' means any corporation, trust, association, cooperative, or other organization that—

(A) is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest;

(B) is not organized primarily for profit; and

(C) uses net proceeds to maintain, improve, or expand the operations of the organization.

(7) STATE.—The term ''State'' means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, and any instrumentality thereof, any multi-State, regional, or interstate entity which has governmental functions, and any Indian Tribal Government.

(8) TRIBAL GOVERNMENT.—The term ''tribal government'' means an Indian tribe, as that term is defined in section 7501(a)(9) of title 31, United States Code.

(9) UNIFORM ADMINISTRATIVE RULE.—The term ''uniform administrative rule'' means a Government-wide uniform rule for any generally applicable requirement established to achieve national policy objectives that applies to multiple Federal financial assistance programs across Federal agencies.

SEC. 5. DUTIES OF FEDERAL AGENCIES.

(a) IN GENERAL.—[NOT] *Except as provided under subsection (b), not* later than [18] *36* months after the date of enactment of this Act, each Federal agency shall develop and implement, *including promulgation of rules and amendments to existing collections of information,* a plan that—

(1) streamlines and simplifies the application, administrative, and reporting procedures for Federal financial assistance programs administered by the agency;

(2) demonstrates active participation in the interagency process under section 6(a)(2);

(3) demonstrates appropriate agency use, or plans for use, of the common application and reporting system developed under section 6(a)(1);

(4) designates a lead agency official for carrying out the responsibilities of the agency under this Act;

(5) allows applicants to electronically apply for, and report on the use of, funds from the Federal financial assistance program administered by the agency;

(6) ensures recipients of Federal financial assistance provide timely, complete, and high quality information in response to Federal reporting requirements; and

(7) *in cooperation with recipients of Federal financial assistance,* establishes specific annual goals and objectives to further the purposes of this Act and measure annual performance in achieving those goals and objectives, which may be done as part of the agency's annual planning responsibilities under the Government Performance and Results Act of 1993 (Public Law 103–62; 107 Stat. 285).

(b) EXTENSION.—[If one or more agencies are unable to comply with the requirements of subsection (a), the Director shall report to the Committee on Governmental Affairs of the Senate and the Committee on Government Reform of the House of Representatives the reasons for noncompliance. After consultation with such committees, the Director may extend the period for plan development and implementation for each noncompliant agency for up to 12 months.] *If an agency is unable to comply with the requirements of subsection (a)(5), the Director may extend the period for the agency to develop and implement a plan that allows applicants to electronically apply for, and report on the use of, funds from Federal financial assistance programs administered by the agency to October 31, 2003.*

(c) COMMENT AND CONSULTATION ON AGENCY PLANS.—

(1) COMMENT.—Each agency shall publish the plan developed under subsection (a) in the Federal Register and shall receive public comment of the plan through the Federal Register and other means (including electronic means). To the maximum extent practicable, each Federal agency shall hold public forums on the plan.

(2) CONSULTATION.—The lead official designated under subsection (a)(4) shall consult with representatives of non-Federal entities during development and implementation of the plan. Consultation with representatives of State, local, and tribal governments shall be in accordance with section 204 of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1534).

(d) SUBMISSION OF PLAN.—Each Federal agency shall submit the plan developed under subsection (a) to the Director and Congress and report annually thereafter on the implementation of the plan and performance of the agency in meeting the goals and objectives specified under subsection (a)(7). Such report may be included as part of any of the general management reports required under law.

SEC. 6. DUTIES OF THE DIRECTOR.

(a) IN GENERAL.—The Director, in consultation with agency heads, and representatives of non-Federal entities, shall direct, coordinate, and assist Federal agencies in establishing—

(1) a common application and reporting system, including—

(A) a common application or set of common applications, wherein a non-Federal entity can apply for Federal financial assistance from multiple Federal financial assistance programs that serve similar purposes and are administered by different Federal agencies;

(B) a common system, including electronic processes, wherein a non-Federal entity can apply for, manage, and report on the use of funding from multiple Federal financial assistance programs that serve similar purposes and are administered by different Federal agencies; and

(C) uniform administrative rules for Federal financial assistance programs across different Federal agencies; and

(2) an interagency process for addressing—

(A) ways to streamline and simplify Federal financial assistance administrative procedures and reporting requirements for non-Federal entities;

(B) improved interagency and intergovernmental coordination of information collection and sharing of data pertaining to Federal financial assistance programs, including appropriate information sharing consistent with section 552a of title 5, United States Code; and

(C) improvements in the timeliness, completeness, and quality of information received by Federal agencies from recipients of Federal financial assistance.

(b) LEAD AGENCY AND WORKING GROUPS.—The Director may designate a lead agency to assist the Director in carrying out the responsibilities under this section. The Director may use interagency working groups to assist in carrying out such responsibilities.

(c) REVIEW OF PLANS AND REPORTS.—Upon the request of the Director, agencies shall submit to the Director, for the Director's review, information and other reporting regarding agency implementation of this Act.

(d) EXEMPTIONS.—The Director may exempt any Federal agency or Federal financial assistance program from the requirements of this Act if the Director determines that the Federal agency does not have a significant number of Federal financial assistance programs. The Director shall maintain a list of exempted agencies which shall be available to the public through the Office of Management and Budget's Internet site.

(e) REPORT ON RECOMMENDED CHANGES IN LAW.—Not later than 18 months after the date of the enactment of this Act, the Director shall submit to Congress a report containing recommendations for changes in law to improve the effectiveness, performance, and coordination of Federal financial assistance programs.

(f) DEADLINE.—All actions required under this section shall be carried out not later than 18 months after the date of enactment of this Act.

SEC. 7. EVALUATION.

(a) IN GENERAL.—[The Director (or the lead agency designated under section 6(b)) shall contract with the National Academy of Public Administration to] *The General Accounting Office shall* evaluate the effectiveness of this Act. Not later than [4] *6* years after the date of enactment of this Act, the evaluation shall be submitted to the lead agency, the Director, and Congress. The evaluation shall be performed with input from State, local, and tribal governments, and nonprofit organizations.

(b) CONTENTS.—The evaluation under subsection (a) shall—

(1) assess the effectiveness of this Act in meeting the purposes of this Act and make specific recommendations to further the implementation of this Act;

(2) evaluate actual performance of each agency in achieving the goals and objectives stated in agency plans; and

(3) assess the level of coordination among the Director, Federal agencies, State, local, and tribal governments, and nonprofit organizations in implementing this Act.

SEC. 8. COLLECTION OF INFORMATION.

Nothing in this Act shall be construed to prevent the Director or any Federal agency from gathering, or to exempt any recipient of Federal financial assistance from providing, information that is required for review of the financial integrity or quality of services of an activity assisted by a Federal financial assistance program.

SEC. 9. JUDICIAL REVIEW.

There shall be no judicial review of compliance or noncompliance with any of the provisions of this Act. No provision of this Act shall be construed to create any right or benefit, substantive or procedural, enforceable by any administrative or judicial action.

SEC. 10. STATUTORY REQUIREMENTS.

Nothing in this Act shall be construed as a means to deviate from the statutory requirements relating to applicable Federal financial assistance programs.

SEC. 11. EFFECTIVE DATE AND SUNSET.

This Act shall take effect on the date of enactment of this Act and shall cease to be effective [5] *8* years after such date of enactment.

Mr. JEFFORDS. Mr. President, I ask unanimous consent the committee

amendments be agreed to, the bill be considered read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

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

The committee amendments were agreed to.

The bill (S. 468) was read the third time and passed.

CORRECTING ERRORS IN THE AUTHORIZATIONS OF CERTAIN PROGRAMS ADMINISTERED BY THE NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION

Mr. JEFFORDS. Mr. President, I ask unanimous consent the Senate now proceed to the consideration of H.R. 2035, which is at the desk.

The PRESIDING OFFICER. Without objection, the clerk will report.

The legislative clerk read as follows:

A bill (H.R. 2035) to correct errors in the authorizations of certain programs administered by the National Highway Traffic Safety Administration.

The Senate proceeded to consider the bill.

Mr. JEFFORDS. I ask unanimous consent the bill be considered read a third time and passed, the motion to reconsider be laid upon the table, and any statements relating to the bill be printed in the RECORD.

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

The bill (H.R. 2035) was ordered to a third reading, was read the third time, and passed.

ORDERS FOR FRIDAY JULY 16, 1999

Mr. JEFFORDS. Mr. President, I ask unanimous consent that when the Senate completes its business today it stand in adjournment until the hour of 9:30 a.m. on Friday, July 16. I further ask consent that on Friday, immediately following the prayer, the Journal of proceedings be approved to date, the morning hour be deemed expired, and the time for the two leaders be reserved for their use later in the day.

I further ask consent that following the cloture vote, the Senate proceed to a period of morning business with Senators speaking up to 5 minutes each with the following exceptions:

Senator COVERDELL or his designee in control of the first hour and Senator BREAUX or his designee in control of the second hour, Senator DOMENICI for 10 minutes, Senator BAUCUS for 10 minutes, Senator HARKIN for 15 minutes, and Senator LEVIN for 5 minutes.

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

PROGRAM

Mr. JEFFORDS. For the information of all Senators, the Senate will convene at 9:30 a.m. Under the previous order, the Senate will debate the Social Security lockbox legislation for 1 hour with a vote to occur at approximately 10:30 a.m. For the information of all Senators, that vote will be the only rollcall vote during Friday's session of the Senate. Following the vote, Senator COVERDELL will be recognized to begin a period of morning business.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. JEFFORDS. Mr. President, if there is no further business to come before the Senate, I now ask unanimous consent the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 9:02 p.m., adjourned until Friday, July 16, 1999, at 9:30 a.m.

CONFIRMATION

Executive nomination confirmed by the Senate July 15, 1999:

DEPARTMENT OF COMMERCE

JOHNNIE E. FRAZIER, OF MARYLAND, TO BE INSPECTOR GENERAL, DEPARTMENT OF COMMERCE.

THE ABOVE NOMINATION WAS APPROVED SUBJECT TO THE NOMINEE'S COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.