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## Senate

The Senate met at 10 a.m. and was called to order by the Honorable HILLARY RODHAM CLINTON, a Senator from the State of New York.

### PRAYER

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

Almighty God, Sovereign of our Nation, Lord of our history and personal Friend to those who trust in You, we thank You that 14 days before the Declaration of Independence on this day, June 20, 1776, Abigail Adams, wife of John Adams, wrote these words to her husband, "I feel no anxiety at the large armament designed against us. The remarkable interpositions of heaven in our favor cannot be too gratefully acknowledged. He who fed the Israelites in the wilderness, who clothes the lilies of the field and who feeds the young ravens when they cry, will not forsake a people engaged in so right a cause, if we remember His loving kindness."

Father, help us to have a cause that is right and to remember Your loving kindness. The two go together. Help us to be sure of Your guidance for the problems we face today and to be equally sure of Your affirmation so that we can unashamedly ask for Your success in just causes You have led us to champion. You are our Lord and Saviour. Amen.

### PLEDGE OF ALLEGIANCE

The Honorable HARRY REID, a Senator from the State of Nevada, led the Pledge of Allegiance, as follows:

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

### APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

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

The assistant legislative clerk read the following letter:

U.S. SENATE,  
PRESIDENT PRO TEMPORE,  
Washington, DC, June 20, 2001.

To the Senate:

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

ROBERT C. BYRD,  
President pro tempore.

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

### RECOGNITION OF THE ACTING MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The Senator from Nevada.

### SCHEDULE

Mr. REID. Madam President, on behalf of Senator DASCHLE, the majority leader, I announce that today we are going to continue the consideration of the motion to proceed to the Patients' Bill of Rights. The debate on the motion will be divided in 30-minute increments, beginning right now, between the managers of the bill. The first speaker on our side will be Senator KENNEDY, the manager of the bill.

There will be a vote on the motion to proceed tomorrow morning at 9:30 a.m. to proceed to the Patients' Bill of Rights.

Madam President, Senator DASCHLE has asked that I again notify everyone that we are going to complete this legislation prior to the Fourth of July break. Everyone, including this Senator, has parades, and other things, during the Fourth of July festivities, but we should all make some calls home to make sure our staffs there indicate to those who are concerned that we may not be able to make it.

I was going home late last night, and I ran into one of the journalists. He

said he had spoken to one of the Senators in the minority who thought this was just a bluff on Senator DASCHLE's part. Everyone should understand, Senator DASCHLE does not bluff. He has announced that we are going to finish this bill and that is the way it is. We all recognize there has been an effort to stall our going forward on this bill. It is not going to work. We are going to complete this bill prior to the Fourth of July recess.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

Mr. THOMAS. Madam President, I thank the Senator for this arrangement. I think alternating half hours is the way to do it. I hope the Presiding Officers will adhere to that.

Further, I want to say that one of the reasons for waiting to proceed to the bill is that it is relatively new to many people. It is something we need to talk more about. Certainly, we will be prepared, as we go through the day, to be able to move on to the bill tomorrow.

Thank you.

### RESERVATION OF LEADER TIME

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

### BIPARTISAN PATIENT PROTECTION ACT—MOTION TO PROCEED

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

The assistant legislative clerk read as follows:

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

The ACTING PRESIDENT pro tempore. Under the previous order, the Senator from Massachusetts is recognized.

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



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Mr. KENNEDY. Madam President, I just want to say at the outset of this debate that this is not a new legislative proposal. We have had very extensive debates on the provisions which are included in the Patients' Bill of Rights. We have had good debates on the provisions when we passed the Frist bill about 2 years ago. And we had additional kinds of debates when we took up the Norwood-Dingell bill a little over a year ago. These matters have been before the Senate. They are matters that have been discussed repeatedly in this Chamber by a number of us over a very considerable period of time.

We want to point out at the outset of this debate, that the kinds of alterations, adjustments and changes that were made over the weekend were basically technical in nature. I went through those yesterday with the Senator from North Carolina. Maybe later in the day, if it is necessary, I might go through them again. But again, they were basically clarifications in response to questions that were raised about different language interpretations of the bill. These were issues that have been raised by the White House, and those who were opposed to the legislation. I think the most recent changes help clarify the language in our bill.

As we have said all along, we are always interested in hearing ideas, suggestions and recommendations, as long as they are consistent with the fundamental purpose of the legislation. Our purpose is protecting patients, and also assuring accountability by HMOs and insurance companies that are making medical decisions and, too often, overruling doctors, nurses, and trained personnel.

So I know there are some concerns. But the way to deal with those kinds of concerns is to engage in debate on these issues. I think if you look at the Frist bill, you will find that it tracks, at least in titles, the Norwood-Dingell and the McCain-Edwards legislation. However, the Frist bill creates numerous loopholes, which I think fails to respond either to the President's desire to make sure that all Americans are covered. We will have a chance during the day to point out some of those differences between their bill and ours.

We are facing a situation where there are many of us, a majority in the Senate, who are in strong support of the McCain-Edwards legislation. On the other side there are those who don't want any legislation and a small group who prefer the Frist-Jeffords-Breaux provision. We will work our way through it. That is the way the Senate functions. We welcome the opportunity.

I note the presence of my friend and colleague, Senator EDWARDS. He and I plan to be here the whole day. We are in the Chamber ready to deal with either amendments or to try to clarify provisions for those Members who fail to understand them. We are also here

to point out, in the case of Breaux-Frist, how we think the McCain-Edwards bill provides better protections for American families. We are glad to do that as well.

That is the framework. We are starting out on day 2. We are glad this bill is before the Senate, even though we will wait until tomorrow for the first amendments. I am heartened by the strong resolution of our leader, Senator DASCHLE, in committing us to the conclusion of this legislation prior to the Fourth of July recess.

Americans have waited too long. They have waited over 5 years for a strong, enforceable Patients' Bill of Rights. This issue has been studied and studied to death. It is time for action. The Senate's failure to take action results in too many of our citizens—too many children, too many women, too many seniors, too many families—being harmed today and experiencing additional kinds of pain and suffering.

It is within that framework that we will hopefully move ahead today.

It is time to pass the Patient Protection Act. Every doctor knows it. Every nurse knows it. Every patient knows it. The American people know it. And in their heart, every Senator knows it, too. Often today managed care is mismanaged care. It is long past time for Congress to act to end the abuses by the HMOs. Too often insurance company accountants are making the medical decisions instead of doctors and patients. It is long past time for Congress to assure that the medical care is based on a patient's vital signs, not an insurance company's bottom line.

The first proposal to do so was introduced in early 1997. We are now in the fifth year of consideration of this essential reform. Patients are still suffering, even dying, because of our inaction. Every day the Congress fails to act, an intolerable additional cost is imposed on patients and their families.

A survey by the School of Public Health at the University of California found that each and every day, 50,000 patients go through added pain and suffering because of the actions of their health plan, 35,000 patients have needed care that is delayed or denied, 35,000 patients have a referral delayed or denied, 31,000 patients are forced to change doctors, and 18,000 patients are forced to change medications. A survey of physicians by the Kaiser Family Foundation and the Harvard School of Public Health found similar results. Every day, tens of thousands of patients suffer serious declines in their health as a result of the action or inaction of their health plan.

Whether the issue is diagnostic tests, specialty care, emergency room care, access to clinical trials, availability of needed drugs, protection of doctors who give patients their best advice, or women's ability to obtain gynecological services, too often HMOs and managed care plans put profits ahead of patients.

The issue is clear: Does the Senate stand with powerful HMOs or with

American families? Do we stand for protecting patients and their doctors or protecting insurance company profits?

There is only one reason this legislation did not pass years ago. It is because of the tens of millions of dollars the insurance companies and their allies have lavished on lobbying, campaign contributions, and misleading advertising. Now is the time to say that the health of every American family is a public trust, not a commodity for sale to the highest bidder.

The need for prompt action on patient protections is great because the dishonor roll of those victimized by HMO abuses is so long and growing.

A baby loses his hands and feet after a medical emergency because his parents believe they have to take him to a distant hospital emergency room covered by their HMO rather than the hospital closest to their home.

A Senate aide suffers a devastating stroke which might have been far milder if her HMO had not refused to send her to an emergency room. Even now, the HMO refuses to pay for her wheelchair.

A woman is forced to undergo a mastectomy as an outpatient instead of with a hospital stay as her doctor recommended. She is sent home in pain with tubes still dangling from her body.

A doctor is denied future referrals of patients by an HMO under a managed care plan because he has told a patient about an expensive treatment that could save her life.

The parents of a child suffering from cancer are told that lifesaving surgery should be performed by an unqualified doctor who happens to be on the plan's list, rather than by a specialist at the local cancer center equipped to perform the operation.

A woman with advanced cervical cancer is denied the opportunity to participate in a clinical trial that could save or prolong her life.

A child with cystic fibrosis is denied the opportunity for treatment at a center with the expertise to treat the disease.

A teenager with a seriously injured hand is told by his insurance company that they will pay for an amputation, but not the more expensive reconstructive surgery that could provide a normal life.

A woman with a relatively minor leg injury ends up losing her leg because her insurance company persistently delays and denies adequate care.

Our legislation corrects all of these problems and many more. It takes HMOs and insurance company accountants out of the practice of medicine and returns decision making to patients and doctors where it belongs. Our proposal guarantees patients the rights that every honorable insurance company already grants, and it provides an effective and timely means to enforce these rights. These protections are basic aspects of good health care

that every family believes they were promised when they purchased health insurance and paid their premiums.

Virtually all of the patient protections in this legislation are already available under Medicare. They have been recommended by the National Association of Insurance Commissioners and the President's Advisory Commission. They have also been proposed as voluntary standards by the managed care industry itself through its trade association. In fact, most of them are features of the patient protection legislation enacted under Governor George Bush in Texas.

Patients should have the right to see a specialist, if they have a condition serious enough to require specialty care.

No parent should be told that their child with cancer has to be treated by an HMO physician who lacks the expertise needed to treat the child effectively.

Patients should have the right to the prescription medicine their doctor says they need. They should not be told that they have to settle for the second best medication for their condition or suffer unnecessary side effects or pay more because the most up-to-date drug is not accepted by the HMO.

Patients should have the right to go to the nearest hospital when they have symptoms of serious illness.

They should have the right to continuing emergency care after their condition is initially stabilized. Medicare patients have these rights, and other Americans should have them, too.

Patients should have the right to participate in a clinical trial if it offers the best hope for a cure or improvement of a serious or fatal illness.

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

Mr. KENNEDY. I am glad to yield for a question.

Mr. EDWARDS. Would the Senator talk briefly about the number of Americans who are being affected by us not having already passed this legislation, and whatever delay may occur in the debate of this bill?

I know the Senator has been involved in this issue for many years now. He has heard all of the HMO horror stories, about what HMOs have done to people around the country. But some of the Americans listening to this debate may not be aware, as the Senator is, of how many people are affected on a daily basis, on a weekly basis, on an annual basis. As we go forward with the debate on this bill, could the Senator talk about that issue first, and then I have a couple of other questions I would love to ask.

Mr. KENNEDY. The Senator is quite right about the fact that every day we delay this legislation, thousands of Americans suffer.

The California study says that 50,000 Americans a day are suffering as a result of delay or treatment. They would not be suffering if this legislation were passed. And 35,000 families are being

turned down by HMOs today for specialty care that they otherwise would have for their children, their parents or another loved one.

Close to 20,000 are taking alternative medicines and not taking the prescription drugs that their doctor says are needed but are not on the formulary of the HMO. The HMO only allows patients to take these alternative drugs. In many instances, patients take their alternative drugs and have two or three adverse reactions before they will come back to the drug that is actually prescribed by the doctors.

So every day that goes on, American families are suffering.

I might mention to the Senator the point made on this chart. This is from the Kaiser Family Foundation and the School of Public Health up at Harvard, July 1999. Doctors know that congressional delays mean patient suffering. This chart indicates the number of doctors each day seeing patients with a serious decline in health from plan abuse. These 14,000 cases represent the number of doctors who every day see denied coverage of recommended prescription drugs.

So 14,000 doctors have said they prescribed prescription drugs and they were denied, 10,000 doctors were denied the diagnostic tests that they believe were necessary in order to make an effective evaluation, 7,000 doctors claim they were denied the opportunity for specialty care, and 6,000 were denied overnight hospital stays. And 6,000 were denied referrals for mental health or substance abuse. The list goes on.

Those are two very important studies that make a very powerful case regarding how American patients are suffering. An additional study from the doctor's point of view came to a virtually identical conclusion—that patients are suffering every day as a result of HMO abuses.

Mr. EDWARDS. This information is so important to this discussion. Is the Senator saying that as of the time of this study in 1999, 14,000 doctors a day are being overruled by HMOs when they recommend prescription drugs? In other words, a patient comes into the doctor, who has training, experience, and expertise, and the doctor recommends that a patient needs prescription medication, and 14,000 doctors a day are being overruled by the HMO? Is that what the Senator's understanding is?

Mr. KENNEDY. The Senator is absolutely correct. That is what is happening regarding prescription drugs, and that includes the tests that are necessary and the specialists that are necessary.

The point I want to mention here, as the Senator was inquiring, is the importance of patients' rights to participate in a clinical trial. I think this is one of the most important guarantees that should be a part of this legislation. Unfortunately, we had a full debate on this 2 years ago in the Senate, and the Senate rejected ensuring patients access to clinical trials.

What we agreed to was a 2-year study of whether clinical trials are effective. That was under the Frist bill that eventually passed this body.

I am wondering whether the Senator would agree with me that we are in the time of doubling appropriations for the NIH budget. We are in the century of the life sciences. We can't pick up a newspaper any single day and not see medical breakthroughs. It is one of the most exciting times in medical history, with the progress that has been made on the human genome, the sequencing of genes and the explosion of different knowledge that is out there. We are going to see the development of all of this knowledge now in the laboratories.

I ask whether the Senator would not agree with me that in order to get it from the laboratories to the bedside, it has to be tested. It has to have clinical trials. This is a time of enormous potential for reducing the kinds of pain and anxiety that disease and illness bring. We can even reduce the demand on resources over a period of time. We know, for example, that if we were to develop some kind of cure for Alzheimer's, half the nursing home beds in Massachusetts would be empty this afternoon. Half of them would be empty. And there is important progress. But it isn't going to get out there unless we have the clinical trials.

Finally, as the Senator understands, insurance companies have over a period of time continued—when a patient needed the clinical trial—the ordinary expenses that were attendant to it. The clinical trial would pick up the additional kinds of expenses. They didn't go to great additional expenses. But even that kind of responsibility is being rejected now by the HMOs. The number of clinical trials is going down and threatening not only the well-being and security of the people who are in those HMOs, but the well-being of the rest of the people in our society.

Mr. EDWARDS. Would the Senator address two questions, please.

First, the fact that the HMOs are denying and not covering patients needing and having access to clinical trials—would he first talk a little about, from his experience and from talking to constituents, what impact that has on the country moving forward in the field of medicine for all of the American people, so we can continue to be the world leader that we have been in the past in advancing medicine in the areas such as Alzheimer's?

Second, would the Senator talk briefly about the difference between the McCain-Edwards-Kennedy bill on access to clinical trials and the competing Frist bill?

Mr. KENNEDY. Well, I will. This is enormously important. Let's look at what clinical trials have meant in recent times. We have made the greatest progress in addressing the challenges that children face with cancer.

Listen to this. We have 70 percent of children with cancer treated through

clinical trials. This is the area where we have seen dramatic progress made. In the last 10 years, it has been miraculous. There is still a long way to go, but regarding children's cancer, we have made progress. Yet less than 3 percent of adults with cancer are enrolled in clinical trials. We have made some progress in the area of the adult cancers, but that number is in danger of decline.

Until recently, the health insurance companies routinely paid for the doctor and hospital costs associated with a clinical trial. In 1998, the CBO found that approximately 90 percent of health insurance companies reimbursed for their patient costs, but HMOs are quickly reversing that life-saving policy. Many of the HMOs are refusing to allow their patients to participate, leaving them with few alternatives.

I want to give the Senator from North Carolina, Mr. EDWARDS, a quick anecdote. One of the important cancer centers is the Lombardi Center, named after one of the great football coaches, Vince Lombardi. Most people in the Washington area are familiar with that center.

Our committee had a hearing at which the director of that center was present. He told us they had to hire more and more people to deal with the insurance companies to persuade the insurance companies to let women who had breast cancer and other cancers participate in these lifesaving trials.

That was their big new expense; not trying to treat more people, not expanding the facility, not bringing the benefits of their research and breakthroughs to other people, but to hire more people to tangle with the insurance companies. They had to do this because, for the most part, women were being turned down, even though the possibilities for their recovery were significant.

As the Senator knows, under his bill, the McCain-Edwards bill, they still have to meet certain requirements. There has to be the likelihood of progress within the clinical trials. There are protocols that have been established by the FDA and NIH. They have to qualify in these areas. There are requirements that have to be met.

We must protect vulnerable populations with these diseases, people who have the hope of being freed of the shackles of sickness. These protections are included in the Edwards-McCain bill. The Frist bill leaves the door ajar but not very much ajar. It allows HMOs to continue to resist applications for clinical trials, resistance that can last as long as 7 or 8 years.

As all of us understand, these are timely occasions. Individuals have to be enrolled in these clinical trials in a timely way to benefit.

When laying these two proposals side by side, one would have to say that under our proposal the guarantee is there, as it has been historically. And on the other side one would say that

there are significant roadblocks and hazards that are being placed in the way of qualified patients to participate in the trials.

Madam President, I believe I have consumed most of my time.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts is correct. The Senator has 2 minutes remaining.

Mr. KENNEDY. Madam President, I look forward to continuing this discussion during the course of the day. It is important during this day to point out exactly what is before the Senate.

There are those who favor our HMO bill, and there are those who favor an alternative. It is important Members understand exactly the protections that are in the Edwards and McCain legislation, which I think are the types of protections that are in the best interest of the patient and are the result of a great deal of review. These protections have the very strong support of the medical profession.

We will have that opportunity later in the day. I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. FRIST. Madam President, we are alternating approximately every 30 minutes. It is an opportune time because we have present two of the principals of the bill that we will be debating over the next several weeks. They just addressed many of the points in their plan.

There have been two bipartisan—ours is tripartisan—Patients' Bill of Rights bills introduced in the Senate, and I think it will be useful to contrast the two bills as we go forward to educate our colleagues but also to educate people who may be watching this debate so they may understand what we are all trying to accomplish, and that is to produce a strong, enforceable Patients' Bill of Rights that will benefit patients by strengthening the doctor-patient relationship, restoring trust to our health care system and making sure patients really are protected. In many ways, the whole swing has gone too far towards managed care. That pendulum has to swing back. How far it should swing back is a balancing act.

Both of these bills attempt to do that and I, of course, believe the Frist-Breaux-Jeffords bill does it in a much more balanced way, in a way that ensures that patient protections are appropriate and ensures a strong appeals process and legal remedies if the appeals process is unsatisfactory.

I begin by outlining what our bill attempts to achieve. It goes back to the principles that the President of the United States, President Bush, introduced several months ago. I applaud his leadership and commitment to a strong, enforceable Patients' Bill of Rights.

The principles he outlined were, No. 1, patient protections should apply to all Americans. That is important because, if we have certain rights, we want them to apply broadly. However,

the breakdown in the discussion is: Is it the Federal Government that specifically defines the wording that applies to all Americans or do we respect what Governors and State legislatures have already been doing to address issues such as prohibiting gag clauses, ensuring access to specialists and access to emergency room care, and ensuring access to something my colleagues were just talking about—clinical trials.

A lot of States have not addressed clinical trials. If they have not addressed it, what should our response be? Does the Federal Government come in and say: You have to address it the way we say or can they address it the way Tennessee might best address it?

The President also said patient protection should be comprehensive. Again, there has been a lot of debate in the last 24 hours on liability, employers, and a little bit on scope. There are patient protections in the Frist-Breaux-Jeffords bill and in the McCain-Edwards-Kennedy bill. The protections are similar and all the media are saying they are exactly alike. They are not exactly alike. There are some things in their bill not in our bill. Some areas of their bill go further than ours. Clinical trials is an example.

Clinical trials, as we all know, are critically important, and they are in both bills. However, the cost in their bill is higher than in our bill because they include thousands of clinical trials that we did not include. Again, we can debate whether that is appropriate or not as we go forward. I will go through those lists of protections shortly.

Third, the President said patients should have a rapid medical review process for denial of care. Both bills do that pretty well. Again, our bill has a more efficient process. The timelines are clearly defined.

The President's fourth principle is that the review process should ensure doctors are allowed to make medical decisions and patients receive care in a timely manner.

The fifth principle of the President is that Federal remedies should be expanded to hold health plans accountable. This is an issue of real debate. We believe that, since this is a new cause of action, it should be a Federal cause of action and should go principally through Federal courts.

However, the bill on the other side, the McCain-Edwards-Kennedy bill, looks at both State court and Federal court and allows patients to go back and forth between Federal and State courts. This raises a concern with the issue of forum shopping. Trial lawyers have an incentive to make money with this new Patient's Bill of Rights, and there is the fear that there will be shopping among the various courts.

The sixth principle of the President is that patient's rights legislation should encourage employers to offer health care. We talked about that yesterday. Everybody has to realize this bill is going to cost hundreds of billions

of dollars in addition to whatever will be paid for health care over the next 10 years. These rights have a cost, a price to pay. That price is hundreds of billions of dollars. Whoever is listening will be paying it. It may be shared, and we may divide it by 260 million citizens, but it will cost hundreds of billions of dollars. That is why we should not rush through the bill too quickly without adequate debate on each and every one of the issues. There is an urge to debate it, get it through, and pass it in a week or a week and a half. Remember, this will drive costs up markedly, no matter what bill passes, and the higher you drive the cost, the higher the premiums, the higher the number of uninsured in this country. We care about the uninsured and have to be careful about how high we drive those costs.

Those are the six principles put forth by the President of the United States.

Senator BREAUX, Senator JEFFORDS, and I have put together a bill that embodies these strong patient protections and fulfills each one of those principles put forth by the President.

No. 1, our bill, written in a non-partisan way, is actually a tripartisan bill. It protects all Americans, while giving the appropriate deference to States. If a State has already addressed gag clauses in the way they think is appropriate, the Governor has signed off on it, the State legislature and elected representatives have agreed to it, we do not believe that we in the Congress need to mandate that they say almost the exact words that we dictate, which causes them to go back and redefine what they have done and bring back an issue they may have addressed.

No. 2, we guarantee comprehensive patient protections. We guarantee emergency room coverage. We guarantee in the Frist-Breaux-Jeffords bill access to specialty care. We guarantee direct access to OB/GYNs. Pediatricians can be the primary care physician. We prohibit a restrictive formula for prescription drugs. We ban gag clauses. We prohibit provider discrimination. We provide access to clinical trials coverage, and continuity of care—if your care for some reason is terminated and you are pregnant, or towards the end of life, these issues, it will be continued.

Mr. KENNEDY. Will the Senator yield?

Mr. FRIST. Because I have not had the opportunity to lay out the bill, let me lay it out. Senator BREAUX is on the floor. We will have time to debate this. I would love to do it, but this is the first time we have had the opportunity to lay out the bill, if that is all right.

No. 3, we require health plans to provide consumers with comprehensive information about their new rights. We provide all the new rights, but we need to make sure the consumer, the patient, receives them in a way that they can truly understand. That is accom-

plished in the Frist-Breaux-Jeffords bill.

No. 4, we ensure a rapid independent external review. If there is disagreement on the patient protections, you need to go both internally and externally and have an independent, unbiased physician make that final decision.

No. 5, doctors—not HMOs, not health plans—need to make medical decisions.

No. 6, we hold health plans accountable through expanded Federal liability. Both bills expand the liability to hold these HMOs accountable. Yes, we believe if HMOs create injury or harm, in essence, something unjust, you should be able to hold them accountable and liable, and you should be able to sue your HMO.

No. 7, we protect employers from costly, unnecessary litigation. We debated that yesterday and will continue to debate that. We will argue that the bill on the opposite side opens the door to frivolous lawsuits. Clearly, we do certain things to try to prevent unnecessary, frivolous, costly lawsuits but at the same time hold the health plans accountable and allow the health plans, not the employers, to be sued.

No. 8, we protect doctors from new lawsuits. The bill introduced Thursday, the McCain-Edwards-Kennedy bill, included some improvements from the version of the bill on the floor until that time. Clearly, as an agent of the plan, doctors could be sued. A lot of doctors did not realize that and will look at the new writings and the new bill they introduced Thursday.

No. 9, we make litigation the last resort. We go to the court as the last resort. They go to the courts much earlier, as a first resort.

No. 10, we protect the role of State courts in holding health plans accountable for quality and treatment decisions. We do not preempt State court. In Texas, if there is a lawsuit for a quality or treatment issue, it can still continue. It is very specifically written in our bill. It is for that new cause of action, a product of this legislation, that we take to Federal court.

I will turn to the other principles shortly. What are the differences between these two bills? What I just outlined and in the first column of this chart is the Frist-Breaux-Jeffords bill. In the second column is the McCain-Edwards-Kennedy bill. The first line is protections applying to all Americans. Both bills achieve that.

Deference to State laws: We achieve it; they do not. They basically say, here are the patient protections. You have to have these on the books or pass them essentially the way we wrote them.

Support State regulation of health insurance: Again, we defer to this 60-year history of health insurance primarily being the State's responsibility in terms of actual coverage.

Comprehensive protections such as emergency room specialists and clinical trials: There is a check in both columns. Both do it well.

Independent medical review: Both do it well.

Independent medical experts making medical decisions: Both do it pretty well.

Avoid slow and costly litigation. We address it. They do not.

Holds health plan accountable in Federal court: Yes, we go to Federal court. They go to Federal court for some contract issues but principally allow people to go to State court.

Protect employers from unnecessary, costly law lawsuits: We will have time to debate that, but we do that; they do not.

Reasonable limits on damages: We talked about that yesterday. They do not have those limits.

President Bush said he will pass our bill as written into law, and he will not pass their bill as written into law.

With that, I defer to the Senator from Louisiana to comment. Both Senator BREAUX and Senator JEFFORDS are present. I would love to hear from them over the next 15 minutes.

Mr. BREAUX. Madam President, I thank the distinguished Senator from Tennessee for his opening comments outlining what is the essence of the Frist-Breaux-Jeffords bill. I point out the obvious; it is the only tripartisan bill that has been introduced in this Chamber dealing with this issue. We have had bipartisan bills introduced, and I congratulate the author, but there is only one bill that has the support of independents, Democrats, and Republicans, as well, and that, of course, is the Frist-Breaux-Jeffords legislation.

I have come to respect all Members engaged in this debate because I think we all have the same goals, and in many cases we all have approached the solution to the problem in a very similar fashion—not identical but very close to being almost the same approach.

I was struck yesterday by a number of our colleagues who were talking about the Senator from New York, the senior Senator, Mr. SCHUMER, and I think the junior Senator from New York was engaged in talking about individual patients, children who have suffered damages because of denial of access to care that is medically necessary.

I thought the points they made were well taken. I don't have any disagreement with the points made. I have no disagreement that these cases should have someplace they can go to ensure the coverage for these individuals, children, elderly, and average citizens, which is needed and determined to be medically necessary. We have come a long way. I think this Congress in general is in agreement that patients should have federally guaranteed rights that are enforceable through a process of internal and external appeals, to get a quick decision that is good for the patient and good for society. If those appeals processes do not work, there should be access to the

courts to enforce these rights that all Americans should have under their health care plans. Indeed, if damage is done, there should be an opportunity for patients to recover damages.

We basically agreed on the rights the Federal Government should guarantee. Senator FRIST went over those rights. They are very similar in both plans. I think theirs probably covers a few more protections for what I would term the providers as opposed to protections for patients, which is what we essentially are talking about. But given that, we are very similar in the things we say should be guaranteed to Americans when they have health insurance. OB/GYN access for patients is guaranteed. Access to specialists is there. Breast cancer treatment plans must be covered. Clinical trials are available. There is continuity of care and emergency room access. There are no gag rules. There are point-of-service provisions. These are things we have in common in both plans.

Congress has agreed there should be certain patients' rights on which they can depend, that are enforceable, and if they are not provided, damages can be provided to compensate the injured parties. We both agree that one methodology of handling the enforcement of these rights is through an appeals process, through an internal and external appeals process.

One of the few things, interestingly, that works in the Medicare Program is, when a Medicare patient, a senior, is denied care, there is an internal and external appeals process that occurs very quickly. What we try to do is not give patients access to courts but access to health care. The fastest and best way to do it is through an appeals process internally, as we provide in this legislation, which requires the company that denies the care to review that decision. They have to do it in a very short timeframe, a matter of hours. If the patient still is denied care, there should be some kind of access to an external panel of independent professionals, medical professionals who will take care of looking at it independently of what the HMO did.

We have both agreed the external appeal should be independent. The question is, How do you do that? Both of them I think require—ours does—that HMOs are responsible for entering into a contract with independent professionals who are in fact going to look at these cases and handle the external appeals.

I do not know, if you require the HMO to enter into a contract, how they are not going to be involved in helping to select the independent reviewers. That is something I think that has to be done. If they are going to enter into a contract to pay for the people who are going to do the independent review, how can they not be involved in the selection? We can talk about that. I think we both agree the external review panel should be totally independent of the HMO. I think both sides

say the HMO has to pay for them. Then how do you guarantee their independence?

We can work on that, but I think we are both in agreement that the external review people should have no connection to the HMO, although we both require the HMO pay for them. How we handle that I think is open, but I think we both agree they should be totally independent of the HMO, as much as humanly practicable that we can devise a plan that will in fact do that.

Another problem you will hear a lot of talk about, that I think will be subject to amendments, is both sides say we don't want the employer to be sued if the employer is not involved in medical decisionmaking. We agree with that. I think this side and the other side agree with that premise as well.

The problem with the approach of the other side, in the sense of how they protect employers, is finding an area that would be protected activities by the employer which would not cause them to be liable for any decisions. The concern many employers have is that doesn't prevent litigation against employers, where they would have to come in and prove they have not done anything that is wrong. I think employers were legitimately concerned about being sued for things and then they would have to come in and show they were not guilty.

Our approach is a little different. I think it is a better approach. It says employers can select a designated decisionmaker who will make the medical decisions, and if they do that, the employer cannot be sued. They don't have to come into court and defend themselves for something they never did in the first place because the designated decisionmaker, which in most cases would be the insurance company, is the entity which should be sued for making the wrong decision. I think our approach in that area is a better approach.

The final point: We both have a convoluted system with regard to where you file suit. In their bill you can file for some things in Federal court and some things in State court. And guess what. In ours you can sue for some things in State court and some in Federal court. We are amending ERISA. It is a Federal statute creating Federal rights. Anytime you litigate under existing ERISA rules, you litigate in Federal court. Therefore, if you expand rights under ERISA by amending it to include a designated set of Federal rights, the proper forum is the Federal court, not 50 different State forums.

I know my good friend from North Carolina suggested lawyers may have a problem finding a Federal court. That is a slight exaggeration. But there is no lawyer I know of who has any difficulty getting into Federal court. They do it on a regular basis very successfully, and I am glad they do.

So we have suggested if you are going to file litigation after the appeals process to enforce Federal rights that are

passed by the Congress and signed into law by the President, it should be in Federal court. If you are going to sue on the existing State medical malpractice laws, the proper forum for that to be litigated is in the State courts. That is where it traditionally has been. It is a right that exists today in State court. If you are going to sue a company for medical malpractice, a doctor or hospital for medical malpractice, you will continue to do it in State courts as is the current situation.

I want to make sure we get something that can become law. If we enact a bill the President will not sign, we have not given the patients in this country one single benefit. We have given them perhaps a good political argument, but we have not created any legal rights for them to enforce when they need medical help and assurances their rights will be protected. Therefore, what I am trying to do in offering this, along with my two colleagues, is to try to create something that can actually become law.

I tell you, I would not lose sleep if the Kennedy-McCain-Edwards bill passed. My concern is not that. My concern is that it cannot become law. Therefore, as legislators, we want to enact something that can actually become law. We have offered a compromise which I think, No. 1, even from their perspective, could give at least 95 percent of what their legislation does in terms of protecting patients. But it gives 100 percent more of what theirs would do if theirs cannot be signed into law. That is just a bottom line as far as being pragmatic and as practical as I possibly can be, to say look, this is something that can become law. I think it can pass, and I think it will be signed into law if it reaches the President's desk. The opposite is true for their version which the President has said time and time again he will not sign.

We can argue whether that is a good decision on his part or not. I am sure they think it is the right decision; others would disagree with it strongly. I think we have offered something that can become law that does address the concerns that have been articulated in the Senate and in the other body for a long period of time. It is time to reach an agreement that can actually become the law of this land.

I yield any time I may have remaining.

Mr. FRIST. Madam President, I understand we have 7 minutes on our side.

The PRESIDING OFFICER. The Senator is correct.

Mr. FRIST. I yield to the Senator from Vermont.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. Madam President, I join my colleagues in explaining and hopefully alleviating the concerns of Members with respect to the question of malpractice and lawsuits.

I am probably the only one who was here back when ERISA was written. ERISA was dealing, not with these kind of parties but with pensions. But it was realized that employers need a common place to go to make sure, when they have their pension plan, there is just one jurisdiction that can take care of the complications and legal aspects. The decision there was to make it the Federal court to have exclusive jurisdiction.

We are still involved, in this case, with employers. Again, it is a different issue from pensions, but it is a very important one for employers. From World War II on, because of some special provisions for getting advantages to businesses being able to provide health insurance which would be nontaxable, it has been quite advantageous for employers to provide health care. We do not want to disturb that.

In order to not disturb that, we should follow what happened in the pension area, and that is to make sure there is uniformity of decisions across this country when we get involved with whether or not an employer would be found liable under the circumstances. We want to distinguish that from the malpractice suits with which we are involved most of the time.

I guess people get to thinking, as we talk here, that we are talking about the malpractice situation.

The malpractice suits because of doctors performing improper care, or nurses, or even the overall operation by not giving the proper medical care is one situation. That goes to State courts. If one is only talking reserving for the Federal courts as to whether or not there really was a decisionmaker who was properly put in place, or other operations totally outside of the delivery of health care, it is a very small and narrow area where you are limited to Federal courts. That is because you have to have uniformity. That is because, if an employer has a business all across this Nation, the employer doesn't have to worry about 50 different jurisdictions as far as where the law applies.

The same is true for pension plans. One Federal rule should apply in those very rare situations where there is a dispute over how much control there is and whether the business had control over the operation of the medical side.

I want to make sure it is clear. For the ordinary case where there is a problem of care, all of those will go to State courts. All we are talking about is this very limited area where the jurisdiction will be in the Federal court only.

I want to straighten that out because I think people are concerned about not being able to go through the court in their hometown where the doctor is practicing. That is absurd. I think it is important we understand that.

The best way to make sure we have good care is to make sure we have a clear idea of where these laws are going and how they are handled in the court system.

There is really little difference in our bills, if any. I don't understand what the arguments are with respect to the malpractice situation, as our plan and their plan are very similar in that regard.

I yield the floor.

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

Mr. FRIST. Mr. President, I thank Senator BREAUX and Senator JEFFORDS for their outstanding participation in putting together the Frist-Breaux-Jeffords Bipartisan Patients' Bill of Rights of 2001. This is a bill that we have jointly worked on aggressively over the last several years. It is a bill that we regard as a balanced approach to this whole issue of patient protections—making sure that patients get the care when they need it, fixing the system itself, and making sure the protections of the rights are there, but also making sure it is done in a prospective way; and then, if the system fails, or if it breaks down, providing appropriate access to legal remedies that make the patient whole.

That is our approach. It is a balanced approach. I believe that is why it has been endorsed by the President of the United States. It meets the principles that he has set forth.

Many times, as it has been discussed, someone will ask: Well, did any other provider groups or physician groups support the Frist-Breaux-Jeffords bill? The answer is yes.

I list the following organizations so people will know that we have listened to the consumers and to the patients as well as the providers: American College of Surgeons; the Society of Thoracic Surgeons; American College of Cardiology; American Society of Anesthesiologists; American Society for Gastrointestinal Endoscopy; American Society of Clinical Pathologists; American Academy of Dermatology Association; American Association of Orthopaedic Surgeons; American Association of Neurological Surgeons; American Urological Association, Inc.; American Association Clinical Pathologists; American College of Emergency Physicians; American Society of Cataract and Refractive Surgery; and the American Physical Therapy Association.

I point that out only because people will say these are the groups that support each of our bills.

I think that is very important. These are the groups to which we have been able to explain our bill. They have endorsed our particular bill. What is most important, however, is the policy beneath the legislation and the rhetoric that we often hear in this chamber.

These groups have looked at our bill, and they agree that it is a balanced bill that keeps the interests of the patient first and foremost.

I, again, thank Senators JEFFORDS and BREAUX for their tremendous work and for the work of their staffs in putting together our bill as we go forth.

I yield the floor.

The PRESIDING OFFICER. The next block of time is controlled by the majority.

The Senator from North Carolina.

Mr. EDWARDS. Thank you, Mr. President.

Mr. President, I thank the Senator from Tennessee, and the Senators from Louisiana and Vermont for their remarks and for their work on this issue.

I did not hear all of the groups that the Senator from Tennessee just read, but the majority of those groups also support our bill.

The bottom line is there is a handful of groups that support both bills. Then there are over 600 consumer groups and medical groups, including the American Medical Association, that support our bill. There is a reason for that, which I will discuss in a few minutes.

From the start to the finish of these two bills that were analyzed side by side, there are significant differences throughout the bills. In every place there is a difference. In every single place their bill sides with the HMOs and our bill sides with the patient and doctors.

That is the reason all of these consumer groups, all of these health care groups, and the AMA support our bill and do not support their bill.

It is not an accident. These are people who have been fighting for patient protection and putting health care decisions in the hands of doctors and patients for many years. They believe deeply in this issue. They have looked at these two bills side by side. They understand that there is significant and important differences that aren't abstract. There are differences that affect the lives of thousands and thousands of families and patients all over the country.

Mr. KENNEDY. Mr. President, will the Senator yield on that point?

Mr. EDWARDS. Yes. I will.

Mr. KENNEDY. Mr. President, we were just talking about one such protection that I think is of concern to families all over this country; that is, the clinical trials.

As I understand it, just to repeat, our bill has the right to participate in clinical trials without discrimination. The patient may not be denied the right to participate in an approved clinical trial if they or their physician can show that they can be appropriate participants in that trial. We have the right to coverage for routine costs associated with clinical trials, and we have the right to participate in all federally funded or federally approved clinical trials.

The other side delays the immediate coverage for routine costs with clinical trials, and the bill has a lengthy negotiated rulemaking process to establish standards for the routine costs that may be covered—a process that may well result in an effective date for insurers as late as January 2007, which adds a 6-year delay.

The current Medicare benefit was carefully crafted and fully vetted

through the Federal rulemaking. In addition, the Institute of Medicine has also released a comprehensive study by experts in the field recommending Medicare coverage for routine costs.

Furthermore, managed care plans that offer the Medicare+Choice option are already required to adhere to the current definition of routine costs. Effectively, we have the clinical trial and the patients protected.

In theirs, they don't even follow the Medicare system, which in terms of cost as a result clinical trials, would be very much deferred. As I understand, theirs does not cover the FDA-approved clinical trials. I do not understand that either because it is in the FDA where the pharmaceutical companies are working through these breakthrough drugs which offer enormous kinds of promise.

So, as the Senator knows, it is important to look at the fine print on these issues in terms of the protections. I just think we have worked with our good friends—and they are good friends, Senator FRIST and Senator BREAUX and Senator JEFFORDS—and we want to try to find common ground to work on this because the differences between us are small compared to those who do not want any bill at all. We want to try to reduce those differences.

It is important to note that it isn't just on the issues of liability, of which the Senator from North Carolina spoke, but that he has concern, as do I, about the protections—whether they provide the range of protections he thinks the patients need.

Mr. EDWARDS. I thank the Senator his questions and comments. He is exactly right. There is a difference on the issue of clinical trials in the two bills. I think the Senator from Tennessee suggested the same in his remarks. But there are differences throughout the bill, starting with the issue of coverage and how you determine whether States opt out or do not opt out of the protections in the bill. There is a difference in the access to specialists outside the plan. There are differences between the two bills. There are differences, as the Senator just pointed out, in access to clinical trials, and as the Senator from Tennessee pointed out a few moments ago.

There are differences in the independent review process. We specifically say that neither the HMO nor the patient can have any control over the body that picks the reviewing panel or the reviewing panel.

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

Mr. EDWARDS. I will, yes.

Mr. BREAUX. I am trying to understand the differences between our two bills on that particular point. We both say the external review panel should be independent. I think we say that the HMO has to contract with these external review people. I think you have been saying they have to have a contract with an HMO to do the same thing. So what is the difference?

Mr. EDWARDS. Reclaiming my time, the difference is, we have specific language in our bill that says neither the HMO nor the patient can have any relationship or any control over who is the group who picks the reviewing panel, No. 1, or the reviewing panel itself. Their bill is silent on that specific issue.

Mr. BREAUX. Will the Senator yield further?

Mr. EDWARDS. If I could continue, this may be an issue on which, working together, we may be able to resolve our differences. There has been some discussion—

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

Mr. EDWARDS. If I could finish, then I will be happy to yield. There was a discussion yesterday in this Senate Chamber about the issue of employer liability. The Senator from Tennessee suggested, a few minutes ago, he thought the intent of both bills was to protect employers from liability. I agree with that. I know that is the intent of our bill. And I know, from my discussions with the Senator from Tennessee, that is the intent of his bill. We have gone about it in different ways.

We believe our bill in fact protects employers. We believe our bill is totally consistent with the President's principles, to which the Senator from Tennessee made reference earlier. The President, in his principles, specifically said employers should not be subject to lawsuits—I don't have the language in front of me, so I am paraphrasing—unless they actively engage in making medical decisions.

That is exactly what we intend our bill to do and we believe our bill does; that employers are protected from lawsuits unless they in fact make medical decisions.

Having said that, this is another issue on which I think we should continue our discussion because, particularly given the fact that both sides want to protect employers from liability and want to protect employers from lawsuits, if there is a better and more effective way to do that, which is also fair to patients, we should explore that. I think that is worthy of further discussion as we go forward.

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

Mr. EDWARDS. Yes, I will yield.

Mr. BREAUX. Back on the point, I am glad we are having this discussion on trying to narrow the differences.

Back to the external review panel, we both agree, if it goes to an external review panel for a decision of whether something is medically necessary or not, that the people making that decision on this external review panel should be independent of the HMO. But my understanding of the Senator's bill is that the HMO would enter into a contract with these independent reviewers in order to have them review the decision.

My question is, Who selects with whom the HMO is going to contract? Is

it that the HMO has to enter into a contract to pay the external review people, and they have to enter into a contract with somebody? Who picks the somebody?

Mr. EDWARDS. That is a fair question. Let me respond to the Senator's question, and then I want to go back to talking about the bill specifically.

What our intention is in our bill is to provide an objective third party who chooses who the group is, who contracts and actually selects the review panel, and then chooses the review panel.

The Senator will recall, in previous bills that have been talked about and debated in this Senate Chamber, that has been one of the mechanisms used so that you do not have the HMO actually involved in contracting either with the group that is choosing the review panel—I think it is important to talk about both because they are both involved—or the review panel itself.

As a practical matter, the HMO is not likely to be choosing the actual review panel because much more likely, in real life terms, as the Senator knows, they would contract with a group that would choose the review panel.

What we want, and is the whole intention of our bill—and we think this is a very significant difference between the bills—is we do not want the HMOs—other than the fact that the HMO, I think in both bills, is responsible for the cost—we do not want the HMOs being able to have control either over the group that chooses the review panel or over the review panel itself.

I think that is an important distinction between these two bills because the way this process works, both bills are structured—with the exception of this difference that the Senator from Louisiana and I have just discussed—exactly the same way to avoid cases going to court.

There has been a lot of rhetoric on the opposing side that our bill will stimulate and foster frivolous lawsuits. The truth of the matter is, our bill does exactly what their bill does to try to avoid cases going to court.

Experience has proven, both in California and in Texas, that when you use that structure, which is that an HMO denies treatment, an HMO denies coverage, the first step is to go to an internal review within the HMO. If that is unsuccessful, the second step is to go to a truly independent third party review. If that is unsuccessful, and if the patient in the interim has been injured as a result of the HMO's behavior, then the case can be taken to court—the two States where that process has been used—and I again will say the structure is the same in both bills, the difference being we prohibit the HMO's involvement in the selection of the independent review process.

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

Mr. EDWARDS. If I can finish, I will be happy to yield. In the two places

where that system has been used before, which is in California and Texas, very few lawsuits have been filed. They are two of the biggest States in the country, some would argue two of the most litigious States in the country. They have a system similar to ours, and actually similar in structure to theirs. In both cases, what has happened is that the vast majority of the hundreds and hundreds of claims that have been filed—an HMO denies a claim, the claim then goes to internal-external review—the vast majority of those cases have been resolved by the appeals process.

That is what we mean when we say our bill is structured to avoid cases going to court. In fact, in most cases it is in the best interests of the patient to get the care and to get it as quickly as possible. That is the reason for the internal review process. That is the reason for the external review process. That is the process we used in our bill. It is the process they used in their bill.

Unfortunately, in some cases, if an HMO arbitrarily or intentionally denies care to a patient—and we have all heard the stories in this Chamber—when that occurs, in some cases a child or a family or a patient can be injured as a result.

If that occurs, then that child or family can take their case to court. That is what has been done in Texas. That is what has been done in California. What we have found is what common sense would tell us, which is that the system works.

Mr. BREAUX. Will the Senator yield?

Mr. EDWARDS. I will.

Mr. BREAUX. I am trying to nail down this point on the independent review. I am trying to do this one point at a time because we have so many points out there. It is my understanding both our bills have the HMO paying for the independent reviewers. Both of them enter into a contract with people who are going to have an independent review. Therefore, in a sense, in both bills the independent reviewer really works for the HMO in the sense that the HMO is going to enter into a contract for their services. The HMO will have to pay for those services. Both bills require that.

Mr. EDWARDS. That is correct.

Mr. BREAUX. The issue is, this should not be an insurmountable task for us to reach agreement on how we select the people who are going to do it. Somebody has to make the selection. I don't know that you have another creature out there who goes out into the world and says: Pick reviewer A versus reviewer B. Somebody has to pick who the independent reviewers are. In both bills the HMO pays for them. It is just a question on how they are selected. Our bill says they should be independent reviewers, and I think there are a lot of companies that do that type of work. The Senator from North Carolina probably knows it far better than I in his practice of law. But there are groups which are totally

independent that offer their services to do this.

Isn't there a way that the two bills can reach agreement on how we select the independent reviewers? The HMOs in both bills are going to pay for the services. It is just a question of how we select them. I want them to be as independent as they possibly can.

Mr. EDWARDS. I appreciate the comments of the Senator from Louisiana. First of all, he made reference to a creature selecting who the review panel is going to be. We don't want that creature to be the HMO.

Looking specifically at the language of our bill, I am looking at page 54 of the bill, it reads:

No such selection process under the procedures implemented by the appropriate Secretary may give either the patient or the plan or issuer any ability to determine or influence the selection of a qualified external review entity. . . .

I have a question for the Senator. My question is, This language specifically prohibits anybody involved in the process from determining or influencing the selection of a qualified external review entity; would the Senator agree to this language?

Mr. BREAUX. Let me answer that with a question.

Mr. EDWARDS. Will the Senator agree to this language?

Mr. BREAUX. Let me answer it with a question. Does that language prohibit the HMO from paying the salaries of the independent reviewers? Is that not influencing the independent reviewers? If the HMO, under your bill, pays for the services of the independent reviewers, is that not influence over their decision?

Mr. EDWARDS. I just read the Senator exactly what the language says.

Mr. BREAUX. I appreciate that. But it says you can't influence the independent reviewer. Under your bill, the HMOs are paying the salaries for the services of the reviewer. Is that not influence?

Mr. EDWARDS. My question to the Senator is, If you say you agree with us conceptually about this, and we have specifically said that no such selection process implemented by the appropriate Secretary may give either the patient or the plan or issuer any ability to determine or influence the selection of a qualified external review entity, would you agree to that language?

Mr. BREAUX. I agree with the principle, but who makes the selection? That is why I used the word "creature." What entity picks the group the HMO has to contract with?

Mr. EDWARDS. The Secretary sets up a process by which the selection of the independent review panel is done and by which the selection of those people who are eligible for the independent review panel is done. The Secretary is responsible for doing that.

My point to the Senator is, his bill doesn't say this. By the way, neither the HMO nor the doctor nor the patient can play any role in that process. If the

Senator agrees with us on that concept, would he agree with the language I just read to him?

Mr. BREAUX. I think we may be close to reaching agreement. If we can't solve this problem, we might as well shut down this place; we will never solve any problem. This is a small problem in comparison with other issues we are going to be faced with in conference.

Let me ask if the Senator suggests that HHS or the Federal Government has an approved list of independent arbitrators.

Mr. EDWARDS. It is actually the Labor Secretary.

Mr. BREAUX. The Labor Secretary would have an approved list of independent reviewers and they would publish that approved list and allow that there be an approved list of independent reviewers that the Secretary of Labor would designate as being independent review people or organizations that do that type work. And then somebody has to pick from among that list. They may have 20 different groups that do that on the list. Then somebody has to enter into a contract with one of those.

In both of our bills, it is the HMO that has to enter into the contract. Is it inappropriate to allow the HMO to pick from a selected approved list by the DOL?

Mr. EDWARDS. Reclaiming my time, first of all, I thank the Senator for this discussion. I hope we will be able to continue to talk about this. My concern is that we specifically say and designate that the Secretary of Labor shall set up a process by which these people are identified. That process is required by law to not allow any of the people involved in the process, which is only fair, to have any control or any influence over who ends up on the panel. We don't set up a specific process. We give the Secretary of Labor the responsibility for doing that.

My point, in response to the Senator's question—then I will go back to the other issues I need to talk about—is that we deal with this issue. He doesn't.

I think it is critically important—I am happy to continue working with the Senator—that when you have an independent review, when you have a second appeal after the HMO internally has denied the claim, that whoever is conducting that review and whoever is on that panel not have any connection with the patient, with the doctor, or, probably most importantly, with the HMO. That is the only way we are going to get a fair and impartial review panel.

Mr. BREAUX. Will the Senator yield for a final question?

Mr. EDWARDS. Yes, I will.

Mr. BREAUX. I am trying to resolve this point. It is not irresolvable. You suggest that the Department of Labor comes up with an approved list of independent external review people. It could be several groups or several individuals who would be in a selected

group of independent reviewers. When that is done, the next step is that somebody has to pick the one for this particular case that is at issue. It is either going to be the HMO that has to enter into the contract or the Department of Labor that is going to have to select the one that is going to be used in every one of these procedures.

It seems to me at that point, if the DOL has selected a group of impartial reviewers, that there is nothing wrong with having the HMO pick one of them to enter into a contract with because it is from an approved list and it has to come from that approved list. Is that bad?

Mr. EDWARDS. Reclaiming my time, responding specifically to the Senator's question, what we actually do—I hate to have to keep repeating this—we deal with this issue. You don't. What we do in this bill is we give the Secretary of Labor responsibility for setting up the process. We don't say to the Secretary of Labor: You identify this group of reviewers or these people who are eligible for the review panel. Instead, what we do is give the Secretary of Labor responsibility for setting up the process. But in setting up the process, the Secretary is required to not allow any of the people involved to be able to influence who is on the panel and who is involved.

I appreciate very much the Senator's questions. I hope we can continue to talk about this. It sounds to me as if he is genuinely concerned and interested in trying to resolve the issue. We appreciate that, but at this moment we don't have a specific solution to this issue, and we are happy to continue to talk about it. But we believe very strongly—it is the reason we address it in the bill—that the HMO and the people involved should have no role; instead, we should have an impartial process. Just like you want an impartial jury, you have an impartial review process.

Now, Mr. President, if I can go back to the overall issue of the bill, and then I want to talk about a particular patient. First, we do want to make it clear to the American people who are listening to this debate that there is a lot of media coverage that suggests that accountability, or taking HMOs to court, is the only major difference between the bills. There are major differences from start to finish—on coverage, on access to specialists outside the plan, on access to clinical trials, as the Senator from Massachusetts suggested a few minutes ago, and on a truly independent review so the decision of the HMO can be reversed, as the Senator from Louisiana and I discussed.

Finally, the issue of accountability. There are two goals in our legislation, and we believe they are met. One is to provide real and meaningful patient protection—to put the law on the side of patients and doctors so that the health care decisions are being made by the families affected by them and by

the people who have the training and experience to make them—the health care providers—and not by some bureaucrat sitting behind a desk working for an insurance company.

Second is to treat HMOs as everyone else. The problem is that some people would suggest that we should help maintain the existing privileged status of HMOs. HMOs are virtually the only entity in America that cannot be held accountable. Their decisions can't be reversed; they can't be appealed; and they can't be taken to court. When they deny coverage, the families are stuck with what they did. We want to simply treat HMOs as every individual American, every small business, every large business; they should be treated the same.

If my colleagues think differently about that, and if they believe HMOs are privileged citizens and they ought to be able to maintain some of the privileged status they have today, they will have to make their case. I believe the American people believe that HMOs should be treated just like the rest of us.

I said earlier that these debates are not abstract and academic; they are real. They affect people's lives. I want to tell the story today about a young man named Gary Wemlinger and his wife Jerrie who live in my State, in Kernsville, NC. Gary, unfortunately, was diagnosed with kidney cancer some time ago. Specialists at Duke University Cancer Center have told Gary that surgery, radiation, and chemotherapy will not help him. In other words, his life cannot be saved by those treatments.

In this photograph are Gary and his wife and his five beautiful children. What they have told him is the only chance he has for recovery and to be able to spend more time with his family is to have a procedure called a stem cell transplant.

Now, what we know medically is that stem cell transplants have saved many lives across this country of patients with cancer. But because this is a fairly new treatment, and particularly for Gary's particular kind of cancer, the insurance company has said that it is experimental and, therefore, they won't pay for it. They have refused specifically to pay for it.

As you would expect, the people around Gary—his family, friends, neighbors, people in the community—have pitched in and they are working very hard to try to raise the money for Gary to have this stem cell transplant that he so desperately needs. They are having a very hard time coming up with the amount of money that it would cost. This is a perfect example of the effect that the McCain-Edwards-Kennedy bill can have.

Under our bill, when Gary needs this stem cell transplant—and his medical doctors at Duke University Cancer Center believe he does—the insurance company not only would be required to give him more serious consideration

initially, but once the decision was made not to pay for the care, he would have the right to go to a truly independent medical review board to get that decision reversed. That medical review board, made up of doctors, would consider, among other things, the recommendations of the cancer specialist at Duke University Medical Center who would tell them that the only way Gary's life would be saved is through this stem cell transplant. Otherwise, these other traditional therapies—radiation, chemotherapy, and other surgeries—will not save his life.

This is a perfect example of a man and his family who would be dramatically affected if the law were on his side, on his family's side, instead of being on the side of the big HMOs.

We can talk about this a lot. There was a quote today in one of the newspaper stories—which we will make reference to later as the debate goes on—from the HMO lobbying group saying that they are prepared to spend whatever is necessary to stop the legislation from passing. They have already spent many millions of dollars and they will continue to spend millions of dollars, and they have been doing it for years. They want to keep their privileged status.

I will tell you who is not spending millions of dollars in this debate. Gary and his family are not spending millions of dollars. They have only us to count on—the people who are in this body and the people down the street on Pennsylvania Avenue. That is who they are counting on, the people they sent to represent them in Washington, DC. You won't see a television ad about this family. You won't see this family spending millions of dollars. Instead, you will see their friends and neighbors and members of their community trying desperately to raise the money that the HMO won't provide.

The point is there are clear lines in this debate. While we want very much to work with our colleagues to find a bill that can pass the Senate, pass the House, and will be signed by the President ultimately, we have to make a decision. We have to make a decision about whether we stand with the big HMOs or whether we stand with patients such as Gary and their families.

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

Mr. EDWARDS. Thank you, Mr. President.

Mr. FRIST. Mr. President, I understand that the next 30 minutes is under our control.

The PRESIDING OFFICER. The Senator is correct.

Mr. FRIST. I yield to the Senator from Pennsylvania—he understands the situation. The Senator from Wisconsin needs how much time?

Mr. FEINGOLD. About 6 minutes.

Mr. FRIST. Would the Senator yield to the Senator from Wisconsin?

Mr. SANTORUM. If the Senator will yield, I will withhold our half hour and have his time come out of the next half hour on the Democratic side.

Mr. FRIST. Mr. President, I ask unanimous consent that the time of the Senator from Wisconsin be taken from the next 30 minutes after the 30 minutes on our side.

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

Mr. FEINGOLD. Mr. President, I certainly thank the Senator from Tennessee and the Senator from Pennsylvania for the courtesy in allowing me to speak at this point.

Mr. President, I rise today to speak about the importance of passing a meaningful Patients' Bill of Rights that will provide patients access to the health care that they need. A real Patients' Bill of Rights is absolutely vital to protecting the quality of health care for all Americans.

I would like to make my colleagues aware of what I have been hearing from Wisconsinites about the importance of protecting patients' rights. At my listening sessions across Wisconsin, I often hear about the grim reality that the American health care system is no longer controlled by those who best understand how to treat patients—our physicians.

Instead, managed care companies, primarily HMOs but also other health insurance providers, have become so involved in the business of health care that they control nearly every aspect of health care including where care is provided, and by whom. Of greatest concern to me is that these managed care organizations can decide whether that health care can be provided at all—they make the key medical decisions.

In other words, regardless of whether that care is determined to be medically necessary by the physician who is treating you, managed care administrators can override your doctor's medical decisions and refuse to cover the care that you need.

How does this happen? Well, managed care companies control costs by limiting supply—screening of the health care providers its enrollees are permitted to see, requiring patients to go through insurance company gatekeepers prior to seeing a specialist, tracking physician proactive patterns to ensure that doctors are complying with HMO's cost-control efforts.

Some HMOs go so far as to impose a gag-rule on doctors, prohibiting physicians in their system from discussing treatment options that the HMO administrators deem too expensive.

I want to highlight two aspects of this legislation that are important examples of the need to ensure access to vital medical treatment—access to live-saving prescription drugs and clinical trials.

Perhaps nowhere has there been more advancement in medical technology than in prescription drugs. They provide patients with cures to life-threatening diseases, and are vital to restoring a patient back to health.

Unfortunately, some HMOs limit the type and amount of medications to cut

down on their cost. While I understand that these costs lead to savings in our health care system, we must ensure that patients can get the drugs if they truly need them.

I commend Senators McCain, Edwards, and Kennedy for reaching a middle ground in the tug of war between cost control and access. Congress must pass legislation that ensures that physicians and pharmacists participate in the decision making process of who has access to prescription drugs. Congress must not forget in this debate that this input is vital for those with allergies to a given medicine. We must remember that we are considering a lifesaving measure for those who have found ineffective the prescription drugs that the health plan authorizes.

Another vital provision of this legislation is that it protects the rights of patients who want to participate in lifesaving clinical trials. The McCain-Edwards-Kennedy bill would ensure that routine health care costs associated with participation in clinical trials would provide all patients with reasonable access that could potentially save their lives.

Health insurance and managed care plans must encourage good science and help define quality care by reimbursing routine patient care costs for those with life threatening diseases who wish to participate in approved clinical trials.

Right now only 3 percent of adult cancer patients are enrolled in clinical trials and lack of insurance reimbursement is often a major obstacle to their participation. We must remedy this problem, and under the McCain-Edwards-Kennedy bill, Congress can do just that.

These patient protections ought to be part of the deal when you enroll in health insurance. These are pretty basic concerns, Mr. President, concerns that I think may get lost in all the political rhetoric.

When we speak about protecting patients' rights, I want to be clear that we are talking about how to make sure that corporate cost-control concerns don't result in people being denied the care that they need.

What we need is some thoughtful, reasoned debate and deliberation of the proposals, not stonewalling and stalemates. I hope that we can work together to craft bipartisan legislation that makes the difference in the lives of patients across America.

Mr. President, I again thank the Senators from Tennessee and Pennsylvania for their courtesy, and I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Mr. President, I want to comment for 1 minute on a statement made earlier on clinical trials to clarify it for people who are following the debate. We are going to have the opportunity to debate hopefully each of these patient protections to refine and improve them. Both the Frist-Breaux-

Jeffords and the Edwards bill have clinical trials addressed as a patient protection, as a right of a patient to have access to clinical trials if they are in employer-sponsored health care.

We do have to be very careful about coverage of clinical trials. What we started with was trying to figure out how many clinical trials are going on today.

Under the Frist-Breaux-Jeffords bill, we include coverage by the Veterans' Administration clinical trials, all the clinical trials in the National Institutes of Health, and Department of Defense clinical trials. The issue is on the FDA, and the FDA obviously does wonderful clinical trials.

One concern we need to address is how many clinical trials is the FDA doing. I was going to ask the Senator from North Carolina earlier how many clinical trials are there in the FDA. Since we are taking people's money to pay for it, we need to know how much it is going to cost.

It is unclear at this juncture, and we need to work together to see how many there are. In fact, we do not know today how many FDA clinical trials are being conducted as part of FDA protocol.

We know the Center for Drug Evaluation, at the end of calendar year 2000, had 11,838. The Center for Biologics Evaluation and Research has 2,869. The Center for Devices and Radiological Health has 1,084. We know there may be some 16,000 clinical trials. Until we understand how many clinical trials, because these clinical trials cost, there is an incremental cost to these clinical trials, before we pass a law and say let's cover everything, since we all know adding incremental costs ultimately translates down to the uninsured, we need to know what these costs are.

Until we get a better feel—and I have been working for a long time trying to find out. I know NIH has 4,200 clinical trials extramurally and intramurally; 1,800 are cancer-related trials. The Department of Defense—we are looking at the number of clinical trials. The VA has 162 clinical trials, 30 of which are with partners; and 729 extramural VA-funded clinical trials, for a total of about 891.

I do not know how many FDA clinical trials are out there or what the cost actually is. We need to look at that sometime in the debate.

I understand we have 30 minutes on our side, and I yield to the Senator from Pennsylvania for such time as needed.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I thank the Senator from Tennessee. I thank him in particular for his excellent work in this area. He is a great leader and obviously an authority, somebody who understands the issue better than any of us in this Chamber. I appreciate his willingness to be fully engaged and participate in crafting a

bill that will solve the problems of the health care system today and, frankly, a bill that will be signed by this President and enacted into law.

That is the balancing act which people need to come to this Chamber and pay attention to.

To start, No. 1, I am certainly for a Patients' Bill of Rights, and I have worked for the past couple of years as a member of the health care task force on our side of the aisle to craft a Patients' Bill of Rights. I feel very strongly there are protections that need to be placed into Federal law for those people who are covered by plans that are regulated by the Federal Government. They do not currently have patient protections.

When I first got into this now over 3 years ago, the state of play in health care was a little different than it is today. We had some issues that were hot-button issues. Maybe 4, 5 years ago, the issue of gag clauses was a big deal. I think everyone now pretty much agrees—even though there is language in the bills that outlaws them—they are gone; they are not around anymore. Most States, 5 years ago, had not really taken this issue up and gotten involved in the area of patient protections. Since that time, every State in the country has at least debated, and almost all of them have passed, some form of patient protection to cover regulated and sponsored plans of the State. We have a little different state of play with respect to the landscape of who is and who is not protected.

Clearly, now the only participants in health insurance in this country who are not protected with any patient protections are those who come under the ERISA plan, or federally sponsored plans. All the others have some sort of State regulation to take care of their concerns because they are State-regulated products; they are products approved and authorized by the State and State insurance commissioners, Governors, and on down.

When it comes to the Federal plans, we need to look at and I am strongly in favor of inserting some patient protections for these federally sponsored plans, called ERISA plans. It is over 100 million people. It is not a small amount of people. That is from where we need to start.

The second thing we need to look at is the differences where we began to take this up 3, 4, 5 years ago and where we are today. A few years ago we thought we had health inflation under control. We were looking at rates of growth in health care costs that were slightly above the rate of inflation. As a result of some of the dynamics in the private health care system, we were settling down, and it looked like we had reined in costs in health care. We were being rather ambitious about how we can provide patient protections and not worried about the impact of costs on the system.

That is a little different today. Today we are looking at double-digit

increases in health care premiums. I was with an employer yesterday who told me his health insurance premiums over the past 2 years have gone up 42 percent. That, according to some other friends of mine with whom I have talked in Pennsylvania, is not unusual. Health care costs are skyrocketing again.

The question is, What do we do here that impacts this system? I always say with respect to anything we do in Washington, DC, first and foremost, is do no harm. We want to do good things. We want to make sure the state of play in America with respect to getting health insurance and good quality health insurance is always to enhance that ability, not detract from it.

One of the major concerns I have with the legislation before us today is what it will do to increasing costs of health insurance. At a time when we have 44 million uninsured, I believe that is the No. 1 problem in health insurance in America. We can talk about one bill covering 56 million people and one bill covering 170 million people and one covering 180 million people. None of them covers the 44 million people who do not have insurance.

If we want to look at what the real problem is in America, it is the 44 million people who do not have any health insurance. There is not one thing in this bill that helps any of those people.

The Congressional Budget Office and others looked at this and determined this legislation will take the 44 million people and turn it into over 45 million people. All it will do is add to their ranks. If misery loves company, this bill helps because it will add to the misery. It will take 44 million people and make them 45 million people with the increased costs in this bill. I would argue, given the employer liability provisions in this bill, that 45 million is just the beginning of the increase in uninsured. We may very well go from 44 million to 45 million if the employer provisions pass. I don't think these provisions will be signed into law because, thankfully, the President said he would veto the bill.

If for some reason the employer liability provision passes, it will open the avenue for lawyers to get in there and sue employers that provide insurance to their employees. No good deed goes unpunished, as they say, so we have employers who go out and provide insurance to their employees, and we would punish employers for doing that if we in the Senate allow them to be sued simply for providing insurance for their employees. To me, that is not just going to increase the uninsured, as some say who have studied the bill, from 44 million to 45 million, but from 45 to 88 or 120 or whatever the case may be. We will have massive uninsured. Employers will be crazy, if they are in the business of making, say, podiums, to allow themselves to be sued by lawyers because they provide health insurance to employees.

This is a very serious issue, the issue of access. I hope, and I believe, there

will be amendments offered over the next week or two—however long we are on the bill—that will do something about access to insurance. If we walk out of this Chamber with our arms raised, saying we have helped patients, and we have done nothing but add to the ranks of the uninsured, it is a hollow victory; we have done nothing for the No. 1 problem in health care, not just to the 44 million who do not have insurance, but to all the people who do have insurance and have to pay higher insurance premiums to pay for the 44 million people who end up at the hospital because they don't have insurance and don't get the primary care that they should at the appropriate time.

Currently, we take care of hospitals that provide uncompensated care for those without insurance coverage. In my major cities—Philadelphia, Pittsburgh, Harrisburg—hospitals are financially strapped because of the high number of people who come through the door who don't have insurance and have to be taken care of, and are willingly taken care of by the nonprofit hospitals. Again, it is uncompensated. What do they do? They lose money. They cannot pass it all over to the insurance because the insurance will not pay for it. This is a huge problem. There is nothing in this bill that takes care of this problem except, as I said before, if misery loves company, we add more to the uninsured as a result of this bill. That is not solving the fundamental problem in health insurance.

When we offer amendments, I hope we can get bipartisan support for some tax provisions that will increase the number of insured in this country, that will deal with the No. 1 problem facing America in the area of health insurance. That is, frankly, the almost embarrassing situation of having that many people on the uninsured lists.

We have a lot of other issues with which I believe we need to deal. One of the things I am hopeful we will offer is an expansion of medical savings accounts. It is a pilot program right now. I would love to see that program expanded to give real choice to people in the private health insurance system, to give them the opportunity to manage their own health insurance needs, to be able to provide for themselves and their family, and do so in a way that they have maximum choice, maximum flexibility. That should be included. Giving people choices, giving people coverage, giving people flexibility—these should be the hallmarks of this discussion, not driving up costs and increasing the uninsured and having lawyers replace doctors as decisionmakers, No. 1; and, No. 2, these lawyers' fees siphon a tremendous amount of money out of the health care system.

There are scarce resources, and this bill is overloaded with rights to sue not just HMOs—we can debate that. I am willing to discuss what we can do as far as suing HMOs. However, I am not willing to discuss, to be very honest, allowing employers to be sued. What are the consequences of employer liability?

Any employer should think about it. Would you allow your business, for which you sweated hard and perhaps built as a family business, or a big corporation, would you allow your corporation to be liable to suit simply because you provided a health benefit to your employees that has nothing to do with your business? If you did, my guess is, if you were a big corporate CEO, you would be fired. No shareholder in their right mind would want their company, their investment, to be wiped out by a group of employees who were unhappy with the health care coverage the employer provided. That is not their business. Their business is making podiums or printing paper or generating electricity. It is not providing health care to their employees. So it is one thing to be sued for the products you make or the services you provide. That comes with the business. But you shouldn't be liable for suit for benefits you provide to your employees. If you are liable for suit, you simply must get out of the business of providing health insurance to your employees. The impact on the number of uninsured in this country will be profound.

I will shortly yield to the Senator from Arkansas, and I am interested to hear what he says. The No. 1 thing to understand in dealing with this issue is, first, do no harm. If we look at the greatest problem in the health care system, it is the number of uninsured in America. And the greatest harm this legislation will create is to explode that number. That is not a victory for patients. That is not putting patients first. That is putting lawyers first, putting litigation first. It is not putting mothers and fathers and children who need and want affordable health insurance first. It is not putting these people first who are saying they need these procedures. Taking insured people who have a problem with their HMO and turning them into uninsured people is not helping them. Taking someone who has a problem with their insurance company and turning them into someone who is no longer covered is not helping them. That is not putting patients first.

What we want to do is put patients first, make sure there are adequate protections in the law, but not create a system where we will simply destroy the private health insurance system in this country. That is what this bill does. We, hopefully, can fix it. We will have amendments to fix it. There is a lot in common with these bills, but we have to fix the things that are the most egregious, and hopefully over the next week or two we will be able to do that.

Mr. FRIST. How much time remains on our side?

The PRESIDING OFFICER. Thirteen minutes.

Mr. FRIST. I thank the Senator from Pennsylvania.

The Senator spelled out frivolous lawsuits, unnecessary costs, unneces-

sary mandates through micromanagement drive up the costs of premiums and it falls on the shoulders of the working poor who cannot afford the insurance. That is where the uninsured come in. I take it a step further: Frivolous lawsuits increase costs, loss of insurance, the uninsured—that translates to less care, a lower quality of care. It is not just the number of uninsured, it is the impact of being uninsured today. That is something on the floor we will have time to debate over the next several weeks.

I yield the remainder of our time to the Senator from Arkansas.

Mr. HUTCHINSON. I thank the Senator from Tennessee for his leadership on this issue, his expertise and knowledge. We are fortunate, indeed, to have someone with his knowledge of this issue as part of our institution.

I associate myself with the remarks of the Senator from Pennsylvania. He is absolutely right. I served on the conference committee on the Patients' Bill of Rights for more than a year. We wrestled with these issues. There was broad consensus that we need a Patients' Bill of Rights. I agree; we need to have a Patients' Bill of Rights. We need to have a set of legislatively codified protections for those who are in managed care systems in this country.

Where we had a problem was in the area of the lawsuits, the liability, the right to sue, and how broad should be that right to sue. While we have broad consensus in this body and in this country that there should be a Patients' Bill of Rights, there is also a growing understanding that if we do this wrong in the next few weeks, all we will do is move hundreds of thousands, if not indeed millions, of people out of the ranks of those who enjoy the protection of health insurance from their employer into the ranks of the uninsured. That is the risk we take and we better do this job right.

The Kennedy-McCain bill ignores what I believe is the most important patient protection of all and that is access to affordable health insurance. They do absolutely nothing to move those 44 million people, who today in this country do not have health insurance, into a situation in which they are covered. This bill does not address that at all.

While we may agree we need patient protections for those in HMOs, we need to be very careful that in enacting those patient protections we do not even exacerbate the problem of the uninsured in this country. The CBO, the Congressional Budget Office, has found the Kennedy-McCain bill would raise health insurance premiums by at least 4.2 percent and cause nearly \$56 billion in lost wages over 10 years.

That 4.2 percent, somebody says that is not much; that is about inflation, isn't it? That is on top of the 10-percent to 13-percent increase in health insurance premiums this year, which is the third consecutive year of annual premium increases in that range. In

fact, in the year 2000, premiums increased 12.4 percent; in 2001, premiums are projected to increase 12.7 percent; and in 2002, premiums are projected to increase 12.5 percent.

We are adding on top of that premium increase another 4.2 percent, as projected by the CBO. I think that is a very conservative estimate, 4.2, so we are making that problem even more severe. The Barents Group data shows for every 1-percent increase in health insurance premiums, 300,000 Americans will lose their health insurance. What that means is the Kennedy-McCain bill could cause as many as 1.3 million Americans to lose their health care, according to the CBO. If the CBO is wrong and they are understating it, as I believe they may well be, instead of 1.3 million Americans losing their health care, it could go considerably higher.

There are 44 million uninsured Americans in our country now. So the Kennedy-McCain bill does nothing to make health insurance more affordable. Instead, it pushes the number of uninsured to even higher levels, from 44 million to 45 million, 46 million, or more.

This is the question I pose to my colleagues: What good are patient protections when 45 million people cannot enjoy them? What good will this bill do for the 45 million who do not even have health insurance today? I will tell you, it does no good at all.

Claims that the Kennedy-McCain bill covers all Americans is the biggest hoax being perpetrated in this debate today. This bill does not cover all Americans. This bill does absolutely nothing for the millions of Americans who cannot afford health insurance. We will do a disservice to this country, a disservice to the health care system in this country if, while addressing patient protections, we do not also address access. I will be offering amendments to that end. I hope my colleagues will be as well.

Dealing with the issue of liability, Kennedy-McCain supporters keep telling the American public their bill protects employers from lawsuits and that it caps damages at \$5 million. Let's be very candid; let's be very honest about this. This cap only applies to punitive damages in Federal court. What Kennedy-McCain proponents fail to mention is that employers can be sued for unlimited economic damages in Federal court, unlimited noneconomic damages in Federal court, unlimited punitive damages in State court, unlimited economic damages in State court, unlimited noneconomic damages in State court, and damages through unlimited class action lawsuits under both Federal and State laws. That is what, according to the CBO, is the second major component of the cost increases that are going to occur to health premiums across this country.

I further point out there is really no exhaustion of the appeals process required. Though the bill says there is,

the exceptions swallow up the rule. Kennedy-McCain requires a patient to file a request for external review within 100 days after the internal review. Nevertheless, Kennedy-McCain allows a patient—this is so important—to go right to court on the 181st day without even having gone through the appeals process by claiming that they just discovered an injury.

It makes sense, then, if you think the insurance company, the HMO, has made a wrong decision and they have been inappropriate in the decision they have made, that you have an expedited internal appeal of that decision. We all agree upon that. It is also logical and consistent, and I think there is a consensus that there should also be an option to go to an external appeal, to an independent medical expert reviewer to look at the case and make a determination as to who is right.

If we are really concerned about health care being provided for the patient, we should require that the internal and external appeal happen, happen quickly, and those appeals be exhausted before there is ever a right to sue. The goal should not be let's see if we can get to court to see who can get the dollars. The goal should be to ensure the patient is getting the health care they deserve. By allowing a patient to simply wait until 180 days have expired and then to simply allege they only now discovered the injury and to go directly to court without ever having gone through an internal appeal, without ever having gone through an external appeal, is to open the floodgates to lawsuits.

Look at the original bill on page 149. You will see that exception is clearly there. This loophole allows an employer to be taken to court 5 years, 10 years, 15 years after its health plan denied a claim for a benefit without ever having gone through an external, independent, medical review process.

What is the result? The result is that if Kennedy-McCain passes as it is now written, we will threaten the very employer-provided health insurance system that has served our country well. Maybe that is the goal. Maybe, instead of patient protections, the real goal in this legislation is to swell the ranks of the uninsured and then come back and say: Look at our huge problem. We have to address this again.

I hope that is not the goal of those who are pushing this lawsuit-gearred so-called Patients' Bill of Rights. Employers will be sued even if they are upheld by the independent medical reviewer's determination under the Kennedy-McCain bill.

Kennedy-McCain is, in fact, a trial lawyer's dream. It is a trial lawyer's bill of rights. New lawsuits under Kennedy-McCain have absolutely nothing to do with ensuring that patients get quick access to needed care. According to the Urban Institute, medical malpractice claims take an average of 16 months to file, 25 months to resolve, and 5 years to receive payment. That is

what we are inviting in this bill, not that patients are going to have rights and that patients are going to be assured that on an expedited basis they are going to be able to get the kind of medical treatment the insurance company has promised. This bill, as it is currently drafted, will ensure the courts are clogged with lawsuits and lawsuits for not months but years and years. That is not in the interest of improving health care in this country.

You would think, after months and years in court, a patient or the patient's family would finally be justly compensated for their injury or their loss, right? Wrong. In fact, the tort system returns less than 50 cents on the dollar to the very people it is designed to help and less than 25 cents for actual economic losses. So the real winners in this lawyers' bill of rights will, in fact, be the trial lawyers. The lawyers win and the process wins and the patients lose. That is why we need to improve this bill.

Madam President, how long do I have remaining?

The PRESIDING OFFICER (Ms. CANTWELL). The Senator has 1 minute 45 seconds.

Mr. HUTCHINSON. It is said over and over again that we have to pass a Patients' Bill of Rights because the American people are demanding it. I think if you ask the American people, if you ask most Members of Congress, are you for a Patients' Bill of Rights, they would overwhelmingly say yes. I would say yes. We all believe patients ought to have greater patient protections and they ought to be codified. They ought to be in law. But it does not tell the whole story.

A recent survey that was conducted in conjunction with the Harvard School of Public Health found this. When the question was asked of the American people, all voters, Republicans, Democrats and Independents, do you favor a Patients' Bill of Rights, 76 percent said yes. But when they were asked this question, what if you heard that this law would raise the cost of health plans and cause some companies to stop offering health care plans to their workers, would you still favor a Patients' Bill of Rights? Instead of 76 percent, 30 percent say they would favor it under that situation.

During the last few weeks, it has become increasingly clear to the American people that the Kennedy-McCain Patients' Bill of Rights, which opens the floodgates to lawsuits, would increase health care premiums and cause millions of people to lose their health care insurance, and they do not favor that kind of bill of rights.

I ask unanimous consent to have printed in the RECORD letters from two of my Arkansas constituents who are employers, telling about the threat this litigation-laden bill poses to their ability to offer health insurance to their constituents.

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

McKEE FOODS CORP.,

Collegedale, TN, June 14, 2001.

Hon. TIM HUTCHINSON,  
U.S. Senate, Senate Dirksen Building, Washington, DC.

DEAR SENATOR HUTCHINSON: The Senate will soon consider a proposal that will give Americans the right to sue their insurance provider in state and federal court for coverage decisions. As a business owner, this prospect has me worried McKee Foods has voluntarily sponsored its own health plan for more than 30 years. All of our employees and their families have the option to take part in our group coverage, including the 1,420 employees who work at our Gentry, Ark., manufacturing facility. In 2000, McKee Foods and its employees spent \$25 million to provide health care benefits for all 6,100 of our employees and their families. The company directly paid for more than 75 percent of this amount.

Over the last two years our group insurance benefit costs are up about 26 percent and our prescription drug benefit cost has nearly doubled. The company has absorbed most of the cost increases, but employee premiums have also risen by 10 percent. It's important to note that none of the proposals presently under consideration have protection in place to protect the health care purchaser, whether individual or company, from the increased cost of coverage due to insurer liability. A health care bill containing additional costs will simply compound the problem of rising costs.

Our health plan, which is governed by ERISA, is self-insured, self-funded and self-administered. Maintaining an ERISA plan allows McKee Foods to provide uniform health care benefits to our employees in all contiguous 28 states. We've reviewed the various proposals put forth by both the Senate and the House of Representatives and have come to the conclusion that McKee Foods can be sued for voluntarily providing health care benefits. Each of the major bills under consideration contains language that defines the liability trigger as "direct participation" or "discretionary authority" over the decision. This standard directly implicates ERISA's fiduciary responsibility duty. For employers who offer a health plan governed by ERISA, liability is real.

I believe that legislation containing liability for companies will certainly lead to more uninsured Americans. I also believe that many employers want to offer health care benefits because this type of benefit helps us attract and retain high quality employees. Please remember that the voluntary employer-based health care system in our country provides coverage for more than 172 million Americans.

I'm asking you to support a health care bill that sets up a strong system for binding external review instead of lawsuits. Let's get patients the medical treatment they need, when they need it. Reaching a conclusion later in a court only benefits the attorneys.

Sincerely,

JACK MCKEE,  
President and CEO.

Springdale, AZ.

DEAR ARKANSAS SENATORS LINCOLN AND HUTCHINSON: I am a small business owner in Springdale, AR. Our company employes 8 very fine people.

Our company has always made an effort to provide, at no expense to our employees, full family health insurance coverage.

A couple of months ago we were forced to begin sharing some of the cost of the health plan with the employees because of 40% plus increases. The monthly cost climbed to over \$4000.00 a month for our relatively young group. I fear passing the S-238 bill will not

only cause greater increases but subject our company to possible legal actions because of our offering health insurance. We could be at the mercy of whoever decides to pay a claim or not—and open the door for the company to be liable.

I think the bill has a lot of danger in it. I urge both of our Arkansas Senators to do all in your power to defeat this bill. I urge you to vote against "cloture" thus limiting the truth to be brought out on the floor.

On behalf of myself, my partner and our employees, thank you in advance for logging this request.

JOHN W. HAYES.

P.S. Your voting records are the proof of your loyalty to the people of the Great State of Arkansas.

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

The PRESIDING OFFICER. Under the previous order, the next block of time shall be controlled by the majority party.

Mr. WELLSTONE. Madam President, I ask for 10 minutes.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. WELLSTONE. Madam President, I say to my colleague from Arkansas that I think what will become clear to the American people over the next week—I certainly take very seriously the words of the majority leader that we will be here as long as it takes to pass this bill—is that this will be a test case of whether or not all Members of the Senate will be there for consumers, or whether or not the health insurance industry will be able to stop this legislation.

It is that clear.

There is an unprecedented lobbying effort going on right now and a tremendous amount of money is being spent with a full court press to block this legislation.

I have no doubt that we will have amendments on the floor over the next week or week and a half which will be an effort to gut this bill through amendments.

But I think that people in the country will have a very clear sense of whether or not we are on their side.

I say to each and every one of my colleagues that I am absolutely convinced from a lot of coffee shop discussions with people in Minnesota that people do not give a darn about the labels left, right, or center. They do not care about any of it. Politics for people is much more personal. Consumers and the people we represent are saying we want to have some protection.

Let me give you some examples. I will not use the real names of people to make this more anonymous. I will never forget a woman coming up to me and saying to me at a farm gathering in Minnesota: I want you to come over and meet my husband, Joe. Remember—you met him about 6 months earlier. The doctor said he only had 2 months to live. But my Joe is a fighter. He had cancer.

I would like for you to come over and say hello.

He was not yet in a wheelchair. But later he was because he was weakened

by this struggle with cancer. He has now passed away.

She said to me: I want you to meet Joe.

I went over, and we talked.

Then she said: Can we talk away from him?

We go away so he can't hear.

She said: It is a nightmare. Every day I am on the phone with the managed care company trying to find out what they will cover. Every day it is a struggle to get the coverage for my husband for the treatment he needs as he struggles with this illness.

No American family with a loved one who needs that care should have to be fighting it out with the insurance companies or managed care plans to get the care their loved one deserves.

That is what this piece of legislation is about that was introduced by Senators MCCAIN, KENNEDY, and EDWARDS with many of us supporting it. That is what this is about, pure and simple.

This is the most important consumer protection legislation we will vote on this year as Senators.

My colleague from Arkansas said: What about the 44 million people who have no insurance? I invite the Senator from Arkansas and other Senators to please join on a piece of legislation I have called Health Security for All Americans.

I am for universal coverage. I haven't heard a lot of my Republican colleagues talking about the importance of comprehensive health care reform, universal coverage, affordable and dignified human coverage for all. I hear them talking in opposition to this piece of legislation.

Why don't we first pass this consumer protection legislation? Then we will move on and we can talk about universal coverage.

I remember a gathering in Minnesota—there are so many stories like this. There was a meeting that I had convened where we had some of the managed care plans there to meet with some of the parents. I do a lot of work in the mental health area.

I can hardly wait to have hearings in the Health Committee and have a bill on the floor doing what Senator DOMENICI calls the Mental Health Equitable Treatment Act to end the discrimination of coverage for people struggling with mental illness.

At this gathering, a lot of the parents wanted to meet with the managed care companies. One mother said: My daughter is struggling with depression. We have asked you and asked you for coverage, and you said that it wasn't medically necessary for her to get the help she needed, to see the psychiatrist that she needed to see. My daughter took her life.

Look. I can't say that she took her life because she didn't get a chance to see this particular psychiatrist. But I can tell you this: There was an article in the Minnesota Star Tribune last Sunday about the costs the State of Minnesota had to pick up because the

health plans did not provide the coverage for people that the doctors said needed to get mental health coverage.

What the patients and their families heard was: You need to see the psychiatrist. You need to be in the hospital for this many days. You need to have outpatient treatment. Instead, they were denied the coverage by their HMOs. Finally, the State just picked up the coverage.

It happens all the time.

A nurse in Minnesota told our state office about a woman who suffered with stomach pains; she saw her doctor who did some tests and then suggested further tests, that were more expensive for which she should get HMO's approval. The HMO denied the additional tests. Since the doctor recommended the tests, you would think that a patient might have some recourse to the HMO's denial of coverage. Instead, the woman endured a series of phone calls with HMO employees, being forwarded from one customer service representative to another, being put on hold for 35 minutes and ultimately being referred to a 50-page benefits manual with no change in the HMO's denial of these recommended tests. No one at the company ever instructed the patient how to file an appeal. She ultimately gave up and paid for the tests herself.

It goes on and on. There is too much gatekeeping, and too much bottom-line medicine. The bottom line has become the only line. There are too many people and their loved ones who can't get the care they need or the care for their children when they need a pediatrician or to get to the emergency room to have it covered when they need to be at the emergency room or to get their parents and their grandparents the coverage they need, to get the child the coverage she or he needs for mental health coverage.

It goes on and on. Too many people go without the care they deserve. Too many doctors and nurses are not able to provide the kind of humane and dignified care they thought they would be able to provide when they were in nursing school or medical school.

What do we do? We say that we are going to have basic patient protection coverage for every citizen no matter what State he or she lives in, no matter what company he or she works for. That is the first part.

What is the second thing that we say? We say if your plan denies you the coverage, then you have a right as a consumer to appeal the decision and go to an independent appeals board or through an independent appeals process—not an appeals process within the managed care company which is the competing proposal. That is crazy. People in the country know it.

And to assist people in dealing with their insurance companies and HMOs I will be offering an amendment with Senator REED of Rhode Island that will have an ombudsman program set up in every State that provides outreach and

assistance when they have trouble getting the care they need or filing the appeal they are entitled to. This would be an important addition to this legislation.

If you have headaches, severe headaches, and you go see your doctor, and you are told by your doctor that you need an MRI, and then the managed care plan says, no, it is not medically necessary, and then you, because you did not have that MRI, later find out you have a malignant brain tumor, and you die because of that—or this happens to someone in your family who dies because of that—you better believe that these companies can be taken to court. They should not have any special protection any different from any doctor or hospital or any other business.

If you are denied the coverage on the basis that it is not medically necessary, of course people can go to State court, which is where it should be. And then we abide by the laws of our States: the laws of Minnesota or the laws of Illinois or whatever state the patient lives in. It is simple.

This is all about whether or not we are finally going to pass legislation that provides consumers, provides patients, provides families, provides children the protection they deserve, the protection they need. That is what this legislation is all about.

I think I introduced a bill in 1994, and then I know Senator KENNEDY introduced a bill a couple years later, and many people have introduced bills; and we have been going through the debate now for 7 years. The time has come. It is real simple.

I conclude on this note: I really believe, more than anything else, the way people judge us is not if we are Democrat or Republican, not if we are liberal or conservative, not if we are right, left or center. None of those labels mean very much.

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

Mr. WELLSTONE. Madam President, I ask unanimous consent for 30 more seconds.

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

Mr. WELLSTONE. The question is simple. Do you, the Senator from the State of Washington or the Senator from the State of Illinois or the Senator from the State of Minnesota know us? Do you care about us? Do you understand us? Are you on our side?

That is what this legislation is all about. This is an important time. Let's step up to the plate and vote to be on the side of families in our States, consumers in our States, and provide them with this protection.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Madam President, how much time remains on the Democratic side on this debate?

The PRESIDING OFFICER. Fourteen minutes nineteen seconds.

Mr. DURBIN. I thank the Chair.

Madam President, I rise in support of this bill that has been brought to this Senate Chamber by Senator KENNEDY, who was here just a moment ago; Senator JOHN EDWARDS, Democrat from North Carolina; and Senator JOHN MCCAIN, Republican from Arizona, who have made this a bipartisan effort.

I think if you listened to the history that Senator WELLSTONE of Minnesota just recounted, you know this issue has been before the Senate and the Congress for many years. We now have an opportunity, because of the change in the leadership in the Senate a few weeks ago, for this issue, which was buried in committee, to now be on the floor of the Senate—an issue with which 80 percent of the American people agree is finally before us for debate, for amendment, for a final vote.

I applaud our majority leader, Senator TOM DASCHLE. He has said to those who want to drag their feet and stop us from this debate and amendment, the party is over. We are going to stay in session in the Senate until we pass this bill.

You will hear moans and groans from my colleagues in the Senate who have taken the Fourth of July recess period and have made plans. Some were political plans, some were personal and family plans, but they had a lot of plans. I have to confess I did, too. But I believe the Senators elected to this body were not elected to march in parades on the Fourth of July. We were elected to march to the floor of the Senate to pass legislation that will make life better for families across America.

So if it means that we have to stay in session on the Fourth of July, and take a recess for a few minutes to look out the window at the fireworks on The Mall, so be it. Let's get our job done. Let's stay and do it. This issue is worth it.

This issue, this Patients' Bill of Rights, will establish, for the first time nationwide, a standard of protection for American families when they go to their doctor or a hospital for medical care.

How important is it? Let me tell you a story. In Joliet, IL, I sat down for lunch with a doctor. He said: Let me tell you what happened to me, Senator. A mother came into my office with her little boy. The boy was about 5 or 6 years old. He had been complaining to his mom about headaches. I asked his mother how long these headaches had gone on. She said for over 3 weeks.

The doctor said to the mother: Is it on one side of his head or the other or what?

She said: It is always on the same side of his head. He complains that it hurts on this side of his head.

The doctor said to me he instantly knew that the appropriate medical response was to take an MRI to determine whether or not that little boy had a brain tumor: 3 weeks, headaches, a little boy complaining, same side of his

head. But before he said that to the mother, before he made that recommendation, he asked her a question: Do you have health insurance?

She said: Yes.

The doctor asked: What is the name of your company?

She gave him the name. He excused himself from the office, went into another office, called the insurance company, described exactly what happened, and said: I am ordering an MRI.

The insurance company said: No.

He said: What am I supposed to do?

The insurance company said: Send the mother home. See if he gets better.

The doctor walked back into the office and said to the mother: I'm sorry but at this point in time I think the best thing for you to do is to go home and call me in a week or two if he is still complaining about it.

That is just one little episode in Joliet, IL, involving a doctor, a woman, and her child. That mother left that office not knowing who had made the medical decision. It was not the doctor she came to see; it was a faceless clerk at an insurance company hundreds of miles away.

When doctors ask these clerks what qualifications they have to make a medical judgment, do you know what they find out? These insurance company clerks are not nurses; they are certainly not doctors; many times they have high school diplomas and a manual in front of them where they can look up: Oh, I see, 3 weeks of headaches, one side of your head, 5-year-old child. No, it takes 4 weeks. Send him home.

That is what this has come down to. That is what this debate is about. It isn't about all the technicalities and complexities that a lot of us bring to this Chamber. It is a question about whether doctors can practice medicine, whether mothers and fathers can walk into a doctor's office and rely on the health care professional to make the judgment. That is what it is all about.

The health insurance industry, the HMOs, are the ones that oppose this bill. They are the only ones that oppose this bill. Every health care group, every consumer protection group, supports the bipartisan bill being offered on the Democratic side—every single one. The only opposition comes from one group, the health insurance companies. Why? They make more money. It is more profitable. They do not want us eating into their profit margin to provide greater and better care for American families. It is just that simple.

The two bills before us are dramatically different. Here are some of the differences shown on this chart. When you take a look at the two bills, this, on the left of this chart, represents the Bipartisan Patient Protection Act, and this side represents the Frist-Breaux bill, which is supported by the health insurance industry.

Take a look at the differences between them as to what kind of protections are provided under the Patients' Bill of Rights.

Our bipartisan bill protects all patients with private insurance. The bill being offered on the Republican side and by the industry, sadly, leaves many people behind. It says: If you can make an effort at protecting patients, good enough. We say, no; it has to be real protection.

Protection for patient advocacy: 100 percent on our side; none on their side.

Prohibition of improper financial incentives: Do you know what that means? Do you know there are at HMOs some doctors who get paid more if they do not provide treatment for patients? At the end of the year, they total it up and say: Dr. So and So, let's see, because you didn't order as many MRIs as we thought you would, you get a bonus check at the end of the year.

Did you know it is a fact that that is going on? There are financial incentives for doctors not to prescribe drugs, not to use treatments, not to hospitalize people. And if they do not do it, they get compensation. Our bill prohibits that. The health insurance industry bill—surprise, surprise—thinks that is just fine.

The ability to hold plans accountable: Our bill makes it clear they are going to be held accountable. I will get into that in a moment.

Independent external appeals: When the health insurance company says, no, we won't cover what the doctor recommends—whether it is a prescription or a treatment—it does not give you a lot of comfort to know you can go hire a lawyer and go to court and 5 years later get a verdict. You need to have an appeals process right now. Some of these are life-and-death decisions.

We want to make sure the appeals process isn't stacked against you. We do not want the health insurance company to be the judge and the jury. The bill supported by the industry leaves the health insurance company to make the final judgement. We believe it should be an independent external appeal process, one that is timely.

Guaranteed access to specialists: Our bill has it; theirs takes a nod in that direction.

Access to clinical trials: Do you know what that is? Let's say you have a rare serious disease and there is a clinical trial underway.

The doctor says to you: There is one possibility, Mrs. Jones. It is a clinical trial. I would like to see if you qualify for it.

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

Mr. DURBIN. I am happy to yield.

Mr. FRIST. The Frist-Breaux-Jeffords bill you are referring to as "the health industry bill," endorsement of their bill, can you name one insurance company or one HMO that has endorsed the Frist-Breaux-Jeffords bill?

Mr. DURBIN. The health insurance industry—and the Senator knows this—objects to, opposes the bipartisan bill which I support. They would gladly accept your alternative because it is much more preferable to them because

it is more profitable to them. That is as obvious as this debate is. I think that is the difference between us.

We stand here supported by nurses and doctors and medical professionals, hospital associations across America. The health insurance companies are our No. 1 opposition. They support your legislation. They don't support ours.

Mr. FRIST. But is the Senator aware that there is not one HMO, to the best of the sponsors' knowledge, that has endorsed our bill, or insurance company, and is the Senator aware that over 362,000 physicians from 70 different organizations have endorsed the Frist-Breaux-Jeffords bill?

Mr. DURBIN. I am sure the Senator's figures are accurate. I wouldn't question them. But the Senator knows, if you are going to total up the medical profession, where they come down on which bill, you don't have a chance, my friend. They are all on this side of the aisle. They support the real patients' protection bill. Finding 300,000 doctors who agree with one thing or the other, congratulations.

I can tell you, when you look at the American Medical Association, the American Nurses Association, the American Hospital Association, they are all on this side of the aisle I think that is very clear.

As you go through here, access to doctor-prescribed drugs, if a doctor says this is the drug you should have, this is what you need to get well, the health insurance company takes a look at the list and says, sorry, that drug is not on our list; you can't prescribe it.

Wait a minute. If that is the drug that you need, that is what you need. That isn't a decision of an insurance company; that is a decision of a doctor. Doctors go to medical school. Insurance company clerks go to business school maybe. They shouldn't be making medical decisions.

The choice of provider, point of service, emergency room access—our bill provides that protection start to finish.

Let me ask, how much time remains?

The PRESIDING OFFICER. The Senator has 4 minutes 10 seconds.

Mr. DURBIN. I would like to address, in the closing time, this whole question of liability. In America, if you go out and do something wrong, if you are negligent, guilty of wrongdoing, we have a system of accountability. If you drink too much at a party, get involved in an accident and get sued, you are held accountable, right? If your business does something that it isn't supposed to do, that is illegal or wrong, you are held accountable, correct? If someone comes to your home, slips and falls, they may sue you; you will be held accountable as to whether or not you are negligent. That is part of the system of accountability in a country of laws.

There are two groups that are above the law in America. The one group above the law is diplomats. You have heard about it: The people who come to

Washington from a foreign country to work in an embassy get involved in a traffic accident, catch the first plane back to their home country, and we can't touch them. Why? Treaties. We have said, for diplomats, you are above the law. I don't like it. I have seen some terrible things happen. But that is a fact.

There is another group above the law—the health insurance companies. We talked earlier about doctors coming up with suggested treatments and health insurance companies saying no. Under the law today, the only liability the health insurance company has for making the wrong decision, not covering you when they are supposed to, is the cost of the treatment, not the result of failing to treat. What is the difference? The difference is the cost of the surgery as opposed to the fact that you might have a permanent disability because you didn't get the surgery.

So we say that health insurance companies are above the law in America. They are squealing like stuck pigs because they know that if this bill passes, they will be brought into court as every other business in America and held accountable.

I don't want to see a runup in court cases and litigation. That doesn't solve the problems of a person who needs medical care right now.

I can tell you this: Once those health insurance companies know that 12 average Americans can sit in a box and listen to a judge and the attorneys and stand in judgment over their actions, they will think twice before they make these terrible decisions that deny people the basic medical care doctors think they deserve.

There has also been the argument made: If you allow us to sue the health insurance companies, you will allow us to sue the employer who buys the health insurance plan. Not so. This is a phony argument. This bill very clearly says that an employer that buys the health insurance plan and doesn't make the medical decision, doesn't say yes to the prescription or no to the treatment, is not liable. The bill is explicit.

Let me read the section from the McCain-Edwards-Kennedy bill:

[This provision] does not authorize any cause of action against an employer . . . or against an employee of such an employer . . . acting within the scope of employment . . . unless there was direct participation of the employer in the decision of the plan.

When could an employer be brought to court for health insurance problems? I will give you one case—I think it is obvious—a case where an employer collects the health insurance premiums from the employee and doesn't pay them to the health insurance company. The employee and his family think they are covered. They are not. They go to a hospital. They say: We belong to XYZ health insurance plan. They say: Your employer never sent in the money you contributed.

Should they be held liable? You bet. That is an employer guilty of wrongdoing. But if the health insurance plan

receives the money for the premiums and makes the wrong medical decision, the employer is not going to be held accountable.

That is a question that has been raised over and over by the other side, and it doesn't make any sense at all.

Do you know who can be sued in America? Incidentally, almost everybody is accountable in court under current law—the Red Cross, the Humane Society, the United Way, every other charitable foundation but not your HMO. And when you go to sue because of medical malpractice, you can sue your doctor, your nurse, your dentist, your hospital, but not the HMO that decided you weren't going to get the treatment. When it comes right down to it, every Fortune 500 company, every family-owned corporation, every small business is subject to lawsuit in America, subject to accountability, but not your HMO.

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

Mr. DURBIN. We need to keep in mind, as we consider this bill, that accountability is part of the system of justice. HMOs should be held accountable.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the next 30 minutes are under the control of the minority party.

The Senator from Tennessee.

Mr. FRIST. Madam President, we continue discussion this afternoon on the Patients' Bill of Rights. Most of the morning we have spent discussing the differences between two bills, the only two comprehensive bills that have been introduced to the Senate. One is the Kennedy-Edwards-McCain bill introduced by the majority. The other is a bill introduced by me, the Frist-Breaux-Jeffords bill. Two Patients' Bills of Rights that address the issue of how to get patient protections to the patients in order to swing the pendulum away from having medical decisions made by HMOs and turn that decisionmaking back to the doctor and the patient and the nurse, that local level where we know health care decisions are best made.

Several differences have been pointed out. Many of those focus on the impact on the employer, whether or not the employer can be sued. Under the Frist-Breaux-Jeffords bill, it is clearly delineated to make sure that everyone knows whether it is the insurance company or the employer or the lawyer or the courts that accept that risk. Somebody does have to have that risk and that liability, and it has to be defined, which we do.

The problem in the McCain-Edwards-Kennedy bill is the liability is kind of shifted around a little bit. You can go after the HMOs if they have wronged or injured a patient. And they need to be held accountable; we agree with that. But the problem is, you can sue the HMO, you can sue other agents of the plan. That is really the key language

in there. Who are the agents of the plan?

Last week a physician stood up and said: I am an agent of the plan. So they introduced a different bill last Thursday to say it can't be the treating physician. I asked about the referring physician. Can you now sue the referring physician as an agent of the plan?

Their bill also allows you to sue the employer. Remember, there are 170 million people today—just about everybody listening to me, whether it is through radio or television or on the floor—who receive their insurance through their employer, if not Medicare or Medicaid—170 million people.

Their employer is arranging for them to have that insurance. If you are an employer out there and all of a sudden you can be sued, what are you going to do? Say your margin is 2 or 3 percent, you are a small business, you are barely scraping by, and all of a sudden there is a lawsuit. Lawsuits can be billions of dollars under that plan. All of a sudden, yesterday you were not subjected to them and today you are.

When that is the case, what are you going to do? Your first reaction is going to be: How much is it going to cost me? What does it mean to me? Maybe I should not offer this insurance. Maybe I should give my employees some money and let them go into the market themselves in order to avoid that. In the short term, that might be OK. I don't think it is OK, but it might be OK.

Ultimately, a number of those employees—and it falls most heavily on the working poor. The premiums go up, and they will not be able to afford this insurance; they become a part of the uninsured. As the Senator from Pennsylvania said earlier, once you become part of the uninsured, with the increased cost and frivolous lawsuits, you can't afford your insurance anymore; your employer is afraid of being sued. The premiums go sky high.

As the Senator from Pennsylvania said, if you have no insurance, the likelihood of getting good health care in the United States is much less. Therefore, this bill has a huge impact on everybody listening to this debate today. Everybody is going to be affected. The health care costs for everybody are going to go up.

Under the McCain-Edwards-Kennedy bill, it is going to go up 45 percent more—the premiums—than it goes up under the Frist-Breaux-Jeffords bill. Yes, in our bill it goes up because we are giving new rights that haven't existed and those rights cost money. The money comes out of the pockets of everybody listening to me right now—everybody—170 million people. We are talking about employer-sponsored insurance for 170 million people. It is going to impact everybody listening.

So when we talk about the cost, it is easy for politicians to show pictures of families and talk about the individuals; but we have to talk about the costs because those pictures can be

pretty and you can really personalize it and make it real, but at the end of the day, if you drive the cost of insurance out of the reach of that family, you are hurting that family, or that individual. Therefore, you are going to hear us come back again and again and talk about the uninsured, the working poor who are going to lose their insurance, about the cost of premiums which are going to go up significantly.

Everybody's premiums, right now, are already going up. Probably they will go up 15 percent this year. Whatever you are paying this year, it will go up another 15 percent regardless of what we do on the floor. We are saying that under this bill, which may pass 2 weeks from now, 3 weeks from now, a month from now—and I want to pass this bill—your premiums, instead of going up 15 percent, are going to go up 20 percent if the McCain bill passes.

Therefore, we are going to again and again say you need to justify that increase in cost for these new rights. We will argue that you should have better balance if you are going to drive these premiums up with frivolous lawsuits—get rid of the lawsuits and have the same patient protections and have a lower cost. That means a lower cost of premiums, and it means fewer people going into the ranks of the uninsured.

That is why balance is critically important in this debate as we go forward. That is why looking at the rhetoric without looking at what is in the bill underneath is unacceptable, because if what is written in that bill ultimately becomes law, that law results in—I am sure it is going to be translated into increased costs. How much depends on the interpretation of what is written in the bill.

Can employers be sued or not? I say again and again that they can be sued. We have heard from the other side of the aisle that under the Edwards-Kennedy-McCain bill, they cannot be sued. Yet, if you read the bill, it says they can be sued.

Well, I started talking to the employers about lawsuits. I had the pleasure of being with a number of middle-sized and small business people yesterday. They were very clear in their concerns that if we pass a bill that exposes them to not million-dollar lawsuits but billion-dollar lawsuits, under the bill on the other side of the aisle, the Democratic-sponsored bill, there will be open-ended lawsuits, unpredictable lawsuits, when they are barely scraping by, these small businesses. And they are saying now their company is going to be exposed to billions of dollars in lawsuits. And they might just have a couple of convenience stores. They can't keep offering that insurance to their employees.

The Republicans are also accused of talking dollars and cost. We do not do a very good job of translating it down to human faces, and that is something with which we have to do better. When we talk about employers, people say: You are just for big business. It is not

just big business. It is the small mom-and-pop operations, such as those convenience store operators.

Yesterday, I had an opportunity to meet with Sam Turner, an owner-operator of Calfee Company in Dalton, GA, with 139 convenience stores. His words were loud and clear. He is not going to be able to offer the insurance today if he is exposed to unlimited, unpredictable lawsuits as the owner of his convenience stores. Paul Braun from Braun Milk Hauling Company employs 40 to 50 people in a town of about 500. The same story. Lynn Martins, president and general manager of Seibel's Family Restaurant in Burtonsville, MD, a second-generation restaurateur, said, "If you expose me to unlimited lawsuits, or if you increase my premiums another 4 or 5 percent, I simply can't afford to keep offering this health insurance for my employees."

If it is not offered through your employer, yes, maybe your employee can go out to an individual market and get some health insurance. But for the most part, they won't do that. That is why we come back to this rule of thumb that is pretty accepted. It is accepted by everybody, in essence, that if you increase health insurance premiums by 1 percent—it doesn't sound like much; it might be a hamburger once a month, or McDonald's—I have forgotten the examples, but if you increase it 1 percent, and when you are talking about 170 million people, what does that 1 percent in premium translate to? It means 300,000 people will lose their insurance. They have their insurance one day, and when we pass a bill that increases it 1 percent, 300,000 people won't have insurance the next day.

Who are those 300,000 people? Those 300,000 people are the ones who, when you increase it by 1 percent, are all of a sudden making the tradeoff between having food that night or having clothes for their kids. They are the working poor, the people who are barely scraping by, who, with the help of their employer, voluntarily comes forward—and, remember, this is all voluntary. This employer-sponsored insurance is voluntary, and therefore if you raise those prices too high, they are going to walk away from the table and leave their employees, unfortunately—in spite of good intentions—to go into the ranks of the uninsured.

How much time do we have on our side?

**THE PRESIDING OFFICER.** Nineteen minutes, 25 seconds.

**Mr. FRIST.** I yield whatever time the Senator from Utah desires.

**THE PRESIDING OFFICER.** The Senator from Utah is recognized.

**Mr. BENNETT.** Madam President, I venture into this debate with a little hesitancy because I don't have the expertise that the Senator from Tennessee and others have in this field. But I want to confine my comments to my experience as an employer.

As those who have listened to me know, I come to the Senate from a

business background and consider myself a businessman rather than a politician. I have the experience of being an employer dealing with health care. It is that experience I would like to share with the Senate today.

I will open by asking unanimous consent that a letter I received today be printed in the RECORD following my remarks.

**THE PRESIDING OFFICER.** Without objection, it is so ordered.

[See exhibit 1.]

**Mr. BENNETT.** This letter is from Ron Christensen, who is the vice president of a construction company in a relatively small town in Utah, and the key points of the letter are those which have been made over and over again during this debate. That is, Mr. Christensen tells us that if the Kennedy-McCain bill passes, he will be forced to stop providing health care for his employees.

A lot of people listen to this threat, and they say businesses are hard-hearted, businesses are just looking for ways to punish their employees, that businessmen and businesswomen are always motivated by greed, and here is an opportunity for them to save money, they will take the opportunity to save money whenever they get the excuse.

Having run a business, I can assure you that is clearly not true. When you run a business, you compete for employees, and you do everything you can to get the best ones to come to work for you. You create salary packages and benefit packages that are better than those at the business down the street so that someone will come to work for you and be loyal to you and help you build your business. You don't view your employees as people to be exploited. You view your employees as a major asset. If you don't have that view, frankly, you won't be in business very long.

So why is this person, who feels this way about his employees and who in his letter describes an excellent health care plan that he offers to his employees, saying that if this bill passes, he will withdraw health benefits and thereby run the risk of losing employees who are so vital and important to his success?

The reason, of course, is fear of lawsuits. He says:

If this legislation becomes law, the only way to protect my company from lawsuits will be to drop health care benefits altogether, and we will do this. I simply cannot afford to expose our company to the potential liability from health care lawsuits. Even if employers could be shielded from liability, more lawsuits against health care plans will result in higher premiums I pay for health care.

I know how true Mr. Christensen's statement is. It is one thing for an employer to say, I have a defined amount of money that I have to spend on health care plans; I am willing to pay that; indeed, I have to pay that if I am going to attract and hold good employees. It is another thing to say, I am

putting the entire future of the enterprise at risk by exposing it to lawsuits. I cannot take that risk, so I will say, even though it is going to jeopardize my business by diminishing my ability to attract and hold quality employees, I have to do it because the alternative is so Draconian that I simply cannot escape it.

That is the real world. It is not the world we live in back here in Washington. That is not the kind of discussion we have here, but it is the real world, and we should understand that as we make our decisions.

I remember during a similar discussion over lawsuits with respect to falling stock prices that eventually resulted in the passage of securities legislation that put out of business some of the striped-suit law firms, that Ralph Nader appearing before the Senate Banking Committee kept pressing the point that lawsuits were always good. He said, Nobody ever settled a lawsuit out of court unless he had something to hide.

I remember that very clearly because Mr. Nader made that statement in response to me and some of the comments I was making.

I pointed out to him that while I was the CEO of the company I headed prior to coming to the Senate, I settled a lawsuit out of court, and I not only had nothing to hide, I felt strongly I was in the right. So why did I settle the lawsuit? Quite simply because I had to save the company.

The legal fees of prosecuting that lawsuit at that point in the company's history were sufficiently high as to jeopardize the survival of the firm. So I swallowed hard the issue of whether or not we were in the right and decided to save the company by settling the suit out of court without proving the point.

I have been there. I know how a lawsuit can threaten the survival of a firm.

How significant is this in terms of decreasing health care coverage for people? A study has been done that says for every 1-percent increase in premium rates, 300,000 Americans lose their health coverage. That is an interesting number when you realize the Kennedy-McCain bill would increase rates, according to the Congressional Budget Office, by 4.2 percent. Do the math: 300,000 lose their health coverage every time it goes up 1 percent. You multiply that by 4.2 and you get 1.26 million more uninsured.

I think that is a low figure, because if you take the evidence coming from the employer whose letter I cited and spread it out over the rest of the country, we find out that, in addition to those who will lose their coverage because the premium goes up, there are those who will lose their coverage regardless of where the premium is simply because of the fear of the lawsuits.

Some cynics have suggested that maybe that is the reason behind the push for the Kennedy-McCain bill.

They want people to lose their coverage so the pool of uninsured Americans will grow so large that there will then be demand for a Government health care plan, which is what Senator KENNEDY has told us he prefers all along.

I would not ascribe those kinds of motives to Senator KENNEDY. I think instead he is simply acting out of unfamiliarity with the way businesses are really run in America.

I want to make it clear that the comments being made by employers around the country that passage of the Kennedy-McCain bill will result in the loss of health care benefits for millions of Americans are not political hyperbole. They are simply statements of fact based on the experience of men and women who are building businesses, employing Americans, moving forward to keep the economy growing, but who are terrified, I think accurately and properly, of the prospect of a wild increase in the number of lawsuits that might come.

We are told some States have already done this and the lawsuits have not gone up; so, therefore, that proves we will not have lawsuits on a national basis. I am not sure we can make that determination and, once again, the State laws are not exactly comparable to this law, and they are not subject to the kind of examination that has been given this law by those who are looking at it through the glasses of realism.

The other thing we hear around here often is: Forget the lawsuit side, the doctors are for this bill, the American Medical Association has endorsed this bill. That is true; the American Medical Association has endorsed the Kennedy-McCain bill and is very active in their statements in favor of it. Normally, that would be something that would impress me, but I share with you, Madam President, and the other Members of the Senate, an experience I had in my office today.

I received a phone call from a doctor in Utah whom I have known for many years. He said, I am here at the meeting of the American Medical Association, and they are whipping us all up to call our Senators in support of the Kennedy-McCain bill. And so I am doing what I have been asked; I am calling my Senator with respect to the Kennedy-McCain bill so I can report back to the American Medical Association that I have done what I was told to do. As long as I have you on the phone, let me tell you what I really think. I am opposed to the Kennedy-McCain bill. I think it is a mistake. I much prefer the Frist-Breaux-Jeffords bill. I think it would work far better for the medical profession in Utah and the patients I deal with in Utah, and, Senator, I trust you to do the right thing.

The American Medical Association succeeded in their lobbying efforts to get a hometown doctor to call me, but they probably were not pleased with what the hometown doctor said. Based

on his experience, based on his understanding of where things are, he recommends we defeat Kennedy-McCain and go in the direction of the Frist-Breaux-Jeffords bill.

The fact is, of course, we do not know in advance what will be all of the consequences of the legislation we pass. The one thing I have learned around here is that whatever other laws we pass, the one law we pass over and over is the law of unintended consequences. We do not know what the unintended consequences will be from either of these bills, but I have learned as a result of discovering the impact of the law of unintended consequences that the impression to go slow, the desire to be careful, the desire to move in incremental steps rather than a sweeping bold approach that we love to call for when we are running for reelection, is the right desire.

That is another reason why we should try the Frist-Breaux-Jeffords bill, which goes further than many of my colleagues on this side of the aisle would like to go toward a Patients' Bill of Rights. Let's see how it works before we take the next step, which could have catastrophic consequences.

I say catastrophic consequences because I am talking about the cancellation of health care for many Americans. I am talking about the rising disillusionment with the whole activity of what we do with respect to health care on the part of many Americans and then ultimately a demagogic call for the Government to take everything over, and we are back into the disaster, the train wreck we went through in the 103d Congress when President Clinton tried to implement that kind of solution. It tied up this body for months. It stopped everything. It produced maximum ill will all the way around. We stepped back from that. We took the approach I am talking about, which is to say let's do it a step at a time, let's do it with something we can get our arms around where the unintended consequences will be less radical and less sweeping. We passed the Kassebaum-Kennedy bill, which I was happy to co-sponsor and support, and then we began to see some of the reforms that we could have had earlier if we had stayed away from the extremes proposed to us.

We see reforms in the Patients' Bill of Rights area, reforms that can work. We see things that will give us experience, that will hold down the severity of the unintended consequences, if we go in the direction of the Frist-Breaux-Jeffords bill, but I fear if we go in the other direction we will only see the consequence that is predicted in this letter that will follow my remarks, where employer after employer will say, Sorry, we can't expose ourselves to this liability. And in the name of trying to help health care, we may end up destroying it altogether. That is, in my view, a serious mistake.

## EXHIBIT 1

CHRISTENSEN & GRIFFITH,  
CONSTRUCTION COMPANY,  
Tooele, UT, June 19, 2001.

Senator ROBERT BENNETT,  
Dirksen Senate Office Building,  
Washington DC,

DEAR SENATOR BENNETT: I suspect I am "preaching to the choir" by sending this letter to you, but I want you to know I am strongly opposed to the Patients' Bill of Rights bill sponsored by Sens. Kennedy and McCain under consideration by the Senate. There are better ways to correct the few problems that get so much attention.

My company prides itself on providing quality health care for our valued employees and their families. We provide a comprehensive plan which includes dental and have never had a complaint that could not be corrected. We are partially self insured and pay the total premium. No cost to the employee. Why mess with a good thing? The present system has kept costs in check and affordable. The politically motivated Kennedy-McCain bill will only drive up the cost of health insurance and encourage employers to pass more responsibility for health care to the employee.

Unfortunately, the Kennedy-McCain bill threatens my ability to provide health care for my employees. However well-intentioned, this bill would expose employers like me to lawsuits between employees and the health care plan my company provides. Despite claims that this bill has a lawsuit "exemption" for employers, this protection is murky, at best, and does not adequately protect employers from lawsuits. In fact my company could be sued for simply having selected a health care plan for employees.

If this legislation becomes law, the only way to protect my company from lawsuits will be to drop health care benefits altogether, and we will do this. I simply cannot afford to expose our company to the potential liability from health care lawsuits. Even if employers could be shielded from liability, more lawsuits against health care plans will result in higher premiums I pay for health care. A survey of construction companies last year found that 77% were faced with increased health insurance premiums, even without the potential added cost of this legislation. In order to stay in business more and more of the cost will have to be passed on to the employee. As an alternative, employees should be given access to a quick, independent external review process that would give patients the right to take their disputes to an independent panel for a quick decision.

Employers are not bad people exploiting their employees as the unions would have us believe. Were it not for employers with a profit motive our economic system would not work. Please oppose this Kennedy-McCain expansion of liability as you consider managed care reform legislation. Don't destroy a system that has served us well and made health care affordable. Thank you for your consideration of my views.

Yours Truly,

R.I. CHRISTENSEN,  
Vice President.

The PRESIDING OFFICER (Mr. NELSON of Florida). The Senator from New Jersey.

Mr. TORRICELLI. Mr. President, when this debate began yesterday on reform of the managed care system in America by establishing a Patients' Bill of Rights, it did so under very uncertain and unfortunate circumstances. There was objection to proceeding to the bill, causing delay and unnecessary

confusion with the American people as to whether we intended to deal with this problem. We can all be pleased the Republican minority now has withdrawn its objections. We can now, tomorrow, begin the serious work of actually debating a Patients' Bill of Rights.

This is a moment that has been 5 years in the making. Before the Senate is honest, compromised, and reasonable legislation to establish a Patients' Bill of Rights. It is a question that involves our most basic responsibilities to the American people to assure their health and welfare.

We all recognize how we arrived at this moment. The Senate may be late, but it is right in dealing with this question.

The extraordinary increase in the cost of health care in the 1970s and 1980s radically increased the ranks of the uninsured in America. By establishing a predetermined list of medical providers at established costs with recognized services, it was everybody's hope that these managed care plans could strike a balance between the rights of consumers and providers with reasonably agreed upon costs.

It was a sound concept, but practice has established that the power disproportionately came to rest with insurance companies and the doctors and that patients lost control over their professional rights or the needs of their families.

During these years that the Federal Government has been unable to deal with this crisis, the ranks of the uninsured have continued to rise to 45 million people despite managed care. The growth of health care costs rose less slowly but has continued to rise, and a feeling of paralysis began to grip the country as doctors no longer believed they could make medical decisions and families could no longer get access to the health care providers that had been a part of the American tradition of family medical practice.

While the Federal Government was paralyzed, interestingly, States began to fashion their own responses. In 1997, my own State of New Jersey enacted the Health Care Quality Act—in some respects a model for what the Federal Government is challenged to accomplish. That law in New Jersey prohibited gag clauses. Doctors had the right, the recognized responsibility, to talk to their patients about medical options. An independent health care appeals program was established so, when care was denied by the insurance company, people had someone to go to, to appeal the judgment. There was a requirement that insurers provide clear information on their services and their limitations.

Interestingly, in 1997 when that act was passed by the State legislature in New Jersey, it was by a Republican legislature and signed by a Republican Governor, something that should be a challenge to Members of the Senate in the minority party today. But this

Senate is now challenged to act because, while that State legislation was properly designed, it was insufficient, not only insufficient in that it was not national in scope but because for many people in my State and across the country in other States, people with similar experiences were exempted by ERISA laws.

Mr. President, 124 million Americans, 83 percent of those who get their health care from their employer, are not covered by State laws because of this exemption. Fifty percent of the people in the State of New Jersey enrolled in HMOs are exempted from the very State protections that I just outlined and that my State government wanted and intended to give to our people because of this exemption under the Employee Retirement Security Act of 1974.

Under this bill, HMOs claimed immunity from State regulations even if there was negligent behavior. It may or may not have ever been the intention of this Congress to exempt managed care in health care, but whether that was our intention or not, that is how the law is operating. So despite the best actions of State government, millions of Americans—124 million Americans—have no protection from the abuses of the managed care system. That is why the responsibility now rests here and why this Senate is the only hope of the American people to get relief from this abuse of power.

The American people understand what needs to happen. Only people in this institution seem to doubt it. A recent survey in my own State of New Jersey by Rutgers University found that one in four people in my State are completely dissatisfied with their health care plan, despite the fact they are paying for it and are enrolled in it and cannot get out of it because their employers have contracted for it. Last October a State report found that patients in my State were not only dissatisfied, but they are more dissatisfied than they were a year ago. The situation is deteriorating.

The legislation now before this Senate, offered by Senators KENNEDY, EDWARDS, and MCCAIN, is an answer. It is not simply bipartisan. That understates what has been achieved. But 500 organizations of patients and doctors stand behind this legislation to get patient protection to all Americans in HMOs. The confrontation that went on for decades between patients' rights advocates and doctors has not only ended but they have come together in a broad national coalition for this legislation. We have not only achieved what once seemed unlikely, the bill represents what once seemed impossible. This is achieved because specific rights would now be guaranteed to the American people.

To many Americans whose children suffer with diseases, whose lives are threatened, this Patients' Bill of Rights, to them, in their suffering or their financial distress, is just as important as the original document

which bears the title a "Bill of Rights." The title is borrowed for this health care emergency because to them this has every bit as much significance.

What are these rights? One is the right to get to a specialist. Under current law in managed care, you can take a family member to your family doctor, but the cancer or the heart problem, the specialized disease or ailment that may plague you and threaten your life, is beyond the capacity of that family doctor. That is not the exception; that is often the rule. With this bill, you will have the right by law to get to a specialist who can save your life.

No. 2 is the right to get to an emergency room. In a nation in which we travel the country every day all across our States, all across our Nation, what kind of system is it, if you have health care insurance and you should be in a car accident or have an illness traveling somewhere in your State or across America and the local emergency room is not in your health care plan? Under this bill, that emergency room will give you coverage, whether they are in the plan or not, because you are there and that is where your illness or your accident happens to be.

No. 3 is the right of women to use an OB/GYN as their primary health care provider. Millions of women have made the medical decision to use their OB/GYN as their principal health care provider. It makes no sense that they have to first go to a family doctor, a general practitioner, for a reference. This establishes that right.

No. 4, as with every other patient, the right of a child to get to a specialist should never be impaired. A child should be able to get to a pediatric oncologist or heart specialist as a matter of right, directly, without delay, without question, if that is the only person who can deal with their illness and that is established.

No. 5, it is unconscionable that, by contract, any doctor should be restricted from discussing with any patient their health care options—the technology, the specialist, the choices that the genius of American technology in medicine has made available. But that is not a theoretical problem, it is something that doctors are facing in America every day, a contractual wall placed between a doctor's knowledge and a patient's need. This bill tears down that wall. No doctor in any managed care plan will ever be told again: In spite of what you know, in spite of what you think is in your patient's best interest, you cannot tell them the choices available. Now they will know as a matter of right.

No. 6 is the right to a review. If a doctor is prescribing a test or a procedure and believes it is vital to a patient and that is denied, that manager of a health care plan, that businessman, is not the last word. There is a right of appeal to a health care specialist, independently placed to oversee the managed care plan, so not only is a doctor making the recommendation but a doctor is the final, independent word.

Finally, the right of accountability. I once heard Bill Clinton say there were only two classes of people in this country by right who are immune from accountability by the legal procedures: Foreign diplomats by treaty and HMO bureaucrats. One of those will be taken away by this bill.

Can you imagine what an American automobile would be like if auto companies did not have the threat of lawsuits if their cars were not safe? We would still be manufacturing clothing in America that was flammable. We might still be living in houses that had carcinogens in them. I guarantee, our cars, our trains, our airplanes would not be as safe. The threat of liability, the knowledge that the courts will hold a company accountable if they do not do whatever is required to be safe, is a great protection for the American people. We have extended it to every other industry in America except to managed health care plans. This bill will change that. There will be access to court. There will be damages.

There will be an expense if managed care health care plans are not ensuring that the right decisions are made, that the law is followed and people are as safe as possible. It is the right judgment.

There are those who are going to come to this floor in the coming days and argue: Oh, that may all be true, that may all be right, but if you give these rights to the American people, those 124 million Americans in managed care who are not getting these rights, the costs will rise so high that the number of uninsured will grow and the problem will become worse and not better.

It would be a sound argument but for the facts. The CBO has estimated that if this legislation is put in place, the average cost per employee will be \$1 per month. That is a lot of protection for millions of Americans at a very modest cost. The CBO continues that, over 10 years, it is estimated premiums would rise by 4.2 percent. That is a lot of protection for a lot of years for very little cost.

But what of the argument that even these modest costs would throw more people into the ranks of the uninsured? The experience has been just the opposite.

In 2000, when health insurance premiums increased by 10 percent, more than twice the amount estimated would happen under this bill, the number of uninsured not only didn't rise but the number of uninsured dropped.

There is no reason to believe—and the empirical evidence suggests overwhelmingly—that we will not cause a rise in the uninsured. We will simply cause better insurance by passing this bill.

This is good legislation. This goes to our most fundamental responsibility to the American people. If this Congress and if this Senate does nothing else in this session, if nothing else is accomplished, we can reach the lives of mil-

lions of Americans who live in fear every day that during the night a child will get ill, a parent will contract a disease, or someone in a family will suffer, and in spite of the fact that family members get up every morning, work every day and pay their health care premiums, when they need their insurance it will not be there for them.

It is not a theoretical fear; it is real. We can do something about it. It is reflected in this bill. If we are ever going to stand with the American people, stand with them now. If we are ever going to do something to change their lives, do it with this bill.

I am proud to be associated with it. I am more than a little proud that the first legislation brought to this floor by a new Democratic majority in the Senate and by our majority leader, TOM DASCHLE, is a Patients' Bill of Rights. That speaks volumes about the Democratic caucus in this Senate. It says everything you need to know about TOM DASCHLE, and it says a lot about why there is still a great chance to be proud of this Senate and this session of this Congress.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Thank you, Mr. President.

First, I want to thank my colleague, the senior Senator from New Jersey, for his passionate commitment to affordable access to health care and patients and families, and I appreciate being on the floor with him today. We appreciate his leadership.

I come to the floor again to speak about this critical issue of passing a Patients' Bill of Rights for the families of our country. One of the reasons that I came to the Senate in January was because of this issue and what it means to the families I represent.

The very first opportunity and honor that I had to speak on the floor of the Senate was to speak about the importance of passing a Patients' Bill of Rights. I am very pleased and thankful and grateful to our new majority leader for his understanding of the priority of this legislation and the fact that he would indicate that under his leadership the first bill to come to this floor would be the bill to guarantee that those who pay for insurance, who have health insurance, and the businesses that pay for insurance for their employees will know that, in fact, care will be given when there is an illness or an emergency.

Yesterday, I spoke about young Jessica and her situation as a young person under an HMO. Today, I want to share another story.

This comes from a letter that I received as a House Member 2 years ago. I shared it on the House floor during the debate at that time. This came from Susan and Sam Yamin. It was a very important letter about the tragedy that befell their family and their fight with an HMO to get emergency care.

Sam Yamin owned his own business. He worked hard. He owned a tree-trimming business. He was working on the job every day to support his family. He and Susan were working hard. One day on the job he had an accident with a chain saw that caused him to fall back and cut his leg down to the bone. This is in Birmingham, MI, a business owner who had an accident. He was rushed to the nearest emergency room where he was prepared immediately for surgery to repair the nerve damage.

The doctors took him in, had him ready, and prepared to have surgery. They called the HMO which said: He is at the wrong emergency room. You can't proceed to save the nerve in this man's leg. You have to tell this man that he has to go across town in metro Detroit to another emergency room in order to be able to be served.

With much distress, as you can imagine, his wife, Susan, packed him up, and drove him over to another emergency room where he waited, on a gurney, in the emergency room, for 9 hours. He didn't see a doctor until he finally literally tore a pay phone off the wall; he was in such pain; and he was crying out for help.

His ordeal continued when orthopedics began making decisions based on the HMO point system for the approved hospital doctors. If a patient has an unsuccessful operation or an expensive procedure, the doctor is given 5 to 10 points under this system. But if the doctor is able to provide a low-cost, quick fix, the point range is 0 to 4. They receive compensation based on how low the points are in this process of looking at payment.

Unfortunately, not only was he trapped by having to move to another emergency room, but this point system which rewards the low-cost fix put him in a situation where he didn't get surgery. He didn't have surgeons who came to his rescue to fix the nerve in his leg. They just simply sewed up the leg. Now Sam Yamin has permanent nerve damage that is spreading up his spine. He lost his business. His health care costs have escalated and have become a serious burden to his family. After many appeals, the HMO finally agreed to refer Sam to what they considered to be an adequate specialist, a podiatrist, a foot doctor. I certainly respect podiatrists, but that is not what this gentleman needs for the disability and the permanent nerve damage in his leg.

Finally, even when they made a referral, it was not to the appropriate specialist.

Sam Yamin is one example of somebody who worked hard, had his own business, cared for his family, played by the rules, and had insurance. He thought his family was covered. He goes to the emergency room, and he is told that he cannot get the help that he needs.

That is what this is about. That is what this Patients' Bill of Rights is about. It is about saying to those families who have health insurance for

their family members that if you are in an emergency, you can go to the nearest emergency room and get care. If you need a specialist, you can have the right to a specialist. If you need a test or a treatment, you can have that, and the doctor or the nurse can make the medical decision and not be overruled because of nonmedical reasons because it is just too expensive to give you the specialist that you need or the test or the procedure.

We really have a choice in front of us this week and next week as we debate the Patients' Bill of Rights. It is time to choose. Are we going to stand up for Susan and Sam Yamin and their family in Birmingham, MI? Are we going to stand up for the doctors and the nurses and the dentists and the therapists and all those who come into the health care profession to be able to treat patients and give them the care they need? Are we going to stand up for the people who pay the bills as consumers of health insurance? Or are we going to side with the HMOs and the insurance companies that have created this problem?

That is the choice. To me, it is a simple choice. We know there are folks in the HMO business and insurance companies that make good decisions. There are HMOs in Michigan that do a good job.

But we also have situations where the wrong decisions are made and people have been hurt. In the end, when the Yamins come to me and say: Why is it that the only part of the health care system that is not held accountable for what they do and the decisions they make are HMOs? I cannot answer that. I cannot answer why the only two groups of people in the United States of America that are not held accountable—cannot legally be held accountable for their decisions—are foreign diplomats and HMOs. I cannot answer the reason why that makes any sense because I believe it does not.

The Yamins are asking me to fight on their behalf. The damage is already done. Mr. Yamin has lost his business. He has lost functioning in his leg. The mounting medical bills for their family will not be reversed. But they have asked me to fight to make sure this does not happen to another family.

I urge my colleagues to join in a bipartisan bill before this body. A lot of hard work has gone on. There have been a lot of changes in the last 5 years since this issue was first brought up. We have an opportunity to pass something meaningful that will make a difference in the lives of our families. I urge we do so.

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

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

The bill clerk proceeded to call the roll.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

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

Mrs. HUTCHISON. Mr. President, I want to address the issue today of patient protection legislation that is now before the Senate. I would like to thank so many of my colleagues who have led the effort to enact sensible patient protection legislation that will protect patients more, give patients more rights, and make sure we keep the costs down so that we will not decrease the number of insured in our country but, in fact, will increase the number of insured people. We would like a goal of every American to have quality health coverage. To do that, we must keep costs down as well as make sure that the quality part of the commitment is kept.

Senator FRIST, Senator BREAU, and Senator JEFFORDS have what I think is the best bill. Of all of the alternatives, I think there are parts of each that are similar, and I think all the three major bills will certainly be able to come together. But I think the Frist-Breaux-Jeffords approach is the one that makes the most sense and addresses the issues that are of most concern.

Senator FRIST, the Senator from Tennessee, is also the only medical doctor in the Senate. Of all people, he would know the danger of turning over patient care to accountants and an insurance company. He also knows the danger of turning patient care over to trial lawyers whose first interest is not the well-being of the patient.

That is why I think his bill is the one that takes the balanced approach of giving more rights and addressing the major concern of quality patient care but also making sure that we do not open the courts to frivolous lawsuits that would cause the cost of health care to increase exponentially.

We all know that quality health care in the United States is unparalleled. There is no argument from anywhere regarding that fact. The question is, How do we maintain this level of quality while expanding it to as many Americans as possible? This is a complicated question, but there is a deceptively simple answer: Cost.

When you review the statistics on the uninsured, it becomes very clear. Only 18 percent of the uninsured come from families who have no connection to a workforce. The Kaiser Commission found that 82 percent of the uninsured come from working families. In fact, 71 percent of the uninsured come from families with one or more full-time workers.

According to a study done by the Center for Studying Health System Change, 20 percent of all uninsured people are offered health insurance by their employer, or a family member has an employer who offers health insurance, and they could get coverage for his or her family, and they choose not to enroll in the plan.

The most cited reason for not enrolling in an offered plan is cost. The costs are a double-edged sword. They are of concern to the patient and the employer who would provide insurance.

High costs have caused people to choose to be uninsured in return for more money in their paycheck, feeling that they need that money for other priorities higher than health care coverage. It also is the stated cause by employers that say they cannot offer health insurance to their employees. That is why it is essential that any bill we pass not increase costs either for the patient or for the employer.

If health costs continue to climb, the potential results could be alarming, as evidenced by a recent series of nationwide polls of employers. In each one, an overwhelming majority of employers stated unequivocally they would have to pass on any new cost to their employees, whether by raising the employees' premium or out-of-pocket costs or by reducing benefits or eliminating coverage of certain services.

As the American economy begins to cool, businesses are beginning to tighten their belts. We are seeing the unemployment rolls go up. This could take a bigger toll on the rolls of the Nation's uninsured. We cannot fool ourselves that a minor increase would make no difference to businesses, especially small businesses with tight profit margins. Indeed, it would not take much at all for small businesses to drop coverage of their employees.

According to a study done by the Employee Benefits Research Institute, a 5-percent increase in premiums would cause 5 percent of small businesses to drop coverage, and a 10-percent increase would cause 14 percent to drop coverage.

There is also some good news in these figures, if we can just address them; that is, this would also work in reverse, with decreases in rates creating more coverage. In fact, just a 10-percent decrease in rates would make 43 percent of small businesses more likely to offer coverage.

We must keep these consequences in mind. We must also remember the consequences of our own actions in another way. Remember the health care debate that we had less than 10 years ago. I doubt that my colleagues across the aisle want to relive the consequences of trying to force upon the American people a nationalized health care system in our fiercely independent, democratic Nation.

If Americans are currently unhappy with decisions being made by their HMO rather than their doctor, then just as in 1993, they are not going to want decisions to be made by a bureaucracy in Washington, DC. Yet today we are considering legislation that would impose numerous new Federal mandates and regulations. I know if we don't learn from the mistakes of the past, we are doomed to repeat them. I didn't think we would be doomed so soon.

We all have the same goals: to ensure high-quality health care is not compromised; that more Americans have access to health care; and that all patients have basic rights and guarantees concerning their health care.

This is about people, not lawyers. We understand that people care more about getting health care, not about filing a good lawsuit. We understand patients want the care. They are not interested in filing a lawsuit later, when the injury may be irreparable. We have the support of the American people on this issue. A recent survey by Market Strategies showed that 83 percent of Americans say lawsuits with few restrictions would make it even harder for the working poor to afford coverage.

We should also listen to States that have already introduced some form of a Patients' Bill of Rights, such as my home State of Texas. One size does not work on humans, and it should not be applied to all States, either. Yet one of the bills that is before us, the Kennedy-McCain bill, would make all States the same. It would penalize States such as Texas that have taken steps toward a Patients' Bill of Rights and where, in fact, it is working.

When Texas enacted the broad set of managed care reforms in 1997, they addressed an issue that we are attempting to address in Congress. Texas successfully tackled even the sticky issue of appeals and lawsuits, one of the greatest hurdles in the debate on the bill today.

In Texas, if an HMO denies a claim, patients have the right to internal and external appeals. Once you have exhausted your administrative remedies and only then can you contemplate suing your HMO in court. The external review section was struck down by a Federal court as the State tried to apply these provisions to federally regulated HMOs. As you can imagine, that didn't stop Texas. They revived their external review section of the law, this time making it voluntary. Despite the ability to decline to participate, HMOs and other health plans are participating, and they are agreeing to be bound by the external review process.

This is how the external review process works in Texas. We let an external review board of professionals, who are not associated with the HMO, decide who is right concerning the patient's care. If the HMO denies coverage for a certain procedure, the patient and the doctor disagree with their decision, then the patient can make an internal appeal within the HMO first.

If after the HMO reviews the appeal they still refuse to change their stance, then the patient can appeal again to an outside panel of experts not associated with the HMO in any way. It works.

In fact, of more than 300 appeals heard under the external review system, fewer than 10 lawsuits has emerged. At the same time, the system has proved to be fair. The conclusions of the appeals are virtually 50/50 in favor of both the patients and the health plans.

I know all of us want the best health care for America. But it is a lot easier to jump on a rhetorical or political bandwagon, sometimes, than to create

good legislation. Rather than rushing a bill through Congress—and this bill has not even had a committee markup—it is important that we examine this bill carefully. We are going to have to do that in this Chamber because the committee process was bypassed.

It is important that we ensure we are not creating more problems than we are trying to solve. We must remember the rule of unintended consequences, that sometimes the end results are vastly different from what we expect or intend.

We can't afford to take a chance with unintended consequences with our health care system. It is too basic to too many people in this country for us to make a mistake and go overboard and find that we have allowed so many lawsuits with not very many limits to create a cost increase in our health care system that would cause people to lose coverage or to start relying on lawsuits instead of talking to their doctors and getting an outside appeal to get the care on a timely basis.

A Patients' Bill of Rights is important. We must make sure that we work together to get this high quality.

Let me describe some of the reasons I am supporting the Frist-Breaux-Jeffords plan. It gives access to emergency rooms without any question and without any delay. In fact, all of the bills agree on these basic issues. I believe if we have a bill that has direct access to an emergency room, direct access, without going through a process, to get to an OB/GYN specialist or a pediatrician or specialty care by a specialist in an area, when that is called for in a diagnosis, then I think that will be a good Patients' Bill of Rights.

If we have a rapid, binding internal and external review process on denials of claims, that would be a good Patients' Bill of Rights.

If we have access to Federal courts, after going through the external review process, with reasonable limitations on noneconomic damages, that will be a good Patients' Bill of Rights.

No one argues that we should have unlimited economic damages if a person is found not to have gotten the proper care. That person needs to have the right to that care that was found to be denied in error.

It is the noneconomic damages that have caused so much rise in cost throughout our health care system, that has caused premiums to go up, hospital costs to go up, equipment costs to go up, doctor visits to go up. We can come to a reasonable compromise that gives people rights to sue and rights to access but doesn't take the cap off responsibility so that the patient care is secondary to the big court reward that you might get even if it is unwarranted.

That hurts everybody in the system because the cost goes up. And who is hurt the most? It is the person who is barely able to afford that insurance coverage but has access to it and might drop it or choose to go uninsured because the costs become unbearable.

This has a ripple effect throughout the health care system. When a person goes uninsured and then has a terrible accident, then the costs must be shared by all taxpayers, by all the people in and out of the system. It is in everyone's best interest that we have quality, affordable health care coverage so people will have their needs met in a responsible way.

That is what I think the Frist-Breaux-Jeffords plan will do. I hope very much that my colleagues will make sure that we do the responsible thing because it would be a bigger harm to our country to do the wrong thing, to take a chance.

I was here during the debate in early 1994 on the health care plan that was put forward, which would have basically nationalized our health care system. After 2 days of debate on that bill, it was pulled down because people began to see that putting our health care system into a government system was going to limit quality. It was going to limit the access that people have to the great quality health care that we have come to enjoy in our country.

When we talk about quality health care, we are talking about new innovations in prescription drugs. We are talking about being able to treat something with prescription drugs today that 10 years ago would have been a huge operation and a 2-week stay in the hospital. We have been in the forefront of the innovation with the newest technologies and the newest prescription drugs that would allow America to have the very best health care coverage of any country in the world. We don't want to lose that. Our freedom to choose has been a big part of the success of that system.

But we are in danger of losing it if we turn our system over to people who are not interested in patient welfare. It could be the accountant in the insurance company office who makes a data entry error and causes the person to lose coverage; or it can be the trial lawyer who is more interested in earning a big fee than in getting the patient the coverage they need.

It is my intention to offer an amendment to this bill that would also make sure that a person can't have coverage dropped without notice. Today, a person can walk into a pharmacy and order a prescription under their insurance policy and be told by the pharmacy that a family member has been dropped from coverage, unbeknownst to the person who walked in the door. What kind of system is it that someone can be told they don't have insurance and, therefore, they can't get their prescription or they must pay for it in full even though they have coverage, and then when the person calls the next week and says, excuse me, but I was told this week, after 6 years of coverage by the same insurance company, that a member of my family was dropped from coverage, and the person says, oh, there was an error made in a data entry and it was a mistake that

your wife was dropped from coverage. That has happened with one of the better insurance companies in this country.

I am going to offer an amendment that would keep an insurance company from dropping without notification someone who has been approved for coverage, so if there is a mistake, the person will have the ability to correct the mistake before suffering the embarrassment of being told that they don't have coverage. I just wonder what would have happened if the person had showed up in the emergency room and was told they didn't have coverage anymore, unbeknownst to them, because of a data entry error that was inadvertently made by a faceless bureaucrat in an insurance company system.

So I do think it is important that we have a Patients' Bill of Rights, and I think it is important that we proceed with the utmost caution to make sure that everything we are doing is going to contribute to the problem's solution and not make it worse. That is the choice that we have today, and the reason that I am supporting the bill created by the only physician in the Senate, Senator BILL FRIST, who has seen firsthand the dangers of an insurance company making a bad decision in an HMO and the dangers of putting patient care in the hands of trial lawyers.

What we want is a Patients' Bill of Rights that puts patient care first and foremost and makes sure that we don't increase costs with unintended consequences. That is the issue that we will be debating for the next 2 weeks. I hope the people of America will take the opportunity to learn the differences between the two major bills that will be before us today and the rest of this week, and probably next week, because a person's insurance coverage and quality of care will be greatly affected by what we do in the Senate in the next 2 weeks.

I urge my colleagues to take the responsible approach to make sure that we keep the high level of quality care that we have been able to enjoy in our country—the best in the world—and let's not take a chance on lowering the quality while we give more people the ability to have guaranteed rights, and that our eye is on more access for more people in our country, not less.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maryland is recognized.

Ms. MIKULSKI. Mr. President, I rise in very strong support of the Bipartisan Patient Protection Act of 2001, which has been sponsored by JOHN MCCAIN, JOHN EDWARDS, and TED KENNEDY.

I am a proud sponsor of this legislation because it meets my principles for managed care reform and, yet, at the same time, it meets the day-to-day needs of my constituents in Maryland and the American people. It is also supported by virtually every health care consumer and provider group.

Mr. President, the time to act is now—not weeks from now, not months from now, not years from now. We have been considering what is the best approach to have a Patients' Bill of Rights to protect people from the arbitrary, capricious, and often dangerous decisions of insurance companies. We have been considering that now for more than 4 years.

Now, nobody said during the debate of the tax bill that we need more time to analyze these amendments. Yet we have irrevocably made a fiscal choice that I think will ultimately shackle us in what we can do for the American people. We did that pretty quickly. They were all set to kind of ram a missile defense shield down our throats, where we were going to spend \$80 billion to come up with a "techno-gizmo" to shoot a bullet with a bullet that might or might not come to us. Yet after 4 years, we need more time to look at the fine print on the Patients' Bill of Rights.

I say the time has come. We have to have this done by the Fourth of July, and I am ready to declare my declaration of independence and really move this bill forward.

In the United States of America, we are geniuses at inventing the third way. We don't have a socialist system. We don't have a comrade system. I agree, we don't want comrades and socialism. Also, we did believe people needed a safety net. We didn't want to leave them to the vagaries of who gets health care—where you could have the rich versus those with no health care at all—kind of a Darwinian, predatory, free-market approach; but at the same time we invented the third way—private insurance that people could buy to protect themselves. We in the United States wanted to give help to those who practice self-help. We invented Medicare and Medicaid for those populations that were either too poor or too at risk for the private market.

So now here we are with the third way—private insurance. But some years ago, in a place called Jackson Hole, where the insurance companies met with lots of tax subsidies to support them at that meeting, they came up with managed care. Managed care is nothing but a euphemism for a moat around medical care. That is what managed care is—a moat around medical care. Jackson Hole created a black hole for patients to be able to go in and get the medical care they need.

So I think the time to act is now. I hope that we will follow some very basic principles. Mr. President, I think we need to fight for patients, not for profits. Medical decisions should be made in the examining room by the doctor, not in the board room by the insurance executive. Patients should have the right to receive the treatment that is medically necessary by the most appropriate provider using the best practices.

Patients need continuity of care. Just because an employer changes in-

surance companies, you should not have to change your doctor, particularly if you are pregnant or a family member is terminally ill or if you are in a rehab center.

Patients should be able to hold their insurance companies accountable for medical decisions in the same way they hold their doctors accountable for medical decisions, and that is by having the opportunity for redress in court. The McCain-Edwards-Kennedy bill meets those principles.

Let me give an example of continuity of care. It is absolutely crucial. I worry about people who are undergoing care for serious and complex medical conditions. Often an employer will change insurance companies, but the employee should not be penalized. Again, if a woman is pregnant, she should have continuity of care. If a family has a child who has leukemia, while they are fighting for their child's life, they should not be fighting with their insurance company to keep their doctor.

If a family member has a stroke and is getting rehab, certainly they should be able to have continuity in that facility with that rehab team for 90 days or until discharge from the facility.

These are the kinds of issues we are talking about in our legislation and what we are fighting for.

I came to the Senate to save lives, to save jobs, and to save communities. This is what we want to do: save lives and make sure we stop the horror stories about Americans who are denied medically necessary treatment.

Mr. President, 31,000 people every year are forced to change doctors; 35,000 people a year have needed care delayed. Thousands and thousands every day have to wait for permission to get their bills paid.

Let me tell you about Jackie from Bethesda, MD. She is a go-getter, as many Marylanders are. She was hiking in the Shenandoah Mountains, lost her footing, and fell down a 40-foot cliff. Thank God there were people there to help her. She was airlifted to a hospital. Guess what. The HMO refused to pay her \$10,000 hospital bill because she did not get prior authorization.

Then there is the story of a little boy who found his diabetic dad lying unconscious after days and days of trying to get an HMO referral to a specialist. This little genius called 911, but, again, though the father was rescued, they then had to fight with the insurance company while they were fighting to bring him back to health so he could go back to work.

Fight, fight, fight always with the insurance company. I am joining with Senator JACK REED on an ombudsman bill that supports programs like the one in Maryland where we actually pay people to deal with the entanglements of denial and dismissal of benefits to which they think they are entitled.

The McCain-Edwards-Kennedy bill is terrific. It guarantees access to emergency care. It provides timely access to specialists.

In this bill, if you have a child, you have access to a pediatrician. A woman has direct access to an OB/GYN. We guarantee continuity of care, and we stop that dreaded practice of drive-by mastectomies. That is why we like the McCain-Edwards-Kennedy bill.

We know Dr. FRIST and Senator JOHN BREAUX and even yourself, Mr. President, look at it another way, and we respect that, but we think that bill has too many loopholes. It leaves out too many protections. There is no protection for a health care provider that advocates on behalf of a patient. It does not prohibit coercive financial incentives for physicians to deliver health care. But I do not want to talk about their bill. I want to talk about the McCain-Edwards-Kennedy bill. I want to talk about getting a bill now. I am talking about a bill that removes the moat around medicine. I am talking about putting patients before profits.

I conclude by saying we are the discovery nation. In the 20th century, we made more scientific and medical breakthroughs than at any other time in world history, and the breakthroughs came from here. They came because the American people funded the NIH and then the private sector and our universities value added to come up with new ideas and new products that are saving lives.

When my mother was first diagnosed with diabetes, she could either go on insulin, oral insulin, or nothing at all. Now there are over 300 different forms of medication to help those patients. We are on our way to finding a cure for Alzheimer's and Parkinson's.

While we are so busy discovering life-saving pharmaceuticals, dramatic new techniques, and new forms of prevention, we should not let the insurance companies prevent our access to the very things we paid to invent.

Let's pass this Patients' Bill of Rights. Let's do it before the Fourth of July break, or I believe the American people will foment another revolution, and we will have to stand out of their way.

I yield the floor.

The PRESIDING OFFICER. The Senator from Georgia is recognized.

Mr. MILLER. Mr. President, I rise in support of the McCain-Edwards-Kennedy patient protection bill of which I am very proud to be a cosponsor.

It is time—it is past time—for us to help millions of Americans obtain their basic rights and protections in dealing with health care providers.

It is time—it is past time—for health insurers to be held accountable when they show more concern for their own bottom line than for the patients' health and safety.

It is time—it is past time—for medical decisions to be made by patients and doctors, not some HMO bean counter.

I am no stranger nor a Johnny-come-lately to this issue. Years ago I became a supporter of Congressman CHARLES NORWOOD's effort, my good friend and

Republican colleague from Georgia, as he went about in his courageous effort to make this change. And I come from a State that passed a strong patient protection law 2 years ago which, by all accounts, is working very well.

Now it is time for Congress to pass a strong Federal law to protect the millions of patients who cannot be protected by the Georgia law or by any other State's law.

This patient protection issue has been on our to-do list for a long time. We often speak of something serious as being a life-or-death matter, but it seldom is. Today this is truly a life-or-death matter for many American families who cannot wait any longer for us to act.

When Georgia wrestled with this issue 2 years ago, at the heart of the debate was the question of how we could best protect the interest of patients enrolled in managed care plans. That question has become increasingly important over the past 20 years because managed care has come to dominate the health care delivery system.

In 1980, managed care was a novelty. Today more than 70 percent of Americans and close to 80 percent of insured employees are covered by some form of managed care.

As the number of Americans enrolled in HMOs and managed care has grown, so have the complaints grown and so have the horror stories grown about being denied adequate care.

The proper role of managed care is to balance the cost of health care with the medical needs of patients, but in too many cases the concerns about cost always come out ahead of the concerns for the patient. In far too many cases, managed care has become mismanaged care.

The Georgia law that was passed in 1999 brought balance to the equation by giving patients explicit access to specialists and emergency care. The law also created an independent external review system to address patients' grievances. These are the essential components of any good bill, and they are the components of the bill I speak for today.

When the Georgia Legislature debated this law, there were critics—critics who made the same arguments that we are hearing in Washington today and that I heard last year and the year before.

In Georgia, the critics paid for ads saying the law would drive up premiums and cause more people to lose coverage. The critics paid for ads claiming employers would be held liable for HMO mistakes. They paid for ads predicting—and I love this alliteration—a “flurry of frivolous” lawsuits. Oh, there was hissing and moaning, but you know what? None of those dire predictions has come true. By all accounts, Georgia's patient protection law is working, and working well. In fact, patients are so satisfied with the independent review process that not a single, solitary patient has filed a lawsuit. No, not one.

Let me read from an article in the Atlanta Constitution on Monday, “Georgia's Pioneer Plan Avoids Legal Side Effects.” The first two paragraphs I will read:

When Georgia's Patient's Bill of Rights became law two years ago, managed-care companies predicted they would be spending a lot of time in court defending their decisions to deny coverage. But there has yet to be a lawsuit filed by a patient who first aired the grievance through the new independent review system, state officials said.

“The law is working as intended,” said Clyde Reese, Director of the Health Planning Division that oversees the patient protection process. “In the two years, no one who has gone through this process and has been denied has filed a lawsuit. It has not given rise to litigation. We're not aware of even one suit that's been processed.”

There it is. The naysayers, Chicken Littles, never give up. Today on this bill, they are telling you that if it is passed, the sky will fall. They claim that the patients' employers can be sued as well as the HMO itself.

Wrong. Not so. This conservative, probusiness, Democratic Senator would never support a bill that exposes employers to that kind of liability. The McCain-Edwards bill specifically protects employers, gives protection even to the directors of the HMO. Those individuals cannot be personally sued, as some would have you believe. Employers are shielded from lawsuits unless they directly participate in a medical treatment decision.

This is also one of the very principles President Bush has said must be included. When President Bush released his principles for a bipartisan Patients' Bill of Rights on February 7, he said: Only employers who retain responsibility for and make medical decisions should be subject to suit.

We agree with President Bush. The principle outlined in February is the exact principle that is in our bill.

Now I am not a judge, and there is not enough of me to be a jury, but that is pretty plain to me. Only the HMO itself can be sued. And who can argue that HMOs should not be held accountable for mistakes? Shouldn't HMOs be treated like any other health care organization or doctor or business or individual?

While the Georgia law is a model for protecting patients, they unfortunately cannot protect all of Georgia's patients. No State law on this issue can protect all the citizens because a Federal law, the Employee Retirement Income Security Act of 1974, also known as ERISA, exempts a large class of employees from State oversight. That means millions of Americans are not covered under any patient protection law. They have no legal recourse in dealing with their HMOs, and they are suffering. It is, for too many, truly a life-or-death matter. That is why I believe so strongly that Congress must act, and act now.

The McCain-Edwards bill would also provide patients with their basic rights and protections in a balanced way. It

guarantees access to medical specialists; it protects patients from having to change doctors in the middle of treatment; it provides fair, unbiased, and timely internal and independent external review systems to address patients complaints; it ensures that patients and doctors can openly discuss all the treatment options without regard to costs; and it includes an enforcement mechanism that ensures these rights are real.

The McCain-Edwards bill is also consistent with all of the principles laid out by President Bush except one: President Bush, a man for whom I have profound respect, wants the Federal courts to have exclusive jurisdiction over patient protection lawsuits. Another bill introduced by Senators BREAUX and FRIST, colleagues for whom I also have great respect, would comply with the President's wish on this point by moving all liability lawsuits to the Federal courts.

I am sorry, but I must respectfully disagree with the President and my colleagues on this one point. A purely Federal solution is not the best solution. The Breaux-Frist bill would preempt Georgia's law, as well as the laws of seven other States that have passed similar patient rights bills. The traditional arena for resolving questions about medical negligence is the State court. I submit that is where the jurisdiction should remain. It is the courtroom that is the closest to the people. Don't make my folks in Brasstown Valley have to go over the mountains, through Unicoi Gap, to get to that big, crowded, white marble courthouse in faraway Gainesville. That "ain't" right. Let 'em go to the county seat, to the courthouse in Hiawasse that they and their family have known for years.

Now, one more thing. Any bill on this issue is going to add to the cost of health insurance premiums. They all do. Ours, in my opinion, is the most reasonable. The Congressional Budget Office estimates if the McCain-Edwards bill is passed, premiums will increase by 4.2 percent over 10 years. That translates to slightly more than \$1 a month for the average employee. I believe most Americans will be more than willing to pay an extra \$1 a month for the protection this bill will afford them.

Let's not drag this thing on. Please, let's not play partisan games with something this important. It has been an issue in three congressional elections now and two Presidential elections. The time has come to resolve this.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, before the Senator from Georgia leaves the floor, I will say a word. I have one daughter—my oldest child is a daughter—and she has four brothers. When she married, we were a little concerned because she married someone from the South, from North Carolina. But he has been such a

wonderful son-in-law and, with his family, we have gotten to know about something that I kind of refer to as southern common sense. My son-in-law, first of all, is very smart. In addition to that, he has so much common sense. He can figure out problems. He has been a great father to three of my grandchildren.

I give that background because the more I am exposed to southern legislatures, the stronger I feel on an affirmative basis about my son-in-law. I think we need more of this southern common sense in the national legislature. The two Members on the floor today epitomize what I think is the direction of the South in influencing legislation in the Senate.

I listened with interest and awe to the statement of the Senator from Georgia. It was as good as I have heard in this Chamber, and I have heard some good ones. It was direct and to the point, as only the Senator from Georgia can be with his wealth of experience being an administrator and legislator.

Another Senator on the floor with the Senator from Georgia is our friend from North Carolina.

My son-in-law is from Kannapolis. We talked about that. It is a place where they made lots of sheets and towels and things such as that, for many years.

I have not had the opportunity publicly to express my appreciation to my colleague for lending his expertise to this legislation because he has not only brought the southern common sense to this legislation but also the respect we all have for him and his legal abilities.

To my two southern friends here today, I say thank you very much for making it possible for us to be able to pass this legislation. Because of the two of you—there are other reasons, of course—we are going to pass this legislation. More than 5 years is enough. We are going to pass this legislation, and we are going to do it in the immediate future, not way down the line. We are going to pass it as soon as we can, which is going to be before the July recess begins.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Mr. President, first I say to my friend from Nevada, he is mighty lucky to have a son-in-law from North Carolina.

Mr. REID. I agree.

Mr. EDWARDS. We are glad he has a son-in-law from North Carolina.

I say to my friend from Georgia, who, some people may not know, lives 6 or 8 miles from the North Carolina line, so North Carolina had a little good influence on him when he was growing up in Georgia. In fact, when I was in western North Carolina not long ago, in the closest town to the Georgia border, they said they started to believe Senator MILLER was their Senator, so I had to make it clear to them, no, it was not true; I represented them, although he does a great job of representing all the people of that area.

I thank the Senator for a number of things.

No. 1, for the eloquence of his speech, because it was so well thought out, so clearly spoken that anyone listening would have understood it.

No. 2, for talking about the actual experience as opposed to some of the rhetoric we hear on both sides of this debate on the issue of what effect this kind of patient protection legislation will have on lawsuits and the potential for lawsuits.

Georgia in fact has a real experience. We do not need to guess about what has happened down there. They have legislation very similar to ours. In the State of Georgia, there have not only been few lawsuits, there has been none during the time that law has been in place. I know the Senator played a role in helping, with his friends down there, to make sure that law in fact happened.

Next, I thank the Senator for his leadership on this issue. As he said, he is no newcomer to this issue. He has been involved in it for a number of years. His expertise and involvement are critically important.

Finally, no one cares more about being certain we are not exposing employers to lawsuits than the Senator from Georgia. He has made very clear from the day he walked in this institution that he is a man of strong character, integrity, and independence. There is no doubt in my mind he means what he says. He would not be in support of this legislation—I might add, nor would I, nor would the Senator from Nevada—none of us would support this legislation if we believed it exposed employers to lawsuits. We all care a great deal about that issue, as we care about protecting patients and providing adequate patient protection against some of the HMO abuses that have occurred.

I wanted to stand briefly and thank my friend from Georgia, thank him for his cosponsorship of our legislation and thank him for his very clear thinking on this issue which has now been expressed to the American people.

I yield the floor.

The PRESIDING OFFICER. Who seeks recognition?

Mr. EDWARDS. Mr. President, I inquire how much time we have remaining.

The PRESIDING OFFICER. The Senator has 2 minutes 20 seconds.

Mr. EDWARDS. Let me speak briefly and then yield the floor to my colleagues on the other side from whom we welcome hearing on this issue.

First, we have now had a number of speakers who have addressed the issues that have been discussed over the course of the last 2 days now, since our legislation was introduced. We pointed out—and I hope we will continue to point out throughout the course of this debate—that there are areas of agreement but there are areas of disagreement. There are important differences between the McCain-Edwards-Kennedy

bill and the competing bill on the other side. Those areas of disagreement go from the beginning of the bill through the end, including such things as access to specialists outside the plan, access to clinical trials—particularly FDA-approved clinical trials, access to a truly independent review process so when the claim of a patient is denied by an insurance company that patient they can go to a group and get that decision reversed, knowing it is a totally impartial review panel, there being no question about the independence of that review panel; finally, as a matter of last resort, the case being able to go to court if in fact these other processes do not work.

But what we now know from the Senator from Georgia, plus the experiences in Texas and California, is that when these appeal processes are in place, when a patient is wrongly denied care by an HMO, there are two places for that decision to be reversed before anybody goes to court. One is the internal review within the HMO; the other is the external review to a truly independent body.

I might add as to the cost—the Senator from Georgia referred to this—our bill, according to the Congressional Budget Office, will raise insurance premiums 4.2 percent over 5 years. The Frist bill raises insurance premiums I believe 2.9 percent over the same period of time.

The difference between the two, the 1.3-percent difference, the majority of that difference has nothing to do with litigation. It rests in areas such as difference in access to specialists, difference in access to clinical trials, difference in quality of care. So the bulk of the cost difference between the two bills goes specifically to the issue of the quality of care that children, families, and patients across America will receive.

To the extent the argument is made that there is an explosion of litigation, that this is going to cost a great deal of money, the reality is that there is a little over 1 percent difference between our bill and the competing bill. The bulk of that difference is accounted for by difference in quality of care.

The American people are going to get a better product. They are going to get better health care. They are going to have a way to get access to clinical trials for their child who needs to be seen by a specialist, to be seen by a specialist. They are going to have a way to reverse a wrongful decision by an HMO. That is what we are talking about. None of that has anything to do with going to court or lawsuits.

As to the issue of going to court, as the Senator from Georgia pointed out so clearly, we are only asking one thing, and that is that HMOs not continue to be treated as privileged citizens; that they be treated as everyone else—they ought to be treated as every other American, every other small business, every other large business—and that they not maintain their sta-

tus as being the only group in America that cannot be held accountable for their actions. That is what this debate is about. We are on the side of patients. That is the reason the groups, AMA and others, support our legislation.

I think it is time now for me to yield the floor to my colleagues on the other side.

The PRESIDING OFFICER (Mr. BURNS). The Senator from Tennessee.

Mr. FRIST. I will take a couple of minutes. I will be brief, and then the Senator from Maine will address many of the issues we discussed.

Clearly, much of the debate centers on what the cost of this bill will be. We both have patient protections. We want to give rights to patients that they deserve, rights to make sure we have medical decisions made by doctors and patients working together, and not medical decisions made by HMOs.

If HMOs make a medical decision, then they need to be held accountable. How do you hold them accountable? That is where much of the difference lies.

In terms of cost, because I do want to clarify this and because the Senator from North Carolina is comparing the Frist-Breaux-Jeffords bill to the McCain-Edwards-Kennedy bill, most of the quoted cost comparisons are from the Congressional Budget Office, upon which we rely. In truth, they are projections. Nobody knows exactly what the cost will be, but it is important to understand how the increase in premiums relates to the overall cost. Specifically, how much will premiums increase for the 170 million people who rely on insurance to obtain their health care? That is what we are discussing. The American people, who are the ones who will be paying more for the cost of this Bill of Rights—what they will pay is substantially different in our bill versus their bill.

In their bill, when you talk about these little percentages, the increase itself is about a 4 percent increase in premiums. When you talk about their 4.2 versus our 2.9 percent, the percentage is only 1 point difference. However, the difference is significant, whether it is 8 percent, or 5 or 4 percent, because for every 1 percent increase, we are talking about 300,000 people losing their health insurance.

In America, when you don't have insurance, you can still go to the emergency room, but you do not have the quality of care that you would have with insurance.

Instead of trying to make these differences sound tiny and small, as a physician, I see the faces of 300,000 individuals. Three hundred thousand individuals, who today have health insurance, but because of frivolous lawsuits and paying trial lawyers too much with no increase in patient protections, they lose their health insurance.

We continue to talk about the relative cost.

One other thing, to clarify what has been said on the floor regarding the

civil remedies part, the Congressional Budget Office scores the Frist-Breaux-Jeffords bill versus the Kennedy-McCain-Edwards bill twice as much in terms of that increase. There is a big difference in terms of the cost. They score theirs .8 and ours is .4 in terms of the cost due to civil remedies.

I yield the floor.

The PRESIDING OFFICER (Mr. ENSIGN). The Senator from Maine.

Ms. COLLINS. Thank you, Mr. President.

Mr. President, I am pleased that the Senate is now considering the issue of how best to ensure that patients receive the health care they need when they need it and that was promised by their insurance plan.

The last 10 years have been particularly turbulent ones for health care providers and patients alike. Concerns about rising costs have led to extensive changes in how health care services are provided and paid for in both public and private health plans.

As a consequence, there is a growing unease across the country about the changes in the way we receive our health care. Families worry that if they or their loved ones become seriously ill, their HMO will deny them coverage and force them to accept either inadequate care or financial ruin—or perhaps both. They feel that vital decisions affecting their lives will be made not by a supportive family doctor but by an unfeeling bureaucracy. They fear that they will have to fight their insurance company as well as their illness.

These are the concerns that have prompted this important debate about how we can ensure that HMOs are held accountable for promised care and that medical decisions are made by individuals wearing stethoscopes, not green eyeshades. People should not have to worry that their HMO will unfairly deny them treatment or force them to accept inadequate care.

Virtually every Senator agrees that medically necessary patient care should not be sacrificed to the bottom line and that health care decisions should be in the hands of doctors, not insurance accountants. But we face an extremely delicate balancing act: as we respond to these concerns, we must be careful not to impose overly burdensome Federal controls and mandates that will drive up costs and cause some people to lose their health insurance altogether. That is the whole crux of the managed care debate.

We should pass a strong, binding Patients' Bill of Rights, but we should do so in a responsible way so that we don't add excessive cost, litigation, and complexity to an already strained health care system. Congress should use the set of principles that President Bush has given us as a road map to develop a bipartisan Patients' Bill of Rights—one that applies meaningful patient protections where they are needed without unduly increasing health care costs.

The biggest obstacle to health care coverage in the United States today is cost. American employers everywhere—from the giant multinational corporation to the small corner store—are facing huge hikes in their health insurance costs. Rising health insurance costs are particularly problematic for people purchasing coverage in the individual market and for small businesses and their employees.

Earlier this year, the dominant carrier in Maine's individual market increased its rates by an average of 23.5 percent for indemnity plans and 32.6 percent for HMO plans. As a result of these increases, many people in my state are either dropping coverage or switching to "catastrophic" plans with very high annual deductibles.

Similarly, many small employers in Maine are facing premium increases of 20 to 30 percent, forcing them either to drop their health benefits or pass the additional costs on to their employees through increased deductibles, higher copays, or premium hikes. This also adds to the ranks of the uninsured as more lower-wage workers, unable to afford the increased costs, drop coverage or turn it down.

No wonder the ranks of uninsured Americans have grown to 43 million. If this happens at a time we have been enjoying a strong economy, just imagine what could happen in an economic downturn.

Higher health insurance premiums lead to significant losses in coverage. Studies have shown that for every one percent increase in insurance premiums, insurance coverage for as many as 300,000 people is jeopardized. This is one of the primary reasons I am so concerned about the McCain-Kennedy version of the Patients' Bill of Rights. According to the Congressional Budget Office, the McCain-Kennedy approach will increase health insurance premiums by an additional 4.2 percent over and above the double-digit premium increases we have already experienced. Moreover, this bill is even more expensive than previous versions of the legislation.

Congress should act to provide the important protections that consumers want without causing costs to soar, and we can do so by passing a carefully crafted bill. I also believe that we should not pre-empt or supercede, but rather build upon the good work that states have done in the area of patients' rights and protections.

States have had the primary responsibility for the regulation of health insurance since the 1940s. As someone who has overseen a Bureau of Insurance in state government, I know that state regulators have done a good job of protecting consumers.

One of the myths in this debate is that unless the federal government pre-empts state insurance laws, millions of Americans will somehow be "unprotected" in their disputes with HMOs. That simply is untrue.

For example, as this chart demonstrates, 48 states have passed laws

prohibiting "gag clauses" that restrict communications between patients and their doctors. Forty-four states have requirements for emergency medical care; forty-seven have prompt payment requirements; thirty-seven require direct access to an OB/GYN; forty-one have requirements for external appeals; and all fifty have requirements for internal appeals and patient information.

As is so often the case, states have been the laboratories for insurance reform.

They have acted without any mandate or prodding from Washington to protect their consumers. They have been way ahead of us in enacting patients' rights.

Moreover, one size does not fit all. What may be appropriate for one State may not work well in another or may simply be unnecessary. For example, what may be appropriate for California, which has a very high penetration of HMOs, may simply not be needed in States such as Alaska and Wyoming where there is virtually no managed care. In these States, imposing a new blanket of heavy-handed Federal mandates and coverage requirements will simply drive up costs that will impede, not expand, access to health care.

That is why the National Association of Insurance Commissioners opposes the approach taken in the McCain-Kennedy bill which would force all States to adopt virtually equivalent Federal standards.

Recently, I received a letter from Kathleen Sebelius, the president of the NAIC, in which she writes:

States have faced the challenges and produced laws that balance the two-part objectives of protecting consumer rights and preserving availability and affordability of coverage. For the federal government to unilaterally impose its one-size-fits-all standards on the states could be devastating to state insurance markets.

Mr. President, I ask unanimous consent this letter from the NAIC be printed in the RECORD at the conclusion of my remarks.

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

(See Exhibit 1.)

Ms. COLLINS. Mr. President, under the McCain-Kennedy bill, the Federal Government could preempt existing State patient protection laws unless they had already enacted identical protections—not just similar ones, identical ones. The approaches taken by the 50 States to the same types of patient protections vary widely and with good reason in many cases.

Why should a State that has already acted on its own to provide strong, workable patient protections have to make extensive changes in their laws to comply with new Federal standards?

Let me give you a recent example from my home State of Maine. Maine is one of just 12 States that require health plans in the fully insured individual and small group market to provide coverage for routine costs for patients participating in clinical trials.

During its consideration of this provision last year, the Maine Legislature made the decision to include only those clinical trials that were approved and funded by the National Institutes of Health. I would note, parenthetically, that this decision was one that was made by a legislature controlled by the Democratic Party.

What would happen under the McCain-Kennedy bill? Under that approach, Maine would have to go back and rewrite its law to include clinical trials approved or funded by the Department of Defense, the Veterans' Administration, and the Food and Drug Administration.

Why should the State of Maine have to revisit its law? The law that the State of Maine came up with to require coverage of certain clinical trials was carefully debated. It was thoroughly considered. And the Maine State legislature decided that this was the best approach for the citizens of Maine. Yet under the legislation we are considering today, Maine would have to change its law or have it completely superseded by the Federal Government taking over control of its health insurance market.

Let me be clear. I believe the Federal Government does have an important role to play in regulating the self-funded plans under ERISA. That is because, under current Federal law, States are precluded from applying patient protections to these Federal plans. That is why we need a Federal law to ensure that consumers enrolled in insurance plans beyond the reach of State regulators enjoy the same kinds of strong patient protections that apply to State-regulated plans.

As I said, and as you can see from the chart, the States have been extraordinarily active in this area. It is all well and good if Congress decides that it wants to impose a specific requirement or mandate on federally regulated ERISA plans, since States are, by law, precluded from regulating these insurance plans. But the Federal Government should not be in the business of second-guessing and overriding the carefully crafted patient protections that have been negotiated by our State legislatures and Governors to meet the needs of that State's citizens.

States that have seized the initiative and acted on their own should not have to revise their carefully tailored laws simply in order to comply with a Washington-knows-best, one-size-fits-all Federal mandate.

Moreover, what if the State has made an affirmative decision not to act in one of these areas for very good reasons, such as the reason I previously gave where a particular State may not have much managed care so that this debate is largely not relevant to its citizens? What if the State legislature, after much discussion and debate, has decided that a particular consumer protection simply isn't needed because the marketplace has already taken care of this issue?

Let's look at the consequences under the McCain-Kennedy bill of a State failing to enact an identical provision to the consumer protections in S. 1052.

The bill proposes, quite simply, a Federal takeover of State health insurance regulation. The Health Care Financing Administration, HCFA, would be charged with enforcing the new Federal standard.

Talk about a right without a remedy. In a report issued in May of this year—5 years after new Federal health insurance standards were enacted under the Health Insurance Portability and Accountability Act, the Mental Health Parity Act, and the Newborns' and Mothers' Health Protection Act—5 years after those laws passed, five States are still out of compliance, and Federal fallback enforcement in these States is virtually nonexistent.

Moreover, HCFA told the GAO that it has not even been able to fully assess whether or not the States have complied with the Mental Health Parity Act enacted 5 years ago, and that law is scheduled to sunset this year. Given the fact that the Patients' Bill of Rights—the version we are considering right now—is replete with new health mandates, consumers should be very concerned that HCFA has already proven beyond a shadow of a doubt that it is incapable of enforcing existing Federal insurance standards in States that do not conform. In fact, HCFA has shown that it is incapable of even assessing whether or not the States have complied with these limited Federal insurance standards. So what makes us think that HCFA could in any way take over the responsibility of regulating health insurance in States that do not comply to the letter with the standards in the McCain-Kennedy bill?

If HCFA has not been able to handle its limited responsibility under the laws that I mentioned, how in the world would it benefit consumers to provide for a Federal takeover of health insurance regulation in this area?

I think the answer is clear. It would be a tremendous disservice to consumers to have HCFA take over health insurance regulation. I know that my consumers, my constituents in Maine will have far better service and far better luck dealing with the Bureau of Insurance in the State of Maine in Gardiner, ME, than trying to call the ERISA office in Boston or the HCFA office in Baltimore. It is that simple.

As we consider Federal patient protection legislation, I believe that true deference should be given to the expert decisionmakers who know best what is appropriate for each State and who are most immediately accessible and accountable to that State's citizens.

Another of the myths—and there are many—in this current debate is that you can't sue your HMO. That, too, is not true. HMOs—even self-insured ERISA plans—can be sued in State court over quality-of-care treatment decisions. They can also be sued, under

current law, in Federal court for injunctive relief to force them to provide needed care or to compensate the patient or provider for the value of the benefit, plus any attorney's fees. This is the exact same legal remedy that is currently available to us as Members of Congress under the Federal Employees Health Benefits Plan.

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

Ms. COLLINS. I do not wish to yield at this point. I would like to conclude my statement.

We do need strong remedies to prevent HMOs from denying needed care. There is no dispute over that point. All of us are deeply troubled by cases in which an HMO has acted in a way that was not in the best interest of the patient. That is not what this debate is about. The debate is about the best way to solve those problems, to ensure that every patient gets the care that he or she needs when they need it. That is what the debate is about.

That is why a strong, independent, and binding appeals process is critical to ensure that patients get the care they need when they need it; that they get the care they were promised. They should not have to hire an attorney and file a lawsuit to get the health care they need. They just can't sue their way to quality care. That is why the key is to make sure that we have an appeals process that is binding, that is independent, and that will force the HMO to provide the care that has been promised.

I am particularly concerned that the liability provisions in the McCain-Kennedy bill, as currently drafted, could well discourage employers that currently voluntarily provide health insurance to 172 million employees and their families from continuing to offer coverage. While the McCain-Kennedy bill claims to protect employers, the fact is, as I read the bill, they would be subject to both new Federal and State lawsuits authorized under the bill.

Under the McCain-Kennedy bill, a trial lawyer just needs to allege that an employer directly participated in a medically reviewable decision to force that employer to court. The direct participation standard in S. 1052 does not shield employers from being sued. It simply gives them a defense that they can raise in court. Being subject to such lawsuits will be particularly hard, potentially ruinous for small business owners who cannot afford the tens of thousands of dollars they would have to spend on attorney's fees to fight these kinds of cases in court.

Many Maine employers have expressed their serious concerns about the liability and scope provisions of the McCain-Kennedy bill. I met, for example, with the assistant director of human resources at Bowdoin College who talked about how moving to a self-funded ERISA plan enabled the college to continue to offer affordable coverage to Bowdoin employees when premiums for their fully insured plan sky-

rocketed in the late 1980s. Since they were self-funded, they were actually able to lower their premiums for their employees and at the same time enhance their benefit package with such features as well-baby care, free annual physicals, and prescription drug cards with low copayments. They told me that a proposal such as the one before us today could seriously jeopardize their ability to offer affordable coverage for their employees.

Similar concerns have been expressed by the Maine Municipal Association, L.L. Bean, Bath Iron Works, and many other very responsible Maine employers that care deeply about providing the best possible health insurance for their employees.

Even though S. 1052 is certain to drive up health insurance costs, it also does nothing to expand access to affordable health insurance. In fact, by driving up costs, it jeopardizes health insurance coverage for people who already have it and puts the cost further out of reach for those who lack it now.

As we proceed with our consideration of legislation to protect patients' rights, we should also be considering ways to expand access to coverage for millions more Americans by making health insurance more affordable.

As the Presidential Advisory Commission on Consumer Protection and Quality noted in its report which was done for President Clinton, I note: Costs matter. Health coverage is the best consumer protection.

As we proceed in this very important debate, I hope we can continue to work to improve S. 1052 so that it truly protects patients without jeopardizing their insurance coverage and without wiping out the good work of the States.

I was encouraged today by a conversation with Senator MCCAIN in which he indicated that he is very open to resolving some of the problems I have raised in my statement. I hope that we can work together, and at the end of the day I hope we can approve, by an overwhelming vote, a responsible Patients' Bill of Rights that will help ensure that patients receive the care they need, when they need it, without having to resort to hiring an expensive lawyer and filing a lawsuit. That should be a goal that should unite us all.

I look forward to the upcoming debate. I think it is an important one. I hope we can come together on a bipartisan bill that the President will sign, that will make a real difference in the health care for America's patients.

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

Ms. COLLINS. I am happy to yield to my friend from Massachusetts.

Mr. KENNEDY. I listened carefully to the Senator. As a member of our committee, I know she gives a good deal of attention and time to health care and education issues, as well as the other matters that come before our committee. We take her words seriously.

While listening to her, I was reminded that the Maine Medical Society, which represents the medical community in the State of Maine, is in strong support of our proposal. Which proposal does the Senator support at this time?

The PRESIDING OFFICER. The Senator from Maine has the floor and she has 1 minute.

Ms. COLLINS. Mr. President, I have worked very closely with the Maine Medical Association on a variety of issues. I know that while they do want to see liability provisions similar to those of the Senator, they are very concerned about the issue I raised about the preemption of Maine's law.

Maine has been very active in passing a number of laws to provide consumer protections. They are carefully balanced laws. On this chart, there is a check mark all the way across. I know the Maine Medical Association was very involved with the legislature in negotiating those provisions. They are concerned about the preemption of Maine's laws which they helped to draft.

Mr. KENNEDY. May I ask one further question. The Maine law includes clinical trials, but does not include FDA clinical trials. The proposal of Senator EDWARDS and Senator MCCAIN does include clinical trials. Most of the women's groups, including women's cancer groups are strongly in support of this provision. They recognize that many pharmaceutical companies are on the edge of breakthroughs in the development of these new products.

I am interested in this illustration. The provisions for clinical trials in Maine are preferable, quite frankly, to the provisions included in Breau-Frist, where there are a number of problems.

Wouldn't the Senator from Maine feel that including the patients in Maine in these FDA protocols might be helpful if they meet the other requirements? For example, what if a doctor feels that participating in these clinical trials means there is a real possibility of relieving a patient's medical condition?

Ms. COLLINS. Mr. President, Maine has led the way on insurance reform. Maine is one of only 12 States that cover clinical trials. The Maine legislators gave careful consideration to what the scope of that coverage should be, and a Democratic legislature and an independent Governor decided, for reasons of cost, to limit the clinical trials provisions to those who were approved by the National Institutes of Health. That is appropriate.

What I object to is that the Kennedy approach, the Kennedy-McCain bill, would say that if a State didn't cover clinical trials exactly as the Senator from Massachusetts wants them covered, then Maine's law is wiped out. I don't think that is right. I notice that Maine has been far more active than Massachusetts in the area of patients' protection, so perhaps that explains

the difference in the approach that the Senator from Massachusetts, my friend, and I take.

I yield the floor.

EXHIBIT No. 1

NATIONAL ASSOCIATION OF  
INSURANCE COMMISSIONERS,  
Kansas City, MO, June 19, 2001.

Hon. SUSAN COLLINS,  
U.S. Senate,  
Washington, DC.

DEAR SENATOR COLLINS: As the Senate prepares to debate legislation designed to protect the rights of health insurance consumers I would like to reiterate the concerns of the nation's health insurance regulators.

The National Association of Insurance Commissioners (NAIC), which represents all fifty-five insurance commissioners in the states and territories, is primarily concerned about federal preemption of state laws and regulations. All states have passed and implemented legislation to protect the rights of beneficiaries. Over 40 states have acted to ensure access to emergency and OB/GYN care, require fair utilization review and internal and external appeals processes, and prohibit discrimination and gag clauses. Over half of the states have laws ensuring access to specialists and non-formulary prescription drugs, a point of service option, and continuity of care.

As members of Congress know from experience, passing patient protection legislation this can be a difficult task with a variety of issues to consider. States have faced the challenges and produced laws that balance the two-part objectives of protecting consumer rights and preserving the availability and affordability of coverage. For the federal government to unilaterally impose its one-size-fits-all standards on the states could be devastating to state insurance markets.

Members of the NAIC are also concerned about enforcement. As you know as a former state regulator, if there is no enforcement then there is no protection. States have developed the infrastructure necessary to receive and process consumer complaints in a timely fashion and ensure that insurers comply with the laws. The federal government does not have this capability, and the proposals do not provide any resources to federal agencies to develop such capability. It has taken the Health Care Financing Administration (HCFA) years to develop the infrastructure required to enforce the Health Insurance Portability and Accountability Act (HIPAA) which included only six basic provisions that most states had already enacted. The proposed patient protection bills are far more complicated than HIPAA and will require considerable oversight.

To resolve these issues, the NAIC urges Congress to include in any patient protection legislation provisions that would preserve state laws and enforcement procedures, such as internal and external review processes. Failure to maintain state authority in this area could lead to the implementation of regulations that are inconsistent with the needs of consumers in a state and that are not enforced effectively.

Protecting patient rights is clearly a goal of both the states and the federal government. Attaining this goal will require cooperation and we look forward to working in partnership with the federal government to implement protections that are in the best interest of consumers in each state.

Sincerely,

KATHLEEN SEBELIUS,  
President, NAIC,

Insurance Commissioner, State of Kansas.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I will inquire of the Senator. If I may have the Senator's attention, is the Senator supporting the Breau-Frist bill at this time? Is the Senator going to work with Senator MCCAIN, a cosponsor with Senator EDWARDS, to try to see if we can find common ground within the next week?

Ms. COLLINS. My friend from Massachusetts may not have heard me when I said earlier—and I don't expect him to be on the edge of his chair through every moment, but I made very clear that my hope is that we can come together on this important issue. It is important, and I think it is unfortunate that we didn't get through a conference on the Patients' Bill of Rights last year. Then we would have had these protections already in place.

It is a shame that last year when we had agreement on 90 percent of the bill, we didn't enact it. Senator BREAU of Louisiana and I suggested just that approach. So I look forward to continuing to work with my colleagues on both sides of the aisle. Just at noontime today, I had a discussion with Senator MCCAIN and he indicated an openness to solving some of the problems I have outlined in my statement. The Senator from Massachusetts knows I always enjoy working very closely with him.

So I look forward to that because my goal is that we can pass a bill that does the job on which we all agree, and yet that would not preempt States' laws when States are doing a good job, and that would not cause health insurance costs to rise to the point where we jeopardize coverage altogether.

I know those are goals we share, and I hope we can indeed work closely together.

Mr. KENNEDY. Finally—and I see the Senator from Connecticut here—the point I would like to clarify is that the Edwards bill isn't preempting the States. They have identical provisions. The States' provisions and protections, if substantial, will stand. They don't have to be identical. I just wanted to clarify that particular issue as we go through the course of debate.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Very briefly, before the Senator from Connecticut speaks, there were some points made by the Senator from Maine.

First, we very much appreciate her open attitude to work with us to try to find a solution to a problem about which we all care a great deal. We appreciate that. She was arguing, I believe, that because of increased costs associated with a Patient Protection Act, people would go from being insured to uninsured, and that is something about which the American people should be concerned.

First of all, I point out that there are two competing bills, one of which will pass the Senate. The difference between those bills is minimal in cost. Second, in the three States that in fact

have enacted patient protection—California, Texas, and Georgia—not only has the number of uninsured not gone up but exactly the opposite has occurred. During the time that patient protection has been in place in California, in Texas, and in Georgia, the number of insured has gone up. In California, for example, in 1998 and 1999, the number of insured went up 2.3 percent. In Texas, it went up .9 percent—just under 1 percent. In Georgia, about which Senator MILLER spoke so eloquently, it went up .8 percent.

So the evidence from the three other States that have enacted laws similar to the McCain-Edwards-Kennedy bill is that because people have a better product, better health care, better rights, not only does the number of uninsured not go up but it goes down. So these rhetorical cries of all of us needing to be greatly concerned about that issue—of course we are, but the actual evidence that exists from the three States that have laws similar to the laws we are here talking about suggests over a relatively short period of time, in fairness, that just the opposite is true—that in fact, because of the quality of the product, the number of people insured can go up as opposed to going down.

With that, I will yield the floor to my friend from Connecticut.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, let me begin by, first of all, commending my good friends and colleagues from Massachusetts, North Carolina, and Arizona, Senators KENNEDY, EDWARDS, and MCCAIN, for their leadership on this issue—bringing a series of reforms that seek to guarantee quality health care for more than 190 million of our fellow citizens.

This is extremely important. We know there are 43 million Americans who have no health insurance at all. We hope at some point we can develop legislation to protect those 43 million fellow citizens who have to go through the anxieties on a daily basis of hoping their children, their families will not suffer from some catastrophic illness which could wipe out whatever meager holdings they have. That debate will have to be reserved for another day.

But there are 190 million Americans who obtain health care coverage through private insurance. So we begin the debate by trying to make sure that those 190 million people who are covered by private health care coverage will be able to have the kind of rights we think they ought to have as citizens of this country.

Mr. President, I also should begin with sort of a disclaimer to you. My colleague from Connecticut, Senator LIEBERMAN, and I represent what is oftentimes referred to as the insurance capital of the world. My good friend, the Presiding Officer, is the Senator from, I suppose, the State of gaming and of family recreation. My State is well known for a variety of insurance

companies that have made significant and positive contributions to the well-being of people not only here in the United States, but around the globe. We are very proud of the fact that we represent insurance companies that have provided great security for millions of people in so many different sets of circumstances.

But it is important to note that, as a Senator from that State, one of the things we are talking about here is the obligations of my constituents, those insurance companies that are involved in providing private health care coverage. So today I suppose I engage in discussion that you may not expect to hear from someone who comes from a State where I represent these interests.

I do so with a degree of sorrow because, unfortunately, in too many cases the industry does not understand the needs of millions of Americans. This is not true of the entire insurance industry in my State. There are many who have reached out and are trying to make a difference, to see to it that people do have access to specialists, emergency rooms, and clinical trials, and that they have an appeals process to turn to when they feel that they have been unfairly denied care.

We have been at this debate now for 5 years. I recall a couple of years ago being a member of a conference committee after this body had dealt with a Patients' Bill of Rights—partisan politics took over. We sat in the committee rooms for days on end and nothing happened. For each day we wait, each week that goes by, every month that passes, these 190 million people in our country run a greater and greater risk that their rights are being denied, that basic health care coverage is not forthcoming.

I hope my colleagues who are engaged, as we have been over the last few days, in delay tactics that won't allow for an amendment process to go forward will cease and desist.

It is not what the American public wants. They may not agree with every dotted "i" and crossed "t" in JOHN MCCAIN's and JOHN EDWARDS' and TED KENNEDY's bill. I respect that. I understand their differences, but not to have any amendments offered, not to be debating this, not to be discussing it beyond the rhetorical comments is not going unnoticed by the American public.

As these days go by, I hope nothing happens to people, which could have been prevented by the passage of this legislation or some compromise version of it.

Let us begin the process of discussion. Let us begin the process of voting. I am disappointed and saddened that we have not.

I mentioned my State and the fact that I represent some of the largest, most successful insurance companies in the world. As many other States, my State has also taken action on this issue of a Patients' Bill of Rights. It has passed its own managed care pro-

tections. The reforms included in the Connecticut law take an important step toward protecting patients and doctors, but today 41 percent of Connecticut employees are denied these very protections because of Federal law preemptions. Almost half of my constituents are not protected by their State law.

Unless we adopt a Federal law, they will go unprotected, and that is true in State after State because of the adoption of ERISA, legislation going back years under the leadership of the former Senator from New York, Jacob Javits, of blessed memory.

Under his leadership, ERISA was passed, but as a result of that fine legislation and with the adoption of State laws providing protections for people's health care rights, a lot of our fellow citizens are preempted by that Federal law.

That is the rationale for us engaging in this debate on a Patients' Bill of Rights. There must be Federal law. If not, we are excluding millions of Americans from the protections their fellow citizens living next door to them, living down the street, working next to them at their businesses are provided under their State protections.

This debate is important, and we ought to be voting on amendments. Every hour that goes by, every day that goes by that we do not do our business raises even further risk that additional people will be harmed.

The increased role of managed care in our health system has brought some very important improvements—better coordinated care, greater efficiency at lower costs, and an enhanced focus on preventive care.

The health maintenance organizations deserve credit for making these positive steps. The benefits, however, have been accompanied by some concerns about the impact on the quality and delivery of care, and that is what the Kennedy-McCain-Edwards bill attempts to address.

Far too often the decision about whether you or your family can get the health care you need is dictated by an insurance policy rather than your doctors. That is why it pains me as a Senator from Connecticut to have to talk about an industry of which I am so proud.

While we all agree on the goal of increasing efficiency and managing costs in our health care system, we cannot do so at the expense of denying needed care. We have to strike that balance, and today that balance does not exist.

I want to take a minute to talk about a single case in my State. I realize we are talking about 190 million people in the country who have private insurance but do not have protections that a Patients' Bill of Rights would provide. I know there are 43 million people who have no health care coverage at all. Sometimes we get to talking about millions of people, millions of dollars, and billions of dollars and get lost in the morass of the

Federal bureaucracy of how a Patients' Bill of Rights would work. We forget we are talking about individual people, families.

I want to take a minute, if I may, and share with my colleagues the story of one family in my State and what happened to them as a result of our failure to have a Patients' Bill of Rights.

I just spoke with this family a few minutes before coming to this Chamber. I did not want to talk about this family without their permission. I called the Moscovitch family in Connecticut and asked them if I could talk about their 15-year-old son, Nitai. Let me tell my colleagues what happened.

This family lives in Brookfield, CT, a small town in my State. They are a hard-working family. In fact, the father was not yet home from work. He was on his way home from his job. Their son, Nitai Moscovitch, suffered from very severe emotional problems. The family was wise and smart enough to recognize their 15-year-old son, Nitai, needed help. He needed medical help immediately.

This family sought that help, particularly after this young boy attempted suicide. He was admitted to the Danbury Hospital in the western part of my State. Despite the fact that the young boy had a history of trying to harm himself, the insurance company that provided coverage for this family would only agree to cover his treatment for several days at the hospital, as if he had been in an automobile accident, or if he had stumbled and broken his leg or been in an athletic injury.

The idea that this was a child suffering from severe emotional illness was not under consideration: We will put on the Band-Aids, provide the stitches, but beyond that, we are not going to provide that coverage.

Even though Nitai threatened to commit suicide if he were removed from the hospital, they saw this as the rantings of a teenage boy, not to be taken too seriously.

Four hours after he was released, Nitai locked himself in a room, undid his belt on his trousers, and committed suicide.

If that is an isolated case I conjured up, then I ought to be ashamed of myself. Unfortunately, this is not an isolated case. This goes on every day, not necessarily with the tragic ending as in this case, but coverage was denied not because someone looked at Nitai and said: We don't think your emotional problems are severe enough to warrant hospitalization. Someone sitting behind a desk, I suppose at some computer terminal, was making the determination that the policy was not going to cover him. That was the medical analysis given to this young man and this family.

That has to stop. I am not suggesting that every medical examination or analysis is going to be right or there are not going to be tragedies involved,

but we have to get away from the situation where the decisions about what kind of care a patient needs, what kind of doctor a patient ought to see is being determined by someone who has no medical training, no medical background at all, and then to further say basically they are not responsible.

Let me complete the story. On behalf of his son, Nitai's father, Stewart Moscovitch, wanted to sue his health maintenance organization for playing the role of doctor and refusing to cover extended treatment at the hospital. But the health plan argued that existing Federal law, the very reason we are engaged in this debate, existing Federal law prevented the family from holding them liable.

After a 3-year battle, this family secured a ruling that the Federal law did not apply in his case. However, today there is still no guarantee that the Moscovitch family or any family would have the right to hold their plan accountable for making treatment decisions.

The bill we are debating will change that. I am not going to suggest that somehow we could have entirely prevented this tragedy from happening. As I said, it is conceivable that a doctor might have arrived at the same decision. Do not assume for a second I was assuming that Nitai's life definitely would have been saved but at least they might have had more choices. At least the choice should have been left to the doctor looking at this young man and not a decision made by an insurance company or an insurance employee who, with all due respect, has no business making the decision of whether or not extended hospital care for this child ought to be covered.

I thank the Moscovitch family for allowing me to talk about their son. I called them to seek their permission to talk about their son. I was told by Nitai's brother that, in fact, the family had discussed it and hoped I would because it might, just might, make a difference. It may convince some who are wavering about whether or not this bill is warranted, whether or not this effort is worthwhile. It may be the case that one family, one individual will have a more profound effect than all of the numbers and millions of people and billions of dollars we talk about. It is family by family, patient by patient that the effects of not passing this legislation are most felt.

Putting patients first means guaranteeing access to emergency room coverage when a rational person would say emergency care was needed. It means ensuring access to doctors qualified to treat a condition, and that it is those doctors who will decide the best course of treatment. Putting patients first means making sure that patients with illnesses that have not been cured by conventional treatment are not denied the chance to participate in potentially life-saving clinical trials. It means making sure that a patient and his family can have the prescription

drugs doctors say they need, not just the drugs the insurance company says are cheaper.

Other managed care bills have been introduced in this Congress that are watered-down versions. They are weaker versions. They are not truly a Patients' Bill of Rights. The Bipartisan Patient Protection Act is the only bipartisan legislation that will offer managed care patients and providers that serve them reasonable protections. The bill allows patients and doctors to determine the best course of care, establishes an independent appeals process for patients who believe they were unfairly denied care, and allows patients to hold health care plans accountable when they make those decisions.

I hope our colleagues allow this debate to go forward. Let not another day pass in delaying a debate on amendments on this bill. It is blatantly unfair. Forget Democrats and Republicans. What you do to my party, sitting on this side of the aisle, is not terribly relevant; put that aside. If you will, think of the people you represent in your States. Even if you don't like this bill, offer your ideas on your approach to this. But allow an amendment process to go forward.

It is unfair to these people, after 5 years, to not allow a full debate on amendments on this bill. That is what this institution was created for. It is what we ought to be engaged in. Now after the second day of listening to statements about this bill, it is time we started debating amendments. My hope is that will be the case.

I understand the commitment of our distinguished majority leader, Senator DASCHLE, when he says we will stay here, we will stay here until this bill is properly and fully considered. It may be defeated. At the end of the day, 51 Members may decide to defeat this bill. I would be terribly unhappy if that were the case, but at least we would have had a chance to debate and consider amendments. Sitting here day after day, hour after hour, without the chance to consider amendments and vote on an important subject such as this is dreadful. My hope is my colleagues who are engaged in this delaying practice will cease and desist.

I commend the authors of this bill and look forward to supporting them in the amendment process. My sincere hope is at the end of this discussion we will have amended the law and that the millions of Americans who are insured and preempted by Federal law as well as all the others with private insurance, will get the protections they deserve.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. How much time remains in this block?

The PRESIDING OFFICER. Six minutes remain.

Mr. DORGAN. Mr. President, my colleague from Connecticut has covered

the subject of needed patient protections well. Let me, in the few short remaining minutes, make a couple of comments—some I have made before.

Let me narrow the issue down. It is about the right of patients to get the health care they deserve and that they think they have under their managed care plans. Often however, that care is actually denied them.

Patients ought to have a right to understand all of their medical options for treatment, not just the cheapest. They ought to have a right to medically necessary care without arbitrary HMO interference. They ought to have a right to go to an emergency room when they have an emergency. They ought to have a right to see a specialist when they have a need to consult a specialist. They ought to have the right to a fair and speedy process for resolving disputes.

Let me see if I can use a couple of pictures to describe what these rights mean. This young child was born with a horrible facial defect. A cleft palate which is a horrible defect of the top lip. Plastic surgeons say in about 50 percent of the cases, a managed care organization says this is something that is not medically necessary to correct. It's correction is not medically necessary? Imagine having this child and being told by a managed care organization that it is not medically necessary to correct this defect!

I spoke yesterday about a young woman named Donna Marie McIlwaine. Donna is from New York. Her mother, Mary Lewandowski, testified before a hearing I held on managed care. This beautiful young lady is not with us any longer. Donna died. Her mother described the circumstances of her death. For want of a \$750 lung scan, this young girl died as a result of a blood clot in her lung the size of a football. Donna's mother called the doctor and she called the hospital, but to no avail. This young woman died because she didn't get a \$750 lung scan that would have shown a blood clot the size of a football in her lung. And she died. She died on the evening of February 8, 1997. Her mother, God bless her, Mary Lewandowski, has been to Washington at her own expense, as a missionary to say "pass this legislation and don't let this happen to another child!"

I have described before, this young man, Christopher Roe, whom I learned about at a hearing I held in November—and if you are tired of hearing about him—I have talked about Christopher several times—if you are tired of hearing about him, tough luck because I will keep talking of his tragic circumstance. His mother held this picture high as she began to sob when she testified about this 16-year-old boy who died on his birthday. Christopher was fighting cancer, and fighting the managed care organization at the same time for the care he needed and didn't get. This young boy had cancer. He needed some treatment. He needed a chance. He needed some experimental

treatment, a chance to get through this and successfully wage war against this dreaded disease.

But time ticked away and the managed care organization said, no, no, no. And finally this young boy, flat on his back in bed, died on his 16th birthday. Before he died, his mother told us, crying: "Christopher looked up at me and said, Mom, how can they do this to a kid?"

This is not some ethereal debate about what you think or what I think. This is about whether patients have the protections they believe exist in their managed care policies.

Are we going to say that we stand on the side of patients? Are we going to stand on the side of doctors? Are we going to stand on the side of nurses who know that the only real good health care that is delivered is delivered by health care professionals in a clinic or in a hospital room? It is not health care delivered or decisions made in an insurance company or managed care office by some junior accountant 1,000 miles away. Yet all too often that is what is happening. It is why Christopher Roe is no longer with us. This young boy lost his battle fighting cancer and he lost his battle fighting a managed care organization.

That, my friends, is not a fair fight. We know that. That is why we propose passing a piece of legislation called the Patient Protection Act or the Patient's Bill of Rights. There will be a lot of discussion and debate about this for a long period. At the end of the day, the only question is, Whose corner are you in? With whom do you stand? Are you with the patients, doctors, and the nurses? Or are you with the managed care organization and the insurance industry who say they don't want this?

In the names of Christopher Roe and Donna, and so many others that I have discussed previously on the floor of the Senate, we ought to do what is right. We ought to do the right thing. This legislation has been four years in the making. This is a long gestation period. We have debated, debated, and debated again. We have compromised, compromised, and compromised on this legislation. It is now time for us to own up to this responsibility. Let's pass this bill. Let's do it now and do it right.

I yield the floor.

The PRESIDING OFFICER (Mr. SCHUMER). The Senator from Missouri is recognized.

Mr. BOND. Mr. President, we are now debating the crucial issue of patients' rights. For better or worse, we have a health care system that increasingly uses managed care to organize and deliver services. Over the next week or two or more, we are here to debate what we need to do to protect patients and to restore balance to our new system dominated by managed care companies, whether insurance companies or HMOs.

Let's be clear; patients need protections. For a variety of reasons—bad

customer service, bad incentives that lead to a conflict between care and the bottom line, and simple carelessness and neglect—too many patients have been mistreated by their health care insurance companies. That is why every State in the Nation has acted on this measure to provide protections because we have seen this mistreatment range from the heartbreaking to the mundane.

We have all heard the rare but tragic horror stories in which a managed care company denies desperately needed care, sometimes with catastrophic results for the patient. Many of us have actually experienced the all too common phenomenon, nuisances of being forced to make phone call after phone call to get routine care authorized or having to wait longer than should be necessary to get an appointment with a doctor in a limited network of managed care providers.

That is why I voted in the past for comprehensive managed care reform bills that will deal with the federally regulated plans. This is why I have confidence that I will again vote for a good patient protection bill at the end of this debate.

We have heard some statements on the floor—I think maybe we ought to bring a little reality to it—saying we have to pass this bill right away. This bill is a moving target; it is a shell game, trying to figure out which version is the latest version, what version is the operative version. It did not go through the committee.

People talked about maybe we want to compromise some of it. Normally the compromise, working out of these details, happens in committee. That is why we send a committee markup to the floor. We did not do it this time. So we are going to have to do the committee's work in this Chamber.

But when I hear people talk about how there are 50,000 people being denied insurance, we hear about tragedies that happen every day, some say if we wait a day longer or a week longer, more patients are going to get denied care—just a little bit of reality. The effective date of the McCain-Kennedy bill is October of 2002. That is October of 2002, a year and a quarter from now. So while it is important that we deal with this bill, it is important that we not pass a bad bill. We have the time, and we must take the time, to make sure what we do is a good product.

Legislating is a difficult job. It inevitably involves striking a balance between competing goals. In this debate, that tradeoff is between specific patient protections and the costs those protections will impose on an already strained health care system.

Mr. President, 43 million Americans lack health insurance coverage. That is an important fact to remember and one we have to keep in mind as we deal with assuring that patients are protected. Even if Congress does nothing here, that number is almost certain to go up, perhaps dramatically, in the

wake of health care costs that are shooting up 13 percent this year, following a year in which they rose by 12 percent. That is more than a 26-percent increase in just 2 years, a rate that is not sustainable. I might add, in the next year or two cost increases are expected to rise by about the same amount.

The goal of managed care, of HMOs and others, is to assure health care but to maintain some limit on the cost because anybody who has studied economics 101 knows if costs are totally unreasonable, you are not going to get the service. That service in this case is the vitally important service of health care coverage.

Employers, particularly small businesses, make a valiant effort to struggle through and provide health care insurance to their employees. I have talked to and listened to an awful lot of small businesspeople and their employees who are concerned about this particular bill as well as health care costs in general. As costs go up, fewer and fewer small businesses will provide care.

In our employer-based health care system, 75 percent of Americans with insurance get all or some of that coverage through an employer. We have to be careful. We have to be careful to ensure that we do not drive, particularly small businesses, out of the business of providing good health care coverage for their employees.

This is the dilemma. It is really the crux of what we will be talking about over the next several weeks: Which patient protections are worthwhile and when is the price of lost coverage too high?

Let me emphasize that. What is the cost in terms of health care coverage to increasing the cost of health care protection? After all, a pro-patient protection bill that takes away a family's health insurance does not provide any protection at all. If they lose their coverage, we have done exactly what we should not have done, and that is to deny them any coverage.

With all this in mind—the importance of patient protections, the danger of rising costs—what should we support? In the past I voted for, and I will vote for again, a strong Patients' Bill of Rights that contains basic, reasonable, commonsense patient protection.

This includes guaranteed access to emergency room care. Americans should not have to worry their insurance company will not pay for necessary emergency care or even for care that reasonably seems to be an emergency. I have gone to the emergency room with problems that looked very serious and after treatment found out, although they were a problem, they needed care but they were not a critical emergency. But those should be covered.

Second, a guarantee that patients get all information on treatment options. Doctors and patients need to be able to

discuss openly all possible treatment options without gag rules.

Third, a right to a quick, independent, and expert appeal process. There must be an appeal to a medical expert outside of the HMO to guarantee the HMO is not focusing too much on its bottom line and not enough on the patient's bottom.

The appeal must be quick so patients get care when they need it, strong managed protections for our children, such as the ones I included in Healthy Kids 2000 legislation 2 years ago. These include the right for a child to go see a pediatrician without being forced to see a nonpediatrician gatekeeper. Pediatricians are not specialists to whom children need to be referred. They should be a child's first line of care.

Next, the right for a child to see a specialist with pediatric expertise, including going to children's hospitals when necessary. Children are different from adults. Their care is different. Doctors who primarily treat adults are not always prepared to interpret and attend the unique needs of children. A sick child needs to go to somebody who specializes in taking care of sick children.

The right to have a pediatric expert review a child's case when appealing an HMO decision. Again, even an experienced medical practitioner who deals only with adults may not have the ability, the expertise, and the training to make a decision about what kind of care a child needs.

Let me tell you a few things about what I do not support in the patient protection debate. Unfortunately, I must put at the top of the list of what I cannot support the McCain-Kennedy bill. The McCain-Kennedy bill contains some good provisions—all of them do. There are good provisions in all of these bills. But the McCain-Kennedy bill is overzealous; it goes much too far towards creating a litigation-heavy, costly new world of health care.

I will take the opportunity in the following days and weeks to go into detail on some of the glaring problems presented by the McCain-Kennedy bill and the profound threat this legislation poses to continued health care coverage for millions of Americans. For now, let me begin by highlighting the major flaws in this significantly flawed bill.

Problem No. 1, the McCain bill will dramatically increase health care costs and will take away the health insurance of more than a million Americans. The new costs this bill imposes will be paid by everybody who has health insurance. The lucky ones will just pay more. The unlucky ones will lose their coverage. That price is simply too high.

Next, the cost of this bill will hit small businesses and small business employees particularly hard. Without the clout of larger companies, small businesses right now face higher prices and have more difficult administrative hurdles when they try to buy health

care. While this makes it far more difficult for small businesses to provide health care, millions of small companies try to find a way and do it anyway. I fear that will dramatically change if the McCain-Kennedy bill passes.

Since late last week when it was announced that we would be debating the McCain-Kennedy bill, my office has been inundated with letters, calls, and faxes from small businesses in Missouri. The message has been unanimous. Missouri's small businesses are struggling to provide health care despite high costs. They fear what the Kennedy-McCain bill will do to their ability to pay for health care. Many say they will drop their coverage if McCain-Kennedy passes.

This is not just a phenomenon related to my State. This is what we in the Committee on Small Business are hearing from across the country.

Let me read excerpts from one of the many letters I have received. I will not use his name, but I want to give you a flavor by telling about the important parts of the letter.

He says:

I am writing this letter in regard to Senator Kennedy's Patients' Bill of Rights, S. 283. My family owns a small agriculture business selling certain kinds of farm equipment and lawn equipment with a fully staffed sales, parts, and service department. I offer health care coverage to my employees and paid 100 percent on the premiums until about 5 years ago when our health care costs got too high to continue. So I went to 50 percent on both the employees and their dependents, thus helping our business but strapping my employees with added costs to raise their families.

This year our health insurance went up 34 percent. Last year, it was only 24 percent. But where is this going to stop? How am I, as a business owner who has 23 families depending on me for their livelihood, supposed to make a profit in order to pay them a livable wage and benefit package in a severely depressed agriculture economy while our liberal Government leaders are trying to further increase my expenses? If these costs escalate much further, I anticipate that I will have to drop my health plan altogether, especially if I am to be held responsible for medical court cases. I will, at a minimum, drop my group health coverage and think very long and hard about closing down and counting my interest and rent checks instead of continuing to run this business.

We need relief from Government regulations that are sucking all the profits out of our organizations causing us to employ one person to do nothing but Government paperwork. We need to eliminate the death tax or inheritance tax. Please just say no to Kennedy care disasters.

From time to time during the debate on this bill I will read from other letters from Missouri businesses to remind us of the real-world impact of this legislation.

On this chart, I have an up to the minute count of the employees of Missouri's small businesses that would, as I understand, lose their health care coverage if McCain-Kennedy passes. These are letters from small businesses

in Missouri that say that, as of this date, if Kennedy-McCain passes, they will drop their health care plan. Our running total on the number of employees who will lose health care if this bill is signed into law right now is 1,042.

That may not seem to be a lot, but that is a tremendous burden on those employees and their families. These are real people. These are the ones who will be totally unprotected if we pass the McCain-Kennedy legislation.

Rest assured that I will seek opportunities during this debate to find ways to shield small businesses and employees from the most outrageous aspects of this legislation.

I don't think anybody intended to cause health care coverage to be dropped. That was certainly not my understanding of the objective of this bill, but sometimes what we do here in Washington has unintended consequences. Very often the unintended consequences are far greater than the beneficial consequences.

Cost-benefit is something we neglect too often. I intend to make sure my colleagues focus on the costs as well as the benefits.

A second problem of the McCain-Kennedy bill is that it focuses too much on lawsuits and trial attorneys by encouraging endless litigation. Lawsuits are an avenue for retrospective blame and incrimination after someone claims they are harmed. Lawsuits in no way contribute to high-quality care. Instead of turning health care over to lawyers, the focus should be on making sure patients get the care when they need it before any harm occurs.

When you are sick, you want to see a doctor—not a lawyer. When I hear about all of these protections from subsequent lawsuits, I am not very interested in leaving my heirs with a bunch of lawsuit claims against a bunch of defendants if I am gone. I want to have a bill that makes sure that I can get the kind of care I need when I am really sick. That is what I think the American people have a right to ask.

A third problem of this bill is that it nationalizes the regulation of health care. State governments have traditionally overseen health care and health insurance, and, as I mentioned, every State in the Nation has done something in this area. They have tried different ways. Many of them have done good jobs.

I believe it was Justice Douglas who said ours is a laboratory where States perform experiments to see which legislation works best. The States have been out there doing it. In fact, as I said, every State has passed some type of State level patient protection act. Now the McCain-Kennedy bill comes along and threatens to impose a one-size-fits-all scheme that will do away with most or all of the tried and tested State law reforms. Some of them may be better than others. We will not know if we pass the McCain-Kennedy bill that eliminates all the State options.

Even worse, it will turn over much of the new Federal regulation of insurance to the Health Care Financing Administration, one of the most heavy-handed, unresponsive, arrogant bureaucracies in all of Washington.

I have spoken in this Chamber before about the Health Care Financing Administration. A couple of years ago, the Health Care Financing Administration was overzealous in its effort to cut the cost of home health care. Instead of saving the \$16 billion that Congress asked it to save, it is on the path to saving \$60 billion by shutting down health care provided in homes.

As chairman of the Committee on Small Business, I was contacted by many small entities providing home health care services. I set up the hearing. I invited the representatives of these home health care agencies who believed they were being unfairly treated by HCFA to come to Washington. A number of my colleagues wanted to testify. I invited HCFA to come and listen to their comments and provide their response. It seems reasonable, doesn't it? You have a Government bureaucracy that is the subject of all kinds of outrage. You let the people come in and tell what they see as the problem. Then you give the bureaucracy an opportunity to respond, to tell their side of the story.

Do you know what HCFA said? They didn't want to sit around and listen to the complaints of those they regulate. They would be happy to testify if they could testify along with other Senators. I forgot to check to see how many States elected the officials of HCFA to serve in the Senate. The best I can tell, none.

This is the agency that would tell State governments what kinds of health care provisions they could have. I don't think so. That is not the way we need to go.

Finally, in what I think is a major oversight in the Kennedy-McCain bill, it doesn't do a single thing to help Americans get access to health coverage. At the same time, it is threatening coverage from millions of Americans. If we are going to do harm, we ought to be prepared to help. That is why I intend to continue with my effort of introducing an amendment that will immediately allow self-employed Americans, including the 34.8 million uninsured Americans in families headed by a self-employed individual, to fully deduct their health insurance expenses.

Patients need protection through a Patients' Bill of Rights. But there is a right way and a wrong way to do it. The right way limits itself to common-sense reforms that help patients get care when they need it. The wrong way—the McCain-Kennedy way—encourages endless litigation, nationalizes health care oversight, and takes away insurance coverage from more than 1 million Americans.

There are some people who say this bill is a lawyers' bill of rights, not a Patients' Bill of Rights.

What is wrong with the right to sue?

The McCain-Kennedy bill is a trial lawyer's dream that will raise health care costs, subject our health care system to frivolous lawsuits, and will make trial attorneys rich. Despite Democratic insistence, this will put employers at risk of being sued. The so-called cap on damages in the McCain-Kennedy bill is practically worthless because it applies only in one area and leaves a variety of other types of damages uncapped. There are no caps on attorneys' fees and the outrageous contingency fees many trial lawyers force on their clients.

What types of lawsuits should we allow?

Because of the destructive capacity of plaintiffs' attorneys, we must be extremely cautious with any new lawsuits. I realize there are some situations where we need to expand the right to sue, but first everything must flow through an appeals process through which a patient can go outside the HMO to get an expert's second opinion.

Before we resort to lawsuits—which can't provide care—we must ask patients to complete this appeals process because it can result in a patient getting care. And that is what we should be talking about. But if a health insurer doesn't comply with a independent expert decision that a patient should get care, on it acts in bad faith or extreme negligence by denying care that the independent expert says is needed, the patient should be allowed to sue for damages.

The McCain-Kennedy bill limits punitive damages—although they call it a "civil assessment" to \$5 million in the new Federal lawsuits their bill will allow. But economic and noneconomic damages in Federal lawsuits are still uncapped. It won't be hard for trial lawyers to find ways to milk these alternative types of uncapped damages for all they are worth.

At the State level, the McCain-Kennedy bill does nothing to impose caps on damages, even for punitive damages. While some States have their own damage caps for malpractice lawsuits, in many States these caps won't apply to the new lawsuits and the new Federalization of State health insurance regulation permitted under the McCain-Kennedy bill.

Bottom line—the caps in the McCain-Kennedy bill barely provide even a fig leaf of protection for those who will be sued.

The State-level health care liability system that exists for doctors has failed. It dramatically increases costs through defensive medicine. It encourages doctors to quit the profession. And not only does it not encourage quality care, it hinders quality care by creating a code of silence that prevents health professionals from talking about how to systematically avoid medical mistakes.

Studies show that most people who get negligently harmed in health care

do not get compensated, and those that are compensated are often not harmed. Again, studies show that whether or not a patient was negligently harmed has almost no connection to whether they get compensated.

The American tort system is like a lottery in which most patients lose, a handful of patients win big on a random basis, and trial lawyers strike it rich by raking off the top of each lawsuit.

This is a huge flaw in the system to which the Kennedy-McCain bill will subject us even more.

Some supporters of the McCain-Kennedy bill claim their bill exempts employers from the new lawsuits permitted by the bill. That is a great line. My colleagues pointed out, on page 144 it says: This "does not authorize a cause of action against an employer or other plan sponsor maintaining the plan . . ." That is the good news. The bad news comes in the next paragraph. It says:

(B) Certain Causes of Action Permitted. Notwithstanding subparagraph (A), a cause of action may arise against an employer or other plan sponsor . . . And then it lists the exceptions. It goes down this page, goes down this page, goes down this page, goes down this page, and comes over to this page. Those are the exceptions. That is what happens to you if you are an employer.

That is why, with four pages of exceptions, a lot of employers of small businesses in my State and around the country are simply going to have to get out of the business of providing health care. It scares the heck out of them, and it should.

As we heard from small businesses, this is their concern. They want good health care for their employees, but they cannot afford to stay in business and expose themselves to the lottery of a tort system out of control.

If employers are so well protected, why are they scared? Well, simply, they are not exempt. If the right to sue is so great, why not provide all employees the right to sue—Federal Government workers, seniors in Medicare, all of the other causes? We look at it, and it is probably too expensive for the Federal Government. Think of what it is for the patients who are employees of small businesses. If they lose their health care coverage, it does little good for them to know that maybe—just maybe—they would have had the right to sue.

We are having the right debate, but the McCain-Kennedy bill is the wrong solution. I urge my colleagues to take a look at this seriously flawed legislation and to help us improve it. If we succeed in making substantial changes, I hope we will pass a dramatically different bill that represents a more reasonable and affordable approach.

I thank the Chair and yield the floor to my distinguished colleague from Tennessee.

The PRESIDING OFFICER (Mr. REED). The Chair recognizes the Senator from Tennessee.

Mr. FRIST. Mr. President, how much time is left on this side?

The PRESIDING OFFICER. Three minutes forty-five seconds.

Mr. FRIST. Three minutes. Thank you, Mr. President.

I will be very brief. I commend the Senator from Missouri for outlining what are really the fundamental problems in this legislation. It boils down to the fact that essentially, with the same patient protections that are in the Frist-Breaux-Jeffords bill, they offer it at a price which drives hundreds of thousands of people to the ranks of the uninsured.

The Senator from Missouri just had up a chart in relation to the number of employees of small businesses who are going to lose their insurance because of this bill. It tells the whole story. Over the next several days we will be able to weave together why. But it goes down to what the Senator from Missouri just outlined.

You have to read the bill. You have to look at the exceptions. In the bill there is the statement that employers are excluded, but then you go through exception after exception after exception, where you have these lawsuits where the employer can be sued. That creates insecurity and uncertainty for the future. Clearly, an employer is not going to maintain that new liability which can put him or her out of business the next day.

One of the problems we will get to in reading the bill—and I only have a couple minutes now—is the fact that under the Kennedy bill, once you get to court, you can go either to State court or Federal court. If you do not like Federal court, you can go back to State court. If you go to State court, since there are 50 different State courts, you can shop from court to court.

If you are an insurance company, and you cover five or six States, and a patient sues you, that patient will say: Well, they cover, for example, Alabama, and there are no caps, no limits there—the tort may be very different—I can sue for an unlimited amount. You have forum shopping on the States.

You can go to State court or Federal court. If you go to State court, there are unlimited economic damages under the Kennedy bill, and unlimited noneconomic damages, and, for pain and suffering, unlimited punitive damages.

Let's say you flip and go to Federal court. If you go to Federal court, again there are unlimited economic damages, unlimited noneconomic damages, and, yes, there is this \$5 million limit on punitive damages. You might decide to go back to State court: No caps, no limits—shopping back and forth. That is what is in the underlying bill.

Can it be changed? Hopefully, it can be changed during the debate. Clearly, this sort of forum shopping between Federal court for nonmedically reviewable decisions—in the new bill, which is just introduced three nights ago, there is a whole new provision which greatly expands what you can go to Federal court for, and I quote what is in the

new bill—it was not in the bill 5 days ago but is in the new bill—"violation of any duty under the plan," which is a brand new expansive right to sue.

Mr. President, how much time do I have at this juncture?

The PRESIDING OFFICER. The Senator from Tennessee has 50 seconds.

Mr. FRIST. Fifty seconds.

So we do have to read the bill. Again, it is going to take time as we go through it line by line. When you see this expansive new right to sue in Federal court, which was not there last week or a month ago or 2 months ago or in last year's bill—I don't know if it was snuck in; it is in this new bill—all of a sudden it opens up a whole new category for which you go to Federal court. But if you do not like that, maybe you will decide to go to State court. There is no bifurcation in the bill as written.

Once again, that is just an example of why we need to read the bill. It is critical that we do so as we move forward; otherwise, we are going to cause hundreds of thousands of people to lose their insurance.

Mr. President, I yield the floor.

Mr. REID. Mr. President, I yield to the Senator from Maryland.

Mr. SARBANES. Mr. President, during the next few days, we have the opportunity to finish important work that was started years ago. We can finally enact meaningful patient protection legislation by passing the McCain-Edwards-Kennedy Bipartisan Patient Protection Act. The time has come to ensure that patients of managed care organizations receive the protections that they deserve and HMOs can be held accountable when they wrongfully delay or deny coverage.

Many times, it is difficult for people to understand how the issues we debate here relate to their everyday lives, but that is not the case with patients' rights legislation. The preponderance of managed care organizations makes it crucial that participants in these plans have basic protections. Over 25 percent of the U.S. population is enrolled in an HMO. Over 60 percent of Americans and over 75 percent of insured employees are in some form of managed care. Receiving health care through managed care organizations is not a matter of choice for most of the 160 million Americans in these plans and uniformly providing quality care should be the standard for health insurers.

I hear from my constituents about this issue constantly and they are anxious for this legislation to be debated, voted on, and signed into law. They want guaranteed access to specialists. They want to be sure they can receive emergency services as soon as possible and from any appropriate provider. They want to be able to participate in life-saving clinical trials. They want a fair, independent and timely appeals process when HMOs deny care. And they want to know that their HMOs will be held accountable for the harm

caused by wrongful denials or delays in coverage. The Bipartisan Patient Protection Act ensures patients receive common sense protections and this bill provides these protections without significantly increasing health care costs or unfairly opening employers up to liability.

Like my colleagues, I have heard from hundreds of constituents who are deeply concerned about the unfair treatment they receive from their HMOs. They have been in situations that any of us would dread. They discover they are ill, or that their child or spouse is ill. These situations are taxing enough, but many of my constituents and many Americans throughout this country find that in addition to fighting a personal or family illness, they have to muster extra strength to battle their HMO. When people are at their most vulnerable, they are being treated unfairly and being denied the care to which they are entitled. This legislation will put a stop to these practices.

The McCain-Edwards-Kennedy bill would not subject an employer to liability for HMOs unless the employer "directly participates" in a health treatment decision. Only those very large employers who run their own HMO would be liable. So if an employer were not acting as an HMO, they would not be held accountable as an HMO. In addition, the Congressional Budget Office has estimated that this legislation would only modestly increase costs—4.2 percent over 10 years. Of this modest increase, only .8 percent is attributed to the liability provisions of the bill.

As we debate this measure, the experience of one of my constituents comes to mind. She is a young woman who loves the outdoors. One weekend during a hiking trip in the Shenandoah Mountains, she lost her footing and plummeted to the ground from a 40-foot cliff. Though she suffered significant injuries, she was fortunate to have survived.

Unfortunately, her fight to get well was not the only challenge she faced after her accident. Her HMO denied her claim on the grounds that she had failed to gain pre-authorization for her emergency room visit. She fractured her arms, pelvis and skull. Her survival was largely dependent upon her being airlifted from the trail to a nearby hospital and her bills climbed to over \$10,000.

Apparently her HMO wanted her to call for preauthorization before she received emergency care. This would have been an impressive feat for her considering she was unconscious at the foot of a mountain. I am unsure exactly when this young woman was supposed to have made this call to her HMO. When she was unconscious on the ground with broken bones? Or maybe when she was in the helicopter being flown to the emergency room?

The fact that she had to fight with her HMO to pay the claims for over a

year illustrates the importance of this legislation. All this time, the unpaid hospital bills stacked up and almost forced her into bankruptcy. Unlike many stories, this one did not end as tragically as it could have. This young woman did eventually get her insurer to pay her medical expenses, but only after the Maryland Insurance Administration ordered the HMO to do so. Her unnecessary ordeal and other stories that end up in tragedy show us that the time has come to stop the delaying tactics and pass meaningful patient protection legislation.

If an HMO wrongfully denies care, if it purposely limits diagnostic tests, if it refuses to cover necessary emergency care, if it withholds access to a needed specialist all in the name of saving money, then the patient who was harmed by these actions should have the right to hold that HMO accountable.

Now we have a bipartisan effort to move this legislation. The authors of this bill have worked tirelessly to try to please opponents and they have made significant adjustments. They have limited punitive damages in Federal court to \$5 million. They have allowed State caps on damages to stand. They have prohibited parallel causes of action in Federal and State court. However, they have not and should not refuse to abandon the main principles of any true patient protection legislation. We have to make sure any bill we pass is as strong as the bill the House passed in 1999.

I commend Senator DASCHLE for placing such a high priority on patients' rights legislation. His decision to make it the first bill to be debated on the floor under his leadership shows his commitment to this issue. The McCain-Edwards-Kennedy legislation provides strong, enforceable Patients' Bill of Rights. This bill is long overdue and we should pass it now.

Mr. REID. I yield to the Senator from Washington.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, I thank the Senator from Nevada for yielding me time.

Families across our country are being denied the medical care they need. These are people who have insurance. They paid their premiums. They think they are covered, but when they need care, too often they find their insurance company is most concerned about its immediate bottom line rather than their health care.

Like my colleagues, I cringe at the stories I have heard: A parent taking a child with a 105-degree fever to the emergency room in the middle of the night only to be told later that their insurance would not pay for the care that was needed; doctors offer their best medical opinions only to see them overruled by an insurance company. Too often the system makes it harder for patients to get the care they need. There is more of a focus on short-term costs than quality care.

The truth is those decisions by insurance companies and HMOs have real consequences. A child's condition may worsen. A dad might not be able to go to work. A mom may need around-the-clock medical care. But under the current system, these patients have no legal recourse. If the company they paid medical coverage to makes a bad decision, there is little recourse. That is wrong. That is one of the problems I hope we can fix by passing the Bipartisan Patient Protection Act.

For several years, I have been working in the HELP Committee, with my colleague presiding today, and here on the floor to make sure that patients get the kind of care they need. Last Congress, the other side put forth a very hollow bill that excluded many Americans and didn't provide the protection patients needed. But this year, we finally have a real chance to help families. That is why I am proud that this is the first major bill being offered in a Democratic-controlled Senate.

I support S. 1052, the Bipartisan Patient Protection Act. It gives patients the protections they need. During this debate, many amendments will be offered. Some of them will weaken the bill and draw the debate away from patient protections. I will call those attempts as I see them. I will work to make sure that patients' rights are not watered down over the course of the debate.

Health care quality and access are top issues for people in my home State of Washington. A few weeks ago, I spoke at a forum on health care in Olympia, WA. We were expecting at the most maybe 100 people would come to that event. When I arrived at the Olympia Center, I saw almost 600 people packed into the auditorium and into rooms they had opened for overflow. They turned out in tremendous numbers and spoke with such great passion because they are concerned about access to health care.

As we begin this year's debate in the Senate, I want to outline some of the problems of our current system and some of the reforms I believe are really needed. I do mention that we are not trying to eliminate managed care. In fact, it is important that we have ways to coordinate care and focus on prevention and wellness and to diagnose problems sooner. When the incentives are right, managed care can work.

In Washington State, it has helped play a role in improving life expectancy, lowering infant mortality, and ensuring women get mammograms. Unfortunately, however, today the incentives are all wrong. They focus more on cost than on care, more on a company's short-term financial health than on a patient's long-term physical health. We need to change the incentives so people are fighting illness, not fighting their insurance company.

We need to make sure insurance protects you when you become ill and prevents you from becoming sick in the first place. 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 can take an injured child to the closest emergency room instead of one that is miles away because the insurer demands it. We need a system where the ultimate decision rests in the hands of patients based on the best medical advice of their own physician.

We need simply to restore the doctor-patient relationship. Too often today a doctor is allowed to be little more than a consultant. Sometimes his or her recommendations are accepted. Other times they are not because someone else made a decision for that patient, someone who has not even seen that patient and who is not even a qualified or licensed health care provider. We need to help companies that are trying to do the right thing but are being beaten out by some bad players. We need a system where patients will know up front what their own rights are.

These days it is only when they become seriously ill that patients learn how good or bad their insurer or their HMO is. That is why we need clear, uniform, Federal quality control standards that protect all consumers. Those are some of the changes we should seek.

I now turn to a few specific points I will be fighting for in this debate.

First of all, we need to guarantee access to specialty care. Secondly, we need to guarantee access to clinical trials and comprehensive care. We need to cover emergency treatment and not just the care provided in the emergency room itself. We need to make sure we protect as many Americans as possible. Some bills have such a limited scope that many patients would get no protection.

Finally, we need to make sure that plans are held accountable for health care decisions and that the external review process is objective and timely.

Those are some of the things I will be fighting to make sure we keep in this debate.

We know that patients aren't getting the care they need. We know what the problems are, and we have a bill in front of us that will fix them.

The American people have been waiting too long for real health care protection, and we have an obligation in the Senate to give them the coverage they need. That is what this coming debate will be about.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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 Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, a number of our colleagues want to ad-

dress the Senate. So I will speak briefly this afternoon.

I want to come back to one of the provisions I believe is so important in our legislation. I don't think there really should be any doubt about our strong commitment in the Senate to protecting American patients on the issue of clinical trials.

As I mentioned earlier when I had a brief exchange with my friend and colleague from North Carolina, I think any Patients' Bill of Rights that is going to be worthy of its name is going to provide good protection for clinical trials. As I have mentioned on other occasions, we have seen a vast expansion of basic research and commitment by this body. We have doubled the NIH budget in recent times. Recently we have witnessed the mapping of the human genome and the sequencing of genes.

Rarely does a day go by when we don't hear on radio, see on television, or read in the newspapers about some new kind of medical breakthrough. These breakthroughs can make a very important difference in the quality of health and life for American patients. Our whole biotech industry has been increasingly effective at making progress in areas which we could not have possibly have imagined. It is true with the orphan drug program, which we intend to reauthorize this year. On just about every front, we have seen the most remarkable progress. But in order for that progress to take life, we have to see the progress made in the laboratory get to the patient. The key aspect of this transition is clinical trials.

We believe clinical trials offer enormous hope for thousands of our fellow citizens. What we have seen in recent times is that one of the most serious abuses by HMOs is the denial to participate in clinical trials. Had these patients been involved in clinical trials, in many instances their lives would have been saved. This has been commented on by our colleagues. Their lives would have been greatly enhanced if they had been able to participate in these clinical trials.

I still remember very clearly the testimony we had before our HELP Committee on this issue a number of months ago. We had the director of the Lombardi Center, named after the great football coach, here in Washington. We asked him about what their principal challenges were as a research center. He said they had hired a number of people, and the people they hired were professionals. However, what they were hiring them for was to wrestle with the insurance companies to permit those individuals who ought to be included in the clinical trials to be so included. They had seen a significant expansion of that—far too many. He said they could have used those resources for additional kinds of trials and benefits for consumers. But he gave so many different examples of people whose lives were basically diminished and, in many instances, lost because of the failure of inclusion.

In the provisions of the McCain-Edwards bill, there are protections which are routine in terms of clinical trials that must be followed. In order to participate, there has to be the prospect that the individual can make progress, and the patient also has to meet other kinds of basic requirements. The last time we debated this issue on a Patients' Bill of Rights, the Senate finally accepted a study on whether clinical trials were really useful, productive, or helpful for American patients.

It is difficult for me to believe that was the final resolution for this body, but it was. What concerns me greatly is the issue of how we are going to eventually resolve this issue.

Recently, the Medicare Program has expanded their clinical trials program. They had to deal with a number of issues. They had to deal with unanticipated patient care costs as a result of participation in the clinical trials. They had to deal with a number of these matters.

It is interesting to note that the alternative proposal from Senator FRIST and Senator BREAUX has a clinical trial provision, but their provision will substantially delay implementation. A fair review of their provision reveals the clinical trials would not go into place for probably 4 or 5 years and also their bill excludes unanticipated patient care costs as a result of participation in clinical trials.

The reason they delay implementation is they want a further study on the allocation of costs between the clinical trials and the insurance companies. The fact is, that study has already been done. That review has already been made. The facts are in and they have been examined, reexamined, and examined again. They are being implemented at the present time and are virtually unchallenged.

We have to ask ourselves why we should have a whole other additional process that is going to delay clinical trials under the proposal of our colleagues. I have not heard the justification or the rationale for that.

Also, the alternative to the McCain-Edwards proposal excludes the FDA clinical trials. That, I understand, is directly as a result of the request of the insurance industry.

That does raise important questions because the FDA reviews are some of the most advanced reviews, some of the most important reviews, and some of the trials are at the edge of potential benefit to consumers. Yet they are completely excluded. They are included in our proposal because we value those important clinical trials.

This provision of clinical trials may not seem as important, but if one asks the breast cancer coalition in this country about what is extremely important in the protections of women and the treatment of women, they will mention clinical trials.

If one talks about other dangers of cancer, by and large, the issue of clinical trials will be at the top of their list, a top priority, a top patient protection, and we believe in that. We share that view. This is something that is absolutely essential if we are going to move ahead with the protections of patients.

We have done that previously. We have seen how there had been an allocation of resources historically between the insurance companies when they covered patients and the trial itself as a general understanding, as I mentioned, under Medicare, about those allocations of resources, what should be allocated for the clinical trial and expenses associated with that, and also what would be allocated by the continuation of care which the HMO would be otherwise required to pay.

One of the loopholes that has been added to this is the issue about some reaction to the clinical trial that may be related to the illness or not, say, someone going in under a cancer protocol and then having some kind of adverse reaction as to make their situation more complicated. Yes, that may happen in certain circumstances, but it does seem to me we ought to address that. We have done that in the past. There is no reason we should not. That has not presented itself as an impediment to moving ahead on this issue. We ought to be able to get that behind us.

I am strongly committed to ensuring that whatever comes out of this body in terms of the Patients' Bill of Rights has these protections.

I might mention a note from the Cancer Society:

On behalf of the American Cancer Society and its 28 million supporters, I am writing to respectfully request that you allow debate on the Patients' Bill of Rights to move forward and that you support the "Bipartisan Patient Protection Act of 2001." As the largest voluntary health organization dedicated to improving cancer care, the Society has set the enactment of a patients' bill of rights that provides strong, comprehensive protections to all patients in managed care plans as one of its top legislative priorities for this session of Congress.

While the Society does not have a position on health plan liability, we have identified several other provisions that are critical to cancer patients.

This is what it is, Mr. President. We are concerned about what is critical to cancer patients in this country. It is spelled out here. I will take a few moments to mention them.

Specifically, we advocate the patient protection legislation that provides all insurance patients with:

Increased access to clinical trials—assuring that cancer patients who need access to the often life-saving treatments provided in both federally and privately-funded or approved high-quality, peer-reviewed clinical trials have the same coverage for routine patient care costs (e.g., physician visits, blood work, etc.) as patients receiving standard care.

Prompt and direct access to the medical specialists. Patients facing serious or life

threatening illnesses, such as cancer, need continuity of care—

This legislation provides it—the option of designating their specialist as their primary care provider—

This legislation provides it—and the ability to have a standing referral to their specialist for ongoing care.

Our legislation provides it.

Strong, independent, and timely external grievance and appeals procedures.

Our legislation provides it.

Mr. President, the letter continues:

We are particularly pleased that—

McCain-Edwards—

includes a strong clinical trials provision that provides access for cancer patients and others with serious and life threatening diseases to both federally and privately-sponsored high-quality, peer-reviewed trials.

The FDA trials as well as other trials.

Clinical trials are a critical treatment option for cancer patients and are also essential in our nation's efforts to win the War Against Cancer. Without clinical trials, new or improved treatments would languish in the laboratory, never reaching the patients who need them. Unfortunately, only three percent of cancer patients currently enroll in clinical trials. Part of the problem is that many health insurers refuse coverage for a patient's routine care costs if the patient enrolls in a clinical trial—effectively denying access to life-saving treatment.

We are interested in dealing with the challenges of cancer in our society, which is the top killer and the one that is most dreaded.

I remember a great leader in the Senate, Warren Magnuson. He was instrumental in setting up the National Institutes of Health, and strongly supported the Cancer Institute. He said his dream of a newspaper headline was "Cancer Conquered." That is something most Americans agree would be the best possible headline.

Clinical trials are indispensable. Nineteen percent of the children who have cancers are involved in clinical trials. We have had the greatest progress and breakthroughs in the area of children's cancers. Researchers say a very significant reason for that is because of their involvement in clinical trials. We have made slower progress dealing with other cancers, and we have reduced numbers of people included in those trials.

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

Mr. GREGG. Mr. President, this bill is a very significant bill. It impacts about everybody in America; about 200 million people presently have health insurance. As a result, if we passed a bad law, the unintended, or intended, consequences of it could be dramatic.

It is important to take a hard, intense look at what is being proposed by Senator MCCAIN and Senator KENNEDY as their bill. This is in the context of bills which have already been proposed by Members from our side, some which are bipartisan such as the Breaux-Frist-Jeffords bill; some do not have Democratic sponsorship, such as the

Nickles amendment. All have as their basic purpose the same intent underlying—certainly I give credit to the McCain bill for this. The basic intent is making sure individuals are properly treated when they interface with their insurance companies; that they have an opportunity for redress that is effective, which allows them to be sure that if they get poor treatment, they have some way to correct it; and that if they are harmed by their health care provider, they have the ability to recover proper compensation for that harm.

That is a goal all Members have. Everyone who is debating in this Chamber understands the importance of making sure that Americans who get health care have adequate recourse when that health care is not supplied correctly. It is also equally important Americans have a certain set of rights when they are dealing with their health care provider in areas such as the type of physician they would see and the type of referrals they would get and the issue of specialists. That is also equally important.

All the proposals that have come forward address that issue. I have not yet heard of a case from the other side of the aisle—and they have presented a number of anecdotal cases, and they are compelling, people who have had problems with their insurers. I have not heard one of those cases where that individual would not have had the ability for redress or be taken care of under either the Nickles or the Breaux-Frist-Jeffords bill. The issue is not about that. It is not about whether or not we are concerned about individuals getting fair treatment from their insurer. It is not about individuals having a set of rights which are protected when they deal with their doctor, who is representing their insurance company, or whether they deal with their insurance company. That is not what this issue is about.

It comes down to a couple of substantive questions as to the differences. The first involves States rights versus Federal rights. That is called scope. It is a question of what authority do we have as a Federal Government to take over authority which has traditionally been handled by the States, especially in the area of insurance. Insurance has traditionally been a State responsibility.

As a former Governor, I know it is something every State takes very seriously and is very committed to. New Hampshire's laws for protecting patients are much more aggressive than proposals in any of the three packages here. That is one element of difference. The other element is something I want to talk about, the area of liability. Liability is a term that has huge implications. The practical effect of the McCain bill, no doubt about it, is that there are going to be created innumerable opportunities for lawsuits to be initiated against not only insurers but equally against employers, small employers and large employers. Mom-and-

pop grocery stores, mom-and-pop gas stations, mom-and-pop restaurants, small, struggling production facilities, software companies, and large employers—Wal-Mart, Ford, whatever, the big ones—those employers are suddenly going to find themselves drawn into literally hundreds of potential opportunities for liability.

What is the effect of that? The effect of that is a large number of employers, especially small and midsize employers, are going to throw up their hands and say: Hey, listen, I can't afford the risk.

The average malpractice lawsuit in this country costs about \$77,000 to defend if you are in an employer situation. There are a lot of small employers for whom \$77,000 is their entire profit margin for the whole year. They may get hit with a multiplicity of lawsuits under this bill that do not exist today. This is a new law created for the purposes of creating new lawsuits. This is a bill that is of the lawyer, for the lawyer, and by the lawyer—for the trial lawyer. And the practical implication is that a lot of employers, a lot of people who want to take care of their people they work with, are not going to be able to, and they are going to simply have to drop their insurance. They are probably going to replace—some of them, the more substantive, will be able to replace their insurance by saying to the employee: Go buy your own insurance. Here is the money.

They will never get as good a package in most instances as their employer could get for them because they will not have the ability to negotiate with the strength of a large number of individuals. Individuals seeking individual policies simply get charged a lot more than groups that have been pursued as a result of a group of employers banning together or even one large employer banning together and pursuing an insurance company. The quality of the insurance will drop for those individuals. An even greater number of employees are simply not going to have insurance at all because small and midsize employers are simply not going to be able to afford it and they will simply eliminate it as an option they present as a benefit in their workplace. So there will be more uninsured.

How can you possibly call something a Patient's Bill of Rights when the practical effect of the bill is to create more people who don't have any insurance at all? So they don't have any rights; they don't have any insurance.

If that is the practical effect of the bill, and it is—you don't have to listen to me. Listen to an independent group such as CBO which has scored this bill as putting 1.2 million people out of insurance. That is the conclusion they came to because of the additional costs that result from the lawsuits, in large part. Those people are not going to have insurance. They don't get any new rights under this bill. They lose all the rights they had. Yet this is claimed to be a Patient's Bill of Rights. Very inconsistent, to say the least.

In the process of setting this bill up, there has been a presentation from the other side that they actually took the other bills that had been pursued in the last couple of years—remember, we have not had a hearing on any of these bills in our committee now for 2 years, which I think is a little bit much—to bring a bill of this size to the floor without any hearings at all so the people who are going to be affected could have a forum to make their points.

Independent of that, there were over the last couple of years bills brought to the floor. There was the prior McCain bill, the prior Kennedy bill, and the prior Norwood-Dingell bill.

The representation has been that the McCain bill has moved to the center from those two bills that were introduced before. In fact, that is not true at all. This bill is much more to the left, and by the left I mean it is much more oriented towards undermining the rights of people to buy insurance and have health insurance. By moving to the left, I mean it interferes much more with States rights and it places much more liability on the backs of small employers and also large employers.

This bill moves significantly to the left, not to the center. There are ways to move this bill to the center. Breau-Frist-Jeffords is a bill that has moved to the center from the Nickles bill that was debated and passed in the Senate last year. If you want to argue center, left, right, this bill moves way out into left field, as compared with the original bills which were introduced and were already pretty far out in left field. This bill, if it were in Fenway Park, wouldn't be in left field; it would be in the bullpen. Well, actually that is in right field. It would be behind the Green Monster.

I point out a few areas where this occurs. First, as I have mentioned, it significantly expands liability for employers. Sponsors of the McCain bill say they have compromised by including a \$5 million cap on punitive damages. However, the cap only applies in the Federal liability provisions added to the bill—it is sort of a bait-and-switch thing—and not to the more expansive liability provisions under State law.

One of the ironies of this bill is you can go forum shopping. This is one of the favorite things trial lawyers like to do. I used to do a little bit of trial work. You love to forum shop. You find out what court has the best judge; you find out what court historically has the juries that give the highest award; you find out what court has the best rules to improve your capacity to win your case on procedural grounds; and you move to that court. If it is a Federal court, you go Federal. If it is a State court, you go State. Under the present law, you cannot do that. You cannot bring an ERISA claim in a State court. But under this bill, it expands dramatically the opportunity for forum shopping. Then it says: But, hold it, we put in a cap so you don't have to worry about that.

Unfortunately, there are a lot of States that have no cap. They have no limitation at all on damages.

Further, the bill itself allows unlimited damages for economic and non-economic losses—damages within the Federal court system. It expands the right to sue for violations of duty under the plan. This is a brandnew concept. It creates a whole new cause of action out there where employers will suddenly become liable for contractual activity on HIPAA or COBRA or ERISA that they are not liable for today, relative to a private lawsuit.

I have a chart. I don't have it on the floor today because I had it up so often I thought people might be getting tired of it. But it shows there are potentially 200 new causes of action just on this one point alone.

Then it says it does not have punitive damages. In fact the earlier bills did not have punitive damages. At least H.R. 990, which I think is the original Norwood bill, did not. But, in fact, it creates a new term of art, which is essentially punitive damages, and it allows those damages, as I mentioned, to be recovered at the rate of \$5 million.

Here is a bill that says it is moving more to the center when, in fact, in the liability area it dramatically expands forum shopping, it dramatically expands punitive damages opportunities, it dramatically expands the number of lawsuits that can be brought on the issue of contracts and contractual obligations of the employer—all of this is directed at the employer—and it dramatically expands, in Federal court, economic and noneconomic damages that can be recovered against the employer. All of this is new. A brandnew attack on the employer by the trial bar will be allowed under this bill.

This is not moving to the center. This is moving to the left.

Another example, the McCain-Kennedy bill effectively requires that all States pass new patients' protection laws identical to the new Federal requirement. This is a huge step, an intrusion into States rights. Earlier versions of the legislation, both the Daschle-Kennedy bill last year and the Norwood bill, used the standard under the Health Insurance Portability and Accountability Act to determine whether or not State laws would be preempted by the new Federal patients' requirements. That standard does not prevent the application of this Federal law versus requiring the application of the Federal law.

The latest McCain bill adds new barriers for States by requiring that State laws be substantially equivalent to and as effective as each new Federal patient protection requirement. This two-part standard will effectively require every State to renegotiate and pass a whole new group of provisions in order that their laws be virtually identical with the Federal provision. If the State fails to do so, the Federal Government will take over and enforce those rules in every State.

So I cannot see how you can claim this bill moves to the center when the practical effect of this section is to essentially usurp and wipe out States' activities in this area.

My colleague from Maine just spoke a little while ago. She put up a list that showed literally almost every State in the country has aggressively addressed the issue of patients' rights and has established a set of requirements and rights which flow to the patient that are fairly consistent with what we all seek in the Senate. But if they are not exactly or substantially equivalent to and as effective as the Federal law, they will be overruled and the Federal Government will come in and usurp the State authority and actually take over the State's insurance enforcement.

We have had State insurance enforcement in this country for quite a while and it has worked pretty well. So you cannot say a bill moves to the center when it essentially says "to heck with the States, we are coming in, we are the big boys, you are out of the game because we know better than you, State legislatures. You, the State legislature, are not interested in the people who live in your States. We here in Washington are."

That is not a movement to the center. That is a dramatic, if not radical, move to the left, to centralization of power here in Washington at the expense of the States.

In addition, another example of the fact this bill does not move to the center but moves way off beyond the Green Monster, out beyond left field, out past Lansdowne Street, probably down by the Massachusetts Freeway—actually it is not a freeway; it costs money—the Massachusetts Turnpike is the effect this bill has on the ability to bypass the appeals process.

The prior proposals, earlier versions which were pretty far left, out there in left field, as I said, of the bill provided where injury or death had already occurred, and therefore the appeals process would be futile, the patient would not be required to exhaust the appeals process before going to court. The new version permits a person to bypass the appeals process and go directly to court to seek monetary damage if the harm would occur by going through the process.

That may sound reasonable, but you have to read behind that language for the practical impact of what it is.

It is noteworthy that this exception would allow lawsuits for virtually unlimited monetary damages rather than simply allowing patients to get the care they need if they would be substantially harmed by completing the review process.

The new version of the McCain bill also contains a late manifestation provision. This is an amazing provision because this provision essentially says that if the appeal process period has run and you decide that you have a manifestation of harm as a result of

being treated, you no longer have to go to the appeal process; You can go directly to court.

The practical effect of this language is essentially to eliminate the statute of limitations. Under this law there is a total abrogation, in my humble opinion, of the statute of limitations. That is a move to the left.

As a trial lawyer, I love the idea that I never have to worry about the statute of limitations because if my office happens to make a mistake and not reach that 3-year window or that 6-year window, I am not going to be subject to the errors and omissions suit that I might get hit with by my client because, if there is no statute of limitations, I will never miss the filing requirement.

But going back beyond the manifestations language, this concept that is totally different than what was in the original Dingell-Norwood bill and the original Daschle-Kennedy bill that you as a patient do not have to exhaust your administrative remedies before you go into court, but you simply have to claim harm, and then you can go right after monetary damages, is a dramatic undermining of the capacity to have an effective appeal process. You essentially have no appeal process.

Now all you have are court decisions. Nobody is going to go down the appeal process route. Everybody is going to race to the courthouse with this bypass language.

The way it should be structured, obviously, is that, sure, if you are injured and you are going to suffer as a result of having to go through the appeal process and you are not getting a response, you should be able to go to court, but you shouldn't get the monetary damages at that time. You should get whatever you need in order to get the right medical care, then go back to the appeal process and find out what the proper resolution should be and then move into the court system for the monetary issues.

That is the logical approach. It is actually the approach, for all intents and purposes, that was in the original bill. Now we have another example of moving way over to the left and not moving back to the center, which this bill claims to do. It doesn't move to the center at all.

These are not minor issues—the liability issue, going straight to court issue, and the States rights issue. These are not minor issues. These are big questions in the scheme of how we deliver health care. The reason they are big questions is because, if this bill passes, it is going to fundamentally change the way health care is delivered in this country. It will push a lot of people into the uninsured ranks. As a result, you are going to have this huge momentum for the nationalization of our system.

At this point, I see our leader coming on the floor. I know he has comments that he wants to make. So I will yield the floor.

The PRESIDING OFFICER. The Republican leader is recognized.

Mr. LOTT. Mr. President, timewise, what is the situation now? Has the time been divided? Is it in blocks of an hour?

The PRESIDING OFFICER. There are 6 minutes 40 seconds remaining.

Mr. LOTT. Thank you very much. Mr. President, I will try to take advantage of that time and make a few remarks. Maybe then I can come back and talk again later.

First of all, I wish to comment briefly with the time we are using now. I think it is an important part of the process that we have opening statements and descriptions of what is in the pending bills—both the Kennedy-McCain-Edwards legislation as well as Breaux-Frist and other legislation—so we can see where the similarities are and find where the problems are.

We did not want to go forward with the amendment process on Monday because there had been changes made in the underlying bill on Thursday of last week, June 14. I presume there will still be more changes offered by the sponsors of the legislation, whether it is Senator MCCAIN, or Senator EDWARDS, or others, as problems are identified and as consideration is given to the reservations. Those will be either amendments or substitutes that will be offered.

I make the point that we are not interested in prolonging the consideration of this legislation. We are prepared to go to the vote in the morning on the motion to proceed. We are prepared to begin the amendment process on Thursday afternoon. Hopefully, we can make progress on amendments on Thursday and Friday and on into next week.

I also hope we will find a way before the Fourth of July recess to complete action on a supplemental appropriations bill. A lot of that will depend on whether or not the Committee on Appropriations can act tomorrow on what is in that legislation. We need to get that done or we are going to see more problems develop with the Department of Defense being able to keep our ships steaming and our planes flying. We will need to do both of these issues as much as we can during the next week.

Let me emphasize a couple of points. Others have noted that many of the core components of the various bills that have been offered, whether it is the original Nickles proposal, the Breaux-Frist-Jeffords proposal, or the McCain-Edwards-Kennedy proposal, have a lot of similarities.

Let me talk a minute about where we agree. We agree that we want a Patients' Bill of Rights to protect patients and to ensure those patients get the care they have been promised. That is why we believe so strongly that we need an immediate review process that will get a result hopefully within a managed care entity or an outside review if that is not satisfactory inside of the managed care entity and that it be

done on an expeditious basis and not drawn out. Get a result.

That is why the idea of going immediately to court has such little appeal to me because legal action, while it might get beneficial results that would be helpful to the heirs, may be of no value to a patient who will have had all kinds of problems, and perhaps even die, before the conclusion of a lawsuit.

All of the bills have a review process. The important thing, in my opinion, is that the review be quick and that it get the results. If the result is not satisfactory, then there has to be some process to get it considered in the courts. I think we will find a way to do that.

We agree that patients have to have access to specialists. That is what caused us to get into the need for a Patients' Bill of Rights. After the managed care concept was established and started going forward, it was doing a good job. It was providing care at a reduced cost. But some of the managed care entities started to make mistakes. The difficulty is they wouldn't make medical records available to patients, which were their own medical records. You can't have that. The idea that you would have to get permission from some other organization to go to an emergency entrance is unacceptable. You have to have access to emergency care in case of an accident, or whatever. Or if you have an OB/GYN doctor seeing a pregnant woman who then leaves that managed care operation, she should be able to continue to have the care of that OB/GYN.

There is no question that we need to make sure that common sense applies and that there is access to physicians. We need to have some way that cancer patients can have access to clinical trials. We need to make sure there is access for women to surgical treatments or for breast cancer. We need to make sure that patients will be able to continue to see their doctor, if the doctor no longer works for the health care plan.

There is a long list of places where we agree that there needs to be access to information that patients and beneficiaries need. We need to make sure that there are new quality measures available.

We should not ignore the fact that there is a lot of common ground. We, clearly, have some areas where we disagree. Of course, primarily it is when, where, and how you have a lawsuit.

I was a lawyer years ago. I was with a trial firm. We did defense work. But we also occasionally filed some plaintiffs' lawsuits.

I am not opposed to having access to the court systems. Americans deserve that right. The question is, Who can be sued? Should a person, or an entity, an employer, that has no involvement in the decision that is made based on business reasons, costs, or medical purposes be sued? Naturally, a good lawyer will throw out his dragnet and bring in employers, doctors, nurses, the man-

aged care entity, the insurance company—everybody who is within range and, by the way, look for the one with the deep pockets. That is what you really want. You want the one from whom you can get the money.

I think we need to be very careful about who is covered by these lawsuits and when they can be filed. Unless and until the review processes are exhausted, we should not be resorting to legal action.

Also, where a lawsuit is filed does make a difference. I know for sure from my own personal experience, since some of my very closest friends and relatives are plaintiff lawyers, that there is this little thing of forum shopping: Let's look around and find the county in the State where we could get the highest judgment. Or maybe it is in a Federal court; let's pick and choose. Or maybe let's file in both Federal and State court.

In my own State of Mississippi, there are a series of articles being done by a Gannett newspaper, the Clarion-Ledger, that would not ordinarily do an article such as this, noting that there are one or two particular counties in my State that are considered a plaintiff's wonderland, where you can get massive damages if you go into these particular counties. By the way, our insurance commissioner—a very fine insurance commissioner of many years a Democrat—has noted that 46 insurance companies have said: We are leaving this State. We are not going to face these exorbitant, ridiculous judgments in this particular county, Jefferson County, MS.

So where you file does make a difference. We need to pay attention to that.

Of course, there is also the question of how much in damages. Is this about a result or is this about a lawsuit? Do we want health care or do we want legal action? Do we want a reasonable judgment for losses that you have incurred or do we want pain and suffering and punishment? Those are basic questions.

But I hope we can bring all sides together and get a result. I want a result. I want us to pass a Patients' Bill of Rights. I think we need it. It is the right thing to do. And I am tired of hearing about it. It is time to act. It is kind of like what we did in the tax relief bill on the marriage penalty. We have been talking about it for 10 years, about how it is unfair, and that we ought to get rid of it. My question was, Why haven't we done it?

We can do this if both sides can be reasonable. I talked to the President yesterday. There is no doubt in my mind the President wants to sign a reasonable and fair Patients' Bill of Rights. But there is also no doubt in my mind he will veto the McCain-Edwards-Kennedy bill in its present form.

I hope we can go through this amendment process, address the delivery questions, the liability questions, and

also see if we can find a way to make health care more accessible to many Americans who are not now covered. Small business men and women have a hard time, even when they really want to, making sure all of their employees are covered because even if they offer them the coverage, and pay half the cost, many employees say: We just can't afford it. We are not going to do it. So they are not covered.

Can't we find a way to give them access to coverage or to help them with the expenses of that coverage? I think we can. I think this is a bill where we can help address that.

Let me note that the distinguished Senator from Nevada is on his feet. I would be glad to yield.

Mr. REID. I just want to say to the Republican leader, you do not have to use leader time. You should not be rushed. Even though you are on Democratic time, you are welcome to it.

Mr. LOTT. That was about the nicest way I have ever been told my time has expired. That is why I was talking fast. I did want to get in a few remarks. I appreciate Senator REID noting that.

At this point, I will yield the floor because we have had very good cooperation in going back and forth every 30 minutes.

I would like to continue that. I will take advantage of leader time another time. But thank you very much, I say to Senator REID.

I yield the floor.  
The PRESIDING OFFICER (Mr. DAYTON). The Senator from Alaska.

Mr. MURKOWSKI. Mr. President, I wonder. There was an agreement that we would go into morning business at 5 o'clock and that I would be recognized at that time.

Mr. REID. I would say to my friend from Alaska, we were told the Republicans would have no one to speak at 4:30. But that was not factual. People did come. And they have used 35 minutes of the 30 minutes. Senator REED has been waiting.

We would ask, under the agreement that we entered into earlier today, that he use his time. I wanted to speak, but I say to my friend from Alaska, if you are the last speaker for the Republicans, I have to be here to close anyway. Senator REED wants to speak for up to 10 minutes.

I say to the Senator, you can speak for however long you desire.

Mr. MURKOWSKI. I respond to the assistant majority leader, I would probably need not more than 10 minutes.

Mr. REID. Mr. President, I ask unanimous consent that the Senator from Rhode Island be recognized for up to 10 minutes—is that adequate?

Does the Senator from Massachusetts wish to speak anymore today?

Mr. KENNEDY. Mr. President, I look forward to addressing the Senate tomorrow morning.

Mr. REID. Mr. President, I ask unanimous consent that the Chair recognize the Senator from Rhode Island for 10 minutes; following that, the Senator

from Alaska for 10 minutes; and then I will close out the evening with whatever time is necessary for that to be done.

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

The Senator from Rhode Island.

Mr. REED. Mr. President, I rise today to support the McCain-Edwards-Kennedy bill and to commend the authors. They have done some great work in trying to reconcile a very pressing need in this country; that is, to give patients the ability to get the health care they need and, indeed, that they either paid for or their employer paid for.

Today I have heard discussion that this is just about lawyers who are going to enrich themselves. But I think that argument misses the point. The point is, there are lots of lawyers on the other side, on the HMOs' side, who are using their skills to deny patients what they thought they purchased with their health care plan, where they are able to use all the loopholes that are rife throughout our statutes, not to provide care but to provide the insurance companies with an out.

The McCain-Kennedy-Edwards bill clarifies the rights of patients. It makes them specific. It makes them less debatable. Let's make these rights less a contest of lawyers on both sides and more something that the patients of America, the citizens of America, can expect will be their right to demand and receive when they pay for health insurance.

So when you have situations where, instead of specifying, as the McCain-Kennedy-Edwards bill does, the right to a pediatrician as the provider of health care services for a child or a pediatric specialist for a child, you have something nebulous like a physician with age-specific qualifications, that is the type of ambiguity that is rife for the competing proposals, and that leads to the denial of care to Americans. In fact, it leads to lots of controversy, strife, discussion, and debate.

So this legislation has been well crafted over many months to specify, delineate, and clearly give patients their rights; in fact, to give them what they believe they are paying for. And they are already paying a lot.

So I believe that this bill has made great progress in moving from the version we considered in the last Congress in this Senate Chamber, and the version that has been proposed by Congressman NORWOOD and Congressman DINGELL in the other body; and we are moving close, I hope, to legislation that can receive the support of this Senate, which can go forward and be combined with a very similar bill on the House side offered by Congressman NORWOOD and Congressman DINGELL, and then go to the President for his signature.

What it would do, I believe, is to, again, specify clearly, unequivocally, what Americans can expect from their health care provider.

There has also been lots of discussion that this really is going to pull in countless numbers of employers, small businesses, who are going to be ensnared in a web of litigation because of this legislation. But that ignores the very specific language in the McCain-Edwards-Kennedy bill that says that an employer can only be liable if that individual played a direct role in a decision to deny a treatment of health care services to a patient. This is not the situation where a small business buys a Blue Cross plan or buys an HMO plan. This is a situation where an individual in that business organization makes the decision to say: No, don't give that service to that individual who is covered by my plan—a very unlikely circumstance, but one I think most people would agree, if you are making those types of decisions, you should at least be potentially liable for the consequences of those decisions.

I believe the discussion of an employer as being ensnared in this web of lawsuits misses the very specific language of the bill. It certainly is not the intent of this legislation. It never has been. With the refined language and the very specific language, I don't think it will be the effect of the legislation either.

We know that this issue is creating a great deal of controversy around the country. It is generating the activity of interest groups left and right. This morning, early today, the junior Senator from Utah spoke about a doctor who was contacted by the American Medical Association to call the Senator and support the McCain-Edwards-Kennedy bill. In the course of the discussion, he discovered that he really didn't support the bill but he favored the Frist-Breaux-Jeffords approach.

That is not the only calls that are being made out there in America as we speak and debate here. My office received a call from a businessman in Rhode Island instigated by the National Association of Manufacturers who said: Call your Senator and tell him not to vote for Kennedy-Edwards-McCain. But when we spoke with the individual, when we explained the provisions of the bill, particularly the provisions with respect to potential lawsuits against employers, he concluded that the Kennedy-McCain-Edwards bill was the type of legislation he could support because he is not just an employer; he is just not a businessperson; he is a family man. His wife had recently been sick, and he understood the difficulties that are faced in trying to get health care out of an insurance company that is committed to the bottom line, not the health care, principally, of their insured members. He preferred, after discussion, the type of protections included in this bill.

I hope that is a sign that when we can come here to the Chamber and clearly explain the contents of this legislation, we can convince many people across the country that this legislation is in the best interest of the families of America.

Now, I have for several years been working to ensure that this type of legislation pays particular attention to children. I am very pleased to say that the McCain-Edwards-Kennedy bill incorporates many of the provisions of legislation I have submitted along with many colleagues. It protects the right of families to have a pediatrician as a primary care provider and the right to make referrals to a pediatric specialist, not just a specialist. There is a vast difference between an adult cardiologist who may have seen a child 1 or 2 years ago and a pediatric cardiologist who specializes in those types of problems for children. If you are a parent, that is the specialist you want to see. This legislation provides for that access clearly, unequivocally.

The alternative legislation would say the company can find someone who has a specific qualification. Again, the lawyers for the insurance company can find many ways to suggest that that is the gentleman or woman who might have seen a child 2 years ago, a cardiologist, rather than the more expensive doctor not in their plan who is, in fact, a pediatric cardiologist.

This is real progress on the bill. I commend the authors for doing this and pushing forward.

There is one area I would like to see included in addition to what has been done. That is a proposal I have made previously on a bipartisan basis with Senators JEFFORDS and COLLINS to create for each State an ombudsman, someone who can be a point of reference and referral to individuals who have questions about their health care plan. Before you even get into a long, protracted internal review or external review, there should be an individual you can contact and say: Do I have a problem here? I think I am covered for this procedure. Am I really covered for this procedure? That type of advice, that type of objective information on a systematic basis can do much to resolve the potential specter of a plethora of lawsuits.

It is a worthwhile initiative. I hope my amendment can be incorporated into this bill. Indeed, I am preparing to offer such as amendment along with Senators WELLSTONE, WYDEN, and CLINTON. I hope when the process begins for amendments, we can make that improvement to what is already a very fine bill.

This is a very clear issue when you boil it all down. Do you stand with the families of America who deserve health care coverage they paid for or do you stand with the insurance companies whose major concern is their financial solvency and well-being? This legislation stands with and for the families of America. I support it.

I yield the floor.

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

## ENERGY CRISIS IN AMERICA

Mr. MURKOWSKI. Mr. President, I recognize that we are debating a motion to proceed to the Patients' Bill of Rights. I am tempted, however, to ask unanimous consent that we set the Patients' Bill of Rights aside and go to the energy legislation that is pending before this body. I shall not do that, in deference to my colleagues on the other side, although I must admit, it is somewhat ideal and timely.

What I am going to do is call on the majority leader of the Senate to set a date to take up the energy crisis in America. Polling indicates the No. 1 issue in this country and concern is not education. It is energy.

Under the previous leadership—and hindsight is cheap—this was the week we were going to be debating a comprehensive energy bill in this body. Senator LOTT had indicated that that was the next order of business after education. Where are we in the order of business? We are on the Patients' Bill of Rights. We are supposedly going to be on the supplemental next week. We may take up the minimum wage. We may be on appropriations. Where is energy in the Democratic list of priorities for this body? I am very disappointed that evidently it has been tossed aside under the new leadership.

Where have we been on this matter? We have been busy. The Energy and Natural Resources Committee, which I previously chaired and on which I worked with Senator BINGAMAN—Senator Bingaman now chairs the committee—has been busy inasmuch as we have held 24 hearings. We have had 164 witnesses over the last year. We clearly know what this country needs. We need to produce more energy. We need to develop alternatives. We need to develop renewables. We need to do a better job of conservation. But we have to come to grips with this crisis. We can't ignore it. It is not going to go away.

The issue is ripe for debate in this body, ripe for debate on the Senate floor. We should proceed forward on behalf of the American public who is looking to Congress to provide a solution.

We all know prices are too high; supplies are too low. We all know that too little is being done as evidenced by the calendar with which we are confronted.

I therefore ask the majority leader at this time to agree to bring the energy policy legislation to the floor of the Senate at a time certain, and certainly no later than July 23. I look forward to his response.

To give some idea of the timeliness of this, one only has to look at what is going on in the committees. Yesterday, the Energy and Natural Resources Committee heard from FERC. We heard from the five members of the Commission.

Today, in Government Affairs, we had the Governor of California, Gray Davis, along with other Western Governors, appearing to tell of the energy crisis in their States. We also heard

from the FERC relative to the action they had taken unanimously to reach a conclusion to basically take the pressure off what was proposed as legislation to mandate wholesale caps and prices.

I think it is fair to say that we can commend the administration, the President and the Vice President, for holding the course because wholesale caps do not encourage investment. We need investment in new power-generating facilities. As the President knows, if you put very tight caps in, investment will not come in regardless of how many permits for construction are issued. The incentive for a reasonable rate of return has to be there.

Now, FERC has come out with an order that addresses this. It takes care of not only investor-owned but municipally owned utilities. It covers both. It sets a 15-month timeframe in which to work, and it bases its great structure at the lowest efficient contributor into the energy pool.

I commend FERC. We can argue why they didn't do it sooner, but it is important to recognize that FERC has just been functioning with its five members for a relatively short period of time, less than 2 weeks. Where were they last year? There is no use going back and trying to figure out why they didn't act sooner. In any event, it is fair to say that what California needs is not political excuses; they really need practical solutions.

FERC, while working out the solution, found that some in California continue to spin the issue away in the hopes that somehow the blame will be deflected. We heard from Governor Davis. He has been blaming virtually everyone for the problems in California—his predecessor, the State legislature, and he even blamed the Texas ownership that contributes only about 12 percent of the energy that comes into California from Texas-owned energy companies. Twelve percent is significant but not overwhelming. He has blamed the President and the Vice President for problems that began 9, 10 months before they even took office. He has not recognized that, indeed, the President and the Vice President, in their proposal in the energy task force, proposed realistic ways to correct the problem—to correct it for California and nationally—by a balanced comprehensive energy policy. He also blamed power producers for price gouging. He hired the head of one of these groups, David Freeman, of the Los Angeles Department of Water and Power, as his energy adviser.

One has to look at the list of those that allegedly have overcharged California. They contribute about \$505 million. Among them is the city-owned Los Angeles agency that distributes water and power in Los Angeles—somewhere in the area of about \$17 million in overcharging. Another significant overcharge allegation was leveled against the Columbia River producers on the Columbia River in Bonneville.

Nearly \$173 million were BC hydro, which constituted about two-thirds of the \$505 million.

I suggest that California spends more time discussing the problem of spinning off responsibility than looking forward to how they can address changes by increasing more production in California. I commend FERC, and I share the President's commitment to market competition, not Federal Government command and control. We must never forget that Government itself doesn't generate one kilowatt of electricity, and neither do controls, if you will, on private investment. Only industry can generate the electricity the public needs. Price controls have never spun a turbine and have never stopped a rolling blackout.

In the pursuit of just and reasonable rates, Congress need not pursue new legislation. As we saw yesterday from the FERC, the system is working. The FERC order clears the way for our work on the long-term solution. We must come together now on focusing our attention on putting in place a comprehensive national energy strategy that will help get us out of this crisis and keep us out. That must be our priority. And recognizing the contribution the administration has made in submitting the energy task force to us, the introduction of bills by both Senator BINGAMAN, myself, and a number of Members, which is a comprehensive proposal for relief, should be on the calendar of this body. It should be on the calendar for action now. It is beyond me why those on the other side have chosen to ignore it at a time when it is the No. 1 priority in the country.

Further, on a sidenote, on May 23 of this year, the Committee on Energy and Natural Resources, which I formerly chaired and now am the ranking member, reported the nomination of Steven Griles to be the Deputy Secretary of the Interior. It has been 28 days and we are still waiting to even get a time agreement, which was noticed to us that would be required. The significance of this particular nominee in the Department of the Interior is that the only confirmed position at the Department of the Interior is the Secretary of the Interior.

That is simply irresponsible. It is time for the Senate to let Steven Griles' nomination go. We look forward to trying to work with the majority to achieve this. There is absolutely no excuse to hold this nominee from being confirmed. He has been voted out of the Committee on Energy, and there is little we can offer the majority. The excuse is that they are holding up the nomination until such time as the committees are determined. But we all know the committees are going to be determined with at least one more Member of the majority going on the committees. I don't know what the minority can do other than to recognize that the Department of the Interior serves all of us—both Republicans and Democrats—and to hold up the functional responsibility when we have had

the hearing and this nominee is waiting to serve the country bears another examination by the majority. I would certainly be glad to get any explanation anybody might care to provide at this time, or at any other time.

I will leave you with one thought. Back in 1992, we had a similar concern in this country that we were facing—an increase in imports. As a consequence of imports, we were increasing domestic production, as well as domestic demand, and as a consequence, we became concerned and passed out of committee a number of items that are shown on this chart. It is interesting to note, though, what we got out of the process when it went to the floor. We had given on all the supply increases associated with increasing domestic production and reducing dependence on foreign oil. As a consequence, it is rather interesting to see on the current energy plan that there is little relief proposed. Yet in our comprehensive bill on the right, clearly we tried to cover all the areas of concern.

The reason that things are different—and I will show you this on the second chart—things aren't the same as they were in 1992—we have kind of a "perfect storm" scenario. We were 37-percent dependent in 1973. Now it is 56 percent. The Department of Energy says it will be 66 percent by 2010. Natural gas prices soared three to four times. They were \$2.16 per thousand, and now it is somewhere between \$4 and \$5. We haven't built a new nuclear plant in over 10 years, no new refineries or new coal plants.

I thank you for the time. I yield to the majority whip.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, I say to my friend that I am still the chairman of the Committee on Environment and Public Works, and we have a number of nominations waiting to help Governor Whitman. We have approved a deputy, Linda Fisher. I wanted to make sure she called, and she said she needed that help very badly; and we worked it out so when the Republicans were under control, I made sure that was released and that she could get over there and help.

We have a number of people waiting to go to the EPA. Governor Whitman needs help also with running that important entity.

I think the Senator should check with people on his side. The reason is that we have been waiting since we took control of the Senate to have a simple organizational resolution passed to allow the committee structure to be effectuated.

Rather than having an arrangement where the minority leader, Senator LOTT, speaks with the majority leader, Senator DASCHLE, a committee was formed to meet with Senator DASCHLE.

As we know, any time committees are chosen, it usually slows things down. Someone told me once that a committee was formed to come up with

a horse, and the committee came up with a camel. That was their version of a horse. I think the committee is not really serving the Senate well.

I have knowledge, and I am sure their intent is good, nothing has happened in all this time. It seems to me the time has come that something should happen. There has been a lot of passing back and forth of memoranda and meetings, but that is what is holding things up.

As I indicated, we have people for EPA. Senator LEAHY has said publicly on a number of occasions he wants to start hearings in the Judiciary Committee.

This is not, as far as I am concerned, payback time. The fact is that 45 percent of President Clinton's nominations for the appellate court never made it through the process—45 percent. When we were in control last time, the average waiting time for a judicial nomination was 85 days. The last full Congress when the Republicans were in control, the waiting time was 285 days.

This is not going to be payback time. Senator DASCHLE has said that. We are going to conduct the Senate and the committee system in an appropriate way.

We have vacancies in Nevada. We have three vacancies for Federal judges in the small State of Nevada that need to be filled. We hope that can take place quickly. Senator ENSIGN and I have agreed on the judges who should be nominated and sent to President Bush. They are down there now.

I say to my friend from Alaska, we also want the organization of the Senate to formally take place, and we hope the committee of five will get together and take care of the other 44 Senators they represent and move on to what we believe is the appropriate function of this Senate.

I will be happy to yield to my friend from Alaska.

Mr. MURKOWSKI. I very much appreciate the comments of my friend from Nevada who has outlined, I think accurately, the overall situation. I did not in my request highlight the overall resolve of this dilemma associated with the committee and the structuring of the committee. What the Senator said certainly is relevant to having the committees take action.

This issue of Steven Griles is entirely different. The reason it is different is he has been waiting 28 days. That was before the Senate changed hands. For the majority whip to indicate he is part of this, in reality, his nomination was pending before Senator JEFFORDS left our side and joined the other side.

At that time, we were negotiating with the Democrats in good faith to agree to a time agreement, and there was an indication that they would require at least several hours, and we were willing to do that.

I want the record to note Steven Griles is different than the other pending nominations because he was pro-

posed and held up prior to the Democratic Party taking control of the Senate.

I again renew my request that special consideration be given him because his is truly a special case.

Mr. REID. Mr. President, I say to my friend from Alaska, I have not spoken to the majority leader about Steven Griles, but I am confident once this organizational resolution is in effect, that will happen pretty quickly.

Mr. MURKOWSKI. If the Senator will yield on one more point.

Mr. REID. Yes, I yield.

Mr. MURKOWSKI. I can appreciate that, but we are still saying Steven Griles is, in effect, held hostage as a consequence of the policies of the majority now when we could have taken action when we had the majority, but we were trying to work with the minority at that time.

Clearly, we are left in this dilemma of him being caught, if you will, in the tidal backwater which affects us all, whether Republican or Democrat.

As the Senator from Nevada knows, he is from a public land State. He needs some help at the Department of Interior. This action of delaying simply puts off Mr. Griles' ability to serve our country and the Department. That is, indeed, unfortunate, particularly in view of the fact he was voted out of the committee and his nomination is still pending.

Mr. REID. Mr. President, I feel confident that it will be in everyone's interest—the minority, the majority, and every State in the Union—if we can get this organizational situation completed. We have waited far too long. The committee of five should meet as often as necessary with Senator DASCHLE. We only have one representing us and five representing them. I think Senator DASCHLE would make himself available any time of the day or night to get this organizational situation resolved.

#### PATIENTS' BILL OF RIGHTS

Mr. REID. Mr. President, there has been a concerted effort since the first day of this week to stall, hinder, slow down—whatever term one can use—the movement of this legislation which is before the Senate, the Patients' Bill of Rights. This method to slow down legislation has come about because the managed care entities and the people who work with them, who make a lot of money, have said to the minority: Do not let this legislation move. And the minority is trying to live up to their request. Keep this legislation boxed up. Tie it up for as long as possible.

I announce to everyone within the sound of my voice and I spread over the Record of the Senate that the "as long as possible" has come to an end. We are going to move this legislation. Five years is long enough. We are going to move this legislation now.

In the morning, we are going to vote on a motion to proceed that should

have taken place a long time ago. We should not even be having a vote on a motion to proceed, but that is the way they decided to slow it down, recognizing if they slow it down this week, then maybe next week we will not want to work very hard. We have the Fourth of July parades, our 10 days at home, and then they will wait until after the Fourth of July, and we will have appropriations bills and maybe there will not be a Patients' Bill of Rights for the sixth year.

That is not going to happen. TOM DASCHLE—whom I have known since 1982; I served with him in the House and I have the good fortune of serving with him in the Senate; we came here together—has said we are going to complete this legislation before the Senate recesses for the Fourth of July break.

TOM DASCHLE is a man of his word. That is what is going to happen, and everyone should understand that.

Why is this legislation called the Patients' Bill of Rights? It is called the Patients' Bill of Rights because it will create a law that gives patients the rights to which they are entitled, which they now do not have. In short, it will once again allow a doctor to care for his or her patient. That is the way it used to be.

Just think, a doctor can prescribe medicine for his or her patient that will heal that patient in the mind of the doctor, relieve pain, prevent disease. The doctor can do that because that doctor thinks that is best for his or her patient.

Imagine a doctor can refer a patient to a specialist if he believes it is appropriate. That is the way it used to be. That is the way it is going to be in the future.

We have heard all kinds of excuses that if this legislation passes, the sky is going to fall. This is not the first time we have heard these statements.

Senator DORGAN and I spoke today to a person who is a very successful businessman. He said: The reason I like Democrats, but the reason you cause businesspeople concern, is you want to change things: Social Security, Medicare. There are things you are trying to do differently. They work out well, but people don't like change.

Just a few years ago, the Family Leave Act was talked about. The Democrats thought it would be a good idea if America was like most civilized countries. If a woman, for example, had a baby, she would not lose her job. It was called the Family Leave Act. We said: Employer, you don't even have to pay the woman, but she should be guaranteed her job when she finishes 6 weeks of maternity leave.

We can't do that. It will drive us out of business. We cannot have temporary employees. It will be awful.

I defy anyone to go home and have anybody raise the question that the Family and Medical Leave Act has hurt their business. Of course, it has not. It helps their business.

The Patients' Bill of Rights is in the same category. It is going to help our society. In the long run, it will help businesses because it will make the employees feel better about the businesses. We are being told the Patients' Bill of Rights will be like the Family and Medical Leave Act; it will drive businesses into bankruptcy. This is not going to happen.

Everything possible is being brought up about this legislation. What are some of the things I have heard this week? Kill the lawyers—they go back to biblical times. Kill all the lawyers. They have not said that, but that is what they mean. They even know how many people are going to be driven out of the insurance protection field because of this legislation. They say keep legislation in Federal court and not have any in State court; it is too expensive. One dollar a month is too much money? Or nothing happened in committee; we need to go back to committee and hold hearings.

This legislation has been going on for 5 years. We have had days of debate on the floor. We have had numerous committee hearings all over the country. The best way to sum this up, with all the crying and whining and stalling from the other side, is with who favors their legislation. The managed care industry, HMOs, that is who favors their legislation. Who favors McCain-Edwards-Kennedy? Everybody else. Does that mean everybody else is dumb? Everybody else is being led around by the greedy lawyers? The greedy doctors? The greedy nurses? Or does it mean this legislation solves a problem in our country? Is this the reason that 85 percent of everybody—Democrat, Republican, Independent—supports this legislation? I repeat: Who does not support it? The managed care industry, HMOs.

Our Patients' Bill of Rights is a bill that is authored by the very courageous JOHN MCCAIN. When we talk about JOHN MCCAIN, why do we add "courageous"? That is what he is. He is a war hero. But he is also legislatively courageous. He is joined by JOHN EDWARDS, a person in this Senate of great intellect, and also TED KENNEDY, a man who has a lifetime of experience dealing with this issue. They have written a bill that is uncompromised. I will be surprised if this side offers amendments. This is a good piece of legislation. We will take it as it is. We know we will put up with a lot of frivolous stalling, mischievous amendments on this side.

Last night, I ran into a journalist. He said to me: Senator DASCHLE thinks he is bluffing. I talked to a Republican Senator, and they think Senator DASCHLE is bluffing because it can't be done in that short a period of time.

This legislation has been handled in a short period of time in the past under the Republican leadership. When this bill came up in 1999, it finished in 4 days. We had a time certain it would pass—4 days. The bill was introduced

and placed on the calendar on July 8. We began consideration July 12. There were no committee hearings either. All amendments were limited to 100 minutes of debate; no more than one second-degree amendment in order per side per amendment. Just prior to the third reading, we agreed that the majority leader, then Senator LOTT, could be recognized to offer a final amendment to which no second-degree amendment was in order. Final passage occurred on that bill. Of course they killed it in conference. Everybody knows that. Final passage was completed in 4 days. We had 17 amendments and 13 rollcall votes. So we can do this in 4 days and complete it by next Thursday if people have the will to do so.

If they don't have the will to do it Thursday night sometime, we will be here Friday, Saturday, Sunday. The Fourth of July is our first day off, a Wednesday, because we are going to work Friday, Saturday, Sunday, Monday, Tuesday, and take Wednesday off and come back on Thursday, the 5th, to complete this legislation. Everyone should know this. It has been done in the past in 4 days. We can do it again.

This afternoon I received a letter. I have a friend in Nevada. He is one of my wife's physicians, a wonderful, kind, thoughtful, considerate man. His name is Frank Nemeč. Frank Nemeč is not some person who does medicine from the back seat of his car, the trunk of his car. Frank Nemeč is an extremely well-known physician around the country. He is published and has written articles for medical journals. He had a Fulbright scholarship to the University of California at Berkeley, graduated with honors from the University of California at Berkeley, attended with a full scholarship the university of California at Los Angeles Medical School, and graduated with honors. He has been president of the State medical society, president of the Clark County Medical Society, Las Vegas, chief of staff of the largest hospital in Nevada, board certified in internal medicine, gastroenterology. This is a fine physician and not somebody out stirring up trouble. He is a man who has been involved in politics only because he believes his patients are being affected.

Here is a letter to me from Frank Nemeč:

As you have heard from so many Nevadans over the past several years, we need a mechanism where patients have options when care is denied. The following case is a clear illustration.

On April 20th, 1999, Joseph Greuble died at the age of 47 from malnutrition. Joseph's malnutrition was a direct complication of his lifelong battle with Crohn's Disease.

I am familiar with Crohn's disease, Mr. President. There are two of what are called digestive bowel diseases, Crohn's disease and gastroenteritis. They are both bad, but the worst is Crohn's. My wife is fortunate not to have such a dread disease as that; she has gastroenteritis. She has spent many months of her life in hospitals.

So I know something about Crohn's disease. The letter continues:

Joseph's gastrointestinal problem was quite complex. His disease was complicated by ulcerations, fistulae, bleeding, obstruction, electrolyte disturbances, seizures, and chronic pain, and Joseph required multiple operations. Continuity of care is most important when dealing with an incurable, chronic, debilitating disease. In Joseph's case, the system's failure to provide continuity of care proved tragic and fatal.

I served as Joseph's personal physician for 11 years. As Joseph's condition worsened he was no longer able to live independently, and he moved into his mother's small apartment in Las Vegas. His mother would accompany him to my office for all of Joseph's visits and as a result, I came to know his mother Marion quite well.

For over a decade, I performed needed physician examinations, arranged for appropriate diagnostic studies, wrote Joseph's prescriptions, and attended to him in the hospital whenever he required admission due to complications of his disease. One of Joseph's most pressing needs was for nutritional support. Joseph had become malnourished as a complication of his Crohns Disease, and required TPN (intravenous nutrition).

I am also familiar with that, Mr. President.

Joseph's weight had fallen to just over 110 pounds, and at 5' 10" tall Joseph needed the TPN to maintain his weight and prevent death due to malnutrition.

In January of 1999, Joseph was told by his HMO that I could no longer treat him. Appeals by both myself and Joseph to have this decision reversed were denied. My offer to see Joseph free of charge was rejected by the HMO, as I still would not have been permitted to write his prescriptions, direct his nutritional support, order any diagnostic testing, or request needed consultations.

While I do not have any of the medical records of Joseph's treatment for the three months after he left my care, Joseph's mother informs me that his TPN had been discontinued, that his malnutrition worsened, his weight dropping to less than 100 pounds. Joseph, malnourished and unable to fight off infection, subsequently developed pneumonia, sepsis, and died.

I have received permission from Mrs. Grouble to share this story. Marion hopes that sharing her son's story will help achieve the needed legislation to prevent this from happening in the future. Holding health plans accountable when they harm patients is not about suing insurance companies and driving up the cost of health care, it is about stopping abuses and bringing compassion back to medicine. Until the health plans are accountable, people like Joseph and his family will continue to suffer.

Again, thank you for all the hard work on this important issue.

Sincerely,

FRANK J. NEMEC, M.D.

Doesn't this say it all? Why are we here? Are we here to talk about people dropped from insurance rolls? Are we here to talk about some lawyer fighting a lawsuit that doesn't exist?

ZELL MILLER was on the floor today. Georgia has a Patients' Bill of Rights. Not one single solitary lawsuit has been filed. In the State of Texas they have a Patients' Bill of Rights that the President of the United States vetoed on two separate occasions. They have a Patients' Bill of Rights there. In over 4 years they have had 17 lawsuits, one

every quarter. It doesn't sound too overwhelming to me. I don't think it is going to drive the HMOs out of business. So let's get real.

This is about money. It is about the Frank Nemec of the world who went to medical school to take care of his patients and he is told he can't take care of his patients. He said: I'll do it for nothing. They said: No, you might write a prescription we don't like.

I don't know, this man might have died soon anyway, but he would not have died as soon as he did. I guess the HMO decided his life wasn't worth anything anyway—he's going to die. He's 5 foot 10, weighs 110 pounds. Let's just terminate it more quickly.

We are going to finish this legislation. We are going to finish this legislation and send it over to the House. They can play whatever games they want with it, but I think the games will end over there because we have very courageous Republicans on that side of this institution, led by CHARLIE NORWOOD from the State of Georgia, who have said they have taken all they can.

I almost cried when I read this letter. Maybe if I were not here in front of the world I might admit when I read it in my office I shed a tear.

This is sad. If you knew Frank Nemec, this gentle, big man, you would know how sincere he is.

So why is this taking place? It is taking place because of money. It is taking place because the HMOs want to hang on as long as they can to keep those stock prices up and make as much money as they can in salaries. They are still going to do just fine after we pass this legislation, but they are not going to do as fine as they have been. They are not going to be able to terminate the care of someone such as Mr. Greuble.

Yesterday I read into the RECORD those organizations with names starting with the letter A that support this legislation. I am going to read for a while tonight. I am not going to read them all. This is a partial list. But I want this spread across the RECORD of this Senate that this legislation is supported by America. It is supported by Minnesota, the people in Minnesota and the people of Nevada.

The B's start with Baker Victory Services in Lackawanna, NY. This is a list of organizations that support the Bipartisan Patients' Bill of Rights:

Baptist Children's Home of NC, Barium Springs Home for Children in Barium Springs, NC, Bazelon Center for Mental Health Law, Berea Children's Home and Family in OH, Bethany for Children and Families, Bethesda Children's Home/Luthera of Meadville, PA, Board of Child Care in Baltimore, MD, Boys & Girls Country of Houston Inc., TX, Boys & Girls Homes of North Carolina, Boys and Girls Harbor, Inc. in TX, Boys and Girls Home and Family Service, Boy's Village, Inc. of Smithville, OH.

Boysville of Michigan, Inc., Brain Injury Association, Brazoria County Youth Homes in TX, Brighter Horizons Behavioral Health in Edinboro, PA, Buckner Children and Fam-

ily Service in TX, Butterfield Youth Services, Cal Farley's Boys Ranch and Affiliates, California Access to Speciality Care Coalition, Catholic Family Center of Rochester, NY, Catholic Family Counseling in St. Louis, MO, Catholic Social Services of Wayne County in IN, Center for Child and Family Services in VA.

Center for Families and Children in OH, Center for Family Services, Inc. in Camden, NJ, Center for Patient Advocacy, Center on Disability and Health, Chaddock, Charity Works, Inc., Child and Family Guidance Center in TX, Child and Family Service of Hawaii, Child and Family Services in TN, Child and Family Services of Buffalo, NY, Child and Family Services, Inc., in VA, Child Care Association of Illinois.

Child Welfare League of America, Children & Families First, Children & Family Services Association, Children and Adults with Attention Deficit/Hyperactivity Disorder, Children's Aid and Family Service in Paramus, NJ, Children's Aid Society of Mercer, PA, Children's Alliance, Children's Board of Hillsborough, Children's Choice, Inc., in Philadelphia PA, Children's Defense Fund, Children's Home & Aid Society of Chicago, Children's Home Association of Illinois.

Children's Home of Cromwell, Children's Home of Easton in Easton, PA, Children's Home of Northern Kentucky, Children's Home of Poughkeepsie, NY, Children's Home of Reading, PA, Children's Home of Wyoming Conference, Children's Village, Inc., ChildServ, Christian Home Association-Child, Clinical Social Work Federation, Colon Cancer Alliance, Colorectal Cancer Network.

Committee of Ten Thousand, Community Agencies Corporation of New Jersey, Community Counseling Center in Portland, ME, Community Service Society of New York, Community Services of Stark County in OH, Community Solutions Association of Warren, OH, Compass of Carolina in SC, Congress of Neurological Surgeons, Connecticut Council of Family Service, Consortium for Citizens with Disabilities, Consuelo Foundation, Consumers Union.

Cornerstones of Care in Kansas City, MO, Corporation for the Advancement of Psychiatry, Council of Family and Child Caring Agencies in NY, Counseling and Family Services of Peoria, Court House, Inc., Covenant Children's Home and Families, Crittenton Family Services in Columbus, OH, Crossroads for Youth, Cystic Fibrosis Foundation.

Mr. President, we are through the C's. Before this is all over, there will be a partial list in the RECORD. I haven't been able to get them all. There are over 500. I have read in the RECORD a few hundred and I will continue to do so.

#### MORNING BUSINESS

Mr. REID. Mr. President, I ask unanimous consent that there be a period for morning business with Senators permitted to speak for up to 5 minutes each this evening.

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

#### WEST VIRGINIA'S BIRTHDAY

Mr. BYRD. Mr. President, I am here to wish a happy birthday to a celebrant near and dear to my heart. The thirty-fifth child in the family, grown from a difficult beginning as a child of war

and conflict into a robust 138-year-old, the birthday girl is entering the new century with confidence and strength.

The birthday party in question is, of course, for the wild and wonderful, great and beautiful State of West Virginia, celebrated this Thursday, June 20. In 1863, West Virginia was born by proclamation—the only state so created. Like Caesar Augustus, West Virginia was wrested from her mother, Virginia, at the point of a sword. Also like Caesar, I foresee greatness ahead for West Virginia.

West Virginia is not a large State, ranking 41st at 24,231 square miles. But the stars shone on her birth, blessing her with natural riches, water, and a central location as the northernmost southern State and the southernmost northern State. I might wish for her more flat land, but, on the other hand, I would not trade a level plain for even a single glorious hillside blanketed by lush tangles of wild rhododendron bisected by a clear, cold stream tumbling over rocky drops amid dense stands of oak and maple. Her mountains are her crowning glory, molding her history and her character. They will continue to shape her future. The steep slopes that so complicate development preserve forests and wildlife. Nearly 75 percent of West Virginia is covered with forest. The slopes capture snow for great skiing. They shelter coursing whitewater rivers that attract kayakers, rafters, and fishermen from around the world. In a nation increasingly concerned with urban sprawl, West Virginia remains an oasis of serenity amid the surging tide of advancing humanity, an island of tranquil forest where eagles still soar and the crime rate is the lowest in the Nation.

The mountains have also shaped the character of her people, reinforcing and sustaining the independence of character and the strong work ethic that are necessary in isolated and challenging environments. West Virginians are friendly, caring neighbors, meeting bad weather and hard times with a community spirit that is itself a force to be reckoned with. West Virginians are patriotic as well. The youngest soldier of World War I, Chester Merriman of Romney, enlisted at the tender age of 14. And West Virginians are close to the Creator, reminded daily of His presence by the natural cathedral of sky, wind, water, wood, and stone that is their environment. With a mean altitude of 1,500 feet, the highest average altitude east of the Mississippi, West Virginians are literally nearer to God, as well.

Over the course of the last 138 years, West Virginia has had her share of firsts. In 1756, the first spa open to the public was established at Bath, VA, now Berkeley Springs. The Golden Delicious apple was first grown in Clay County. The Grimes Golden apple was first grown in Brooke County. In 1787, the first steam-powered motor boat was launched in the Potomac River by James Rumsey at New Mecklenburg,

now known as Shepherdstown. One of the first papers in the nation devoted mainly to the interests of women was published in Harper's Ferry on February 14, 1824. One of the first suspension bridges in the world was completed in Wheeling in November 1849.

The Civil War brought a number of "firsts" to West Virginia history books. The first major land battle fought between Union and Confederate forces in that conflict was the Battle of Philippi, on June 3, 1861. The first Union soldier had been killed a few days earlier, at Fetterman, Taylor County.

West Virginia has had other notable "firsts" since achieving statehood. West Virginia was also the site of the first rural free mail delivery in the nation. It began in Charles Town on October 6, 1896, before spreading throughout the rest of the United States. About 1908, outdoor advertising had its start when the Block Brothers Tobacco Company painted bridges and barns around Wheeling with the words "Treat Yourself To the Best, Chew Mail Pouch." Some people now spend their vacations hunting down and photographing those old barns.

On the political front, in 1928, Mrs. Minnie Buckingham Harper became a member of the House of Delegates by appointment and was, according to the West Virginia Archives, the first black woman to become a member of a legislative body in America. A less popular political first for West Virginia is its place as the first state to enact a state sales tax, which took effect on July 1, 1921. As a final "first," I would be remiss not to note here that Mother's Day was first observed at Andrews Church in Grafton, WV, on May 10, 1908. So West Virginia can claim motherhood and apple pie to offset that more sinister pair—death and taxes. We really do have it all.

West Virginia has experienced great change over the last 138 years. She remains a great resource for the country. Her coal and natural gas will continue to fuel the nation, just as her forests will provide homes and paper that the electronic age still has not supplanted. She has greatness still in store, nurtured in the bright minds of her young people, encouraged by the wisdom and foresight of her elders, carried on the strong shoulders of her workers and innovators, who love the state and want not to leave it for greener economic shores but to carry that tide into the mountains.

It has given me great pleasure over the years to help West Virginia grow. I may not have been born a West Virginian, but this transplant has taken well to the soil there. I have grafted. I hope that my efforts on her behalf have borne fruit that will help sustain her through the next 138 years. That is the best birthday gift that I can think to give her.

West Virginia, how I love you!  
Every streamlet, shrub and stone,  
Even the clouds that flit above you

Always seem to be my own.

Your steep hillsides clad in grandeur,  
Always rugged, bold and free,  
Sing with ever swelling chorus:  
Montani, Semper, Liberi!

Always free! The little streamlets,  
As they glide and race along,  
Join their music to the anthem  
And the zephyrs swell the song.

Always free! The mountain torrent  
In its haste to reach the sea,  
Shouts its challenge to the hillsides  
And the echo answers "FREE!"

Always free! Repeats the river  
In a deeper, fuller tone  
And the West wind in the treetops  
Adds a chorus all its own.

Always Free! The crashing thunder,  
Madly flung from hill to hill,  
In a wild reverberation  
Makes our hearts with rapture fill.

Always free! The Bob White whistles  
And the whippoorwill replies,  
Always free! The robin twitters  
As the sunset gilds the skies.

Perched upon the tallest timber,  
Far above the sheltered lea,  
There the eagle screams defiance  
To a hostile world: "I'm free!"

And two million happy people,  
Hearts attuned in holy glee,  
Add the hallelujah chorus:  
"Mountaineers are always free!"

SPECIAL AGENT TIMOTHY F. DEERR, FORMER EXECUTIVE DIRECTOR, AIR FORCE OFFICE OF SPECIAL INVESTIGATIONS

Mr. THURMOND. Mr. President, I rise today to honor a dedicated and innovative public servant, Timothy F. Deerr, the former Executive Director of the Air Force Office of Special Investigations, who recently retired after more than 26 years of loyal and selfless service.

As any citizen of the United States should know, two major powers emerged from the ashes and ruins of World War II—the United States of America and the now defunct Union of Soviet Socialist Republics. The ideologies and interests of these two nations were diametrically opposed and the aspirations of Soviet communists for global control made it imperative that America's foot soldiers and leaders in national security affairs exercise vigilance and sacrifice in defense of freedom. For almost fifty years, these two superpowers engaged in a "cold war," where conflict was waged through proxies, brinksmanship, espionage, and counterespionage. It was in this environment in 1975 that Timothy Deerr joined the battle as a civilian Special Agent of the Air Force Office of Special Investigations.

By the time he completed his career earlier this year, Timothy Deerr had spent most of his professional life as a cold warrior and spy catcher. But, before he entered what has alternately been called the "world's second oldest profession" and the "wilderness of mirrors," he started out as a criminal investigator in Dayton, Ohio. It was here, at Wright-Patterson Air Force Base, that Special Agent Deerr learned and

honed his skills as an investigator, gaining invaluable experience in how to read people, analyze facts, and test hypotheses.

After 6 years of working criminal cases in Ohio, Special Agent Deerr swapped the Buckeye State for the divided city of Berlin. Since renamed as the Capital of a united Germany, Berlin was then a city carved into sectors of control—a virtual battleground of espionage and counter-espionage activities. Intelligence operatives from the east and west worked feverishly against one another, both to steal secrets and to protect secrets from being compromised. For two years, Special Agent Deerr conducted critical and successful counterintelligence operations defending against foreign intelligence services stationed in the communist sector of Berlin. As a demonstration of the sensitivity of the operations he conducted, his experiences and cases in Berlin remain classified to this day, twenty years after he initially reported for duty there and ten years after the fall of the Berlin Wall.

From 1987, when he left Berlin, until 1994, Special Agent Deerr earned and held positions of increasing responsibility and importance within the Office of Special Investigations, including those of Chief, Central European Counterintelligence Operations, Wiesbaden, West Germany. Later, as the OSI Director of Counterintelligence, he managed OSI counterintelligence investigations and operations around the world and represented OSI and the Air Force on a number of senior policy boards that crafted our national counterintelligence strategy and policies.

While freedom loving people in the United States and throughout the world heralded and celebrated the implosion of communism in the early 1990s, an ironic byproduct of the end of the Soviet Union ensured America's Cold Warriors would enjoy little respite. While the USSR was a threat to peace and security for almost fifty years, it was a threat that we were able to identify and engage. After the Cold War, the world became, in many regards, a puzzling patchwork of active and potential adversaries of the United States and American citizens. Not only were foreign governments targeting our secrets and threatening our security, so were criminal and terrorist organizations. In recognition of this new dynamic, in 1994, the President of the United States directed a re-examination of the U.S. Counterintelligence Program, including ways to improve coordination, integration and accountability of American counterintelligence efforts. As a result, Presidential Decision Directive 24 was issued in May 1994. The directive, in part, mandated the establishment of the National Counterintelligence Center, and Special Agent Deerr was tapped as the Deputy Director of the new National Counterintelligence Center, an impressive distinction and a testament to his reputation and suc-

cess as one of America's premier spy catchers.

In 1996, Special Agent Deerr returned to Air Force OSI as its Executive Director—the senior civilian Special Agent in the United States Air Force. During his five-year tenure in the top civilian position within OSI, Mr. Deerr earned a reputation for innovation and excellence in leadership. He took the helm at an interesting and challenging time in the history of OSI. As a result of the end of the Cold War, diminishing budgets, and retirements of personnel who entered government service at the height of the Cold War, he faced personnel upheaval and institutional reorganization. America and our Armed Forces were faced with new and daunting challenges that required institutional agility, professional creativity, and cutting-edge technical skills. Under Executive Director Deerr's steady stewardship, OSI "re-invented" itself as a model for the 21st Century in the fields of counterintelligence, anti-terrorism, and crime fighting.

OSI built DoD's Computer Forensics Laboratory—America's premier electronic media forensics lab dedicated to ferreting out evidence of computer crime, network intrusions, and felony tampering with DoD computer systems. OSI started and still manages the Defense Computer Investigations Training Program—DoD's "graduate school" for those tasked with investigating cyber-related crimes. Furthermore, Executive Director Deerr emerged as a visionary leader of the Defense Criminal Investigative Organizations, DCIO, Enterprise-Wide Working Group, the DEW Group. Mr. Deerr and the DEW Group devised innovative enterprise-wide pilot programs to leverage scarce DoD resources, improve training and deployment of America's front line investigators, and save taxpayer dollars.

Executive Director Deerr's influence and innovations extended far beyond DoD. Through his active membership in the International Association of Chiefs of Police and the IACP International Policy Committee, Tim Deerr was instrumental in proliferating enduring principles of policing professionalism, integrity, civil liberties, and selfless service to the international policing executive community across the globe.

After 26 years of service, Executive Director Timothy Deerr left Air Force OSI an even better agency than the one he joined in 1975. His career ran the gamut from criminal investigations to catching spies, and from being a rookie agent to the top civilian on the payroll. During his almost three decades of service, the world changed dramatically from a bipolar one where there was a constant threat of nuclear war to one where the United States must be prepared to counter threats on a multitude of new fronts. Through his uncommon dedication and selfless devotion to duty he has left an indelible

mark on the face of counterintelligence within the U.S. Government. I am certain that all my colleagues will want to join me in commending Mr. Deerr on a successful career and a job well done as well as wishing him, his wife Terri, and their daughter Alexandra, great health, happiness, and prosperity in the years to come.

#### LOOMING NURSE SHORTAGE

Mr. ROCKEFELLER. Mr. President, as chairman of the Committee on Veterans' Affairs, I am enormously pleased to bring to my colleagues' attention not only a serious problem that threatens health care throughout this Nation, but my optimism that the Department of Veterans Affairs can serve as a pathfinder in seeking solutions to this problem.

On June 14, the Committee held a hearing to explore reasons for the imminent shortage of professional nurses in the United States, and how this shortage will affect health care for veterans served by Department of Veterans Affairs, VA, health care facilities. Quality of care issues have always been important to this committee and to me, and skilled nurses are indispensable to high quality health care. Representatives of nursing associations, unions, and VA testified about the conditions that have created this critical nurse shortage and what VA—the largest employer of nurses in the United States—can do to address them.

The problem can be stated simply: too few nurses are caring for too many patients in our Nation's hospitals. Fewer young people seek nursing careers every year, while the demand for skilled nursing care, especially long-term care, is climbing. Although we have faced health care staffing shortages before, experts warn that we are on the brink of a severe and long-lasting crisis. Unless we take steps to address this problem now, the demand for nurses will exceed the supply for many years to come.

Working conditions for nurses—never easy—have become even more challenging. Managed care principles lead hospitals to admit only the very sickest of patients with the most complex health care needs. As the pool of highly trained nurses shrinks, many health care providers rely heavily upon mandatory overtime to meet staffing needs. Several registered nurses, including Sandra McMeans from my state of West Virginia, testified before the committee that unpredictable and dangerously long working hours lead to nurses' fatigue and frustration—and patient care suffers.

Astonishingly, VA has not been included in the other hearings on the nurse shortage that have taken place during this session of Congress. VA is the largest employer of nurses in the Nation, and its nurses are closer to retirement age than those in other health care systems. This makes the problem even more critical in VA

health care facilities. However, VA enjoys a lower rate of nurse turnover, and a handful of VA nurses have managed to carve out innovative programs to improve nurse recruitment and retention. Several of these innovators testified at the hearing on June 14.

Programs initiated within VA to improve conditions for nurses and patients have focused on issues beyond staffing ratios and hours. A highly praised scholarship program that I spearheaded allows VA nurses to pursue degrees and training in return for their service, thus encouraging professional development and improving the quality of health care. Nursing administrators in an award-winning program at the Tampa VA Medical Center have looked for ways to include nurses in decisionmaking, and to keep up with technical innovations that can make the job safer and less physically demanding. In the Upper Midwest, the special skills of nurses and nurse practitioners are being recognized in clinics that provide supportive care close to the veterans who need it.

As nursing careers have dropped from favor for young women, the sort of training programs that provided so many with their first glimpses of patient care have fallen by the wayside. Much to my surprise, one of our witnesses testified that the "candy stripper" programs of the past no longer exist to serve as training grounds for future nurses. Through a "nurse cadet" program at the VA Medical Center in Salem, VA, VA is attempting to fill that void by providing leadership in testing community mentoring programs designed to spark the next generation's interest in nursing careers.

Clearly, more can be—and must be—done to address this problem. Although the nursing crisis has not yet reached its projected peak, the shortage is already endangering patient safety in the areas of critical and long-term care, where demands on nurses are greatest. We must encourage higher enrollment in nursing schools, improve the work environment, and offer nurses opportunities to develop as respected professionals, while taking steps to ensure safe staffing levels in the short-term.

We do not have the luxury of reflecting upon this problem at length; we must act now. Fortunately, we have as allies hardworking nurses who are dedicated to helping us find ways to improve working conditions and to recruit more young people to the field. I look forward to working with VA to provide a model for the Nation on how to accomplish these difficult tasks.

In closing, I ask unanimous consent that a Raleigh, North Carolina, News and Observer article that focuses on the innovative nursing programs, and the enthusiastic and committed nurses, at the Durham VA Medical Center be printed in the RECORD. It is just this sort of commitment which gives me confidence that VA can indeed assume a leadership role as we as a Nation confront the nurse shortage.

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

[From the Raleigh North Carolina News and Observer, May 6, 2001]

DURHAM VA NURSES SERVING THOSE WHO SERVED

The Durham Veterans Administration Medical Center provides care to Armed Forces veterans through three inpatient critical care units, three acute medical-surgical units, two extended-care rehabilitation units and one in-patient psychiatric unit, all of which coordinate care with a large out-patient service. "Nursing care is provided to veterans in a traditional nursing service structure by a staff of over 300 RNs," said Kae Huggins, RN, MSN, CNA, and director of nursing. "They are empowered to deliver patient-centered care within a shared-leadership environment."

Durham VA nurses said they are given the opportunity to provide quality patient centered care, which creates a culture that supports problem solving, risk-taking and participation in decision-making.

When asked to share their reasons for choosing to pursue their careers at the Durham VA Center, several registered nurses were eager to tell their story.

Irene Caldwell, RN, nursing instructor and Vietnam veteran Army nurse said, "There is no greater honor than to care for those who through their service allow us to enjoy all that we have in this nation. The VA Medical Center in Durham is part of the network that is 'keeping the promise.' Having over 30 years of employment as a registered nurse at the VA in Durham, I am proud to be one of the 'Promise Keepers.'"

Ken O'Leary, RN, staff nurse (USAF) in the Surgical Intensive Care Unit, said, "Being a vet, it is great to take care of fellow vets. Hearing their stories and sharing their memories of history in the making is so rewarding. It is nice to do for those who have done so much for the freedom we enjoy in this country."

Laura Smith, RN in psychiatry and critical care, said, "It is a real pleasure to serve those who gave us the freedom to live the way we do. The veterans are the most caring and appreciative group of patients I have ever known and are fiercely independent."

"Nursing here gives you pride in your country, and the DVAMC gives you support to stay in nursing. The nursing field is every-changing and the education staff at DVAMC works very hard to keep us up to date on all the latest items involving our careers. They also support innovations to make our jobs easier, such as lift equipment, computerized medication administration system and electronic charting."

Jackie Howell, RN, community health nurse, said, "Working at the Durham VA Medical Center not only affords us an opportunity to give back to those veterans who so bravely served our country, but it also affords us the opportunity to advance professionally. It is one of the few hospitals that truly values nurses and nursing. The philosophy of shared leadership has empowered the nursing staff to be decision makers and innovators, thus maintaining quality of care. Nursing at the Durham VA allows us to be all we want to be."

Reginald Horwitz, RN, Coronary Care Intensive Care Unit, had this to say: "As a Filipino-American given the chance to serve out veterans, it gives me a different outlook, in that I have the opportunity to give back to the very group of people who have given their all for the freedom in this country we now all enjoy and cherish. Moreover, the VA nurse is allowed to grow personally and professionally in an environment that takes the

entire health care team into account in making decisions that best serve the interests of our veterans. It is an honor to be a VA nurse."

Linda Albers, RN, IV team, said enthusiastically, "Just today a patient said to me, 'I like coming here, YOU KEEP YOUR WORD.' How accurately he described the VA. As federal employees, we do keep the promise Congress made to veterans who are unfailingly grateful for the care we provide. The VA also kept its word to employees. We are involved in clinical-based research, which improves patient outcomes, impacts healthcare and is certainly healthy for our careers, as are the educational opportunities provided. Everyone at the VA is committed to keeping our promise to veteran patients, which enhances our culture of camaraderie and cooperation. In one sentence—The VA keeps its word—to veterans and employees."

Suchada Dewitya, nursing home RN, said emphatically, "These patients have risked their lives for our freedom. When they get sick, they should be treated with dignity and respect. We now have an increasing number of women veterans who come here for their care. We have a Veteran Women's Department that provides primary care. They all deserve quality, complete service. I am proud to deliver that."

Ester Lynch, RN, said: "I started here as a nursing student, new graduate, surgical floor nurse, and now I'm a nurse manager! There is no other place I'd rather be in nursing. It is so rewarding to serve veteran patients."

Virginia Brown, RN and retired from the Army Nurse Corps, said, "Some of the brightest, the best and the most professional nurses I've met were VA nurses. The patient population and their families become a special community throughout North Carolina and the nation. I especially like being a staff nurse with direct patient care. And only at the VA can a nurse choose to be a staff nurse and be supported financially for their contributions. I, too, am a veteran, and retired from the ANC through the U.S. Army Reserve."

Mary Kay Wooten, enterostomal therapy clinical nurse specialist, said "I have been a nurse at this VA Medical Center for my entire professional nursing career. I have stayed here for many reasons, but the overwhelming one is our patients. Our patients have given so much to our country and many times have received so little in return. I am proud to be able to give them something in return. Professionally, I have had the opportunity to do everything that I have wanted. I have had a variety of roles and worked in a variety of settings in the acute-care setting. I have also received many educational opportunities. As our nurse recruiter, Joe Foley, says, "The VA is the best-kept secret around." Having worked here for 29 years, I can't imagine working any other place."

Wooten said VA nurses have state-of-the-art equipment available to them, and cited the Wound Vac as an example. The Wound Vac is a method of treatment for management of acute and chronic wounds that VA nurses have been using since 1995, shortly after its FDA approval. This advanced technology has allowed VA nurses to focus on other aspects of patients' care as it has decreased length of stay, improved wound healing and increased patient satisfaction, all at a cost savings.

#### KEY INFLUENCES ON YOUTH DRUG USE

Mr. GRASSLEY. Mr. President, I rise today to draw attention to key influences in youth drug use as reported in

a national study, released by the Substance Abuse and Mental Health Services Administration, SAMHSA, entitled *Risk and Preventive Factors for Adolescent Drug Use: Findings from the 1997 National Household Survey on Drug Abuse*.

As summarized in the Spring 2001 edition of the magazine *SAMHSA News*, this study reported “[p]eer use and peer attitudes are two of the strongest predictors of marijuana use among all young people.” For youth in the age range of 12–17, using marijuana in the past year was 39 times higher if close friends had used it versus if they had friends who had not used it. The odds for the same age group were 16 times higher if adolescents thought their friends would not be “very upset” if they used marijuana. While peer attitudes were more influential than parental attitudes, youth were still 9.6 times more likely to smoke marijuana if they viewed their parents “would not be very upset” versus “very upset.”

Other risk factors for past-year marijuana use were the youth’s own use of alcohol and tobacco, the parent’s attitude about alcohol and tobacco, if youth could not talk to their parents about serious problems, if youth were not enrolled in school, if youth were receiving poor grades in school, or if they did not attend religious services once a week. Interestingly, the factors that most correlated with cigarette use were the same factors associated with alcohol, marijuana, and other illegal drugs. Finally, youth who had not received in-school drug/alcohol education were slightly more likely to have used marijuana in the past year than those who had not. The analysis results were uniform across race/ethnicity.

The average person, much less a teenager, does not wake up one day and decide to do a line of cocaine or take a hit of heroin. There is a general progression of both actions and attitudes. The so-called “softer” drugs of cigarettes, alcohol, marijuana, and other club or synthetic drugs are actually “gateways” that precede the use of cocaine and heroin. According to a 14-year veteran of drug treatment in New York City, the average age of new users she sees has dropped from 17 or 18 years to now 13. Quoting her from a recent newspaper article, “[w]e’ve seen the age of first use drop dramatically”. . . “[k]ids are going from doing marijuana to drugs like ecstasy and rohypnol in months.” A Spartanburg County South Carolina sheriff, also quoted in a recent newspaper article, reminds us “[t]hat the first responsibility of parenthood is to protect the child.” Backing up the SAMSHA observations on peers and peer attitudes, he concluded “parents need to pay close attention to the way their children act and who they’re hanging around with.”

It may be difficult to raise teenagers or keep your children off all illegal substances, but there are some easy first steps and warning signs to heed. According to the National Institute on

Drug Abuse, NIDA, handbook “Preventing Drug Abuse Among Children and Adolescents,” the best “protective factors” include “strong bonds with parents, experience of parental monitoring with clear rules of conduct within the family unit, involvement of parents in the lives of their children, success in school performance, strong bonds with prosocial institutions such as family, school, and religious organizations, and adoption of conventional norms about drug use.” With respect to family relationships, NIDA research shows that “parents need to take a more active role in their children’s lives, including talking to them about drugs, monitoring their activities, getting to know their friends, and understanding their problems and concerns.”

These are simple, positive actions that all of us, as friends, peers, coworkers, concerned adults, or parents can start today.

#### COMMEMORATION OF WORLD REFUGEE DAY

Mr. GRAHAM. Mr. President, today I commemorate World Refugee Day, a day designated for our country to celebrate the multiple contributions that immigrants have made to make America a richer, more perfect union.

It is tragic that while immigrants continue to make the fabric of our Nation stronger, many immigrants continue to be barred from vital safety net services including access to health care.

For the past several years there has been heated discussion regarding the number of uninsured in America.

There are uninsured children in every State, county and community in America. States have sought to address this issue through programs such as Medicaid and the Child Health Insurance Program (CHIP). Through these Federal-State programs, States have been able to insure millions of eligible children.

There has been recent success in providing coverage for those families and children who have gone without health insurance. We were pleased by the new census date on the number of uninsured in America. The data shows that the number of Americans without health insurance fell from 44.3 million to 42.6 million in 1999. This is the first decline since 1987. And this is good news.

In the last Presidential campaign, Vice President Gore and then-Governor Bush focused on the critical importance of insuring our nation’s children and families. Today Congress is struggling with how best to cover the nations uninsured. The national press is writing article after article regarding outreach and enrollment of children in to the Medicaid and Children’s Health Insurance Program. These are laudable discussions, but there is a critical element that was missing in Presidential rhetoric, congressional deliberations and the media’s stories. This “missing

piece” is the regrettable fact that the current federal policy, denies public health insurance to legal immigrant children and pregnant women.

While we are seeing declines in the overall level of uninsured in America, the fact is that the proportion of immigrant children who are uninsured remains extremely high. A report by the Center on Budget and Policy Priorities, shows that in the last year, nearly half of low-income immigrant children in America had no health insurance coverage.

Additionally, the percentage of low-income immigrant children in publicly-funded coverage—which was low even before enactment of the 1996 welfare reform law—has fallen substantially. Providing Medicaid and CHIP to legal immigrant children is critical in order to guarantee a healthy generation of children in America.

We all know that if we are lucky enough to have health insurance, regular health care services, particularly preventive care, is critical for maintaining good health. Children who need these services should receive them, regardless of how long they have lived in this country.

Pregnant women, regardless of their immigration status, want to make sure that their unborn children are growing and healthy. A child who is sick just wants to feel better. She does not understand that laws or her immigration status could prevent her from seeing a doctor.

Legal immigrant children, regardless of their date of entry, should have the opportunity to be treated and cared for by a doctor. Access to early medical attention can often mean the difference between curing a minor illness and dealing with a serious, potentially life threatening, medical emergency. No parent in America should have to stand by and watch their child suffer unnecessarily through an illness.

Five years is too long to wait.

Moreover, all children should be able to see a pediatrician when they are well—to prevent problems before they start. For example, immunizations in the first few years of life are critical to keep children protected from terrible diseases and to protect those around them. And for pregnant women, prenatal care helps to ensure that their newborns will be born healthy, without the worries and costs that come with a sick or premature baby.

Giving States the option to provide health insurance coverage to newly arrived legal immigrant children would help states in their efforts to enroll more low income children. States could simplify their child application and enrollment procedures by dispensing with complex immigrant eligibility determinations. In addition, outreach messages could be simplified, making it easier for community groups such as schools and churches to help enroll legal immigrant children.

I believe that providing Medicaid and CHIP to legal immigrant children is

critical in order to guarantee a healthy generation of children in America. To this end, I, along with my Senate and House colleagues, have introduced the Immigrant Children's Health Improvement Act, 582 and H.R. 1143, to give States the option to provide health care coverage through Medicaid and CHIP.

Legal immigrant children who came to this country after August 22, 1996 are no different than those who arrived before that date or kids who were born on American soil. Our children go to school together, study together and play together.

On this World Refugee Day, I call upon the Congress and the President to work in earnest to eliminate the arbitrary designation of August 22, 1996 as a cutoff date for allowing children to get health care.

Let us treat the hard working people in our nation, regardless of their immigration status, with fairness and dignity.

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#### TELECOMMUNICATIONS ACT OF 1996

Mr. FRIST. Mr. President, I am increasingly concerned about the stalled promise of the Telecommunications Act of 1996. There are many indications that the pro-competitive course we charted in 1996 when we enacted the Telecommunications Act is not moving as quickly as we intended. In response to that landmark law, hundreds of companies invested billions of dollars in an effort to bring a choice of service provider to local consumers. Yet the competitive telecommunications industry has virtually collapsed in the past year. Every day brings reports of competitors declaring bankruptcy, shutting down operations, or scaling back plans to offer service. Even in my home State, five competitive local exchange carriers with major operations in Tennessee have gone bankrupt.

We have all read recent reports of the difficulties that competitive telecommunications firms are facing in the current economic downturn. For those that continue to struggle in operation, stock prices have plunged, and the capital market has virtually dried up. While telecommunications companies captured an average of two billion dollars per month in initial public offerings over the last two years, they raised only \$76 million in IPOs in March, leading numerous companies to withdraw their IPO plans.

The difficulty in entering local markets has also caused nearly all competitors to scale back their plans to offer service. Covad had established offices in Chattanooga, Knoxville, Memphis and Nashville, but is now closing down over 250 central offices, and will suspend applications for 500 more facilities. Rhythms has cancelled plans to expand nationwide. Net2000 has put its plans for expansion on hold. Numerous other competitors, such as DSL.net, have resolved to focus on a

few core markets. Each of these decisions has been accompanied by hundreds of eliminated jobs. In all, competitive local carriers dismissed over 6500 employees nationwide in the last year while attempting to remain in business. Tennessee is among the hardest hit States.

The repercussions of these events on consumers is significant. Competitors reinvested most of their 2000 revenues in local network facilities. Competitors that declared bankruptcy in 2000 had planned to spend over \$600 million on capital expenditures in 2001. Those competitive networks will not be available to consumers.

In this uncertain financial climate, it is imperative that we maintain a stable regulatory framework. The 1996 Telecom Act established three pathways to a more competitive local telecommunications marketplace: a new entrant could purchase local telephone services at wholesale rates from the incumbent and resell them to local customers; a competitor could lease specific pieces of the incumbent's network on an unbundled basis, using what the industry calls unbundled network elements; or a competitor could build its own facilities and interconnect them with the incumbent's network. Each of these alternatives must remain available to new entrants. Making fundamental changes to the structure of the 1996 Act will destabilize the already shaky competitive local exchange industry, depriving consumers of even the prospects for meaningful choice.

Recent press reports indicate that investors will not sink more money into local competitors when there is a "growing view that regulators are working against the new entrants." We need to ensure that the market-opening requirements of the 1996 Act are vigorously implemented. Without a supportive regulatory environment, there will be no more capital flowing to new entrants in the local telecommunications market spurring competition and lower consumer prices. This was not the promise of the Telecommunications Act I voted for in 1996.

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#### LOCAL LAW ENFORCEMENT ACT OF 2001

Mr. SMITH of Oregon. Mr. President, I rise today to speak about hate crimes legislation I introduced with Senator KENNEDY in March of this year. The Local Law Enforcement Act of 2001 would add new categories to current hate crimes legislation sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred November 7, 1998 in Easton, MA. An Easton teenager threw a large rock at a 17-year-old boy he thought was gay, kicked him in the head and yelled, swore, and called the victim a "fag." The victim suffered a broken nose and a concussion. A week before the assault, the perpetrator told friends he hated gay people and thought they should be beaten up.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act of 2001 is now a symbol that can become substance. I believe that by passing this legislation, we can change hearts and minds as well.

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#### AMENDMENT NO. 805 TO ESEA

Mr. TORRICELLI. Mr. President, yesterday, the Senate passed, by unanimous consent, an important amendment that will protect our children from pesticide exposure in our Nation's schools. Inadvertently, Senators BOXER and REID were left off this amendment as original cosponsors. I would like the record to reflect that Senator BOXER and Senator REID should have been listed as original cosponsors of amendment #805 to H.R. 1, the Better Education for Students and Teachers Act.

I regret this unfortunate oversight, as these two Senators are largely responsible for the passage of this amendment. They have as much claim to authorship of this important effort as any Member of this body. If not for their commitment to the protection of our Nation's children, we would not be celebrating the passage of this amendment today. Were it not for Senator BOXER's unwavering commitment to protecting our children, as she has done with the introduction of the Children's Environmental Protection Act, the Senate would not even be having this debate. Were it not for Senator REID's understanding of the important issues facing the Senate, and his advocacy as a member of the Environment and Public Works Committee, this amendment would not have enjoyed the support that it has.

I thank my friends for their support and ask that the Senate recognize Senator BOXER and Senator REID as original cosponsors of the School Environmental Protection Amendment.

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#### THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Tuesday, June 19, 2001, the Federal debt stood at \$5,641,114,076,861.51, five trillion, six hundred forty-one billion, one hundred fourteen million, seventy-six thousand, eight hundred sixty-one dollars and fifty-one cents.

One year ago, June 19, 2000, the Federal debt stood at \$5,649,976,000,000, five trillion, six hundred forty-nine billion, nine hundred seventy-six million.

Five years ago, June 19, 1996, the Federal debt stood at \$5,120,985,000,000, five trillion, one hundred twenty billion, nine hundred eighty-five million.

Ten years ago, June 19, 1991, the Federal debt stood at \$3,498,343,000,000, three trillion, four hundred ninety-eight billion, three hundred forty-three million.

Fifteen years ago, June 19, 1986, the Federal debt stood at \$2,039,961,000,000,

two trillion, thirty-nine billion, nine hundred sixty-one million, which reflects a debt increase of more than \$3.5 trillion, \$3,601,153,076,861.51, three trillion, six hundred one billion, one hundred fifty-three million, seventy-six thousand, eight hundred sixty-one dollars and fifty-one cents during the past 15 years.

#### ADDITIONAL STATEMENTS

##### THE RETIREMENT OF REVEREND EDDIE K. EDWARDS

• Mr. LEVIN. Mr. President, I want to pay tribute to a remarkable person from my home State of Michigan, the Reverend Eddie K. Edwards, who celebrates his retirement as CEO of Joy of Jesus, Inc. on Friday, June 22. Reverend Edwards, has received national acclamations, for having developed and implemented a strategy that served to revitalize the Ravendale Community, one of Detroit's most distressed and underserved areas. He has embodied the work of his ministry and fulfilled his mission of providing positive direction and opportunities for those in need of such guidance.

In 1976, Reverend Edwards established Joy of Jesus, Inc. a nonprofit organizations which set as its primary goal, the task of promoting positive values and healthy lifestyles as a means to help underprivileged youth become responsible citizens who can make a meaningful contribution to society. For this work, he has received national attention: a Points of Light Award and was featured in a national award-winning TV documentary entitled, "A Neighborhood Redeemed." Reverend Edwards serves on the board of numerous community and civic organizations, all of which he devotes an inordinate amount of time. He is in frequent demand as a speaker on the topics of church empowerment, collaboration of churches, neighborhood revitalization, and various other community issues. He has repeatedly demonstrated his expertise in developing non-traditional partnerships and collaboratives which have had significant impact on his community and in particular, the lives of our younger generation. And, in spite of his commitment and involvement in community, he is a devoted husband and father of six adult children.

I can only hope that in Reverend Edward's retirement he finds future endeavors are as successful and fulfilling as the previous ones. For certain, he will remain active in his many church and community activities, but will have more time to dedicate to his favorite hobbies—golfing and jogging. I am pleased to join his colleagues and friends in offering my thanks for all he has accomplished in making his community a better place.

Reverend Eddie K. Edwards can take pride in his long career of service and dedication to Church, Community and

Family. I invite my colleagues to join me in saluting Reverend Edwards' work, and in wishing him well in the years ahead.●

#### MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

#### EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

#### MESSAGE FROM THE HOUSE

At 1:02 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 819. An act to designate the Federal building located at 143 West Liberty Street, Medina, Ohio, as the "Donald J. Pease Federal Building".

H.R. 1291. An act to amend title 38, United States Code, to increase the amount of educational benefits for veterans under the Montgomery GI Bill.

H.R. 1753. An act to designate the facility of the United States Postal Service located at 419 Rutherford Avenue, N.E., in Roanoke, Virginia, as the "M. Caldwell Butler Post Office Building".

The message also announced that the House has agreed to the following concurrent resolutions, in which it requests the concurrence of the Senate:

H. Con. Res. 154. A concurrent resolution honoring the continued commitment of the Army National Guard combat units deployed in support of Army operations in Bosnia, recognizing the sacrifices made by the members of those units while away from their jobs and families during those deployments, recognizing the important role of all National Guard and Reserve personnel at home and abroad to the national security of the United States, and acknowledging, honoring, and expressing appreciation for the critical support by employers of the Guard and Reserve.

H. Con. Res. 163. A concurrent resolution recognizing the historical significance of Juneteenth Independence Day and expressing the sense of Congress that history be regarded as a means of understanding the past and solving the challenges of the future.

The message further announced that the House has passed the following bill, without amendment:

S. 1029. An act to clarify the authority of the Department of Housing and Urban Development with respect to the use of fees during fiscal year 2001 for the manufactured housing program.

The message also announced that the House has agreed to the following concurrent resolution, without amendment:

S. Con. Res. 41. A concurrent resolution authorizing the use of the Capitol grounds for the National Book Festival.

The message further announced that pursuant to 20 U.S.C. 4703, the majority leader appoints the following Member of the House of Representatives to the Board of Trustees of the Barry Goldwater Scholarship and Excellence in Education Foundation: Mr. STUMP of Arizona.

The message also announced that pursuant to section 303(a) of Public Law 106-286, the Speaker appoints the following Members of the House of Representatives to the Congressional-Executive Commission on the People's Republic of China: Mr. BERUTER of Nebraska, co-Chairman; Mr. LEACH of Iowa, Mr. DREIER of California; Mr. WOLF of Virginia; and Mr. PITTS of Pennsylvania.

#### MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 819. An act to designate the Federal building located at 143 West Liberty Street, Medina, Ohio, as the "Donald J. Pease Federal Building"; to the Committee on Environment and Public Works.

H.R. 1291. An act to amend title 38, United States Code, to increase the amount of educational benefits for veterans under the Montgomery GI Bill; to the Committee on Veterans' Affairs.

H.R. 1753. An act to designate the facility of the United States Postal Service located at 419 Rutherford Avenue, N.E., in Roanoke, Virginia, as the "M. Caldwell Butler Post Office Building"; to the Committee on Governmental Affairs.

The following concurrent resolutions were read, and referred as indicated:

H. Con. Res. 154. Concurrent resolution honoring the continued commitment of the Army National Guard combat units deployed in support of Army operations in Bosnia, recognizing the sacrifices made by the members of those units while away from their jobs and families during those deployments, recognizing the important role of all National Guard and Reserve personnel at home and abroad to the national security of the United States, and acknowledging, honoring, and expressing appreciation for the critical support by the employers of the Guard and Reserve; to the Committee on Armed Services.

H. Con. Res. 163. Concurrent resolution recognizing the historical significance of Juneteenth Independence Day and expressing the sense of Congress that history be regarded as a means of understanding the past and solving the challenges of the future; to the Committee on the Judiciary.

#### 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-2521. A communication from the Assistant Secretary of State for Legislative Affairs, transmitting, a draft of proposed legislation entitled "Foreign Relations Authorization Act, Fiscal Years 2002 and 2003"; to the Committee on Foreign Relations.

EC-2522. A communication from the Director of the Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, a cumulative report on rescissions and deferrals dated June 14, 2001; transmitted jointly, pursuant to the order of January 30, 1975, as modified by the order of April 11, 1986; to the Committees on Appropriations; the Budget; and Foreign Relations.

EC-2523. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Cyprodinil; Time-Limited Pesticide Tolerance" (FRL6778-7) received on June 18, 2001; to the Committee on Agriculture, Nutrition, and Forestry.

EC-2524. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Tebufenozide; Re-establish Tolerances for Emergency Exemptions" (FRL6788-4) received on June 18, 2001; to the Committee on Agriculture, Nutrition, and Forestry.

EC-2525. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Pyrodaben; Pesticide Tolerance Technical Correction" (FRL6786-5) received on June 18, 2001; to the Committee on Agriculture, Nutrition, and Forestry.

EC-2526. A communication from the Administrator of the Environmental Protection Agency, transmitting, a draft of proposed legislation entitled "Amendment to Toxic Substances Control Act"; to the Committee on Environment and Public Works.

EC-2527. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Revision to the California State Implementation Plan, Antelope Valley Air Pollution Control District" (FRL6998-3) received on June 18, 2001; to the Committee on Environment and Public Works.

EC-2528. A communication from the Acting Deputy General Counsel, Office of Size Standards, Small Business Administration, transmitting, pursuant to law, the report of a rule entitled "Size Eligibility Requirements for SBA Financial Assistance and Size Standards for Agriculture" (RIN3245-AE29) received on June 18, 2001; to the Committee on Small Business.

EC-2529. A communication from the Assistant Secretary of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled "Documentation of Immigrants and Non-immigrants Under the Immigration and Nationality Act, As Amended—Refusal of Individual Visas" (22 CFR Parts 41 and 42) received on June 18, 2001; to the Committee on Foreign Relations.

EC-2530. A communication from the Assistant Secretary of Legislative Affairs, Department of the Treasury, transmitting, pursuant to law, the annual report of the National Advisory Council on International Monetary and Financial Policies for Fiscal Year 1998; to the Committee on Foreign Relations.

EC-2531. A communication from the White House Liaison, transmitting, pursuant to law, the report of a nomination confirmed for the position of Assistant Attorney General, Office of Policy Development, Department of Justice, received on June 14, 2001; to the Committee on the Judiciary.

EC-2532. A communication from the White House Liaison, transmitting, pursuant to law, the report of a nomination for the position of Assistant Attorney General, Office of Justice Programs, Department of Justice, re-

ceived on June 14, 2001; to the Committee on the Judiciary.

EC-2533. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy and a nomination for the position of Deputy Secretary, Department of the Interior, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2534. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy and a nomination for the position of Solicitor, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2535. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy and a nomination for the position of Assistant Secretary, Indian Affairs, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2536. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy and a nomination for the position of Secretary of the Interior, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2537. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy and a nomination for the position of Assistant Secretary, Policy, Management and Budget, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2538. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy and the designation of acting officer for the position of Director, Office of Surface Mining, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2539. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy and the designation of acting officer for the position of Director, Bureau of Land Management, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2540. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy and the designation of acting officer for the position of Director of National Park Service, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2541. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy and the designation of acting officer for the position of Director, Fish and Wildlife Service, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2542. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy for the position of Assistant Secretary, Land Minerals and Management, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2543. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy for the position of Commissioner-Reclamation, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2544. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy for the position of Assistant Secretary, Water and Science, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2545. A communication from the Director of the Office of Personnel Policy, Department of the Interior, transmitting, pursuant to law, the report of a vacancy for the position of Assistant Secretary, Fish, Wildlife and Parks, received on June 18, 2001; to the Committee on Energy and Natural Resources.

EC-2546. A communication from the Program Analyst of the Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Amendment to Class E Airspace; Salisbury, MD; Correction" ((RIN2120-AA66)(2001-0102)) received on June 18, 2001; to the Committee on Commerce, Science, and Transportation.

EC-2547. A communication from the Staff Attorney of the Research and Special Programs Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Harmonization with the United National Recommendations, International Maritime Dangerous Goods Code, and International Civil Aviation Organization's Technical Instructions" (RIN2137-AD41) received on June 18, 2001; to the Committee on Commerce, Science, and Transportation.

EC-2548. A communication from the Executive Director of the Committee for Purchase From People Who Are Blind or Severely Disabled, transmitting, pursuant to law, the report of additions to the procurement list, received on June 18, 2001; to the Committee on Governmental Affairs.

EC-2549. A communication from the Chairman of the Consumer Product Safety Commission, transmitting, pursuant to law, the report of the Office of the Inspector General for the period October 1, 2000 to March 31, 2001; to the Committee on Governmental Affairs.

EC-2550. A communication from the Administrator of the National Aeronautics and Space Administration, transmitting, pursuant to law, the report of the Office of the Inspector General for the period October 1, 2000 to March 31, 2001; to the Committee on Governmental Affairs.

EC-2551. A communication from the White House Liaison, transmitting, pursuant to law, the report of a nomination for the position of Director, Bureau of Justice Assistance, Department of Justice, received on June 14, 2001; to the Committee on the Judiciary.

EC-2552. A communication from the White House Liaison, transmitting, pursuant to law, the report of a nomination confirmed for the position of Assistant Attorney General, Criminal Division, Department of Justice, received on June 14, 2001; to the Committee on the Judiciary.

#### INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. DURBIN (for himself and Mr. SPECTER):

S. 1065. A bill to amend the Inspector General Act of 1978 (5 U.S.C. App.) to establish an Inspector General for the Federal Bureau of Investigation, and for other purposes; to the Committee on the Judiciary.

By Mr. HATCH (for himself and Mr. KERRY):

S. 1066. A bill to amend title XVIII of the Social Security Act to establish procedures for determining payment amounts for new clinical diagnostic laboratory tests for which payment is made under the medicare program; to the Committee on Finance.

By Mr. GRASSLEY (for himself, Mr. TORRICELLI, and Mr. CRAIG):

S. 1067. A bill to amend the Internal Revenue Code of 1986 to expand the availability of Archer medical savings accounts; to the Committee on Finance.

By Mrs. BOXER:

S. 1068. A bill to provide refunds for unjust and unreasonable charges on electric energy; to the Committee on Energy and Natural Resources.

By Mr. LEVIN (for himself, Mr. KOHL, Mr. FEINGOLD, Mr. SCHUMER, Mr. JOHNSON, and Ms. STABENOW):

S. 1069. A bill to amend the National Trails System Act to clarify Federal authority relating to land acquisition from willing sellers from the majority of the trails in the System, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. REED:

S. 1070. A bill to amend title XXVII of the Public Health Service Act and part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 to establish standards for the health quality improvement of children in managed care plans and other health plans; to the Committee on Health, Education, Labor, and Pensions.

By Mr. BOND:

S. 1071. A bill to amend title 23, United States Code, to require consideration under the congestion mitigation and air quality improvement program of the extent to which a proposed project or program reduces sulfur or atmospheric carbon emissions, to make renewable fuel projects eligible under that program, and for other purposes; to the Committee on Environment and Public Works.

By Mr. ROBERTS:

S. 1072. A bill to extend eligibility for loan deficiency payments and payments in lieu of loan deficiency payments; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. INHOFE:

S. 1073. A bill to establish a National Commission to Eliminate Waste in Government; to the Committee on Governmental Affairs.

By Mr. SCHUMER (for himself and Mr. HATCH):

S. 1074. A bill to establish a commission to review the Federal Bureau of Investigation; to the Committee on the Judiciary.

By Mr. GRASSLEY (for himself, Mr. BIDEN, Mr. SMITH of Oregon, and Mr. DASCHLE):

S. 1075. A bill to extend and modify the Drug-Free Communities Support Program, to authorize a National Community Antidrug Coalition Institute, and for other purposes; to the Committee on the Judiciary.

#### ADDITIONAL COSPONSORS

S. 170

At the request of Mr. REID, the name of the Senator from Nebraska (Mr. NELSON) was added as a cosponsor of S. 170, a bill to amend title 10, United States Code, to permit retired members of the Armed Forces who have a service-connected disability to receive both military retired pay by reason of their years of military service and disability compensation from the Department of Veterans Affairs for their disability.

S. 278

At the request of Mr. JOHNSON, the name of the Senator from Missouri (Mrs. CARNAHAN) was added as a cosponsor of S. 278, a bill to restore health care coverage to retired members of the uniformed services.

S. 283

At the request of Mr. MCCAIN, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 283, a bill 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.

S. 421

At the request of Mr. GRASSLEY, the name of the Senator from Mississippi (Mr. LOTT) was added as a cosponsor of S. 421, a bill to give gifted and talented students the opportunity to develop their capabilities.

S. 480

At the request of Mr. DEWINE, the name of the Senator from Missouri (Mr. BOND) was added as a cosponsor of S. 480, a bill to amend titles 10 and 18, United States Code, to protect unborn victims of violence.

S. 550

At the request of Mr. DASCHLE, the name of the Senator from Colorado (Mr. CAMPBELL) was added as a cosponsor of S. 550, a bill to amend part E of title IV of the Social Security Act to provide equitable access for foster care and adoption services for Indian children in tribal areas.

S. 583

At the request of Mr. KENNEDY, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 583, a bill to amend the Food Stamp Act of 1977 to improve nutrition assistance for working families and the elderly, and for other purposes.

S. 626

At the request of Mr. JEFFORDS, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 626, a bill to amend the Internal Revenue Code of 1986 to permanently extend the work opportunity credit and the welfare-to-work credit, and for other purposes.

S. 672

At the request of Mrs. FEINSTEIN, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 672, a bill to amend the Immigration and Nationality Act to provide for the continued classification of certain aliens as children for purposes of that Act in cases where the aliens "age-out" while awaiting immigration processing, and for other purposes.

S. 677

At the request of Mr. HATCH, the name of the Senator from Alaska (Mr. MURKOWSKI) was added as a cosponsor of S. 677, a bill to amend the Internal Revenue Code of 1986 to repeal the required use of certain principal repay-

ments on mortgage subsidy bond financing to redeem bonds, to modify the purchase price limitation under mortgage subsidy bond rules based on median family income, and for other purposes.

S. 697

At the request of Mr. HATCH, the names of the Senator from Florida (Mr. NELSON) and the Senator from Connecticut (Mr. DODD) were added as cosponsors of S. 697, a bill to modernize the financing of the railroad retirement system and to provide enhanced benefits to employees and beneficiaries.

S. 706

At the request of Mr. KERRY, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of S. 706, a bill to amend the Social Security Act to establish programs to alleviate the nursing profession shortage, and for other purposes.

S. 731

At the request of Mr. NELSON of Florida, the name of the Senator from Arizona (Mr. MCCAIN) was added as a cosponsor of S. 731, a bill to ensure that military personnel do not lose the right to cast votes in elections in their domicile as a result of their service away from the domicile, to amend the Uniformed and Overseas Citizens absentee Voting Act to extend the voter registration and absentee ballot protections for absent uniformed services personnel under such Act to State and local elections, and for other purposes.

S. 732

At the request of Mr. THOMPSON, the names of the Senator from Maine (Ms. COLLINS) and the Senator from Indiana (Mr. BAYH) were added as cosponsors of S. 732, a bill to amend the Internal Revenue Code of 1986 to reduce the depreciation recovery period for certain restaurant buildings, and for other purposes.

S. 778

At the request of Mr. KENNEDY, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of S. 778, a bill to expand the class of beneficiaries who may apply for adjustment of status under section 245(i) of the Immigration and Nationality Act by extending the deadline for classification petition and labor certification filings.

S. 801

At the request of Mr. JEFFORDS, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 801, a bill to amend the Internal Revenue Code of 1986 to repeal the limitation on the use of foreign tax credits under the alternative minimum tax.

S. 860

At the request of Mr. GRASSLEY, the names of the Senator from South Dakota (Mr. JOHNSON) and the Senator from Utah (Mr. BENNETT) were added as cosponsors of S. 860, a bill to amend the Internal Revenue Code of 1986 to provide for the treatment of certain expenses of rural letter carriers.

S. 950

At the request of Mr. REID, the names of the Senator from New York (Mr. SCHUMER) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. 950, a bill to amend the Clean Air Act to address problems concerning methyl tertiary butyl ether, and for other purposes.

S. 1017

At the request of Mr. DODD, the names of the Senator from Massachusetts (Mr. KERRY) and the Senator from South Dakota (Mr. DASCHLE) were added as cosponsors of S. 1017, a bill to provide the people of Cuba with access to food and medicines from the United States, to ease restrictions on travel to Cuba, to provide scholarships for certain Cuban nationals, and for other purposes.

S. 1037

At the request of Mrs. HUTCHISON, the names of the Senator from Missouri (Mr. BOND) and the Senator from Connecticut (Mr. DODD) were added as cosponsors of S. 1037, a bill to amend title 10, United States Code, to authorize disability retirement to be granted posthumously for members of the Armed Forces who die in the line of duty while on active duty, and for other purposes.

S. 1050

At the request of Mr. SANTORUM, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 1050, a bill to protect infants who are born alive.

S. RES. 68

At the request of Mr. JOHNSON, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. Res. 68, a resolution designating September 6, 2001 as "National Crazy Horse Day."

S. RES. 71

At the request of Mr. HARKIN, the names of the Senator from Hawaii (Mr. INOUE), the Senator from Indiana (Mr. BAYH), the Senator from New York (Mrs. CLINTON), the Senator from Maryland (Ms. MIKULSKI), and the Senator from Nevada (Mr. REID) were added as cosponsors of S. Res. 71, a resolution expressing the sense of the Senate regarding the need to preserve six day mail delivery.

AMENDMENT NO. 805

At the request of Mr. TORRICELLI, the names of the Senator from California (Mrs. BOXER) and the Senator from Nevada (Mr. REID) were added as cosponsors of amendment No. 805 proposed to H.R. 1, a bill to close the achievement gap with accountability, flexibility, and choice, so that no child is left behind.

#### STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. HATCH (for himself and Mr. KERRY):

S. 1066. A bill to amend title XVIII of the Social Security Act to establish

procedures for determining payment amounts for new clinical diagnostic laboratory tests for which payment is made under the Medicare Program; to the Committee on Finance.

Mr. HATCH. Mr. President, I rise to introduce the Medicare Patient Access to Preventive and Diagnostic Tests Act. This bipartisan legislation will establish new procedures under Medicare for determining the coding and payment amounts for clinical diagnostic laboratory tests. I am pleased to have my colleague, Senator JOHN KERRY, as the lead Democratic sponsor of this bill. Similar legislation has been introduced in the House of Representatives by Congresswoman JENNIFER DUNN and Congressman JIM MCDERMOTT.

Innovative clinical laboratory tests help save lives and reduce health care costs by detecting diseases, such as cancer, heart attacks, and kidney failure in their early stages, when they are more treatable. However, there are serious flaws in the way that the Center for Medicare and Medicaid Services, CMS, formally known as HCFA, currently sets reimbursement rates for diagnostic tests.

This cumbersome bureaucratic system makes it difficult for physicians and laboratories to offer these diagnostic tests to their patients who need them. Due to institutionalized flaws in the current Medicare reimbursement system, revolutionary and innovative diagnostic tests may not benefit patients for years to come. In addition, it has been shown that lower laboratory payments correlate with lower utilization. The payment rates vary significantly from region to region and State to State.

For example, in my home State of Utah, a patient is sent for blood work to test for kidney disease. Based upon the 2001 Medicare Lab Reimbursement schedule, the Utah lab would receive \$2.12 for performing the test. However, labs in Arizona, Nevada, Montana, New Mexico and Wyoming, would receive \$6.33 to perform the same test. This makes no economic or medical sense to me.

A recent Institute of Medicine, IoM, report stated that Medicare payments for outpatient clinical laboratory services should be based on a single, rational fee schedule. Medicare should account for market-based factors such as local labor costs and prices for goods and services in establishing the fee schedule. In addition, CMS should provide opportunities for stakeholder input and develop better communication with contractors while policies are being developed and after these policies are adopted.

Our bill, based upon the principles of this IoM report, would require CMS to establish a national fee schedule for new and current tests, based upon an open, transparent, and rational public process for incorporating new tests, as well as to provide clear explanations of the reasoning behind its reimbursement decisions. This new process would

be based upon science based methodologies for setting prices for new technologies that are designed to establish fair and appropriate payment levels for these items and services.

CMS's procedures would provide that the payment amount for tests would be established under either the so-called gap-filling or cross-walking methodologies, and they would specify the rules for deciding which methodology will be used and how it will be employed. In particular, the legislation would require that if a new test is clinically similar to a test for which a fee schedule amount has already been established, through cross-walking, CMS will pay the same fee schedule amount for the new test. In determining whether tests are clinically similar, CMS will not take into account economic factors.

Finally, this new process would provide a mechanism for any laboratory or other stakeholder to challenge CMS fee schedule decisions. The cost of these changes is small in light of the significant impact on improving the quality of patient care.

I hope my colleagues will join me in cosponsoring this bill. The laudable goal of this bipartisan legislation is to establish an open and transparent public process for incorporating new laboratory tests into the Medicare program. Many seniors currently do not have full access to the medical care they need due to the antiquated process for assigning billing codes and setting reimbursement rates. We need to bridge the gap between seniors and the life-saving lab tests they need to preserve their health and promote their well-being.

I ask my colleagues to join with me in supporting this legislation and ask unanimous consent that the text of this bill be printed in the RECORD.

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

S. 1066

*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 "Medicare Patient Access to Preventive and Diagnostic Tests Act".

#### SEC. 2. CODING AND PAYMENT PROCEDURES FOR NEW CLINICAL DIAGNOSTIC LABORATORY TESTS UNDER MEDICARE.

(a) DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395f(h)) is amended by adding at the end the following new paragraph:

"(9)(A) The Secretary shall establish procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2002 (in this subsection referred to as 'new tests'). Such procedures shall provide that—

"(i) the payment amount for such a test will be established only on—

"(I) the basis described in paragraph (10)(A); or

“(II) the basis described in paragraph (10)(B); and

“(i) the Secretary shall determine whether the payment amount for such a test is established on the basis described in paragraph (10)(A) or the basis described in paragraph (10)(B) only after the process described in subparagraph (B) has been completed with respect to such test.

“(B) Determinations under subparagraph (A)(ii) shall be made only after the Secretary—

“(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which the establishment of a payment amount under paragraph (10) is being considered for a year;

“(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations from the public on the appropriate basis under paragraph (10) for establishing payment amounts for the tests on such list;

“(iii) not less than 30 calendar days after publication of such notice, convenes a meeting to receive such comments and recommendations, with such meeting—

“(I) including representatives of each entity within the Health Care Financing Administration (in this paragraph referred to as ‘HCFA’) that will be involved in determining the basis on which payment amounts will be established for such tests under paragraph (10) and implementing such determinations;

“(II) encouraging the participation of interested parties, including beneficiaries, device manufacturers, clinical laboratories, laboratory professionals, pathologists, and prescribing physicians, through outreach activities; and

“(III) affording opportunities for interactive dialogue between representatives of HCFA and the public;

“(iv) makes minutes of such meeting available to the public (through an Internet site and other appropriate mechanisms) not later than 15 calendar days after such meeting;—

“(v) taking into account the comments and recommendations received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under paragraph (10) for each such code, together with an explanation of the reasons for each such determination, and the data on which the determination is based;

“(vi) on the same day such list is made available, causes to have published in the Federal Register notice of a public meeting to receive comments and recommendations from the public on the proposed determinations;

“(vii) not later than August 1 of each year, but at least 30 calendar days after publication of such notice, convenes a meeting to receive such comments and recommendations, with such meeting being conducted in the same manner as the meeting under clause (iii);

“(viii) makes a transcript of such meeting available to the public (through an Internet site and other appropriate mechanisms) as soon as is practicable after such meeting; and

“(ix) taking into account the comments and recommendations received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of whether the payment amount for such tests will be determined on the basis described in paragraph (10)(A) or the basis described in paragraph (10)(B), together with the rationale for each such de-

termination, the data on which the determination is based, and responses to comments and suggestions received from the public.

“(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

“(i) identify the rules and assumptions to be applied by the Secretary in considering and making determinations of whether the payment amount for a new test should be established on the basis described in paragraph (10)(A) or the basis described in paragraph (10)(B);

“(ii) make available to the public the data (other than proprietary data) considered in making such determinations; and

“(iii) provide for a mechanism under which—

“(I) an interested party may request an administrative review of an adverse determination;

“(II) upon the request of an interested party, an administrative review is conducted with respect to an adverse determination; and

“(III) such determination is revised, as necessary, to reflect the results of such review.

“(D) For purposes of this subsection—

“(i) the term ‘HCPCS’ refers to the Health Care Financing Administration Common Procedure Coding System; and

“(ii) a code shall be considered to be ‘substantially revised’ if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).

“(10)(A) Notwithstanding paragraphs (1), (2), and (4), if a new test is clinically similar to a test for which a fee schedule amount has been established under paragraph (5), the Secretary shall pay the same fee schedule amount for the new test.

“(B)(i) Notwithstanding paragraphs (1), (2), (4), and (5), if a new test is not clinically similar to a test for which a fee schedule has been established under paragraph (5), payment under this subsection for such test shall be made on the basis of the lesser of—

“(I) the actual charge for the test; or

“(II) an amount equal to 60 percent (or in the case of a test performed by a qualified hospital (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for the test for a locality or area for the year (determined without regard to the year referred to in paragraph (2)(A)(i), or any national limitation amount under paragraph (4)(B), and adjusted annually by the percentage increase or decrease under paragraph (2)(A)(i));

until the beginning of the third full calendar year that begins on or after the date on which an HCPCS code is first assigned with respect to such test, or, if later, the beginning of the first calendar year that begins on or after the date on which the Secretary determines that there are sufficient claims data to establish a fee schedule amount pursuant to clause (ii).

“(ii) Notwithstanding paragraphs (2), (4), and (5), the fee schedule amount for a clinical diagnostic laboratory test described in clause (i) that is performed—

“(I) during the first calendar year after clause (i) ceases to apply to such test, shall be an amount equal to the national limitation amount that the Secretary determines (consistent with clause (iii)) would have applied to such test under paragraph (4)(B)(viii) during the preceding calendar year, adjusted by the percentage increase or decrease determined under paragraph (2)(A)(i) for such first calendar year; and

“(II) during a subsequent year, is the fee schedule amount determined under this clause for the preceding year, adjusted by the percentage increase or decrease that applies under paragraph (5)(A) for such year.

“(iii) For purposes of clause (ii)(I), the national limitation amount for a test shall be set at 100 percent of the median of the payment amounts determined under clause (ii)(I) for all payment localities or areas for the last calendar year for which payment for such test was determined under clause (i).

“(iv) Nothing in clause (ii) shall be construed as prohibiting the Secretary from applying (or authorizing the application of) the comparability provisions of the first sentence of such section 1842(b)(3) with respect to amounts determined under such clause.”.

(b) ESTABLISHMENT OF NATIONAL FEE SCHEDULE AMOUNTS.—

(1) IN GENERAL.—Section 1833(h) of the Social Security Act, as amended by subsection (a), is amended—

(A) in paragraph (2), by striking “paragraph (4)” and inserting “paragraphs (4), (5), and (10)”;

(B) in paragraph (4)(B)(viii), by inserting “and before January 1, 2002,” after “December 31, 1997,”;

(C) by redesignating paragraphs (5), (6), and (7), as paragraphs (6), (7), and (8), respectively; and

(D) by inserting after paragraph (4) the following new paragraph:

“(5) Notwithstanding paragraphs (2) and (4), the Secretary shall set the fee schedule amount for a test (other than a test to which paragraph (10)(B) applies) at—

“(A) for tests performed during 2002, an amount equal to the national limitation amount for that test for 2001, and adjusted by the percentage increase or decrease determined under paragraph (2)(A)(i) for such year; and

“(B) for tests performed during a year after 2002, the amount determined under this subparagraph for the preceding year, adjusted by the percentage increase or decrease determined under paragraph (2)(A)(i) for such year.”.

(2) CONFORMING AMENDMENTS.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) of the Social Security Act (42 U.S.C. 1395(a)) are each amended by striking “the limitation amount for that test determined under subsection (h)(4)(B).”.

(c) MECHANISM FOR REVIEW OF ADEQUACY OF PAYMENT AMOUNTS.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395(h)), as amended by subsection (b), is amended by adding at the end the following:

“(11) The Secretary shall establish a mechanism under which—

“(A) an interested party may request a timely review of the adequacy of the existing payment amount under this subsection for a particular test; and

“(B) upon the receipt of such a request, a timely review is carried out.”.

(d) USE OF INHERENT REASONABLENESS AUTHORITY.—Section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) is amended by adding at the end the following:

“(E)(i) The Secretary may not delegate the authority to make determinations with respect to clinical diagnostic laboratory tests under this paragraph to a regional office of the Health Care Financing Administration or to an entity with a contract under subsection (a).

“(ii) In making determinations with respect to clinical diagnostic laboratory tests under this paragraph, the Secretary—

“(I) shall base such determinations on data from affected payment localities and all sites of care; and

“(II) may not use a methodology that assigns undue weight to the prevailing charge

levels for any 1 type of entity with a contract under subsection (a).”

(e) PROHIBITION.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395(h)), as amended by subsection (c), is amended by adding at the end the following new paragraph:

“(12)(1) Notwithstanding the preceding provisions of this subsection, the Secretary may not establish a payment level for a new test that is lower than the level for an existing, clinically similar test solely on the basis that the new test may be performed by a laboratory with a certificate of waiver under section 353(d)(2) of the Public Health Service Act (42 U.S.C. 263a(d)(2)).

“(2) Nothing in paragraph (1) shall be construed to limit the authority of the Secretary to establish a payment level for a new test that is lower than the level for an existing, clinically similar test if such payment level is determined on a basis other than the basis described in such paragraph or on more than 1 basis.”

(f) EFFECTIVE DATES.—

(1) ESTABLISHMENT OF PROCEDURES.—The Secretary of Health and Human Services shall establish the procedures required to implement paragraphs (9), (10), (11), and (12) of section 1833(h) of the Social Security Act (42 U.S.C. 1395(h)), as added by this section, by not later than January 1, 2002.

(2) INHERENT REASONABLENESS.—The amendments made by subsection (d) shall apply to determinations made on or after the date of enactment of this Act.

By Mr. GRASSLEY (for himself, Mr. TORRICELLI, and Mr. CRAIG):

S. 1067. A bill to amend the Internal Revenue Code of 1986 to expand the availability of Archer medical savings accounts; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, today, on behalf of myself and my colleague, Senator TORRICELLI, I am introducing legislation, the Medical Savings Availability Act of 2001, which would make the availability of medical savings accounts permanent and would make it possible for any individual to purchase a medical savings account. Our bill would liberalize existing law authorizing medical savings accounts in a number of other respects.

Medical savings accounts are a good idea. They are basically IRAs, an idea everybody understands, which must be used for payment of medical expenses.

The widespread use of medical savings accounts should have several beneficial consequences.

They should reduce health care costs. Administrative costs should be lower. Consumers with MSAs should use health care services in a more discriminating manner. Consumers with MSAs should be more selective in choosing providers. This should cause those providers to lower their prices to attract medical savings account holders as patients.

Medical savings accounts can also help to put the patient back into the health care equation. Patients should make more cost-conscious choices about routine health care. Patients with MSAs would have complete choice of provider.

Medical savings accounts should make health care coverage more de-

pendable. MSAs are completely portable. MSAs are still the property of the individual even if they change jobs. Hence, for those with MSAs, job changes do not threaten them with the loss of health insurance.

Medical savings accounts should increase health care coverage. Perhaps as many as half of the more than 40 million Americans who are uninsured at any point in time are without health insurance only for four months or less. A substantial number of these people are uninsured because they are between jobs. Use of medical savings accounts should reduce the number of the uninsured by equipping people to pay their own health expenses while unemployed.

Medical savings accounts should promote personal savings. Since pre-tax monies are deposited in them, there should be a strong tax incentive to use them.

As I understand it, there are approximately 100,000 MSA accounts covering a total of approximately 250,000. I understand also that approximately one-third of those who have set up medical savings accounts were previously uninsured.

But medical savings accounts have fallen short of their promise because of various restrictions in the authorizing law.

The present law has a sunset of December, 2001, which has discouraged insurers from offering such plans. Current MSA law prohibits around 70 percent of the working population from purchasing them because purchase is limited to the self-employed or to employees of small businesses of less than 50 employees.

The bill we are introducing today would eliminate the restrictions that have limited the availability of MSAs: First, it would remove the December, 2001, sunset provision and make the availability of MSAs permanent; second, it would repeal the limitations on the number of MSAs that can be established; third, it stipulates that the availability of these accounts is not limited to employees of small employers and self-employed individuals; fourth, it increases the amount of the deduction allowed for contributions to medical savings accounts to 100 percent of the deductible; fifth, it permits both employees and employers to contribute to medical savings accounts; sixth, it reduces the permitted deductibles under high deductible plans from \$1,500 in the case of individuals to \$1,000 and from \$3,000 in the case of couples to \$2,000; seventh, the bill would permit medical savings accounts to be offered under cafeteria plans; and finally, the bill would encourage preferred provider organizations to offer MSAs.

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. 1067

*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 “Medical Savings Account Availability Act of 2001”.

**SEC. 2. EXPANSION OF AVAILABILITY OF ARCHER MEDICAL SAVINGS ACCOUNTS.**

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(B) Section 138 of such Code is amended by striking subsection (f).

(b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(1) of such Code (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 subparagraph (C).

(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.

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

“(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to ½ of the annual deductible (as of the first day of such month) of the individual’s coverage under the high deductible health plan.”

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking “75 percent of”.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (4) of section 220(b) of such Code (as redesignated by subsection (b)(2)(C)) is amended to read as follows:

“(4) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer’s gross income for such taxable year.”

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(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” in clause (i) 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 to read as follows:

“(g) COST-OF-LIVING ADJUSTMENT.—

“(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) 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 such taxable year begins by substituting ‘calendar year 1997’ for ‘calendar year 1992’ in subparagraph (B) thereof.

“(2) SPECIAL RULES.—In the case of the \$1,000 amount in subsection (c)(2)(A)(i) and the \$2,000 amount in subsection (c)(2)(A)(ii), paragraph (1)(B) shall be applied by substituting ‘calendar year 2000’ for ‘calendar year 1997’.

“(3) ROUNDING.—If any increase under paragraph (1) or (2) is not a multiple of \$50, such increase shall be rounded to the nearest multiple of \$50.”

(f) PROVIDING INCENTIVES FOR PREFERRED PROVIDER ORGANIZATIONS TO OFFER MEDICAL SAVINGS ACCOUNTS.—Clause (ii) of section 220(c)(2)(B) of such Code is amended by striking “preventive care if” and all that follows and inserting “preventive care.”

(g) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking “106(b).”

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

By Mrs. BOXER:

S. 1068. A bill to provide refunds for unjust and unreasonable charges on electric energy; to the Committee on Energy and Natural Resources.

Mrs. BOXER. Mr. President, earlier this week the Federal Energy Regulatory Commission issued an order to provide price mitigation to California's electricity market. This order is a stunning turnaround for an agency that refused to recognize that this energy crisis is a regional problem and that cost-based pricing is in order. However, FERC's order does not adequately address past grievances regarding refunds for overcharges by the generators.

Therefore, today I am introducing the Electricity Gouging Relief Act in an effort to bring much needed relief to consumers, businesses and the State of California from price gouging by electricity generators. This legislation helps to right past wrongs by providing rebates in cases where companies were engaged in gouging.

Generators' profits increased on average by 508 percent between 1999 and 2000. One company, Reliant Energy, experienced a 1,685 percent increase in profits in the same time period. This compares to a 16 percent increase in profits across the electric and gas industry and an increase in demand of only four percent.

My bill would require the Federal Energy Regulatory Commission, FERC, to order refunds for past electricity purchases in cases where FERC determined that the prices charged by the generators were “unjust and unreasonable.” The bill would affect electricity

sales that took place between June 1, 2000—when price spikes first occurred in San Diego and June 19, 2001—the day before FERC's order became effective.

I encourage my colleagues to support this bill. FERC's actions on Monday are a step in the right direction. Now, we need to refund overcharges by the generators to consumers.

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. 1068

*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 “Electricity Gouging Relief Act of 2001”.

**SEC. 2. REFUNDS FOR EXCESSIVE CHARGES.**

Section 206 of the Federal Power Act (16 U.S.C. 824e) is amended by adding at the end the following:

“(e) REFUNDS FOR EXCESSIVE CHARGES.—

“(1) Notwithstanding any other provision of this section, the Commission shall, within 60 days after enactment of this subsection, order a refund for the portion of charges on the transmission or sale or electric energy that are or have been deemed by the Commission to be unjust or unreasonable. Such refunds shall include interest from the date on which the charges were paid.

“(2) The refunds ordered under paragraph (1) shall apply to charges paid between June 1, 2000 and June 19, 2001.”

By Mr. LEVIN (for himself, Mr. KOHL, Mr. FEINGOLD, Mr. SCHUMER, Mr. JOHNSON, and Ms. STABENOW):

S. 1069. A bill to amend the Natural Trails System Act to clarify Federal authority relating to land acquisition from willing sellers from the majority of the trails in the System, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. LEVIN. Mr. President, today I am introducing the Willing Seller Amendments of 2001 which would amend the National Trails System Act, NTSA, to provide Federal authority to acquire land from willing sellers to complete nine national scenic and historic trails authorized under the Act. The legislation gives the Federal agencies administering the trails the ability to acquire land from willing sellers only. The legislation would not commit the Federal Government to purchase any land or to spend any money but would allow managers to purchase land to protect the national trails as opportunities arise and as funds are appropriated.

For most of the national scenic and historic trails, barely one-half of their congressionally authorized length and resources are protected. Without willing seller authority, Federal trail managers' hands are tied when development threatens important links in the wild landscapes of the national scenic trails or in the sites that authenticate the stories of the historic trails. With willing seller authority, sections of

trail can be moved from roads where hikers and other trail users are unsafe, and critical historic sites can be preserved for future generations to experience. Moreover, this authority protects private property rights, as landowners along the nine affected trails are currently denied the right to sell land to the Federal Government if they desire to do so.

Willing seller authority is crucial for the North Country National Scenic Trail, which runs through my home State of Michigan, because completion of the Trail faces significant challenges. These challenges which relate to development pressure and the need to cross long stretches of private and corporate held lands are common themes throughout the seven states linked by the 4,600-mile long North Country Trail.

This legislation is also vital on a national level and accomplishes several important goals. First, it restores basic property rights—Section 10 (c) of the National Trails System Act as currently written diminishes the right of thousands of people who own land along four national scenic trails and five national historic trails to sell their property or easements on their property, by prohibiting federal agencies from buying their land. Many of these landowners have offered to sell their land to the Federal Government to permanently protect important historical resources that their families have protected for generations or to maintain the continuity of a national scenic trail. Providing this authority to Federal agencies to purchase land from willing sellers along these nine trails will restore this basic property right to thousands of landowners.

Second, it restores the ability of Federal agencies to carry out their responsibility to protect nationally significant components of our nation's cultural, natural and recreational heritage. The National Trails System Act authorizes establishment of national scenic and historic trails to protect important components of our historic and natural heritage. One of the fundamental responsibilities given to the Federal agencies administering these trails is to protect their important cultural and natural resources. Without willing-seller authority, the agencies are prevented from directly protecting these resources along nine trails—nearly one-half of the National Trails System.

Third, it restores consistency to the National Trails System Act, NTSA. Congress enacted the National Trails System Act in 1968 “. . . to provide for the ever-increasing outdoor recreation needs of an expanding population and . . . to promote the preservation of, public access to, travel within, and enjoyment and appreciation of the open-air, outdoor areas and historic resources of the Nation . . . by instituting a national system of recreation, scenic and historic trails . . .” The agencies are authorized to collaborate

with other Federal agencies, State and local governments and private organizations in planning, developing and managing the trails; to develop uniform standards for marking, interpreting and constructing the trails; to regulate their use; and to provide grants and technical assistance to cooperating agencies and organizations. The NTSA is supposed to provide these and other authorities to be applied consistently throughout the National Trails System. However, land acquisition authority, an essential means for protecting the special resources and continuity that are the basis for these trails, has been inconsistently applied. The Federal agencies have been given land acquisition authority for thirteen of the twenty-two national scenic and historic trails but have been denied authority to acquire land for the other nine trails. This bill restores consistency to the National Trails System Act by enabling the Federal agencies to acquire necessary land for all twenty-two national scenic and historic trails.

Finally, this legislation enables Federal agencies to respond to opportunities to protect important resources provided by willing sellers. The willing seller land acquisition authority provided for these nine trails and subsequent appropriations from the Land and Water Conservation Fund will enable the Federal agencies administering them to respond to conservation opportunities afforded by willing landowners.

I am pleased today to introduce this important legislation to restore parity to the National Trails System and provide authority to protect critical resources along the nation's treasured national scenic and historic trails.

By Mr. REED:

S. 1070. A bill to amend the XXVII of the Public Health Service Act and part 7 of subtitle B of title 1 of the Employee Retirement Income Security Act of 1974 to establish standards for the health quality improvement of children in managed care plans and other health plans; to the Committee on Health, Education, Labor, and Pensions.

Mr. REED. Mr. President, today I am introducing legislation that I believe is very pertinent to the current debate over managed care protections. My longstanding concern has been to ensure that the needs of children in managed care are not left out of the debate. That is why I am reintroducing the Children's Health Insurance Accountability Act.

This legislation sets the standard for what kinds of protections ought to be in place for children who receive care through health maintenance organizations. Specifically, this bill provides common sense protections for children in managed care plans such as: access to necessary pediatric primary care and specialty services; appeal rights that address the special needs of children, including an expedited review if a

child's life or development is in jeopardy; quality measurements of health outcomes unique to children; utilization review rules that are specific to children with evaluation from those with pediatric expertise; and child-specific information requirements that will help parents and employers choose health plans on the basis of care provided to children.

I am pleased that the major provisions of this legislation are incorporated into the McCain-Edwards-Kennedy Patient Protection bill, S. 1052. It is difficult enough to have a sick child, but to face barrier after barrier to necessary care for your child is unconscionable. Our current system is often failing our kids when they most need us. It is this simple: if we do not have health plan standards, there is no guarantee that we are providing adequate care for our children. And when it comes to our children, we should not take risks.

Not one of us can deny that managed care plays a valid role in our health care system. Managed care's emphasis on preventive care has benefits for young and old alike. And HMOs have resulted in lower co-payments for consumers and higher immunization rates for our children. However, many questions have arisen about patient access to medical services and the consequences of cost-cutting measures and other incentives under managed care.

The Children's Health Insurance Accountability Act seeks to address these concerns as they relate to children. Children are not small adults and often have very different health and developmental needs. We should be sure that we are always vigilant when it comes to their health and well-being, not only in the context of patient protection legislation, but in other policy measures we consider this year.

I am pleased that this legislation is supported by a number of children's health and advocacy organizations, including the American Academy of Pediatrics, the Children's Defense Fund and the National Association of Children's Hospitals.

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. 1070

*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 "Children's Health Insurance Accountability Act of 2001".

**SEC. 2. FINDINGS.**

Congress makes the following findings:

(1) Children have health and development needs that are markedly different than those for the adult population.

(2) Children experience complex and continuing changes during the continuum from birth to adulthood in which appropriate health care is essential for optimal development.

(3) The vast majority of work done on development methods to assess the effectiveness of health care services and the impact of medical care on patient outcomes and patient satisfaction has been focused on adults.

(4) Health outcome measures need to be age, gender, and developmentally appropriate to be useful to families and children.

(5) Costly disorders of adulthood often have their origins in childhood, making early access to effective health services in childhood essential.

(6) More than 200 chronic conditions, disabilities and diseases affect children, including asthma, diabetes, sickle cell anemia, spina bifida, epilepsy, autism, cerebral palsy, congenital heart disease, mental retardation, and cystic fibrosis. These children need the services of specialists who have in depth knowledge about their particular condition.

(7) Children's patterns of illness, disability and injury differ dramatically from adults.

**SEC. 2. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.**

(a) PATIENT PROTECTION STANDARDS.—Title XXVII of the Public Health Service Act is amended—

(1) by redesignating part C as part D; and

(2) by inserting after part B the following:

“PART C—CHILDREN'S HEALTH PROTECTION STANDARDS

**“SEC. 2770. ACCESS TO CARE.**

“(a) ACCESS TO APPROPRIATE PRIMARY CARE PROVIDERS.—

“(1) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for an enrollee to designate a participating primary care provider for a child of such enrollee—

“(A) the plan or issuer shall permit the enrollee to designate a physician who specializes in pediatrics as the child's primary care provider; and

“(B) if such an enrollee has not designated such a provider for the child, the plan or issuer shall consider appropriate pediatric expertise in mandatorily assigning such an enrollee to a primary care provider.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of services.

“(b) ACCESS TO PEDIATRIC SPECIALTY SERVICES.—

“(1) REFERRAL TO SPECIALTY CARE FOR CHILDREN REQUIRING TREATMENT BY SPECIALISTS.—

“(A) IN GENERAL.—In the case of a child who is covered under a group health plan, or health insurance coverage offered by a health insurance issuer and who has a mental or physical condition, disability, or disease of sufficient seriousness and complexity to require diagnosis, evaluation or treatment by a specialist, the plan or issuer shall make or provide for a referral to a specialist who has extensive experience or training, and is available and accessible to provide the treatment for such condition or disease, including the choice of a nonprimary care physician specialist participating in the plan or a referral to a nonparticipating provider as provided for under subparagraph (D) if such a provider is not available within the plan.

“(B) SPECIALIST DEFINED.—For purposes of this subsection, the term ‘specialist’ means, with respect to a condition, disability, or disease, a health care practitioner, facility, or center (such as a center of excellence) that has extensive pediatric expertise through appropriate training or experience to provide high quality care in treating the condition, disability or disease.

“(C) REFERRALS TO PARTICIPATING PROVIDERS.—A plan or issuer is not required under subparagraph (A) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer

does not have an appropriate specialist that is available and accessible to treat the enrollee's condition and that is a participating provider with respect to such treatment.

“(D) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers a child enrollee to a nonparticipating specialist, services provided pursuant to the referral shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received by such a specialist that is a participating provider.

“(E) SPECIALISTS AS PRIMARY CARE PROVIDERS.—A plan or issuer shall have in place a procedure under which a child who is covered under health insurance coverage provided by the plan or issuer who has a condition or disease that requires specialized medical care over a prolonged period of time shall receive a referral to a pediatric specialist affiliated with the plan, or if not available within the plan, to a nonparticipating provider for such condition and such specialist may be responsible for and capable of providing and coordinating the child's primary and specialty care.

“(2) STANDING REFERRALS.—

“(A) IN GENERAL.—A group health plan, or health insurance issuer in connection with the provision of health insurance coverage of a child, shall have a procedure by which a child who has a condition, disability, or disease that requires ongoing care from a specialist may request and obtain a standing referral to such specialist for treatment of such condition. If the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall authorize such a referral to such a specialist. Such standing referral shall be consistent with a treatment plan.

“(B) TREATMENT PLANS.—A group health plan, or health insurance issuer, with the participation of the family and the health care providers of the child, shall develop a treatment plan for a child who requires ongoing care that covers a specified period of time (but in no event less than a 6-month period). Services provided for under the treatment plan shall not require additional approvals or referrals through a gatekeeper.

“(C) TERMS OF REFERRAL.—The provisions of subparagraph (C) and (D) of paragraph (1) shall apply with respect to referrals under subparagraph (A) in the same manner as they apply to referrals under paragraph (1)(A).

“(c) ADEQUACY OF ACCESS.—For purposes of subsections (a) and (b), a group health plan or health insurance issuer in connection with health insurance coverage shall ensure that a sufficient number, distribution, and variety of qualified participating health care providers are available so as to ensure that all covered health care services, including specialty services, are available and accessible to all enrollees in a timely manner.

“(d) COVERAGE OF EMERGENCY SERVICES.—

“(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits for children with respect to emergency services (as defined in paragraph (2)(A)), the plan or issuer shall cover emergency services furnished under the plan or coverage—

“(A) without the need for any prior authorization determination;

“(B) whether or not the physician or provider furnishing such services is a participating physician or provider with respect to such services; and

“(C) without regard to any other term or condition of such coverage (other than exclusion of benefits, or an affiliation or waiting period, permitted under section 2701).

“(2) DEFINITIONS.—In this subsection:

“(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—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 condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

“(B) EMERGENCY SERVICES.—The term ‘emergency services’ means—

“(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in subparagraph (A)); and

“(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

“(3) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance issuer offering health insurance coverage, shall provide, in covering services other than emergency services, for reimbursement with respect to services which are otherwise covered and which are provided to an enrollee other than through the plan or issuer if the services are maintenance care or post-stabilization care covered under the guidelines established under section 1852(d) of the Social Security Act (relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after an enrollee has been determined to be stable).

“(e) PROHIBITION ON FINANCIAL BARRIERS.—A health insurance issuer in connection with the provision of health insurance coverage may not impose any cost sharing for pediatric specialty services provided under such coverage to enrollee children in amounts that exceed the cost-sharing required for other specialty care under such coverage.

“(f) CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—A health insurance issuer in connection with the provision of health insurance coverage shall ensure that such coverage provides special consideration for the provision of services to enrollee children with special health care needs. Appropriate procedures shall be implemented to provide care for children with special health care needs. The development of such procedures shall include participation by the families of such children.

“(g) DEFINITIONS.—In this part:

“(1) CHILD.—The term ‘child’ means an individual who is under 19 years of age.

“(2) CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—The term ‘children with special health care needs’ means those children who have or are at elevated risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type and amount not usually required by children.

“SEC. 2771. CONTINUITY OF CARE.

“(a) IN GENERAL.—If a contract between a health insurance issuer, in connection with the provision of health insurance coverage, and a health care provider is terminated (other than by the issuer for failure to meet applicable quality standards or for fraud) and an enrollee is undergoing a course of treatment from the provider at the time of such termination, the issuer shall—

“(1) notify the enrollee of such termination, and

“(2) subject to subsection (c), permit the enrollee to continue the course of treatment with the provider during a transitional period (provided under subsection (b)).

“(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—

“(A) 60 days from the date of the notice to the enrollee of the provider's termination in the case of a primary care provider, or

“(B) 120 days from such date in the case of another provider.

“(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 shall include reasonable follow-up care related to the institutionalization and shall also include institutional care scheduled prior to the date of termination of the provider status.

“(3) PREGNANCY.—If—

“(A) an 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.—

“(A) IN GENERAL.—If—

“(i) an enrollee was determined to be terminally ill (as defined in subparagraph (B)) at the time of a provider's termination of participation, and

“(ii) 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 enrollee's life for care directly related to the treatment of the terminal illness.

“(B) DEFINITION.—In subparagraph (A), an enrollee is considered to be ‘terminally ill’ if the enrollee has a medical prognosis that the enrollee's life expectancy is 6 months or less.

“(c) PERMISSIBLE TERMS AND CONDITIONS.—

An issuer may condition coverage of continued treatment by a provider under subsection (a)(2) upon the provider agreeing to the following terms and conditions:

“(1) The provider agrees to continue to accept reimbursement from the issuer at the rates applicable prior to the start of the transitional period as payment in full.

“(2) The provider agrees to adhere to the issuer's quality assurance standards and to provide to the issuer necessary medical information related to the care provided.

“(3) The provider agrees otherwise to adhere to the issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan approved by the issuer.

“SEC. 2772. CONTINUOUS QUALITY IMPROVEMENT.

“(a) IN GENERAL.—A health insurance issuer that offers health insurance coverage for children shall establish and maintain an ongoing, internal quality assurance program that at a minimum meets the requirements of subsection (b).

“(b) REQUIREMENTS.—The internal quality assurance program of an issuer under subsection (a) shall—

“(1) establish and measure a set of health care, functional assessments, structure, processes and outcomes, and quality indicators that are unique to children and based on nationally accepted standards or guidelines of care;

“(2) maintain written protocols consistent with recognized clinical guidelines or current consensus on the pediatric field, to be used for purposes of internal utilization review, with periodic updating and evaluation by pediatric specialists to determine effectiveness in controlling utilization;

“(3) provide for peer review by health care professionals of the structure, processes, and outcomes related to the provision of health services, including pediatric review of pediatric cases;

“(4) include in member satisfaction surveys, questions on child and family satisfaction and experience of care, including care to children with special needs;

“(5) monitor and evaluate the continuity of care with respect to children;

“(6) include pediatric measures that are directed at meeting the needs of at-risk children and children with chronic conditions, disabilities and severe illnesses;

“(7) maintain written guidelines to ensure the availability of medications appropriate to children;

“(8) use focused studies of care received by children with certain types of chronic conditions and disabilities and focused studies of specialized services used by children with chronic conditions and disabilities;

“(9) monitor access to pediatric specialty services; and

“(10) monitor child health care professional satisfaction.

“(c) UTILIZATION REVIEW ACTIVITIES.—

“(1) COMPLIANCE WITH REQUIREMENTS.—

“(A) IN GENERAL.—A health insurance issuer that offers health insurance coverage for children shall conduct utilization review activities in connection with the provision of such coverage only in accordance with a utilization review program that meets at a minimum the requirements of this subsection.

“(B) DEFINITIONS.—In this subsection:

“(i) CLINICAL PEERS.—The term ‘clinical peer’ means, with respect to a review, a physician or other health care professional who holds a non-restricted license in a State and in the same or similar specialty as typically manages the pediatric medical condition, procedure, or treatment under review.

“(ii) HEALTH CARE PROFESSIONAL.—The term ‘health care professional’ means a physician or other health care practitioner licensed or certified under State law to provide health care services and who is operating within the scope of such licensure or certification.

“(iii) UTILIZATION REVIEW.—The terms ‘utilization review’ and ‘utilization review activities’ mean procedures used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings for children, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review specific to children.

“(2) WRITTEN POLICIES AND CRITERIA.—

“(A) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

“(B) USE OF WRITTEN CRITERIA.—A utilization review program shall utilize written clinical review criteria specific to children and developed pursuant to the program with the input of appropriate physicians, including pediatricians, nonprimary care pediatric specialists, and other child health professionals.

“(C) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals, including health care professionals with pediatric expertise who shall oversee review decisions.

“(3) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

“(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and, to the extent required, who have received appropriate pediatric or child health training in the conduct of such activities under the program.

“(B) PEER REVIEW OF ADVERSE CLINICAL DETERMINATIONS.—A utilization review program shall provide that clinical peers shall evaluate the clinical appropriateness of adverse clinical determinations and divergent clinical options.

**“SEC. 2773. APPEALS AND GRIEVANCE MECHANISMS FOR CHILDREN.**

“(a) INTERNAL APPEALS PROCESS.—A health insurance issuer in connection with the provision of health insurance coverage for children shall establish and maintain a system to provide for the resolution of complaints and appeals regarding all aspects of such coverage. Such a system shall include an expedited procedure for appeals on behalf of a child enrollee in situations in which the time frame of a standard appeal would jeopardize the life, health, or development of the child.

“(b) EXTERNAL APPEALS PROCESS.—A health insurance issuer in connection with the provision of health insurance coverage for children shall provide for an independent external review process that meets the following requirements:

“(1) External appeal activities shall be conducted through clinical peers, a physician or other health care professional who is appropriately credentialed in pediatrics with the same or similar specialty and typically manages the condition, procedure, or treatment under review or appeal.

“(2) External appeal activities shall be conducted through an entity that has sufficient pediatric expertise, including subspecialty expertise, and staffing to conduct external appeal activities on a timely basis.

“(3) Such a review process shall include an expedited procedure for appeals on behalf of a child enrollee in which the time frame of a standard appeal would jeopardize the life, health, or development of the child.

**“SEC. 2774. ACCOUNTABILITY THROUGH DISTRIBUTION OF INFORMATION.**

“(a) IN GENERAL.—A health insurance issuer in connection with the provision of health insurance coverage for children shall submit to enrollees (and prospective enrollees), and make available to the public, in writing the health-related information described in subsection (b).

“(b) INFORMATION.—The information to be provided under subsection (a) shall include a report of measures of structures, processes, and outcomes regarding each health insurance product offered to participants and dependents in a manner that is separate for both the adult and child enrollees, using measures that are specific to each group.”.

(b) APPLICATION TO GROUP HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—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:

**“SEC. 2707. CHILDREN'S HEALTH ACCOUNTABILITY STANDARDS.**

“(a) IN GENERAL.—Each health insurance issuer shall comply with children's health accountability requirement under part C with respect to group health insurance coverage it offers.

“(b) ASSURING COORDINATION.—The Secretary of Health and Human Services and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding between such Secretaries, that—

“(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under part C (and this section) and section 714 of the Employee Retirement Income Security Act of 1974 are administered so as to have the same effect at all times; and

“(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.”.

(2) CONFORMING AMENDMENT.—Section 2792 of the Public Health Service Act (42 U.S.C. 300gg-92) is amended by inserting “and section 2707(b)” after “of 1996”.

(c) APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.—Part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-41 et seq.) is amended by inserting after section 2752 the following:

**“SEC. 2753. CHILDREN'S HEALTH ACCOUNTABILITY STANDARDS.**

“Each health insurance issuer shall comply with children's health accountability requirements under part C with respect to individual health insurance coverage it offers.”.

(d) MODIFICATION OF PREEMPTION STANDARDS.—

(1) GROUP HEALTH INSURANCE COVERAGE.—Section 2723 of the Public Health Service Act (42 U.S.C. 300gg-23) is amended—

(A) in subsection (a)(1), by striking “subsection (b)” and inserting “subsection (b) and (c)”;

(B) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(C) by inserting after subsection (b) the following new subsection:

“(c) SPECIAL RULES IN CASE OF CHILDREN'S HEALTH ACCOUNTABILITY REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 2707 and part C, and part D insofar as it applies to section 2707 or part C, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on health insurance issuers as the requirements imposed under such provisions.”.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2762 of the Public Health Service Act (42 U.S.C. 300gg-62) is amended—

(A) in subsection (a), by striking “subsection (b), nothing in this part” and inserting “subsections (b) and (c)”;

(B) by adding at the end the following new subsection:

“(c) SPECIAL RULES IN CASE OF CHILDREN'S HEALTH ACCOUNTABILITY REQUIREMENTS.—Subject to subsection (b), the provisions of section 2753 and part C, and part D insofar as it applies to section 2753 or part C, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on health insurance issuers as the requirements imposed under such section.”.

**SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.**

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

**“SEC. 714. CHILDREN'S HEALTH ACCOUNTABILITY STANDARDS.**

“(a) IN GENERAL.—Subject to subsection (b), the provisions of part C of title XXVII of the Public Health Service Act shall apply under this subpart and part to a group health plan (and group health insurance coverage offered in connection with a group health

plan) as if such part were incorporated in this section.

“(b) APPLICATION.—In applying subsection (a) under this subpart and part, any reference in such part C—

“(1) to health insurance coverage is deemed to be a reference only to group health insurance coverage offered in connection with a group health plan and to also be a reference to coverage under a group health plan;

“(2) to a health insurance issuer is deemed to be a reference only to such an issuer in relation to group health insurance coverage or, with respect to a group health plan, to the plan;

“(3) to the Secretary is deemed to be a reference to the Secretary of Labor;

“(4) to an applicable State authority is deemed to be a reference to the Secretary of Labor; and

“(5) to an enrollee with respect to health insurance coverage is deemed to include a reference to a participant or beneficiary with respect to a group health plan.”

(b) MODIFICATION OF PREEMPTION STANDARDS.—Section 731 of the Employee Retirement Income Security Act of 1974 (42 U.S.C. 1191) is amended—

(1) in subsection (a)(1), by striking “subsection (b)” and inserting “subsections (b) and (c)”;

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(3) by inserting after subsection (b) the following new subsection:

“(c) SPECIAL RULES IN CASE OF PATIENT ACCOUNTABILITY REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 714, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on group health plans and health insurance issuers in connection with group health insurance coverage as the requirements imposed under such provisions.”

(c) CONFORMING AMENDMENTS.—

(1) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185(a)) is amended by striking “section 711” and inserting “sections 711 and 714”.

(2) 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 713 the following new item:

“Sec. 714. Children’s health accountability standards.”

#### SEC. 4. STUDIES.

(a) BY SECRETARY.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall conduct a study, and prepare and submit to Congress a report, concerning—

(1) the unique characteristics of patterns of illness, disability, and injury in children;

(2) the development of measures of quality of care and outcomes related to the health care of children; and

(3) the access of children to primary mental health services and the coordination of managed behavioral health services.

(b) BY GAO.—

(1) MANAGED CARE.—Not later than 1 year after the date of enactment of this Act, the General Accounting Office shall conduct a study, and prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives a report, concerning—

(A) an assessment of the structure and performance of non-governmental health plans, medicaid managed care organizations, plans under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and the program

under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) serving the needs of children with special health care needs;

(B) an assessment of the structure and performance of non-governmental plans in serving the needs of children as compared to medicaid managed care organizations under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); and

(C) the emphasis that private managed care health plans place on primary care and the control of services as it relates to care and services provided to children with special health care needs.

(2) PLAN SURVEY.—Not later than 1 year after the date of enactment of this Act, the General Accounting Office shall prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives a report that contains a survey of health plan activities that address the unique health needs of adolescents, including quality measures for adolescents and innovative practice arrangement.

By Mr. INHOFE:

S. 1073. A bill to establish a National Commission to Eliminate Waste in Government; to the Committee on Government Affairs.

Mr. INHOFE. Mr. President, today I rise to bring attention to an issue that affects all Americans, government waste. As we all know, the Federal Government is infamous for its profligate programs and approaches to problem solving. In the last decade, we have seen inefficiency of mammoth proportions within the government.

As a result, I have introduced legislation that would establish a national commission to eliminate government waste. This act would resurrect President Reagan’s work to find an equitable way to enact fiscal responsibility and accountability within the government. During the Reagan Administration, a private sector study of government was commissioned to dispose of Federal waste, mismanagement, and abuse. Led by industrialist J. Peter Grace, the Grace Commission produced 47 reports with 2,478 recommendations. As a result of this study, President Reagan issued executive orders that saved the Federal Government more than \$110 billion.

Today, many Federal agencies still use cumbersome bureaucratic procedures. The National Commission to Eliminate Waste in Government Act would establish a commission to conduct a private sector survey on management and cost control within the government. It would also provide an opportunity for the commission to review existing reports on government waste. Because the commission would be funded, staffed, and equipped by the private sector, it would not cost the government one dime.

I urge my colleagues to support this end to government waste and the beginning of discipline and efficiency within our government.

By Mr. GRASSLEY (for himself, Mr. BIDEN, Mr. SMITH of Oregon, and Mr. DASCHLE):

S. 1075. A bill to extend and modify the Drug-Free Communities Support

Program, to authorize a National Community Antidrug Coalition Institute, and for other purposes; to the Committee on the Judiciary.

Mr. GRASSLEY. Mr. President, I rise today to introduce legislation to re-authorize the Drug Free Communities Act. I am pleased to be joined by my colleagues Senator BIDEN, Senator Smith, and Senator DASCHLE in introducing this legislation which will continue for another 5 years the successes that we have found with Drug Free Communities Program. In addition, it builds upon the successes that coalitions have had by encouraging them to establish a coalition mentoring program for nearby communities. Finally, this act will authorize funding for the National Anti-Drug Coalition Institute, which will provide education, training, and technical assistance to leaders of community coalitions.

Substance abuse remains a problem in communities across the country. Substance abuse is the cause of or associated with many of today’s problems, but is a preventable behavior. Community anti-drug coalitions are implementing long-term strategies to address the problem of substance abuse in their communities. By bringing together a cross-section of the community to address a common problem, community coalitions are discovering and implementing unique community solutions to reduce and prevent the incidence of substance abuse in their communities. And that idea, that communities are best suited to address their own problems, is the underlying premise that has been proven with the success of the Drug Free Communities program.

There are three key features to the Drug Free Communities Act. First, communities must take the initiative. In order to receive support, a community coalition must demonstrate that there is a long-term commitment to address teen-drug use. It must have a sustainable coalition that includes the involvement of representatives from a wide variety of community activists.

In addition, every coalition must show that it can sustain itself. Community coalitions must be in existence for at least 6 months before applying. They are only eligible to receive support if they can match these donations dollar for dollar with non-Federal funding, up to \$100,000 per coalition.

An Advisory Commission, consisting of local community leaders, and State and national experts in the field of substance abuse, has worked closely with the Office of National Drug Control Policy to oversee the successful management and growth of this grant program. Because of this partnership, grants have gone to communities and programs that can make a difference in the lives of our children.

Today, we have better evidence that coalitions are working, that they are making a difference. A recent study sponsored by the Annie E. Casey Foundation documented the difference that

eight community coalitions, all of which have received funding through the Drug Free Communities program, from around the country have made in their communities.

In addition to continuing this successful program, this re-authorization legislation adds the possibility for a supplemental grant to the Drug-Free Communities Grant Program. The supplemental grant is available to any coalition that has been in existence for at least 5 years, achieved measurable results in youth substance abuse prevention and treatment, have staff or Coalition members willing to serve as mentors for persons interested in starting or expanding a Coalition in their community, identified demonstrable support from members of the identified community, and have created a detailed plan for mentoring either newly formed or developing Coalitions.

Coalitions receiving the supplemental grant must use these funds to support and encourage the development of new, self-supporting community coalitions focused on the prevention and treatment of substance abuse in the new coalition's community. This supplemental grant can be renewed provided the recipient coalition continues to meet the underlying criteria and has made progress in the development of new coalitions.

Starting a new anti-drug coalition is a difficult exercise, which makes the success of these coalitions I mentioned earlier all the more remarkable. But I also know this from personal experience. For the past 4 years, I have worked with leaders from across my State of Iowa to start and grow the Face It Together Coalition, a State-wide, anti-drug coalition designed to bring together people from all walks of life, business leaders, doctors and nurses, law enforcement, school professionals, members of the media, and so on, to work together toward a common goal: keeping kids drug free.

In working with FIT, it has become clear that by working together, everyone can accomplish more. This is a solid, grass-roots initiative that can work. But it hasn't been an easy process, and it will continue to require the dedication and commitment of all of our board members. One of the biggest challenges that we face has not been finding ideas of what to do, or even finding effective ongoing projects in the State, but identifying and securing funding to support the expansion of our activities. Much can and has been done by volunteers, and through the networking connections that the Board members are able to bring to the table.

In addition, this legislation will authorize \$2 million in federal funding for two years for the National Community Anti-Drug Coalition Institute. Modeled after the success we have seen from the National Drug Court Institute, this national non-profit organization will represent, provide technical assistance and training, and have special expertise and broad, national-level experi-

ence in community anti-drug coalitions.

The funding for the Institute will be to 1. provide education, training, and technical assistance to key members of community anti-drug coalitions, 2. develop and disseminate evaluation tools, mechanisms, and measures to assess and document coalition performance, and 3. bridge the gap between research and practice by providing community coalitions with practical information based on the most current research on coalition-related issues. The Institute is expected to last for more than 2 years, and to pursue and obtain additional funding from sources other than the Federal Government.

In conclusion, I encourage all of my colleagues to join me in supporting this legislation. It is supported by the Administration. It has the support of communities all across the Nation. The Drug Free Communities Program works. I look forward to working with my colleagues here and in the House to ensure quick passage.

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. 1075

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. EXTENSION OF DRUG-FREE COMMUNITIES SUPPORT PROGRAM.**

(a) FINDINGS.—Congress makes the following findings:

(1) In the next 15 years, the youth population in the United States will grow by 21 percent, adding 6,500,000 youth to the population of the United States. Even if drug use rates remain constant, there will be a huge surge in drug-related problems, such as academic failure, drug-related violence, and HIV incidence, simply due to this population increase.

(2) According to the 1994-1996 National Household Survey, 60 percent of students age 12 to 17 who frequently cut classes and who reported delinquent behavior in the past 6 months used marijuana 52 days or more in the previous year.

(3) The 2000 Washington Kids Count survey conducted by the University of Washington reported that students whose peers have little or no involvement with drinking and drugs have higher math and reading scores than students whose peers had low level drinking or drug use.

(4) Substance abuse prevention works. In 1999, only 10 percent of teens saw marijuana users as popular, compared to 17 percent in 1998 and 19 percent in 1997. The rate of past-month use of any drug among 12 to 17 year olds declined 26 percent between 1997 and 1999. Marijuana use for sixth through eighth graders is at the lowest point in 5 years, as is use of cocaine, inhalants, and hallucinogens.

(5) Community Anti-Drug Coalitions throughout the United States are successfully developing and implementing comprehensive, long-term strategies to reduce substance abuse among youth on a sustained basis. For example:

(A) The Boston Coalition brought college and university presidents together to create the Cooperative Agreement on Underage Drinking. This agreement represents the

first coordinated effort of Boston's many institutions of higher education to address issues such as binge drinking, underage drinking, and changing the norms surrounding alcohol abuse that exist on college and university campuses.

(B) The Miami Coalition used a three-part strategy to decrease the percentage of high school seniors who reported using marijuana at least once during the most recent 30-day period. The development of a media strategy, the creation of a network of prevention agencies, and discussions with high school students about the dangers of marijuana all contributed to a decrease in the percentage of seniors who reported using marijuana from more than 22 percent in 1995 to 9 percent in 1997. The Miami Coalition was able to achieve these results while national rates of marijuana use were increasing.

(C) The Nashville Prevention Partnership worked with elementary and middle school children in an attempt to influence them toward positive life goals and discourage them from using substances. The Partnership targeted an area in East Nashville and created after school programs, mentoring opportunities, attendance initiatives, and safe passages to and from school. Attendance and test scores increased as a result of the program.

(D) At a youth-led town meeting sponsored by the Bering Strait Community Partnership in Nome, Alaska, youth identified a need for a safe, substance-free space. With help from a variety of community partners, the Partnership staff and youth members created the Java Hut, a substance-free coffeehouse designed for youth. The Java Hut is helping to change norms in the community by providing a fun, youth-friendly atmosphere and activities that are not centered around alcohol or marijuana.

(E) Portland's Regional Drug Initiative (RDI) has promoted the establishment of drug-free workplaces among the city's large and small employers. More than 3,000 employers have attended an RDI training session, and of those, 92 percent have instituted drug-free workplace policies. As a result, there has been a 5.5 percent decrease in positive workplace drug tests.

(F) San Antonio Fighting Back worked to increase the age at which youth first used illegal substances. Research suggests that the later the age of first use, the lower the risk that a young person will become a regular substance abuser. As a result, the age of first illegal drug use increased from 9.4 years in 1992 to 13.5 years in 1997.

(G) In 1990, multiple data sources confirmed a trend of increased alcohol use by teenagers in the Troy community. Using its "multiple strategies over multiple sectors" approach, the Troy Coalition worked with parents, physicians, students, coaches, and others to address this problem from several angles. As a result, the rate of twelfth grade students who had consumed alcohol in the past month decreased from 62.1 percent to 53.3 percent between 1991 and 1998, and the rate of eighth grade students decreased from 26.3 percent to 17.4 percent. The Troy Coalition believes that this decline represents not only a change in behavior on the part of students, but also a change in the norms of the community.

(H) In 2000, the Coalition for a Drug-Free Greater Cincinnati surveyed more than 47,000 local seventh through twelfth graders. The results provided evidence that the Coalition's initiatives are working. For the first time in a decade, teen drug use in Greater Cincinnati appears to be leveling off. The data collected from the survey has served as a tool to strengthen relationships between

schools and communities, as well as facilitate the growth of anti-drug coalitions in communities where they had not existed.

(6) Despite these successes, drug use continues to be a serious problem facing communities across the United States. For example:

(A) According to the Pulse Check: Trends in Drug Abuse Mid-Year 2000 report—

(i) crack and powder cocaine remains the most serious drug problem;

(ii) marijuana remains the most widely available illicit drug, and its potency is on the rise;

(iii) treatment sources report an increase in admissions with marijuana as the primary drug of abuse—and adolescents outnumber other age groups entering treatment for marijuana;

(iv) 80 percent of Pulse Check sources reported increased availability of club drugs, with ecstasy (MDMA) and ketamine the most widely cited club drugs and seven sources reporting that powder cocaine is being used as a club drug by young adults;

(v) ecstasy abuse and trafficking is expanding, no longer confined to the “rave” scene;

(vi) the sale and use of club drugs has grown from nightclubs and raves to high schools, the streets, neighborhoods, open venues, and younger ages;

(vii) ecstasy users often are unknowingly purchasing adulterated tablets or some other substance sold as MDMA; and

(viii) along with reports of increased heroin snorting as a route of administration for initiates, there is also an increase in injecting initiates and the negative health consequences associated with injection (for example, increases in HIV/AIDS and Hepatitis C) suggesting that there is a generational forgetting of the dangers of injection of the drug.

(B) The 2000 Parent’s Resource Institute for Drug Education study reported that 23.6 percent of children in the sixth through twelfth grades used illicit drugs in the past year. The same study found that monthly usage among this group was 15.3 percent.

(C) According to the 2000 Monitoring the Future study, the use of ecstasy among eighth graders increased from 1.7 percent in 1999 to 3.1 percent in 2000, among tenth graders from 4.4 percent to 5.4 percent, and from 5.6 percent to 8.2 percent among twelfth graders.

(D) A 1999 Mellman Group study found that—

(i) 56 percent of the population in the United States believed that drug use was increasing in 1999;

(ii) 92 percent of the population viewed illegal drug use as a serious problem in the United States; and

(iii) 73 percent of the population viewed illegal drug use as a serious problem in their communities.

(7) According to the 2001 report of the National Center on Addiction and Substance Abuse at Columbia University entitled “Shoveling Up: The Impact of Substance Abuse on State Budgets”, using the most conservative assumption, in 1998 States spent \$77,900,000,000 to shovel up the wreckage of substance abuse, only \$3,000,000,000 to prevent and treat the problem and \$433,000,000 for alcohol and tobacco regulation and compliance. This \$77,900,000,000 burden was distributed as follows:

(A) \$30,700,000,000 in the justice system (77 percent of justice spending).

(B) \$16,500,000,000 in education costs (10 percent of education spending).

(C) \$15,200,000,000 in health costs (25 percent of health spending).

(D) \$7,700,000,000 in child and family assistance (32 percent of child and family assistance spending).

(E) \$5,900,000,000 in mental health and developmental disabilities (31 percent of mental health spending).

(F) \$1,500,000,000 in public safety (26 percent of public safety spending) and \$400,000,000 for the state workforce.

(8) Intergovernmental cooperation and coordination through national, State, and local or tribal leadership and partnerships are critical to facilitate the reduction of substance abuse among youth in communities across the United States.

(9) Substance abuse is perceived as a much greater problem nationally than at the community level. According to a 2001 study sponsored by The Pew Charitable Trusts, between 1994 and 2000—

(A) there was a 43 percent increase in the percentage of Americans who felt progress was being made in the war on drugs at the community level;

(B) only 9 percent of Americans say drug abuse is a “crisis” in their neighborhood, compared to 27 percent who say this about the nation; and

(C) the percentage of those who felt we lost ground in the war on drugs on a community level fell by more than a quarter, from 51 percent in 1994 to 37 percent in 2000.

(b) EXTENSION AND INCREASE OF PROGRAM.—Section 1024(a) of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1524(a)) is amended—

(1) by striking “and” at the end of paragraph (4); and

(2) by striking paragraph (5) and inserting the following new paragraphs:

“(5) \$50,600,000 for fiscal year 2002;

“(6) \$60,000,000 for fiscal year 2003;

“(7) \$70,000,000 for fiscal year 2004;

“(8) \$70,000,000 for fiscal year 2005;

“(9) \$75,000,000 for fiscal year 2006; and

“(10) \$75,000,000 for fiscal year 2007.”.

(c) EXTENSION OF LIMITATION ON ADMINISTRATIVE COSTS.—Section 1024(b) of that Act (21 U.S.C. 1524(b)) is amended by striking paragraph (5) and inserting the following new paragraph (5):

“(5) 8 percent for each of fiscal years 2002 through 2007.”.

(d) ADDITIONAL GRANTS.—Section 1032(b) of that Act (21 U.S.C. 1532(b)) is amended by adding at the end the following new paragraph (3):

“(3) ADDITIONAL GRANTS.—

“(A) IN GENERAL.—Subject to subparagraph (F), the Administrator may award an additional grant under this paragraph to an eligible coalition awarded a grant under paragraph (1) or (2) for any first fiscal year after the end of the 4-year period following the period of the initial grant under paragraph (1) or (2), as the case may be.

“(B) SCOPE OF GRANTS.—A coalition awarded a grant under paragraph (1) or (2), including a renewal grant under such paragraph, may not be awarded another grant under such paragraph, and is eligible for an additional grant under this section only under this paragraph.

“(C) NO PRIORITY FOR APPLICATIONS.—The Administrator may not afford a higher priority in the award of an additional grant under this paragraph than the Administrator would afford the applicant for the grant if the applicant were submitting an application for an initial grant under paragraph (1) or (2) rather than an application for a grant under this paragraph.

“(D) RENEWAL GRANTS.—Subject to subparagraph (F), the Administrator may award a renewal grant to a grant recipient under this paragraph for each of the fiscal years of the 4-fiscal year period following the fiscal year for which the initial additional grant under subparagraph (A) is awarded in an amount not to exceed amounts as follows:

“(i) For the first and second fiscal years of that 4-fiscal year period, the amount equal to 80 percent of the non-Federal funds, including in-kind contributions, raised by the coalition for the applicable fiscal year.

“(ii) For the second, third, and fourth fiscal years of that 4-fiscal year period, the amount equal to 67 percent of the non-Federal funds, including in-kind contributions, raised by the coalition for the applicable fiscal year.

“(E) SUSPENSION.—If a grant recipient under this paragraph fails to continue to meet the criteria specified in subsection (a), the Administrator may suspend the grant, after providing written notice to the grant recipient and an opportunity to appeal.

“(F) LIMITATION.—The amount of a grant award under this paragraph may not exceed \$100,000 for a fiscal year.”.

(e) DATA COLLECTION AND DISSEMINATION.—Section 1033(b) of that Act (21 U.S.C. 1533(b)) is amended by adding at the end the following new paragraph:

“(3) CONSULTATION.—The Administrator shall carry out activities under this subsection in consultation with the Advisory Commission and the National Community Antidrug Coalition Institute.”.

(f) LIMITATION ON USE OF CERTAIN FUNDS FOR EVALUATION OF PROGRAM.—Section 1033(b) of that Act, as amended by subsection (e) of this section, is further amended by adding at the end the following new paragraph:

“(4) LIMITATION ON USE OF CERTAIN FUNDS FOR EVALUATION OF PROGRAM.—Amounts for activities under paragraph (2)(B) may not be derived from amounts under section 1024(a), except for amounts that are available under section 1024(b) for administrative costs.”.

## SEC. 2. SUPPLEMENTAL GRANTS FOR COALITION MENTORING ACTIVITIES UNDER DRUG-FREE COMMUNITIES SUPPORT PROGRAM.

Subchapter I of chapter 2 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1531 et seq.) is amended by adding at the end the following new section:

### “SEC. 1035. SUPPLEMENTAL GRANTS FOR COALITION MENTORING ACTIVITIES.

“(a) AUTHORITY TO MAKE GRANTS.—As part of the program established under section 1031, the Director may award an initial grant under this subsection, and renewal grants under subsection (f), to any coalition awarded a grant under section 1032 that meets the criteria specified in subsection (d) in order to fund coalition mentoring activities by such coalition in support of the program.

“(b) TREATMENT WITH OTHER GRANTS.—

“(1) SUPPLEMENT.—A grant awarded to a coalition under this section is in addition to any grant awarded to the coalition under section 1032.

“(2) REQUIREMENT FOR BASIC GRANT.—A coalition may not be awarded a grant under this section for a fiscal year unless the coalition was awarded a grant or renewal grant under section 1032(b) for that fiscal year.

“(c) APPLICATION.—A coalition seeking a grant under this section shall submit to the Administrator an application for the grant in such form and manner as the Administrator may require.

“(d) CRITERIA.—A coalition meets the criteria specified in this subsection if the coalition—

“(1) has been in existence for at least 5 years;

“(2) has achieved, by or through its own efforts, measurable results in the prevention and treatment of substance abuse among youth;

“(3) has staff or members willing to serve as mentors for persons seeking to start or expand the activities of other coalitions in the prevention and treatment of substance abuse;

“(4) has demonstrable support from some members of the community in which the coalition mentoring activities to be supported by the grant under this section are to be carried out; and

“(5) submits to the Administrator a detailed plan for the coalition mentoring activities to be supported by the grant under this section.

“(e) USE OF GRANT FUNDS.—A coalition awarded a grant under this section shall use the grant amount for mentoring activities to support and encourage the development of new, self-supporting community coalitions that are focused on the prevention and treatment of substance abuse in such new coalitions’ communities. The mentoring coalition shall encourage such development in accordance with the plan submitted by the mentoring coalition under subsection (d)(5).

“(f) RENEWAL GRANTS.—The Administrator may make a renewal grant to any coalition awarded a grant under subsection (a), or a previous renewal grant under this subsection, if the coalition, at the time of application for such renewal grant—

“(1) continues to meet the criteria specified in subsection (d); and

“(2) has made demonstrable progress in the development of one or more new, self-supporting community coalitions that are focused on the prevention and treatment of substance abuse.

“(g) GRANT AMOUNTS.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), the total amount of grants awarded to a coalition under this section for a fiscal year may not exceed the amount of non-Federal funds raised by the coalition, including in-kind contributions, for that fiscal year.

“(2) INITIAL GRANTS.—The amount of the initial grant awarded to a coalition under subsection (a) may not exceed \$75,000.

“(3) RENEWAL GRANTS.—The total amount of renewal grants awarded to a coalition under subsection (f) for any fiscal year may not exceed \$75,000.

“(h) FISCAL YEAR LIMITATION ON AMOUNT AVAILABLE FOR GRANTS.—The total amount available for grants under this section, including renewal grants under subsection (f), in any fiscal year may not exceed the amount equal to five percent of the amount authorized to be appropriated by section 1024(a) for that fiscal year.”

### SEC. 3. FIVE-YEAR EXTENSION OF ADVISORY COMMISSION ON DRUG-FREE COMMUNITIES.

Section 1048 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1548) is amended by striking “2002” and inserting “2007”.

### SEC. 4. AUTHORIZATION FOR NATIONAL COMMUNITY ANTIDRUG COALITION INSTITUTE.

(a) IN GENERAL.—The Director of the Office of National Drug Control Policy may, using amounts authorized to be appropriated by subsection (d), make a grant to an eligible organization to provide for the establishment of a National Community Antidrug Coalition Institute.

(b) ELIGIBLE ORGANIZATIONS.—An organization eligible for the grant under subsection (a) is any national nonprofit organization that represents, provides technical assistance and training to, and has special expertise and broad, national-level experience in community antidrug coalitions under section 1032 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1532).

(c) USE OF GRANT AMOUNT.—The organization receiving the grant under subsection (a) shall establish a National Community Antidrug Coalition Institute to—

(1) provide education, training, and technical assistance for coalition leaders and community teams;

(2) develop and disseminate evaluation tools, mechanisms, and measures to better assess and document coalition performance measures and outcomes; and

(3) bridge the gap between research and practice by translating knowledge from research into practical information.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for purposes of activities under this section, including the grant under subsection (a), amounts as follows:

(1) For each of fiscal years 2002 and 2003, \$2,000,000.

(2) For each of fiscal years 2004, 2005, 2006, and 2007, such sums as may be necessary for such activities.

Mr. BIDEN, Mr. President, today I introduce legislation to reauthorize the Drug Free Communities Act, a program which currently funds more than 300 community coalitions across the country that work to reduce drug, alcohol, and tobacco use.

Four years ago, I worked with Senator GRASSLEY, Representatives Sandy Levin and Rob Portman, and others to create this important program to fund coalitions of citizens—parents, youth, businesses, media, law enforcement, religious organizations, civic groups, doctors, nurses, and others—working to reduce youth substance abuse.

Community coalitions across the country—including two in my home State of Delaware—are galvanizing tremendous support for prevention efforts. They are helping fellow citizens make a difference in their communities. And they are helping all sectors of the community send a consistent message about alcohol, drugs, and tobacco.

I have been fighting for this type of anti-drug program for local communities for over a decade because I believe that prevention is a critical—but too often overlooked—part of an effective drug strategy.

Substance abuse is one of our Nation’s most pervasive problems. Addiction is a disease that does not discriminate on the basis of age, gender, socioeconomic status, race or creed. And while we tend to stereotype drug abuse as an urban problem, the steadily growing number of heroin and methamphetamine addicts in rural villages and suburban towns shows that is simply not the case.

We have nearly 15 million drug users in this country, 4 million of whom are hard-core addicts. We all know someone—a family member, neighbor, colleague or friend—who has become addicted to drugs or alcohol. And we are all affected by the undeniable correlation between substance abuse and crime—an overwhelming 80 percent of the 2 million men and women behind bars today have a history of drug and alcohol abuse or addiction or were arrested for a drug-related crime.

All of this comes at a hefty price. Drug abuse and addiction cost this Nation \$110 billion in law enforcement and other criminal justice expenses, medical bills, lost earnings and other costs each year. Illegal drugs are responsible for thousands of deaths each year and for the spread of a number of

communicable diseases, including AIDS and Hepatitis C. And a study by the National Center on Addiction and Substance Abuse at Columbia University (CASA) shows that 7 out of 10 cases of child abuse and neglect are caused or exacerbated by substance abuse and addiction.

Another CASA study recently revealed that for each dollar that States spend on substance-abuse related programs, 96 cents goes to dealing with the consequences of substance abuse and only 4 cents to preventing and treating it. Investing more in prevention and treatment is cost-effective because it will decrease much of the street crime, child abuse, domestic violence, and other social ills that can result from substance abuse.

If we can get kids through age 21 without smoking, abusing alcohol, or using drugs, they are unlikely to have a substance abuse problem in the future. But there are still those who shrug their shoulders and say “kids are kids—they are going to experiment.” Others find the thought of keeping kids drug-free too daunting a task, and they give up too soon.

But the truth is that we are learning more and more about drug prevention as researchers isolate the so-called “risk” and “protective” factors for drug use. In other words, we now know that if a child has low self-esteem or emotional problems; has a substance abuser for a parent; is a victim of child abuse; or is exposed to pro-drug media messages, that child is at a higher risk of smoking, drinking and using illegal drugs. But the good news is that we are also learning what decreases a child’s risk of substance abuse.

The Drug Free Communities program allows coalitions to put prevention research into action in cities and towns nationwide by funding initiatives tailored to a community’s individual needs.

In my home State of Delaware, both the New Castle County Community Partnership and the Delaware Prevention Coalition’s Southern Partnership are working to prevent youth substance abuse by helping kids do better in school, addressing their behavioral problems, and teaching them the dangers associated with drug, alcohol, and tobacco use. The Delaware coalitions know that teachers who have high expectations of their students and help them develop good social skills also help to prevent substance use. And they know that if kids think that drugs, alcohol, and tobacco are bad for them, they will be less likely to use them.

Other coalitions are working to engage the religious community. In Florida, the Miami Coalition for a Safe and Drug Free Community has developed a substance abuse manual for religious leaders so that they will know how to identify substance abuse and help people who need treatment find it. They are also teaching religious leaders how to incorporate messages about substance abuse into their sermons.

Still other groups are working with the business community. A coalition in Troy, MI, is working with the Chamber of Commerce to form an Employee Assistance Program for a consortium of small businesses who could not otherwise afford to have one.

These are just a few examples of the efforts that are making a difference and just a few of the reasons why I am proud to support community coalitions.

Drug abuse plagues the entire community. We all feel the consequences—crime, homelessness, domestic violence, child abuse, despair—and we all need to do something about it. Prevention messages must come from all sectors of the community, from a number of different voices. Coalitions bring those groups together, give them information they need, help develop programs that work, and nurture them to success.

I believe that the Drug Free Communities program is a powerful prevention initiative and I urge my colleagues to support its reauthorization.

I ask unanimous consent that the full text of the bill be printed in the RECORD.

Mr. SMITH of Oregon. Mr. President, I rise today to join my distinguished colleagues to support the reauthorization of the Drug-Free Communities Support Program. Drug-Free Community grants have had an extremely positive impact on my home State of Oregon, and I know that the program has benefitted a great number of communities all across this country. I am proud to be an original cosponsor of this important bill.

Federal Drug-Free Community grants serve programs in 14 Oregon communities in urban, suburban, and rural areas alike. All Drug-Free Community grants go directly to communities to support a wide variety of innovative drug-abuse prevention programs, ranging from community education programs and after-school programs to parenting classes and youth camps. Communities are invested in the process through a dollar-for-dollar match requirement, ensuring their interest in getting results, and they are getting results. With help from Federal Drug-Free Community dollars, Oregon drug abuse prevention groups are increasing citizen participation and they have produced a measurable decrease in both adult and youth substance abuse.

Portland's Regional Drug Initiative, RDI, for example, has promoted the establishment of drug-free workplaces among the city's large and small employers. Over 3,000 employers have attended an RDI training session, and of those, 92 percent have instituted drug-free workplace policies, resulting in a 5.5 percent decrease in positive workplace drug tests. At the Southern Oregon Drug Awareness program in Medford, OR, 320 young people have participated in its violence prevention course, and upon completion, two-thirds of

those students report having no additional discipline referrals in school. These are two fine examples of how the Drug-Free Communities Support Program is directly responsible for positively impacting lives in Oregon and all across our Nation.

This bill will reauthorize the Drug-Free Communities Support Program to provide grants for an additional five years. The bill will also authorize the creation of a National Community Anti-Drug Coalition Institute, which will serve as a valuable information clearing house for programs seeking to improve themselves by using the best practices of other successful community programs. The bill also establishes a new coalition mentoring program which will enable established coalitions like the Oregon Partnership to help communities develop their own local drug prevention coalitions.

Substance prevention works, and drug abuse is becoming less common through community prevention efforts, but this is no time to rest on our laurels. Over the next fifteen years, the youth population in the United States will grow by 21 percent, and we must ensure that the programs are in place to prevent these youths from succumbing to drug-related problems, such as academic failure, drug-related violence, and HIV infection. The Drug-Free Communities Support Program is an important partner in local efforts to prevent these problems, and I urge my colleagues to join me in supporting its reauthorization.

#### NOTICES OF HEARINGS

##### COMMITTEE ON INDIAN AFFAIRS

Mr. INOUE. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on June 26, 2001, at 10:30 a.m. in room 485 Russell Senate Building to conduct a hearing to receive testimony on the goals and priorities of the Great Plains Tribes for the 107th session of the Congress.

Those wishing additional information may contact committee staff at 202/224-2251.

##### COMMITTEE ON INDIAN AFFAIRS

Mr. INOUE. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on June 28, 2001, at 10:00 a.m. in room 485 Russell Senate Building to conduct a hearing to receive testimony on the goals and priorities of the Montana Wyoming Tribal Leaders Council for the 107th session of the Congress.

Those wishing additional information may contact committee staff at 202/224-2251.

#### AUTHORITY FOR COMMITTEES TO MEET

##### COMMITTEE ON ARMED SERVICES

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the

Senate on Wednesday, June 20, 2001, at 4 p.m., in executive session to meet with NATO Secretary General the Right Honorable Lord Robertson of Port Ellen to discuss alliance matters.

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

##### COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 20, 2001, to conduct a hearing on "The Condition of the U.S. Banking System."

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

##### COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Wednesday, June 20 at 9:30 a.m. to conduct a hearing. The committee will consider the nominations of Patricia Lynn Scarlett to be an Assistant Secretary of the Interior (for Policy, Management, and Budget); William Gerry Myers III to be the Solicitor of the Department of the Interior; and Bennett William Raley to be an Assistant Secretary of the Interior (for Water and Science).

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

##### COMMITTEE ON FINANCE

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on Wednesday, June 20, 2001, to hear testimony regarding Trade Promotion Authority.

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

##### COMMITTEE ON FOREIGN RELATIONS

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 20, 2001 at 10 a.m. to hold a hearing titled, "U.S. Security Interests in Europe" as follows:

"U.S. Security Interests in Europe," Wednesday, June 20, 2001, 10 a.m., SD-419.

Witness: The Honorable Colin Powell, Secretary of State, Department of State, Washington, DC.

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

##### COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Wednesday, June 20, 2001 at 9:30 a.m. for a hearing to examine the Role of the Federal Energy Regulatory Commission Associated with the Restructuring of Energy Industries.

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

## COMMITTEE ON THE JUDICIARY

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a hearing on Wednesday, June 20, 2001, at 1:00 p.m. in Dirksen 226.

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

## SELECT COMMITTEE ON INTELLIGENCE

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Wednesday, June 20, 2001 at 2:30 p.m. to hold a hearing on intelligence matters.

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

## PRIVILEGES OF THE FLOOR

Mr. REID. Madam President, I ask unanimous consent that Diane Baker, a fellow in my office, be granted floor privileges during the consideration of S. 1052, the Patients' Bill of Rights.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. WELLSTONE. Madam President, I ask unanimous consent that Lauren Wilcox and Clara Filice be granted floor privileges for the duration of the debate on this bill.

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

Mr. REID. Mr. President, I ask unanimous consent that Anne Ekedahl DiBiasi, a fellow in Senator DASCHLE's office, the majority leader, be granted the privilege of the floor during debate on S. 1052.

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

Mr. REID. Mr. President, I ask unanimous consent that the following staff members of the Senate Finance Committee be granted access to the Senate floor for the duration of the debate on S. 1052: Legislative fellows Traci Gleason and Gary Swilley; Interns Annabelle Bartsch, Liz Liebschutz, and Emilie Klein, Law clerk Jonathan Selib.

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

## CONDEMNATION OF MURDER IN INDONESIA

Mr. REID. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 67, S. Res. 91.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A resolution (S. Res. 91) condemning the murder of a United States citizen and other civilians, and expressing the sense of the Senate regarding the failure of the Indonesian judicial system to hold accountable those responsible for the killings.

There being no objection, the Senate proceeded to consider the resolution which had been reported from the Committee on Foreign Relations with an

amendment and an amendment to the preamble, as follows:

*Whereas on September 6, 2000, a paramilitary mob in the West Timor town of Atambua brutally killed 3 United Nations aid workers, including United States citizen Carlos Caceres, in an unprovoked attack;*

*Whereas Caceres, an attorney originally from San Juan, Puerto Rico, whose family now resides in the State of Florida, had e-mailed a plea for help saying that "the militias are on their way," and that "we sit here like bait" before he and the others were killed;*

*Whereas on May 4, 2001, an Indonesian court in Jakarta handed down only token sentences to the murderers of Carlos Caceres and the other United Nations workers, and failed to allot any punishment to the Indonesian military personnel alleged to have sanctioned this attack;*

*Whereas these token sentences were condemned as "wholly unacceptable" by United Nations Secretary General Kofi Annan, and described by the Department of State as acts that "call into question Indonesia's commitment to the principle of criminal accountability";*

*Whereas the self-confessed killer of Carlos Caceres, a pro-government militia member named Julius Naisama, was sentenced to spend not more than 20 months in jail, and remarked afterwards, "I accept the sentence with pride";*

*Whereas the murders of Carlos Caceres and the other United Nations workers fit a pattern of killings perpetrated, sanctioned, or condoned by certain elements within the Indonesian military in Timor, both during and since the end of the Suharto regime;*

*Whereas, despite the stated intent of the Government of Indonesia to put into place a system of increased judicial accountability, since the initiation of democratic rule in Indonesia in 1998, no senior military official has been put on trial for human rights abuses, extrajudicial killings, torture, or incitement to mob violence; and*

*Whereas the Government of Indonesia could probably have prevented both the murder of the United Nations workers and the subsequent miscarriage of justice if the government had—*

*(1) upheld its explicit commitment, made after the August, 1999, referendum in East Timor, to ensure that Indonesian military forces would safeguard United Nations workers and Timorese refugees from attacks by the paramilitary militias on the island who had killed approximately 1,000 East Timorese civilians in the preceding weeks;*

*(2) brought charges of murder or manslaughter against the 6 men who admitted to killing the United Nations workers, rather than only the lesser charge of conspiring to foment violence; and*

*(3) brought charges against senior military commanders who, according to the United Nations, the Department of State, and the Government of Indonesia itself, are suspected of arming and directing the paramilitary militias responsible for the carnage on Timor: Now, therefore, be it*

*Resolved, That (a) the Senate—*

*(1) condemns the brutal murder of Carlos Caceres, a United States citizen, and the other United Nations aid workers, and offers condolences to their families, friends, and colleagues;*

*(2) decries the inadequately disproportionate sentences handed down by the Indonesian court to the self-confessed killers of the United Nations aid workers;*

*(3) calls on the prosecutorial organs of the Government of Indonesia to indict and bring to trial the senior military commanders described in a September 1, 2000, statement by that government as suspects in the mass killings following the August, 1999, East Timor referendum.*

*(b) It is the sense of the Senate that—*

*(1) officials of the Department of State should, at every appropriate meeting with officials of*

*the Government of Indonesia, stress the importance of ending the climate of impunity that shields those individuals, including senior members of the Indonesian military, suspected of perpetrating, collaborating in, or covering up extra-judicial killings and abuses of human rights in Indonesia; and*

*(2) the President should consider the willingness of the Government of Indonesia to make substantive progress in judicial reform, and in the criminal accountability of those responsible for human rights abuse on the island of Timor, among those factors taken into account when determining the level of financial support provided by the United States to Indonesia, whether directly or through international financial institutions.*

*SEC. 2. The Secretary of the Senate shall transmit a copy of this resolution to the President.*

Mr. NELSON of Florida. Mr. President, I, along with my colleagues Senators FEINGOLD, HARKIN, and LEAHY, have introduced S. Res. 91, a resolution that condemns the brutal murder of Carlos Caceres, an American citizen, decries the inadequately disproportionate sentences given by the Indonesian judicial system to the self-confessed killers of the three U.N. aid workers, and offers condolences to the family, friends and colleagues of Carlos Caceres and the other victims of the September 6 attack.

This resolution also expresses the sense of the Senate that:

(1) the officials at the U.S. Department of State should, at every appropriate meeting with officials of the Indonesian government, stress the importance of ending the climate of impunity which shields those individuals, including senior members of the Indonesian military, suspected of perpetrating, collaborating in, or covering up extrajudicial killings, and other abuses of human rights.

(2) the President should consider the willingness of the government of Indonesia to make rapid and substantive progress in judicial reform, and in the criminal accountability of those responsible for human rights abuses on the island of Timor, among those factors taken into account when determining the level of U.S. financial support provided to Indonesia, whether directly or through international financial institutions.

On September 6, 2000, a paramilitary mob killed three United Nations aid workers, including the United States citizen Carlos Caceres, in the West Timor town of Atambua. Mr. Caceres and the other victims were stabbed and hacked to death with exceptional brutality, and their bodies were then set on fire and dragged through the streets. Mr. Caceres previously had emailed a plea for help saying that "The militias are on their way" and that "we sit here like bait."

Several weeks ago, an Indonesian court in Jakarta meted out only token sentences to the murderers of Carlos Caceres and the other U.N. workers, and failed to allot any punishment whatsoever to the Indonesian military commanders alleged to have sanctioned this attack. In addition, the self-confessed killer of Carlos Caceres, a pro-government militia member was sentenced to spend no more than 20 months in jail, and remarked afterwards, "I accept the sentence with pride."

The murders of Carlos Caceres and the other U.N. workers fit a pattern of killings perpetrated or sanctioned by the Indonesian military in Aceh, Irian Jaya, and other parts of the nation. Despite government promises of judicial accountability, since the initiation of democratic rule in Indonesia in 1998 no senior military official has yet been put on trial for human rights abuses, extrajudicial killings, torture, or incitement of mob violence. I propose that the U.S. Senate go on record to stress the importance of ending the climate of impunity which shields those individuals—especially senior members of the Indonesian military—suspected of perpetrating, collaborating in, or covering up extrajudicial killings, torture, and other abuses of human rights. The Senate urges the President and Congress to make every effort to consider the need for reform when determining policy towards Indonesia.

Mr. REID. Mr. President, I ask unanimous consent that the committee amendment be agreed to, the resolution, as amended, be agreed to, the preamble, as amended, be agreed to, the motion to reconsider be laid upon the table, and that any statements relating thereto be printed in the RECORD.

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

The committee amendment was agreed to.

The resolution (S. Res. 91), as amended, was agreed to.

The preamble, as amended, was agreed to.

#### ORDERS FOR THURSDAY, JUNE 21, 2001

Mr. REID. Mr. President, I ask unanimous consent that when the Senate

completes its business today, it adjourn until the hour of 9:15 a.m. on Thursday, June 21. I further ask unanimous consent that on Thursday, immediately following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate proceed to the consideration of the motion to proceed to S. 1052, the Patients' Bill of Rights, with the time until 9:30 equally divided between the managers of the bill or their designees.

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

#### PROGRAM

Mr. REID. Mr. President, as announced, we are going to convene at 9:15 a.m. tomorrow. We will have about 10 minutes of debate equally divided between the proponents and opponents of this legislation. Following the vote on the motion to proceed, there will be approximately 2 hours for debate equally divided between the leaders or their designees.

At 12 noon, Senator LOTT, or his designee, will be recognized to offer an amendment in regard to this legislation, S. 1052.

As has been indicated several times, we are going to conclude this legislation prior to the Fourth of July recess.

As indicated, Senators are advised and their staffs should be making alternative arrangements in case we have to work through the weekend.

#### ADJOURNMENT UNTIL 9:15 A.M. TOMORROW

Mr. REID. Mr. President, if there is no further business to come before the

Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 6:03 p.m., adjourned until Thursday, June 21, 2001, at 9:15 a.m.

#### NOMINATIONS

Executive Nominations received by the Senate June 20, 2001:

##### THE JUDICIARY

JOHN D. BATES, OF MARYLAND, TO BE UNITED STATES DISTRICT JUDGE FOR THE DISTRICT OF COLUMBIA, VICE STANLEY S. HARRIS, RETIRED.

REGGIE B. WALTON, OF THE DISTRICT OF COLUMBIA, TO BE UNITED STATES DISTRICT JUDGE FOR THE DISTRICT OF COLUMBIA, VICE STANLEY SPORKIN, RETIRED.

##### IN THE ARMY

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

##### To be major general

BRIG. GEN. KEITH B. ALEXANDER, 0000  
 BRIG. GEN. ELDON A. BARGWELL, 0000  
 BRIG. GEN. DAVID W. BARNO, 0000  
 BRIG. GEN. JOHN R. BATTISTE, 0000  
 BRIG. GEN. PETER W. CHIARELLI, 0000  
 BRIG. GEN. CLAUDE V. CHRISTIANSON, 0000  
 BRIG. GEN. ROBERT T. DAIL, 0000  
 BRIG. GEN. PAUL D. EATON, 0000  
 BRIG. GEN. KARL W. EIKENBERRY, 0000  
 BRIG. GEN. ROBERT H. GRIFFIN, 0000  
 BRIG. GEN. JOHN W. HOLLY, 0000  
 BRIG. GEN. DAVID H. HUNFOON JR., 0000  
 BRIG. GEN. JAMES C. HYLTON, 0000  
 BRIG. GEN. GENE M. LACOSTE, 0000  
 BRIG. GEN. DEE A. MCWILLIAMS, 0000  
 BRIG. GEN. RAYMOND T. ODIERNO, 0000  
 BRIG. GEN. VIRGIL L. PACKETT II, 0000  
 BRIG. GEN. JOSEPH F. PETERSON, 0000  
 BRIG. GEN. DAVID H. PETRAEUS, 0000  
 BRIG. GEN. MARILYN A. QUAGLIOTTI, 0000  
 BRIG. GEN. MICHAEL D. ROCHELLE, 0000  
 BRIG. GEN. DONALD J. RYDER, 0000  
 BRIG. GEN. HENRY W. STRATMAN, 0000  
 BRIG. GEN. JOE G. TAYLOR JR., 0000  
 BRIG. GEN. N. ROSS THOMPSON III, 0000  
 BRIG. GEN. JAMES D. THURMAN, 0000  
 BRIG. GEN. THOMAS R. TURNER II, 0000  
 BRIG. GEN. JOHN M. URIAS, 0000  
 BRIG. GEN. MICHAEL A. VANE, 0000  
 BRIG. GEN. WILLIAM G. WEBSTER JR., 0000