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Senate

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

PRAYER

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

Almighty God, You are the healing power for the physical and emotional illnesses of Your people. Through the ages You have guided the development of medical science in the discovery of cures for the diseases of humankind. You use surgeons, physicians, nurses, technicians, and pharmacologists to facilitate Your healing. Throughout history, You have motivated the building of hospitals for the care of the sick, and You have made medical science and the practice of medicine a divine calling. Now, at the end of the 20th century, when commercialism often blocks humanitarianism, guide the Senators in their debate of health care issues. May their deliberations on differing plans to assure patients' rights bring them to compromises and solutions that are right and just for the future of all Americans. We pray that Your abundant healing mercy be the ambience of their attitude in this crucial debate. O Divine Healer, Source of the miracle of healing, grant this Senate the miracle of agreement. In Your reconciling power. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore. Senator ALLARD is now designated to lead the Senate in the Pledge of Allegiance.

The Presiding Officer (Mr. ALLARD) led the Pledge of Allegiance, as follows:

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

RECOGNITION OF THE MAJORITY LEADER

The PRESIDING OFFICER. The majority leader is recognized.

SCHEDULE

Mr. LOTT. Mr. President, today the Senate will immediately proceed to a period of morning business until 10 a.m. I see Senator GRAMS is here for some remarks after my opening statement.

Following morning business, the Senate will resume consideration of the Patients' Bill of Rights Plus, and a number of amendments will be offered, I am sure, throughout the day. Debate will resume on the pending Dodd amendment regarding coverage of clinical trials.

As we go forward today, I remind Senators that we will continue to have what I am sure everybody will agree has been a good debate. I assume there will be several amendments offered today, and so there will be votes, I hope, even this morning or early afternoon and then throughout the rest of the afternoon. By previous consent, the Senate will complete action, I remind Senators, on the pending bill during tomorrow's session of the Senate. We may go into the evening, but it will be a normal evening. We have tried to make sure we had full time allocated for this debate and amendments. We agreed in the beginning that we would at least have normal days or more.

Actually, so far, on Monday we spent 6 hours 17 minutes on this bill. The average Mondays are 4 hours 46 minutes. On Tuesday we spent 7 hours 5 minutes. The average Tuesdays are 7 hours and 30 minutes. The average Wednesdays are usually around 9 hours 39 minutes. So we are going to stay right on track. I encourage my colleagues to make their best case, offer their amendments, make their speeches, but at the end of this week I hope we will come to a conclusion that will produce a bill which will address the important areas of patients' rights, consumer rights, protections they need, the right to access of documents, the rights that they should have to care, including emergency instances, but there has to be a prudent standard; there has to be some common sense applied to all of this.

I would also say at this point how proud I have been of the only doctor we have in the Senate. I think we are really blessed and privileged to have Dr. BILL FRIST here. Not only is he an outstanding human being but, unlike a lot of us, he knows what he is talking about. Having been a highly acclaimed heart surgeon, having a family that has been involved in hospital care, he has an extent of knowledge when it comes to clinical tests or how patients are treated, what procedures are necessary, most of us just do not have. So it has been a real pleasure to watch him at work over the past few days.

The Senate may consider any available appropriations bills when we complete the Patients' Bill of Rights. I remind Senators we are scheduled to have a vote on the Abraham-Domenici Social Security lockbox on Friday. There have been indications that the President supports a lockbox concept. I asked him in our meeting on Monday: Mr. President, what is your plan? Do you support the House version, which is a real lockbox? The Senate version is really tight because it bases the lockbox on the declining debt that would result from locking the Social Security funds up and not allowing them to be spent for anything but Social Security. Or the House version, which is a more procedural effort to keep these funds from being spent, requiring a supermajority vote, for instance, in the Senate of 60 votes in order to spend that money for anything but Social Security, which I think it should not be. Or is there some compromise version?

Senator DASCHLE and I have communicated on that a couple times over the past 2 days. We hope that maybe we can come to some agreement and get this Social Security lockbox done, set those moneys aside so that we can move on and deal with other issues such as Medicare reform and returning

some of the tax overpayment to working American families.

So after the Patients' Bill of Rights, we do have the vote scheduled on Friday on the lockbox for Social Security, and then we are looking at other appropriations bills that we could go to Friday or early next week or the intelligence authorization bill. We will confer with leadership on both sides before that announcement is made.

With that, I thank my colleagues, and I yield the floor so that Senator GRAMS can make his statement.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, leadership time is reserved.

MORNING BUSINESS

The PRESIDING OFFICER. Under the previous order, there will now be a period for the transaction of morning business not to extend beyond the hour of 10 a.m. with Senators permitted to speak therein for not to exceed 5 minutes each. Under the previous order, the Senator from Minnesota, Mr. GRAMS, is recognized to speak for up to 15 minutes.

The Senator from Minnesota.

Mr. REID. Mr. President, parliamentary inquiry.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. It is my further understanding that under the unanimous consent agreement of last night the Senator from Wisconsin is to be recognized for 10 minutes and the Senator from Rhode Island is to be recognized for 5 minutes. Is that true?

The PRESIDING OFFICER. The Senator is correct.

Mr. REED addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. REED. Further parliamentary inquiry. Would that carry us past the 10 o'clock hour?

The PRESIDING OFFICER. The Senate then would go past the 10 o'clock hour.

Mr. REED. I thank the Chair.

The PRESIDING OFFICER. The Senator from Minnesota.

PATIENTS' BILL OF RIGHTS

Mr. GRAMS. Mr. President, I rise today to talk a little bit about the health care bill we are debating in this Chamber.

Our colleagues on the other side of the aisle have day after day asserted that their Patients' Bill of Rights legislation is better than the Patients' Bill of Rights Plus legislation, of which I am a proud cosponsor.

If we are to believe that raising the cost of every insured individual's premiums by 6.1 percent and increasing the number of uninsured by roughly 1.8 million people is what is good for America, then, yes, this could be called a better bill. I, however, don't think those statistics suggest it's a better bill. Most Americans who know that this legislation increases costs and increases the number of uninsured do not think it is a better bill at all.

I firmly believe that the Patients' Bill of Rights Plus, S. 300, is a much more productive solution to problems facing Americans in the health care market today.

Mr. President, eight to ten percent of Minnesotans are uninsured today. Now, we in Minnesota enjoy a lower uninsured rate than the national average and we have historically had one of the lowest uninsured populations in the country.

However, if S. 6 is adopted into law, I could expect to see about 36,000 more Minnesotans become uninsured. Nationally, about 15 percent of our population today is without insurance. They may be uninsured for a number of reasons, but I bet the biggest obstacle for most people is access, and access is determined by costs. They simply cannot afford the costs of insurance.

These uninsured Americans would be left even further behind if we adopt the Kennedy-Daschle health care bill. Our colleagues make no effort whatsoever to address the problems of the uninsured. I do not think this is good policy, I do not think it is good for the Nation, and it certainly is not good for those already uninsured or those who will be forced to drop health care insurance because of increased costs.

Thankfully, we have an alternative, and it is called the Health Care Access and Equity Act of 1999, or S. 1274. I was pleased to introduce this legislation along with my colleagues Chairman ROTH and also Senator ABRAHAM of Michigan. When we introduced this bill on June 24, we did so with the support of 15 of our colleagues.

The Health Care Access and Equity Act does several things to increase access to health insurance, but one of the most important components is the full deductibility of health insurance costs for those without access to health insurance coverage through their employer. The Health Care Access and Equity Act of 1999 presents us with the opportunity to create the most comprehensive tax deductible coverage system in our Nation's history. It achieves this by eliminating one of the most discriminatory portions of the Tax Code: the disparate treatment between an employer purchasing a health plan as opposed to an individual purchasing health insurance on their own.

When employers purchase a health care plan for their employees, he or she can fully deduct the cost of providing that insurance, effectively lowering the actual cost of providing that coverage. However, when an employee purchases an individual policy on their own, they must do so with after-tax dollars and cannot fully deduct the cost of that plan. They do not have the ability or the advantage offered to employers to reduce the actual costs of their policy by deducting the premiums from their taxes every year. Therefore, health insurance is too costly and, for many, they usually wind up without health coverage. The Health Care Access and Equity Act will end this discrimination within the Tax Code and make health care available for many more Americans.

Let's make the same tax incentives for purchasing health insurance now available to employers apply to everybody. Let's level the playing field, and we will have taken the next logical step in the evolution of our health care system.

I believe Congress should be doing what it can to lower the cost of health insurance, making it more affordable—not by proposing legislation that will raise the costs and will make health insurance more and more difficult to afford.

I have a chart with me that shows the impact my legislation would have for my constituents. As you can see, it would reduce health insurance costs by anywhere from $796 to $1,384 for a family of four living in Mankato, MN, and also $887 to about $1,542 for a family of four living in St. Paul, or the Twin Cities. This is because they could deduct their premiums on their taxes, and this is what they would save off their tax bills which they could use then to pay for health insurance policies, thus making health care more affordable.

These are very significant costs which could make health insurance coverage available for many more people in my State, as well as across the country, who are currently in the individual health insurance market, and that is more than my colleagues on the other side of the aisle can say about their bill.

It seems most proposals before the Senate are just out there forcing some Federal definition of quality health plans onto the consumers and then sticks them with the bill, the increased cost for those mandates. It is not good policy, it does nothing for those who are uninsured, and it will not help those who will be forced to drop their health insurance because they can no longer afford the increase in those health care premiums.

Even without the increased costs associated with the so-called Patients' Bill of Rights legislation, employers are already anticipating premium increases of between 7 to 10 percent over and above the costs that would be forced to go up under the plan by Senator KENNEDY. Add on to that the costs of the Patients' Bill of Rights and you get higher numbers across the board, you get higher premiums, higher uninsured and higher frustration because any raise in pay that a middle-class worker might expect will now go toward even higher health care premium costs.

It is estimated that benefit mandates comprise over 20 percent of the price of health plan premiums already in the

State of Minnesota, and if you add on top of that the 5- to 6-percent tax on health plans and we are getting close to one-third of that premium being attributed to taxes or mandates.

You might say: Employers can cover the premium increases. Some may, but some may not. Regardless, the money employers use to cover higher health insurance premiums could be used to increase the employee's salary. By increasing the employers' costs, Congress will force employees to forego a pay increase. My colleagues across the aisle may believe this is a good direction for the country to go in, but I do not, and I know that most Minnesotans do not agree.

If all this were not bad enough, 57 percent of small businesses say they will stop providing health insurance for their employees if they are exposed to the Kennedy-Daschle bill's liability provisions. This is not just a threat. Most small businesses are not able to absorb higher operating expenses without cutting back or eliminating some costs, and that could mean as well some jobs that would be lost.

Let's talk about the liability issue a little bit.

Under Senator KENNEDY's legislation, employees will be able to sue their employers for something the employer is not obligated to provide. That sounds a little strange to me, so I have to say it again. People will be able to sue their employer if they are unhappy with something their employer is not in any way obligated to provide.

Proponents of increasing costs through liability will say: We have carved out employers from the liability provisions so only insurers, HMOs, and third-party plan administrators would be liable. This may be true in theory, but what they will not tell you is that there is already no way to separate the two under recent guidance from the Department of Labor. The guidance clarifies that employers have a fiduciary obligation to monitor plan quality. This responsibility renders so-called carve-outs ineffective because there is no way employers can completely absolve themselves of benefit decisions under their health plan which is required under the Democrats' illusionary carve-outs.

As I have mentioned before, the Kennedy-Daschle approach will increase costs, and even if employers could meet the guidelines for that liability exemption, the costs are still passed on to the employers and, of course, those costs are then passed on to their employees. Essentially, the Kennedy-Daschle liability provision does not guarantee quality health care. What it does guarantee is increased health premium costs for every American.

What fork in the road is this country taking when a notion such as this is given any serious discussion? Isn't it apparent to supporters of the Kennedy bill that if companies are exposed to this type of liability they would just drop insurance coverage for their employees?

I have never believed we need more litigation in this country, and this is certainly not an exception. We all want patients to have protection as much as anyone else. Yet how do we ensure patients are receiving the health care they need in a timely fashion?

I believe a strong, independent, quick, and easily accessible appeals process for those who have been denied health care services they and their physicians believe is necessary is what is needed and appropriate means to resolve coverage disputes. Again, as an original cosponsor of the Patients' Bill of Rights Plus legislation, I support an idea for this strong, independent, external appeals process to ensure people receive the health care they need and to make sure they get it when they need it.

Perhaps the best part of the appeals process is the fact that the external appeal is binding on the health plan but not binding on the person who is appealing. What does that exactly mean?

It means if you were denied care you and your physician believe is necessary, go through the appeals process and the appeals board agrees with you, the health plan then is legally bound to pay for that care. However, if you are unsatisfied with the outcome of the appeals process, you can then sue the health plan under current law, which allows the collection of attorney's fees, the cost benefit, court costs, injunctive relief, and other equitable relief.

No one can sue their way to good health, but we can give them the tools they need to get the care they need when they need it, and the Patients' Bill of Rights Plus gives consumers those tools.

The Kennedy-Daschle bill also includes a provision which, on the surface, also sounds very reasonable. It allows physicians and patients to determine what is medically necessary. Who could be against that? But what they do not tell you is creating such a standard could, under some circumstances, work against the patient's best interest. I will give an example of how this could happen.

Under Senator KENNEDY's bill, health plans would be required to cover the costs of whatever setting or duration of care a physician decides is ''medically necessary.'' The bill goes on to define medical necessity as whatever is consistent with generally accepted principles of professional medical practice.

This effectively prohibits health plans from intervening in situations when it is clearly in the patient's best interest. For instance, the Centers for Disease Control figures indicate that approximately 349,000 unnecessary caesarean sections were performed in 1991. While decisions regarding these individual procedures were based on generally accepted principles, a large number of women were needlessly subjected to major surgery and risk of infection.

Another shortcoming of the generally accepted principles of medical practice is the variance in treatments from region to region. Let's take a look at what the Dartmouth Atlas of Health Care 1998 says about treatments for breast cancer;

> Once diagnosed, surgery is universally recommended for the treatment of breast cancer. There are two principle surgical approaches: breast sparing surgery (lumpectomy, which is followed by radiation therapy) and mastectomy (complete removal of the breast). Randomized clinical trials have shown that these two approaches have nearly identical rates of cancer cure. . . . Despite scientific evidence that the survival rate is the same for breast sparing surgery and for mastectomy, and in spite of wide consensus that patient preferences should determine which treatment is chosen, the wide variations in surgical rates suggest that physician, rather than patient, preferences are the deciding factor on most cases.

That's what the Dartmouth Atlas of Health Care 1998 has to say about the choice between lumpectomies and mastectomies. Let me tell you about a related incident which actually happened in my state of Minnesota.

Several years ago, one of the major health plans in Minnesota received a telephone call from a Minnesota physician seeking authorization to perform an outpatient mastectomy on a woman suffering from breast cancer. This physician wanted to admit a woman to a same-day surgical center, remove her breast and then send her home later that day.

The health plan's medical director had never heard of an outpatient mastectomy being done before. In answer to questioning by the health plan, the physician admitted he had done the procedure only one time before. When asked why he wanted to do this procedure on an outpatient basis, he told the plan it was at the request of the patient. The plan's representative told the physician to wait and make no plans to do the procedure outpatient.

The health plan then went to the patient and asked why she would want to procedure done as an outpatient. She told the plan's representative that the physician told her the plan was ordering him to do the procedure on an outpatient basis. ''You know how insurance companies are,'' she said he told her.

When the plan told her they hadn't ordered the physician to do the procedure outpatient, she began to cry. She did not want the procedure done outpatient.

The health plan called the physician back and told him that due to the lack of medical necessity, they were denying his request for authorization to do the mastectomy on an outpatient basis. The patient had the mastectomy as an inpatient, and because of complications, she ended up staying in the hospital for several days.

Mr. President, this women was a single-mother of three who would have been totally incapable of caring for herself, much less her three children, if the physician had done the procedure outpatient as he originally requested.

This example demonstrates how health plans can and do contribute to

quality in our health care system. Are there problems in some areas? Have mistakes been made? Yes. But, let's think about the consequences of what we do here today. Will the Kennedy bill really make health care better? More quality oriented? I don't think it will.

New breakthroughs in pharmaceuticals and medical devices are unveiled almost daily. Many of these breakthroughs come from Minnesota companies and research facilities. These breakthroughs represent opportunities for individuals to live longer, healthier, more productive lives. I believe it would be difficult for physicians, or anyone, to be able to keep up with all the latest technology and treatments by themselves. Yet, that's what we're forcing them to do if the medical necessity provision included in the Kennedy bill passes as written. Further, if plans are required to pay for whatever procedure, treatment, drug or device providers offer, we could be putting patient's health, and perhaps their lives, at stake.

To show the inconsistency of President Clinton and Senator KENNEDY display by insisting the medical necessity provision be part of the Patients' Bill of Rights, they directly contradict a report issued in February by the Office of Inspector General of the Department of Health and Human Services. The report found that the majority of all Medicare fee-for-service fraud cases is a lack of medical necessity. You may recall Secretary Shalala holding a press conference in response to this report calling on America's seniors to be more vigilant when receiving health care services to assure that fraud is not being committed.

If the administration is urging consumers and health plans to take action in order to reduce fraud in the Medicare program, why is it proposing to bar health plans from using the very same tools to prevent fraud in their programs?

While I'm thinking about Medicare and the Patients' Bill of Rights, it was President Clinton who insisted, under the threat of a veto, a provision be included in the Balanced Budget Act which denies seniors one of the most basic patient's rights—the ability to use their own money to pay for the health care services they believe are necessary. Our Democratic colleagues agreed with the President and have stalled reconsideration of this egregious violation of a basic right. I am hopeful we can get to that patient's right later this year.

The problems our health care system faces are not just the result of managed care. If it were, Minnesota, where 90 percent of health care consumers are in managed care organizations, would not have the longest life expectancy in the United States. The Twin Cities of Minneapolis and St. Paul would not have the lowest health care costs of the top 20 metropolitan areas in the United States, and we wouldn't have an uninsured rate half the national average. Minnesota has found a way to live and thrive with managed care. It's not without problem, but for the vast majority of Minnesotans, it works well. With all due respect to my colleague from Massachusetts, Minnesotans don't want his definition of a quality health plan and we don't want him to tell us what protections we need or don't need.

During my first term in Congress, President Clinton introduced the Health Security Act, which is now commonly referred to as ''Clinton Care.'' I was opposed to the President's legislation because it was nothing short of a government take-over of the best health care system in the world. I remain opposed to this type of legislation because it is too prescriptive, too centralized and limits health care choices.

Over the past two years, we've seen bill after bill introduced which propose, in the name of quality health care, to allow federal bureaucrats, Congress and lawyers to practice medicine without a license. Benefit mandates are thrown around Congress as if there were no consequences. I've heard it referred to as legislating by body part.

We are told by those on the other side of the aisle, ''we need to have benefit mandates so Americans can receive quality health care,'' and ''let's preempt the states because they don't know what they're doing.'' I disagree, and the very individuals who regulate HMOs and every other type of health plan for the respective states—the insurance commissioners—also strongly disagree. In fact, State insurance commissioners have already spoken to Congress on this issue. The National Association of Insurance Commissioners wrote this to Chairman JEFFORDS in March of this year.

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

The letter goes on to explain very precisely their view of pending legislation:

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

There has been a lot of smoke blown around here about how many health-based organizations have endorsed this bill or that bill, but when it comes to regulating health insurance policies, I believe we need to put more stock in the option of those who are currently responsible for regulating health insurance—our state insurance commissioners. They know best what the people in their states need—they know best how to achieve their goals, and Congress should know better than to question their ability or willingness to meet those challenges.

As we get deeper and deeper into the details of the Kennedy-Daschle bill, I am reminded of something Minority Leader DASCHLE said in the opening hours of this debate. He claimed that the reason insurance companies call them HMOs ''is that H-M-O stands for their patient philosophy: Having Minimal Options.'' Mr. President, I suggest that it is the Kennedy-Daschle bill that would take away options and our colleagues should be willing to admit it.

We have seen our colleagues' true motives when they backed President Clinton's Health Security Act, when they backed President Clinton taking away a senior's right to use their own earnings to pay for medical services without the government and now we see it with the Kennedy-Daschle Patients' Bill of Rights. Consumer's options are becoming minimal and we have government to thank for that.

To suggest that our bill—the only one expanding options for the American people by eliminating restrictions on medical savings accounts, allowing the self-employed to fully deduct the cost of purchasing health insurance, and permitting the carryover of unused funds in flexible spending accounts—limits Americans choices, ignores the contents of our bill and ignores the reality of the Kennedy-Daschle bill.

Another issue I would like to talk about is something I have taken great interest in over the past three years—emergency medical services. This is perhaps one area in our debate which Republicans and Democrats have agreed is important enough to ensure access for Americans in need of immediate care. Every proposal in Congress contains some form of the prudent layperson standard for emergency services. That is with good reason.

The Federal Government has some precedence in dealing with access to emergency care through a law enacted in the 1980s called EMTALA, or The Emergency Medical Treatment and Active Labor Act. This act requires hospitals to treat everyone and anyone who enters their emergency department regardless of ability to pay as a precondition to participation in the Medicare program.

All the proposals before Congress with the prudent layperson standard include some reference to EMTALA. Where I have concern is the lack of any mention of ambulance services in any Patients' Bill of Rights legislation. While there has been some mention of ambulance services being included as part of the ancillary services clause under EMTALA, this simply will not work.

I will remind my colleagues that EMTALA only affects what happens once an individual arrives at a hospital's emergency room door. It covers none of the pre-hospital care people receive from courageous EMS personnel

all over the Nation whose sole function is to get the sickest among us to the emergency room quickly, efficiently and safely so emergency physicians can tend to our condition.

Contrary to what most people think, EMS personnel do not make diagnoses. They do not make decisions about whether a patient should or should not be transported to an emergency room based on their medical condition. Ambulance personnel respond to calls initiated in any number of ways, arrive at the location, assess the patient's condition, stabilize them and ready them for transportation to a facility with the personnel trained to make a diagnosis.

The reason I wanted to bring this to everyone's attention is because I believe many of us have not taken the time to fully understand the function ambulance services performs in the health care delivery system. We cannot afford to continue ignoring the important role EMS plays in health care.

For the past 3 years, I have introduced legislation which would address some of the problems ambulance services faces every day. My most recent iteration is S. 911, the Emergency Medical Services Efficiency Act. I invite any and all of my colleagues to join me as a cosponsor of this important legislation. I am hopeful we can include several of its provisions in the Patients' Bill of Rights legislation before us today.

For every 1 percent increase in premiums, there are an additional two to four thousand uninsured in Minnesota. Whether it's a family of four in Ada, Minnesota or a single mother of two in Zumbrota, I don't want to be responsible for any Minnesotan losing their health insurance coverage. I believe if I were to vote for the Kennedy-Daschle bill, I would be doing just that—ensuring that 36,000 Minnesotans will be forced to drop their coverage because they can no longer afford it.

That is something I, along with 97 of my colleagues in the Senate, voted not to do in a sense-of-the-Senate resolution last year. I urge my colleagues to honor the promise they made in that vote and defeat the government-centered, one-size-fits-all vision of health care illustrated by the Kennedy-Daschle Patients' Bill of Rights. Patients will get a bill all right—one taken out of their paychecks every month.

I urge my colleagues to say yes to creating choices, yes to protecting consumers who aren't currently protected, yes to being mindful of costs, and yes to increasing the number of insured—they can do all that with one vote for the Patients' Bill of Rights Plus.

The PRESIDING OFFICER. Under the previous order, the Senator from Rhode Island is recognized to speak for up to 5 minutes.

Mr. REED. Thank you, Mr. President.

PATIENTS' BILL OF RIGHTS

Mr. REED. Mr. President, I will discuss several issues that are central to the debate we are having on managed care in the Patients' Bill of Rights.

First, I was very disappointed that the Senate rejected Senator KENNEDY's amendment which would have extended the protections of the Patients' Bill of Rights to all privately insured Americans. Those in favor of much more limited coverage, very much restricted coverage, argue that the cost in the Democratic alternative would cause many Americans to lose their health insurance through increased premiums. They argue, as we have heard time and time again, that premiums would rise and that employers would drop coverage.

When you actually talk to many employers, particularly those in small businesses who are represented by the American Small Business Alliance, for example, they tell quite a different story. They talk about a situation in which they have already seen premiums rise, but they get very little for what they pay for.

For example, Mr. Brian McCarthy, President of McCarthy Flowers and Cabs, from Scranton, PA, had this to say. His words:

> Workers who spend time out sick or are consumed in battles with their health plan wreak havoc on the bottom line. That lost productivity costs my business a lot more than the modest premium increases that may result from this legislation.

He went on to add:

> The Patients' Bill of Rights is about giving people the care they need and deserve, and it clearly gives small businesses a better deal for their health care dollar.

That is not the voice of a Senator, but of a small businessperson who has seen the effects of managed care on his own bottom line.

Another small business owner, Mr. Tom Reed, who owns Lake Motors in Eagle Lake, TX, said:

> My premiums go up now and I get nothing, or sometimes even less coverage. The Patients' Bill of Rights at least will give me something tangible, bringing me better value for the health care money I spend.

Those are the words of businesspeople who are struggling with the issues. They are in favor of this legislation because they want to get what they have been paying a lot for, and that is quality health care. They will only get that with the Democratic Patients' Bill of Rights.

There have been studies that have supported these anecdotal comments. The Kaiser-Harvard Program on Health Policy surveyed small business executives from the small business sector, and they found that 88 percent support independent appeals such as those that are in the Democratic alternative; 75 percent support the right to see a specialist without prior approval; 61 percent favor giving people the right to sue their health plan; and fewer than 1 percent suggested that they might drop coverage if rates increased.

These are small business executives. This is compelling and persuasive evidence that, in order to be responsive to the needs of small businesses throughout the country, it is imperative that we pass the Democratic alternative.

There is another aspect of this legislation which deserves discussion, and that is the fact that health care plans, HMOs, are immune from liability because of what is apparently a loophole in the ERISA law.

A physician can be sued for malpractice, a physician can be sued for making misjudgments, but an insurance company, often working through nonphysicians, administrators, and reviewers, are immune from such suits.

This aspect of accountability is critical to making sure that we have rights that are enforceable and that actually produce tangible results throughout the country.

In another survey, the Kaiser Family Foundation found that 73 percent of those surveyed believe that patients should be able to hold their managed care plans accountable through the courts.

This is not to suggest that anyone is encouraging a mass exodus to the courthouse. In fact, there is quite a bit of experience that suggests this probably will not happen.

In Texas, in May of 1997, bipartisan legislation was passed making it the first State where managed care organizations can be sued for medical malpractice. Like the Democratic plan, the Texas liability law is closely tied to tough, independent external review processes. In fact, you cannot take advantage of the right to sue until you have been through this independent review process.

Despite all the warnings about a flurry of lawsuits—the same thing we are hearing today—this has not been the experience in Texas. Neither has the State experienced increased premiums. What has happened is that both sides now are claiming success. HMOs are saying: Look, this is working. And consumers are saying: This is helping us out. In fact, according to Texas State Senator David Sibley——

The PRESIDING OFFICER. The time has expired.

Mr. REED. I ask unanimous consent for an additional minute

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

Mr. REED. I thank the Chair.

According to one of the sponsors, Texas State Senator David Sibley, who is Republican, in his words, stated:

> [T]he Texas experience has been very positive. . . . Both sides are claiming victory: the HMOs are saying ''see how well it works; people aren't filing many reviews.'' The consumer groups are saying that HMOs are being more responsive and are looking more carefully at the needs of patients before they deny claims.

Mr. REID. Will the Senator yield?

Mr. REED. Yes.

Mr. REID. Is the Senator aware that George W. Bush, Governor of the State

of Texas, vetoed the initial HMO bill in the State of Texas?

Mr. REED. I was not aware of that. But I think experience is showing that it would have been an error because the law is working very well. We have a rare historic opportunity to do something to help the American people. It has been done already by the great State of Texas in many respects, but we can do much more, and we shall do much better. I would like to see the same type of protections that are available to the good people of Texas afforded to everyone in this great country.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Wisconsin, Mr. FEINGOLD, is recognized to speak up to 10 minutes.

THE IMPORTANCE OF PATIENT PROTECTIONS

Mr. FEINGOLD. Mr. President, I rise today to speak about the importance of passing a meaningful Patients' Bill of Rights package that will ensure that managed care companies cannot put their cost-control measures ahead of the well-being of their patients. This legislation is absolutely vital to protecting the quality of health care for all Americans.

Many of my colleagues have spoken on various aspects of this issue over the past few weeks. But I would like to bring my colleagues' statements ''home'' by speaking a bit about what we mean when we talk about ''Protecting Patients' Rights.'' We are talking 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 the health care is provided, and by whom. Of greatest concerns to me the most 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 which health care providers its enrollees are permitted to see, requiring patients to go through insurance company gatekeepers prior to seeing a specialist, tracking physician practice patterns to ensure that doctors are complying with HMOs' 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.

Managed care companies control how—or even whether—we receive health care. Their control over what goes on in the examination room can be matched only by their significant political clout in Washington, which they've gained in part through generous political donations. Mr. President, during earlier remarks I gave on the Patients' Bill of Rights, I talked about the power special interests wield in the health care debate, but I want to remind my colleagues and the public of those remarks, because I think it's vital that we keep the power of these wealthy interests in mind throughout this discussion.

During the last election cycle, managed care companies and their affiliated groups spent more than $3.4 million on soft money contributions, PAC, and individual contributions—roughly double what they spent during the last mid-term elections.

Managed care giant United HealthCare Corporation gave $305,000 in soft money to the parties, and $65,500 in PAC money to candidates;

Blue Cross/Blue Shield's national association gave more than $200,000 in soft money and nearly $350,000 in PAC money;

And the managed care industry's chief lobby, the American Association of Health Plans, has given nearly $60,000 in soft money in the last two years.

Mr. President, these numbers are just the tip of the iceberg, but I mention them today to present a clearer picture of the power the managed care industry wields in Washington as we debate managed care reform. As we talk here on the floor about why Americans have such an important stake in this body passing the Patients' Bill of Rights, we should also be aware of what a huge stake the industry has in stopping this legislation, and how they have used the campaign finance system to protect their interests.

Regardless of how you feel about any particular Patients' Bill of Rights proposal, I think any reasonable person would agree that an arrangement where someone has financial incentives to deny health care to my family and me—that the very existence of such incentives has to raise flags. As a parent, and as a consumer, I want to be sure that managed care cost-control systems don't compromise the quality of health care for my family and me.

So I want to make it clear that the central goal of protecting patients' rights is to ensure that medical necessity is what drives our health care. That's what we're talking about. We need to be sure that the people making health care decisions are licensed health care professionals, not administrative personnel whose primary mission is to protect their bottom line. I do not think that is an outrageous, pie-in-the-sky goal. I think it's a common sense expectation when I buy health insurance for my family, and I don't think any of my colleagues would demand any less from their own health insurance.

During the year or so since Senators DASCHLE and KENNEDY first introduced the Patients' Bill of Rights, I have had the opportunity to visit every county in my state to speak with my constituents and to find out what issues they care about. I can tell you that health care—the quality of health care, the availability of health care—is consistently one of the top issues that my constituents raise with me. In general, the quality of health care in Wisconsin is quite good. Wisconsin was one of the first states to regulate HMOs as insurance providers, and the state has developed a set of basic, common sense patient protections—many of which are included in S. 6, the Democratic Patients' Bill of Rights.

Mr. President, I would like to share a story that was told to me by a pediatrician who practices in Madison, Wisconsin. This pediatrician told me about a newborn infant she saw who looked fine upon first examination, but on the second day, the pediatrician detected a heart murmur. Knowing that this newborn urgently needed to see a specialist, the pediatrician immediately called for a referral to a pediatric cardiologist, which in this particular HMO requires first going through an adult cardiologist for the referral to a pediatric specialist. By sheer luck, a pediatric cardiologist happened to be in the hospital on a separate matter and was able to examine the baby.

The pediatric cardiologist ordered an echocardiogram and diagnosed coarctation, a tightening or narrowing of the aorta that is specific to newborns. That pediatric cardiologist happened to be in the right place at the right time—but under usual circumstances, time would have been lost while a referral was sought from an adult cardiologist. As a result, that baby immediately began receiving medication—prostaglandin—intravenously until she could be transported to Children's Hospital in Milwaukee to receive emergency heart surgery. The baby survived and is doing well.

When I heard this story, apart from relief that the baby survived, my first question was, ''What would have happened if you and the baby's parents had to go through the normal processes of the HMO's rules?'' The pediatrician told me that that process, even if expedited, would have taken at least 24 hours, which didn't sound very long until the pediatrician informed me that the untreated coarctation would have resulted in the baby's death within a few hours.

I am greatly relieved and happy that this particular baby was cared for and survived. But what I find frightening, though, is that this baby survived almost as a fluke, in spite of the system. The Patients' Bill of Rights includes a guarantee of access to pediatric specialists. Fortunately for the family of

the baby with the heart murmur, many pieces fell into place to save the baby, including a dedicated and vigilant pediatrician willing to be an advocate for her patient and a pediatric specialist in the right place at the right time. This situation didn't turn into a horror story. But we simply cannot let these sorts of happy endings happen only by chance. We must enact meaningful patient protections, such as guaranteed access to pediatric specialists as contained in the Democratic Patients' Bill of Rights but lacking in the Republican bill, to ensure that people get the care that they need.

The patient protections we are talking about 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 obscured sometimes when we get into jargon like ''prudent layperson,'' ''point of service,'' and so on. So 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.

I thank the Chair.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

PATIENTS' BILL OF RIGHTS ACT OF 1999

The PRESIDING OFFICER. The Senate will now resume consideration of S. 1344, which the clerk will report.

The legislative clerk read as follows:

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

Pending:

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

Dodd amendment No. 1239 (to amendment No. 1232), to provide coverage for individuals participating in approved clinical trials and for approved drugs and medical devices.

The PRESIDING OFFICER. Who yields time on the pending amendment?

Mr. REID. Mr. President, I yield the Senator from California 7 minutes.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. I thank the Chair, and I thank the Democratic whip for yielding me this time.

Mr. President, I rise in favor of the Dodd amendment, which deals with access to clinical trials and access to prescription drugs. I think this is a very important amendment, and I am very proud to speak in favor of it.

Yesterday, as I left the floor of the Senate, I realized what the score was for the people: Zero. In very close votes in each case, this Republican majority voted, with rare exception, for the HMOs and against the patients of this country. It is stunning to me to see that, a most amazing thing.

As I discussed some of what happened yesterday with my Democratic friends, who happened to be women, we were all stunned at the vote against a very straightforward amendment by Senator ROBB which basically said, after a mastectomy, a doctor should determine the length of stay. It is stunning to me that that couldn't pass the Senate. The hold and the grip of the HMOs is extraordinary.

There is a cartoon in today's Washington Post that I find very interesting. It pictures huge campaign contributions. The Senator from Wisconsin talks about that all the time. I am not surprised people are cynical. All I hope is that they wake up and listen to this debate. This amendment on clinical trials is one they ought to listen to.

What is a clinical trial? A clinical trial occurs when there is a promising new therapy for a condition, a disease for which traditional therapies are not working for everyone. So what happens is people will enroll in these clinical trials; usually, they are pretty desperate at that point because their disease is not responding well to the traditional therapies. They want to get into this trial, and they want to see if they have a chance at surviving. The good news about this for society is not only will this individual have a chance of surviving, but we learn about the therapy, and, of course, it is the way we have seen therapies move into the mainstream of treatment.

Well, what is happening now with the HMOs—because they are so interested in their profits and paying their CEOs $30 million, in one case, and $50 million a year in another case—is they are cutting back on costs. So where they used to pay the costs associated with a clinical trial, not for the experimental therapy itself, because that is paid by the company that invented it, but by the associated costs, if there are reactions to the therapy, et cetera, they are cutting back on this treatment. So by their refusal to pay for the patient cost, many research institutions—particularly cancer centers—are cutting back on the clinical trials because there is a lack of payment by the HMOs, and we are running into a real serious problem.

When you continually put profit before patient care, when you continually put dollar signs ahead of vital signs, what happens is we are losing the opportunity to test these promising treatments for cancer, for Alzheimer's, for Parkinson's, for diabetes, for AIDS—you name the disease. By the way, if you ask the average American what they fear most, they will tell you it is illness; it is cancer; it is heart disease; it is stroke; it is the loss of a loved one.

So what we have is a situation where HMOs are refusing to pay the patient costs in clinical trials, and clinical trials are being cut back at the very time when we are making tremendous strides in learning more about therapies. This is a sad day.

So what we do in this amendment is essentially say let's go back to the way it always was, where the HMOs pay for the costs associated with these clinical trials for their patients. If we don't pass this amendment and this trend continues, we will reverse the trend of finding better cures for disease.

The other thing this amendment does, which is really important, is it deals with access to prescription drugs. Nearly all the HMOs have developed what is called a formulary, which is a limited list of prescription drugs for which the HMO will pay. They do this to receive discounts from drug companies and to limit the number of medications for which they pay. This is a cost-saving measure. I don't have a problem with this—except when the formulary drug isn't right for the patient, except when a doctor says the drug his patient needs is not in the formulary. What this amendment says is that the HMO must pay for the drug that a doctor determines his patient needs, even if it isn't in the list that the HMO provided.

It also says in this amendment that HMOs cannot classify a drug that is approved by the FDA as experimental, which is one of the ways they get around having to pay for a drug. They say to a patient: Well, I know your doctor wants you to use this drug, but it is experimental.

Well, if a drug is approved by the FDA, the Food and Drug Administration, then it is clear that the drug has been approved and ought to be available.

So this is a very important measure. This will ensure we keep making progress on clinical trials. This will ensure people get access to the needed drugs. I hope we will stand up, not as we did yesterday, because this Senate sat down for the people and stood up for the big money interests in this society, the HMOs and their bottom line. Let's stand up for the people and let's support this Dodd amendment.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. FRIST. Mr. President, very quickly, let me state where we are, and then I will yield to the Senator from Florida.

We are presently considering an underlying amendment on clinical trials which was put forth by Senator DODD. It is an issue we have discussed a great deal in committee. It deserves discussion and it deserves a great deal of debate because it is important. As one who has been a principal investigator in clinical trials and has been involved in clinical investigations and trials for pharmaceutical agents and the application of medical devices, such as cardiac valves and stints, all of which I am familiar, it allows me to say it is critically important we debate and address

this issue, that we make sure we do move forward in a direction to capture and support the great benefits which are available in clinical trials.

A clinical trial is fairly straightforward in patient care. It is to figure out whether or not something works or whether it is harmful or not harmful. It is necessary to use and investigate patient populations where one group of the population receives it and one group does not receive it, to see what the adverse effects are, what works and what does not work. It is the accepted way of making and capturing the great advances which we all know are both being realized, but even more exciting—whether it is in the field of cancer or heart disease or bone disease or stroke—is that we are going to make our great breakthroughs.

In the underlying bill we are considering, we have a study by the Institute of Medicine to look at the factors which might hinder patient participation in those trials and also to figure out what the cost of these trials are, because you have one population that is not getting either a specific device or pharmaceutical agent and one population that does. But to compare these two populations, you need to do more testing, more examinations. If you have side effects or an adverse reaction from a medication, maybe you have to have a longer hospitalization or new treatments.

Well, the challenge we have as a nation is to figure out what that additional cost is. There have been only three good studies completed to date to determine the difference between those incremental costs to carry out that investigation. What we are considering is a new mandate and whether or not that new mandate should be placed on the HMOs' backs, or the private sector's back, in order to make the great advances in which we all want to participate. If we open that door—and I think we can go further than what is in the underlying bill—we have to be very careful not to impose a huge, very expensive mandate on our private health insurance system—something we haven't been able to do in Medicare, the public system. We have struggled with it, and we haven't been able to figure it out with the public dollars. So before we put in a huge mandate, we have to be careful not to dump on the private sector something we haven't been able to do in the public sector. That is the essence of the bill we will be passing over the next 48 hours.

I think we can make great strides. Probably the first thing to do is to look at the clinical trials. In this body, no Member has spent as much—or more—time looking at this issue of clinical trials than the Senator from Florida.

I yield 10 minutes to the Senator from Florida.

The PRESIDING OFFICER (Mr. ROBERTS). The Senator from Florida.

Mr. MACK. Thank you, Mr. President. I thank Senator FRIST for yielding me time. I also appreciate greatly the comments made with respect to the clinical trials. Again, I look forward to continuing to work with him in the future on this issue.

Mr. President, I want to respond to one provision of the amendment offered last night by my friend from Connecticut, Senator DODD. This provision goes to a concern that has been raised by patients throughout our country—the issue of health coverage for patients who are participating in clinical trials.

As Members of the United States Senate, we must seek legislative solutions to a wide array of public policy issues. These issues include health policy, as we are doing today. They include tax policy, economic policy, foreign policy, and education policy. The list is quite expansive. Frequently, we find ourselves divided on issues of the day.

However, I can think of no issue which better unites Republicans and Democrats, conservatives and liberals, as the issue of biomedical research.

In addition to Senator DODD, we are fortunate to have many, many leaders in the Senate on this important issue. Senator SPECTER and Senator HARKIN are leading the historic bipartisan effort to double funding for the National Institutes of Health. Senator JEFFORDS, Senator FIRST, Senator KENNEDY, and Senator MIKULSKI have worked hard in their committee to authorize and oversee the activities of the HIH. Any many more of my colleagues have each contributed in their own way to help make funding for HIH the national priority it is today. As I said, few issues unite the Senate like medical research.

One of the highlights during my 17 years as a Member of the Senate and House of Representatives has been to meet the scientists who are revolutionizing the way man fights disease, and to improve our quality of life. It doesn't matter if they are a young bench scientist or a Nobel Laureate, their mission remains the same—to find ways to detect and treat diseases. Today, there is a level of commitment and enthusiasm to this monumental endeavor that I've never seen before. Today, researchers dare to use the word, ''cure.'' That wasn't the case very long ago.

As we work to make sure that scientists have the necessary resources to continue their remarkable progress, we must also address the ethical, legal and social implications of biomedical research. Science is moving faster than public policy can keep pace. It's as though science is on the Concorde, and Congress stalled at Kitty Hawk trying to get off the ground.

There are very difficult, complex scientific issues which require Congressional action, but these issues also require thoughtful and careful deliberation. For example, Congress has been working for many years to ensure that health plans do not discriminate against people because of their genetic information. As a cancer survivor, I know how important it is to have confidence in knowing that a genetic test will be used for information, not discrimination. I've been part of a bipartisan effort to resolve this issue, starting with legislation introduced by our former colleague, Senator Mark Hatfield.

Genetic nondiscrimination is a very complex issue with wide-ranging ramifications. There have been many questions to answer. Congress has struggled with how best to define medical and scientific terms. We have examined the impact of our actions on the cost and availability of health insurance. Frequently, we have determined that much more information was needed before deciding the best approach.

We have addressed the issue of genetic nondiscrimination with thoughtful deliberation, and I believe the Congress must take the same thoughtful, deliberative approach when it comes to coverage of clinical trials.

There are many questions to be answered. What are the cost implications? How will this new benefit impact the availability of health insurance? What impact will coverage of clinical trials have on health insurance premiums? How will it impact small business owners, who are struggling to provide health insurance for their employees? What is the best approach to defining medical and scientific terms, such as ''routine patient costs''?—becasue that definition will determine what the underlying costs of this effort will be.

These are very important questions, involving very complex issues, with very significant implications.

Mr. President, I support comprehensive coverage of clinical trials. But, as this time, we need more information before we go that far.

Later today, or tomorrow, I will be introducing an amendment, along with Senator FRIST, Senator JEFFORDS, Senator COLLINS, and others, which will help provide patients, scientists, lawmakers, employers, health plans and others with answers to the many questions associated with health insurance coverage for clinical trials. I will outline our approach at that time.

Mr. President, medical research is a bipartisan issue. We all agree that the basic scientific research funded by the National Institutes of Health must be translated into new forms of treatment through well-designed clinical trials. Earlier this year, Senator ROCKFELLER and I introduced legislation to provide Medicare coverage for cancer clinical trials. I am pleased to say that a bipartisan group of 36 Senators have cosponsored this bill. Senator SNOWE and others have introduced legislation to provide coverage through private health plans. We may approach the issue in different ways, but we all agree that the Senate must address the issue of clinical trial coverage, and we must do so now.

Mr. President, I look forward to discussing my amendment later in the debate.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Tennessee.

Mr. FRIST. Mr. President, I yield 20 minutes to the Senator from Idaho.

The PRESIDING OFFICER. The Senator from Idaho.

Mr. CRAIG. Mr. President, let me, first, thank one of the true leaders in the Senate on the issue of health care for yielding me time, and to say how much I have appreciated his work in the last month and in the last few days during this critical debate on the Patients' Bill of Rights.

I am pleased the Senate is, once again, debating the issue of health care reform. I am pleased because here we have an opportunity, I think, to reclaim for the American people their right to control their health care. I am excited we have this opportunity to talk about medical savings accounts, restoring patients rights, and making health care insurance affordable—or at least this should be the essence of the debate.

I must tell you that I am disappointed to see only one side is interested in truly talking about patients' rights instead of more regulation, more government, and, somehow, more control. While Republicans are talking about giving all Americans access to health care insurance and letting them control their medical health care, our Democrat friends are talking about driving up costs, canceling health care coverage for millions of Americans, and putting American health care under the control of more Federal Government.

I am aware my friend, the Senator from Connecticut, has an amendment on the floor. I will speak to that amendment in just a few moments. But I think it is important to set that amendment in the context of the debate on the bill yesterday, today, and the balance of the week.

First, I want to look at what it is our Democrat friends on the floor of the Senate are asking us to swallow. I believe this will help us better understand the amendment offered by the distinguished Senator from Connecticut.

We have heard a lot of talk about the cost of the Kennedy bill—some of it on this floor. Yesterday we even saw our colleagues parade out the President of the United States to downplay the cost of the Kennedy bill. Our Democrat colleagues have a mantra when it comes to the cost of the bill. Over and over again, they say, well, it is less than a Big Mac; it is less than $2 a month.

Let me look at this chart for a moment, and maybe you will join with me in it. It is ''less than a Big Mac.'' That is what Senator KENNEDY said. They even say the nonpartisan Congressional Budget Office says this bill will cost less than a Big Mac.

If you look at the Congressional Budget Office report—and I recommend you read it in its entirety—you will see it says nothing about a Big Mac. But this is what it does say: According to the Congressional Budget Office, the Kennedy bill will increase premiums an average of 6.1 percent over and above the normal inflationary costs of health care.

For instance, let's read from the CBO report because an awful lot of my colleagues on the other side of the aisle seem to be confused about what the Congressional Budget Office has said about this bill.

I am quoting the CBO report:

> Most of the provisions would reach their full effect within the first 3 years of its enactment. The CBO estimates the premiums for an employer-sponsored health plan would rise by an average of 6.1 percent in the absence of any compensating changes on the part of the employer.

What are the ''compensating changes''? There is a clear history in health care that, as costs go up, people either leave or are dropped from the system.

The CBO says of the Kennedy bill on compensating changes:

> Employers could respond to premium increases in a variety of ways to reduce their impact. They could drop health care insurance entirely.

Yes, that is an option. CBO says it is.

''Reduce the generosity of the benefit package.''

That is quite typically what happens. They keep narrowing the scope of the coverage.

''Increase cost sharing by beneficiaries.''

We know what that means—the consumer pays more of the bill.

Or ''increase the employee's share of the premium.''

If my colleagues on the other side of the aisle think the CBO had a nice thing to say about their bill, I suggest they read the entire report. ''They could drop health insurance entirely'' is a quote. This is perhaps the most frightening part of the Kennedy bill to any American family. So many families across America are struggling to get by—we know that—even in prosperous times. There is a very large chunk of America that does not share totally in that prosperity. They depend on their health insurance to protect them when things go wrong.

Yet every Democrat Member of this Chamber has thrown their support behind a bill that would take protection away from an estimated 1.9 million Americans. That is one estimate. Here is another estimate commissioned by our friends at the AFL-CIO. They indicate that the Kennedy bill could cancel health care coverage for approximately 1.8 million Americans.

I suggest a new slogan for my colleagues when they talk about the bill. I am talking now about ''golden arches.'' Over 1.8 million Americans are uninsured by the Kennedy bill. That is a Big Mac attack directly at the American consumer and directly at the American family.

A few weeks ago when I made the same comment on the floor of the Senate, my colleague from North Dakota—who happens to be on the floor now, Senator DORGAN—made a very remarkable statement. I don't think I have heard it yet in the debate. My friend said the Kennedy bill might actually increase coverage because it would make health care so attractive that people who are now uninsured would sign up to get its coverage. I say this is a remarkable statement for a very obvious reason. First, my friend seems to think we in the Senate can repeal the law of supply and demand. Raise the price, and more people are going to come and get it? I doubt it. History shows quite the opposite.

So instead of demand decreasing as price goes up, consumers will buy more of the product because it is more pricey and, yes, it does have more benefits or possibly more? I don't think so.

Divide the dollars each family spends. They have to put food on the table; they have to take the risk when it comes to health insurance.

While 14 percent of the public want Congress to reform medical care or to reform managed care, a whopping 82 percent of America wants Congress to make health care more affordable. That is what we ought to be about: Extending coverage, protecting the patient, and while doing it, certainly not raising costs but hopefully making it more affordable.

That hardly fits my friend's description of a ''public clamor'' for a more expensive health insurance program.

Finally, if my colleagues know so much about health care insurance and how attractive they can make it to the consumers, I suggest they resign from the Senate and go run a health care insurance company because obviously they know a new formula and they could make a killing.

Enough about Big Mac attacks. That is what the Kennedy bill ought to be called—a Big Mac attack. We have seen the number of uninsured Americans rise from 32 million to 43 million in just 10 years. Since 1995, the uninsured in my home State of Idaho has risen from 15 to 18 percent of the population. That is higher than the national average. Every year we add 1 million Americans to the ranks of the uninsured. The Kennedy bill would speed up that process instead of slow it down. What the Senate ought to be about right now and what our Government ought to be about is trying to slow it down and make it more affordable.

My colleague from Connecticut has offered an amendment that he says will improve access to cancer treatment. Before we vote on this amendment, I will discuss the impact of the Kennedy bill and what it would do in the context of this amendment in our fight against cancer.

We have heard from my colleague from Florida who, thank goodness, survived cancer. Most Members have not

had to go through that trauma. What he said was critically important. The 1.9 million Americans who would lose their health care coverage under the Kennedy bill represent more than 1 out of every 100 Americans with private coverage. Private health care insurance in this country pays for millions of Americans to undergo cancer screening meant to catch the deadly illness quickly, when it can be treated and defeated.

The Centers for Disease Control say every year private health insurance pays for 33 million American women to undergo exams meant to detect breast cancer. The Kennedy bill would cancel coverage for, it is now estimated, 189,000 such breast exams every year. I don't really believe that is what they intend, but that is the unintended consequence of this kind of legislation. Mr. President, 189,000 women could go without breast exams if the Kennedy bill became law.

The Centers for Disease Control say each year private health insurance pays for 9 million American women to have a mammogram. The Kennedy bill would cancel coverage for 53,000 of those mammograms on an annual basis. Run the statistics, run the percentages, run the figures. If you are going to take 1.8 or 1.9 million Americans out from under coverage, statistically I am accurate.

Yesterday my colleague from California, Senator BOXER, said, ''Republicans are turning their backs on America's women.'' She was on the floor just a few moments ago repeating that. I want to know how Senator BOXER and all sponsors of the Kennedy bill reconcile their commitment to women and women's health with the fact that they are supporting a bill that could cause thousands of malignant lumps to go undiagnosed every year.

The Centers for Disease Control says each year private health insurance pays for 41 million women to have pelvic exams and 24 million Pap smears. These tests are meant to detect ovarian, uterine, and cervical cancers. Yet the Kennedy bill would cancel coverage for 238,000 pelvic exams and 135,000 Pap smears. That is every year, according to the statistics, according to CBO, and according to the examination and study by the AFL-CIO.

I want to hear the Kennedy bill supporters begin to reconcile these numbers, if their mantra is to fight cancer. We are talking about access to the system. We want people to have these tests. We want them protected. Yet if you shoot the cost up, people will take the risk. There are only so many fungible dollars in every citizen's life. They have to make real choices. My friends, that is the marketplace. I am afraid that is the unintended consequence of the Kennedy bill.

It does not harm just women. The Kennedy bill could and would cancel—if you run the statistics, there it is again—23,000 prostate exams every year.

As a final example, the Kennedy bill could cancel coverage for 439,000 skin cancer exams every year. I say this is a final example because the list is not exhaustive. It would be impossible to track all the ways the Kennedy bill threatens the health of 1.9 million Americans who it would leave without protection from the life-threatening diseases they will face.

When my Republican colleagues raised the cost issue yesterday, I believe my colleague from Massachusetts called it a red herring. If this passes, I wonder what he will say to the women and the men who will lose their fight against cancer because they did not get the early detection. Because they did not have the money, they did not have the coverage to walk through the door and get the exam.

Mr. HARKIN. Will the Senator yield on that point?

Mr. CRAIG. I will not yield.

I find it astounding that this is what my colleagues have contributed to the debate on patients' rights. How can a patient have a right if a patient cannot have access? Every study shows a 6.1-percent increase in premiums above inflation will drive 1.9 million Americans out of health care.

My Republican colleagues and I support a different approach, a substantially different approach. We have a bill that puts patients in control of their own health care and that makes health care simply more affordable. Our bill achieves it by giving all Americans access to medical savings accounts, along with all of the other kinds of health care insurances that are now available.

Since we introduced the limited MSA, or the Medical Savings Pilot Program, something really very wonderful in health care has happened. I know the other side does not want to recognize it. I am so frustrated, trying to understand why they would ignore that the General Accounting Office estimates that 37 percent of medical savings account buyers previously had no coverage whatsoever, and 82 percent of the American public rate the high cost of medical health care coverage their chief concern. Medical savings accounts meet that concern. Our bill has that in it. That is not driving people out of the system. That is reaching out, bringing people into the system, into the system for their Pap smears, into the system for their pelvic exams, into the system for early detection of cancer. There is the difference, driving people out or encouraging people to come in, making health care more affordable.

A medical savings account gives you 100-percent coverage, 100 percent of doctors to choose from. My Democratic colleagues have gone to great lengths to say our bill does not generate direct access to specialists; that our bill does not generate direct access to OB/GYNs; that we do not guarantee access to pediatricians; that we do not let patients choose their doctors; that we do not ensure that medical decisions will be made by a patient and that patient's doctor. They could not be more wrong.

If you own a medical savings account and you own insurance, you choose your own doctor, always. If you feel you need a specialist, then you go to the specialist. If you need direct access to an OB/GYN, you have it. If you need direct access to a pediatrician, nobody is sitting there as the gatekeeper they like to talk about; you are the person in power. You have the direct access.

Once again, for mandatory referral, you are in control of your destiny and the destiny that comes in cooperation with your primary care physician. That is what we are talking about, about personalizing health care and taking the Federal Government out of it. That is why Republicans have always supported MSAs. We are not saying everybody ought to have them. We are simply saying open up the option. Make it available as a matter of choice so you can choose between what you can afford and what has now become even more affordable. So we are not thrusting the Federal bureaucracy on the system and shoving up the cost by every legitimate estimator's estimation. We are, in fact, potentially driving those costs down.

A program that decreases the number of uninsured and gives patients direct access to their doctors is what this Senate ought to be about. If my Democrat colleagues truly want Americans to have affordable medical care that patients control, they should be clamoring for a medical savings account.

How can my colleagues stand up for a patient's right to greater access to cancer treatment when they are supporting a bill that leaves millions without health care coverage? I quoted the statistics, and they are very easy to extrapolate out of those figures. We are talking about hundreds of thousands fewer exams for potential cancer under what is now being proposed.

The answer is they really have not thought their bill through. They do not think the marketplace works, that somehow you can reform it and change it and control it by simply enacting a Federal regulation. Will costs not go up? We know they will go up. We know every time we have tampered with health care for the better benefit or for the less, we have had the direct impact on the marketplace that has driven health care costs up. Every time it is driven up, it is driven beyond the point of access by some Americans.

Why would they do this? I am not sure why they do this. I guess I could quote President Clinton at the defeat of health care last time, when he said:

> Now what I tried before won't work, maybe we can do it another way. That's what we've tried to do, a step at a time, until eventually we finish this.

I think that is the essence of what the Kennedy bill does, one step at a time, toward a greater sense of Federal control driving the cost up so the American consumer says, OK, give me

Federal health care; I can't afford it any other way.

Mr. ROCKEFELLER. Mr. President, regular order.

The PRESIDING OFFICER. The Senator's time has expired. The Senator from Nevada is recognized.

Mr. REID. Mr. President, pursuant to the agreement with the Senator from Tennessee, I yield 3 minutes to the Senator from Illinois; following that, 3 minutes to the Senator from West Virginia; then 3 minutes to the distinguished Senator from Iowa.

The PRESIDING OFFICER. The distinguished Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, yesterday was a banner day on the floor of the Senate for the insurance industry. Three different amendments were considered, amendments which the insurance industry of America opposed. The first of those amendments said a woman could keep her OB/GYN as her primary physician no matter what the HMO said. The Republican majority and the insurance industry defeated that.

The second said you should have access to the emergency room closest to your home when you have a family emergency. That amendment was defeated by the insurance industry and the Republican majority.

The third amendment said if you have a dispute with your insurance company about coverage, we are truly going to have an independent panel decide who is right and who is wrong. That amendment was defeated by the insurance industry and the Republican majority.

They may be dancing in the board rooms and the canyons of K Street, but I can tell you the people of America understand this debate, and they know they lost on the floor of the Senate yesterday.

We are now debating an issue of equal importance. If you have a health insurance plan and your doctor says: You have a serious condition; we need to try a new drug; it has been approved by the FDA; it may work and it may not; in that situation many health insurance companies say: No, we will not pay for it because it is ''experimental.''

Have you walked into a convenience store in your hometown and seen those little canisters on the counter asking you to leave 50 cents or a dollar to help that local family pay for a medical bill they cannot afford? Many of these same people are paying for drugs, reimbursement for which was turned down by health insurance companies because the treatment was experimental. People literally on the brink of life or death, following doctors' orders, using FDA-approved drugs, have been turned down by these insurance companies.

Senator DODD offers an amendment to protect our rights to use these drugs as doctors call for them to save our lives. The Republican majority and the insurance industry oppose it. We will face another vote today and another question as to whether American families will win or lose.

Last Sunday in Chicago, I met this little fellow in this picture. His name is Rob Cortez. He will melt your heart. He is about a year old. He suffers from spinal muscular atrophy. For a year, his family has been fighting to keep him alive, trying to keep their own courage together, trying to fight his disease, and every day fighting another insurance company decision that would turn off the ventilator which would be the end of his life. Imagine what that family goes through.

They had a drug that was prescribed by a doctor to fight infection in this poor little guy, and the insurance company said: No, it is experimental. We will not pay for it.

The battle goes on day after day in households across America. The Republicans can come to the floor with their cartoons and their slogans, but America's families understand this debate. What is at stake is our health and our health insurance. If people across America do not wake up to the reality of this debate, we are going to lose an opportunity to give piece of mind to families all across Illinois, all across the Nation, and to protect the lives of other vulnerable little kids. That is what the debate is all about.

I also want to make it clear that this clinical trial approach is cost-effective. Sloan-Kettering and M.D. Anderson have made it clear it is money saved.

I yield the floor.

The PRESIDING OFFICER. The Senator's time has expired. The Senator from West Virginia is recognized for 3 minutes.

Mr. ROCKEFELLER. I thank the Chair.

Mr. President, this is an extraordinary discussion, and it is one of those things where I believe we ill serve the American people because points are made too extremely.

The Senator from Idaho was making the point about driving people out of health care because of rising costs, and that is just flat out undeterminable. GAO says so. CBO says so. He quotes things that say they do. I say they do not. I will be happy to show him the language if he is interested in seeing it.

I do not know if this is about ideology or not or if it is about preaching. I have no idea. But I do know this, Mr. President: Clinical trials are incredibly important. This has been a battle a number of us, cancer groups and others, have been fighting for many years. My friend, the Senator from the State of Iowa, will expand on this more eloquently.

It is a terribly important fight. It is a question of, can people have access to clinical trials? Insurance companies used to pay for them. Insurance companies now do not pay for them. Some people have come to a point where they have exhausted—and they might be in their thirties and forties; we are not talking necessarily about people in their eighties or nineties but people in their thirties, forties, and fifties—every possible approach trying to do something about their very dreadful disease, which could be any number of things, not just cancer but any number of things.

The insurance companies used to pay for that. Now the HMOs will not, and they will not for a very good reason: because those things tend to be costly sometimes.

It comes down to the classic choice: Does the HMO get the advantage at the bottom line or does the patient get the advantage? That is the basic decision and the difference between Members on the two sides of the aisle who are otherwise informed and are trying to do the right thing on this subject. All of us are trying to do our best.

We have to have clinical trials. The usual and ordinary expenses associated with that have to be paid; otherwise, people will not be able to afford it; they will not get clinical trials; therefore, they will die or they have a chance of dying. Finally, of course, clinical trials often are the best experiment and research that can possibly be done because they lead to new discoveries and new opportunities.

I hope very much the Dodd amendment can be adopted. It is an extremely important amendment. When people hear ''clinical trials,'' they are not sure what we are talking about. There are hundreds of thousands of Americans at this point who have given up on regular therapies, but there is something out there on the cutting edge and they are ready to use it, but now the insurance companies will not pay for it, and the Democratic Patients' Bill of Rights will do that.

The PRESIDING OFFICER (Mr. HUTCHINSON). The time of the Senator from West Virginia has expired. The Senator from Iowa is recognized for 3 minutes.

PRIVILEGE OF THE FLOOR

Mr. HARKIN. Mr. President, I ask unanimous consent that the privilege of the floor be granted to the following members of my staff during the pendency of S. 1344: Ann Procter and Bryan Johnson.

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

Mr. HARKIN. Mr. President, first I will address the issue that was brought up by the Senator from Idaho who stated that women are going to be driven out of cancer care because of this legislation. I could not believe what I was hearing. I asked the Senator from Idaho to yield for a question, but he would not yield to me. Therefore, I will bring it up now.

The Senator from Idaho stated that, because of this bill, thousands of people with breast cancer and lung cancer will be denied coverage. Why then, I ask, do the following organizations support our bill: The Alamo Breast Cancer Foundation, the Alliance for Lung Cancer, Advocacy Support and Education, the American Cancer Society supports this bill, the California Breast Cancer organization, Cancer Care, Inc., Minnesota

Breast Cancer Coalition, National Alliance of Breast Cancer Organizations, the National Breast Cancer Coalition, the National Coalition for Cancer Survivorship, the North American Brain Tumor Coalition, the Rhode Island Breast Cancer Coalition, the Susan G. Komen Breast Cancer Foundation, the YME National Breast Cancer Organization—on and on. Why do all these cancer organizations support our bill?

If you listen to the Senator from Idaho, it is because they do not want anyone treated for cancer. How ridiculous. It just shows the ridiculous nature of the arguments made on the Republican side on this bill. What absolute, total nonsense.

That brings me to another ridiculous assertion made earlier. Someone on the other side of the aisle stated that to have people in clinical trials is going to be very expensive.

Sloan-Kettering did a study of the costs associated with clinical trials. They looked at a number of people over 3 years, and here is what they found: Hospital stays, 24 percent lower for clinical trials; radiation therapy, 25 percent lower cost; drugs and supplies, 25 percent lower cost; operating room, 8 percent lower cost. These are for clinical trials.

That was backed up by another study done by M.D. Anderson in Houston, and this was done on 3,000 patients enrolled in clinical trials. They found costs for ovarian cancer patients were 35 percent less. They found lung cancer costs 36 percent less. In prostate cancer trials, there was a negligible difference between research and standard care patients.

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

Mr. KENNEDY. Mr. President, of all the votes we will have and have had in the Senate yesterday, today and tomorrow, this ought to be the easiest. This ought to be the easiest if you are interested in research, if you are interested in the protection of patients.

If we look at what has happened historically, insurance companies have paid for routine care associated with clinical trials. The reason they have paid for it because they knew it was right. Secondly, as the Senator from Iowa has pointed out, covering routine costs associated with clinical trials actually provided savings to the insurance companies. But we now see a dramatic decline in clinical trial enrollment.

What are clinical trials? What do they represent? This is what they represent: A woman has cancer—it can be ovarian cancer, breast cancer, cervical cancer—and is told the ordinary treatments for cancer will not cure her disease. Her prospects are extremely grim. Her doctor advises that her only chance of survival is a treatment under study in a clinical trial. We should not permit the insurance companies or their bureaucrats to deny her access to that clinical trial. That is what this amendment is all about—access to the only treatment that may give her a chance of survival.

The greatest progress in cancer treatment has been made in childhood cancer, and it is no coincidence that the greatest number of clinical trials performed in this country have been in children's cancer. The reason, as most researchers and most cancer centers recognize, is the types of clinical trials that are taking place.

Congress is doubling the NIH budget to take advantage of what I like to think will be the life science century. Progress in making breakthroughs in so many different areas of disease—whether it be Alzheimer's or cancer or Parkinson's disease—potentially emptying nursing homes around this country and improving the health of Americans demonstrate the importance of clinical trials. Clinical trials are the critical aspect in finding effective treatment and cures for diseases. That is why this amendment is so important. All HMOs have to do is continue what insurance companies have historically done and that is cover the routine costs associated with clinical trials. The clinical trial sponsors pay the remaining costs.

The Republican proposal to study the importance of clinical trials is poppycock. The choice is: Will we maintain what every researcher, every patient organization, every doctor who works in the areas of these critical diseases recognizes as absolutely vital for medical progress, or will we study this issue some more?

The Republican proposal says let's do another study and let's get a report to the committee. We are saying that if the doctor says there are sound medical reasons for this type of treatment, access should not be denied by a bureaucrat or an insurance company. That is the issue this amendment addresses.

This amendment should receive overwhelming support. It is ridiculous that we are spending so much time debating the issue of whether clinical trials are important. Every single country in the world envies the progress the United States has made in the area of pharmaceuticals—every single country. Why? Because we have breakthrough drugs. Why? Because we move these breakthrough drugs from the laboratory to the bedside. How is that done? It is through clinical trials. We cannot move breakthrough drugs from the laboratory to the bedside without clinical trials.

That is what this issue is about. That is why we have such strong support from the cancer societies and organizations concerned about diseases like Alzheimer's and Parkinson's Disease. That is why we have the support of the disability community. That is why we have support from so many children's disease organizations.

That is why I hope the Dodd amendment will be accepted.

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Would the Chair state how much time the minority has?

The PRESIDING OFFICER. The minority has 7 minutes 10 seconds.

Mr. REID. I yield 4 minutes to the Senator from Washington.

The PRESIDING OFFICER. The Senator from Washington has 4 minutes.

Mrs. MURRAY. Thank you, Mr. President.

I thank my colleagues who have been on the floor talking about an issue this morning that I think is becoming more and more critical, and that is access to clinical trials, the amendment by Senator DODD.

It seems to me that in the Senate we have talked, in a bipartisan way, about making sure we have increased funding for NIH so we can have access to the best new research for diseases such as cancer, diabetes, and multiple sclerosis.

A lot of great research is occurring right now at NIH. Members have said many times that needs to be increased. In fact, the Labor Committee has worked very hard, and I am very proud of the fact we have increased funding to NIH by almost 40 percent.

However, today, citizens, taxpayers, who are paying the dollars for that increased research at NIH, are being routinely denied access to that new research when their HMO says they will not pay for a new clinical trial—these are new medications, new medical devices that have been researched and we have paid for the research through our own taxpayer dollars.

But when it comes to our constituents, who have paid for this research, having access to the clinical trials, having access to this new research, they are not allowed because their HMO denies it. That is why I think this amendment is so important to the taxpayers of this country.

I met recently with a number of cancer survivors in my own home State of Washington. Some of them were patients at the Fred Hutchinson Cancer Center, a very well known cancer research facility, one of the premiere centers in this country. The doctors and the patients told me about how they were routinely being denied access to these clinical trials—these people who have no other recourse, who may have MS or cancer or another severe illness, who have no other hope out there except for access to a clinical trial. It is their last chance at life and their doctors recommended it. The doctors at the Fred Hutchinson Cancer Center said: This is their chance at life, and their insurance company, their HMO, said: No, sorry; we're not going to pay for it.

One of the things the doctors said, which made an impression on me, was that a patient was going to receive some kind of care with some kind of cost that their insurance company was going to have to pay for, and, in fact, the clinical trials, for the most part,

cost less than the treatment this person was going to have. So they did not understand why the insurance company was going to decide which treatment they were going to have. They felt very strongly the doctors ought to be the ones deciding what kind of medical treatment this patient should be having. And the clinical trials were their best chance at recovery and hope for life.

I hope the Members of the Senate will agree with Senator DODD and the other sponsors of this amendment and allow people to have access to the research they have paid for by taxpayers when they need it, when they are victims of cancer, when they have MS, when they have diabetes, and allow them to have access to clinical trials.

We will all win in the end because, without these clinical trials, we will not have the research we need to make sure these kinds of medical devices or these prescription drugs are then available to the general public as routine care that is paid for by HMOs.

I commend my colleagues for their debate on this issue. I urge all of us who have said we are for increased funding at NIH and increased funding for research to now allow our constituents in this country access to that care.

I thank the Senator.

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

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

Mr. KENNEDY. I yield 2 minutes to the Senator from Washington.

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

Mr. KENNEDY. If I could ask a question, through the Chair, of the Senator. You have one of the great cancer research centers in Washington—the Fred Hutchinson Cancer Center—that is world renowned. It is known throughout the United States as having the very best expertise in treating cancer.

I would be interested, as would the American people—we have one of the great children's research center—recognized recently as the No. 1 children's center doing great research—what does that center do for the citizens of Washington and the citizens of this country in terms of research programs, clinical trials?

Mrs. MURRAY. In response to the Senator from Massachusetts, the doctors at the Fred Hutchinson Cancer Center are very concerned about their patients who are being denied access to medical care because they say these trials are what will not only help patients but will help them give the best care to all of their patients. They are not able to do the job we expect them to do any longer, not because of medical decisions they make but because of the decisions made by HMOs.

Mr. KENNEDY. The doctors at that world-class cancer research are recommending clinical trials because they think those clinical trials can perhaps save the life of an individual who may have breast or cervical or ovarian cancer. You are finding in your State that managed care plans are denying access to clinical trials for their members?

Mrs. MURRAY. The Senator from Massachusetts is absolutely correct. These are world-class physicians, top physicians in cancer research, who think the best thing they can do for this patient is the clinical trial; and they are being told no.

Mr. KENNEDY. Would the Senator be surprised that the head of the Lombardi Cancer Research Center, one of the great research centers in Washington, DC, testified they had to hire eight individuals to deal with the insurance companies just on the issue of enrolling persons in clinical trials. Doctors were referring women to the Lombardi Center for lifesaving cancer treatment—for clinical trials—and the HMOs were denying coverage? These eight individuals were trying to deal with the HMOs so that these patients could receive potentially lifesaving treatments.

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

Mr. KENNEDY. All our amendment is trying to say is: if there is a clinical trial available, the value of the clinical trial is established, and if a doctor believes his patient can benefit from that clinical trial, the HMO ought to allow access. That is what this amendment is about. Without this amendment, there will be an increase in the number of clinical trials that are terminated.

Mrs. MURRAY. The Senator is absolutely correct. Not only will it hurt the health of the woman who has been denied access to the clinical trial who has ovarian cancer or breast cancer, but it also denies us, all the rest of us, access to good health care because we will never know whether or not that clinical trial works, which could then be available to the rest of us.

Mr. KENNEDY. In other words, the benefits of the research from the clinical trial will benefit people whether they live in the State of Nevada or the State of Massachusetts?

Mrs. MURRAY. That is correct.

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

Mrs. FEINSTEIN. Mr. President, I support the amendment offered by Senator DODD to increase patient access to life-saving clinical trials. This amendment could assist in prolonging the lives of millions of patients with life-threatening or serious illnesses, for which no standard treatment is effective, by offering them access to new experimental therapies.

Clinical trials are the primary means of testing new therapies for deadly diseases such as cancer, congestive heart failure, Alzheimer's, and diabetes. Many health insurance plans cover the patient's routine costs associated with clinical trials. Recently, however, research institutions—particularly cancer centers—are finding that managed care plans will not pay for the costs associated with clinical trials. For many patients whose conditions have not responded to conventional therapies, clinical trials may be the only viable treatment option available.

The Dodd amendment requires health plans to cover the routine patient costs associated with these trials. Eligible patients are those with life-threatening or serious illnesses for which no standard treatment is effective, and those for whom participation offers meaningful potential for significant clinical benefit. Trials are limited to those approved and funded by one or more of the following: the National Institutes of Health (NIH); a cooperative group or center of the NIH; or, certain trials through the Department of Defense or the Veterans Administration.

The Republican bill does not provide for coverage of any routine costs related to clinical trials. Instead, they require only a study on the issue. The Republican bill does not offer hope to patients who have exhausted all other options except the promise of experimental treatment. We should not have to tell the thousands of desperate women with terminal breast cancer that we need to study this issue some more before we can offer them access to clinical treatment that might save their lives.

Republicans claim that we do not have enough information about the costs of clinical trials. They say we need, once again, yet another study. Every day we delay, with conversations about the need for another study which will undoubtedly demonstrate the continue importance of clinical trials, another patient suffers; another patient dies. The Republicans' claim that clinical trials are more expensive than conventional therapies is unjustified. The fact is that the cost of conventional therapies is not known with any precision. The cost varies case-by-case.

Republicans claim that covering the cost of patient care in clinical trials would be too expensive. The Congressional Budget Office found that 90 percent of health plans already cover routine patient costs in clinical trials. In an attempt to block patient access to clinical trials, insurance companies try to claim that a clinical trial is more expensive than conventional therapy. However, at Memorial Sloan-Kettering Cancer Center in New York, the cost of treating pancreas, breast, colon, lung, and ovarian cancer pursuant to a clinical trial were compared to the costs of treating the same cancers with standard therapies. Utilizing Medicare patients for this comparison, the average cost per patient was actually lower for those patients enrolled in clinical trials.

Let me explain who pays for trials. There are three categories of costs associated with a clinical trial:

First, the cost of the investigational drug is provided free of charge by the pharmaceutical sponsor.

Second, the costs associated with collecting and analyzing the data from

the trial is covered by the trial sponsor through a federal research grant or other funding source (i.e., National Institutes of Medicine, Food and Drug Administration).

Third, routine patient care costs—physician charges, hospital fees and routine diagnostic tests—are the only costs that managed care plans would be asked to cover for patients participating in clinical trials. And as I mentioned earlier, over 90 percent of health plans already cover routine patient costs in clinical trials.

By early in the next century, Hispanics, African-Americans, and Native Americans will comprise nearly one-half of our nation's. In fact, Hispanics are the fastest-growing ethnic group in America today. This is alarming since heart disease, cancer, tuberculosis, HIV/AIDS and diabetes are disproportionally affecting minority communities.

Some specific forms of cancer affect ethnic minority communities at rates up to several times higher than national averages. African-American males develop cancer 15 percent more frequently than white males. Although the rate of breast cancer among African-American women is not as high as that among white women, African-American women are more likely to die from the disease once it is detected. Cervical cancer is nearly five times more likely among Vietnamese American women than white women, and it disproportionally affects Hispanics. Liver cancer is more than 11 times higher among Vietnamese Americans than among whites. Colon and rectal cancer is higher among Alaska Natives than other ethnic groups. Lastly, American Indians experience the lowest cancer survival rate of any U.S. ethnic group.

However, access to clinical trials is especially limited for racial and ethnic minorities. Of the people participating in clinical cancer trials, only 2–3 percent are minorities. The September Cancer March's Research Task Force said that one way of encouraging more participation is to require public and private insurers to cover the routine medical costs associated with clinical trials. Senator DODD's amendment to the Patients' Bill of Rights does just that.

In addition, women, the elderly, ethnic and racial minorities, and cancer patients are not participating in clinical trials proportional to the population. The September Cancer March's Research Task Force testified before the Senate Cancer Coalition that only 2 percent of cancer patients are enrolled in clinical trials. Of those participating, only 25 percent are elderly, even though the elderly represented some 63% of the cancer patient population during the mid-1990s.

Breast cancer is one of many diseases that cause more deaths among minorities than among white women. Researchers and patient advocates agree that understanding differences in disease progression requires the recruitment of a representative number of minorities to clinical trials. So why don't more ethnic/racial minorities participate in clinical trials? There are several reasons. Lack of access to health care and lack of insurance coverage are major reasons; 43 million Americans are uninsured. This number does not include the millions who are under-insured.

In closing, real improvements in health care, advancements in medical knowledge, are possible only through increased scientific clinical research and development. We cannot lose sight of the fact that without continued clinical research and access to clinical trials, life threatening diseases such as cancer will continue to ravage communities. Encouraging participation in clinical trials is essential, if not crucial, to the millions of Americans who live daily with life-threatening diseases. The unrelenting focus by HMOs on cutting rather than focusing on the long-term quality of our health care system is harming the American people, and we are not gaining scientific knowledge.

As our nation continues to move to a managed care based health system, patient enrollment in clinical trials is dropping. One of the reasons for this decline is the unwillingness of many health plans to cover routine patient care costs associated with participation in a clinical trial. This amendment to the Patients' Bill of Rights is the first step to ensuring access to clinical trials. We cannot continue to let HMOs put profits before patients.

Mr. FRIST. Mr. President, how much time remains on each side?

The PRESIDING OFFICER. The Senator has 18 minutes 24 seconds remaining.

Mr. FRIST. And the other side?

The PRESIDING OFFICER. All time has expired.

Mr. FRIST. Mr. President, we are currently debating an amendment on clinical trials. It is something that is very close to my heart because, as I said earlier, I have been involved in clinical trials. I have seen the great advantages of having such clinical trials in that it allows us, through that final stage, to determine whether or not a particular intervention, whether it be a new medicine that might potentially cure prostate cancer or a medical device that might be used to hold open the coronary artery after a heart attack, a heart attack which results in a squeezing down or atherosclerosis or blockage of a coronary artery, put a little stint in that, opens it up, how do you take that to the clinical setting? How do you take that to where it can be distributed broadly across America and across the world, if it is beneficial?

I should mention that the United States is the leading Nation in taking such innovation and such creativity, capturing it, studying it carefully, putting it in appropriate clinical trials, and then having it applied, if it is safe, if it is effective, to people around the country and the world. It should give all of us in this body and in the country a great deal of pride that we are the leaders in medical technology, medical innovation, whether it be the use of pharmaceutical agents; that is, medicines, whether it is treatment of chemotherapy; that is, using medicines to treat cancer, or the application of medical devices.

Just a few days ago I was in Boston and visited some of the great, young, aggressive research people who, by hand, make those little stints, the stints that look like little springs, that keep thousands and thousands of people's coronary arteries open. They come in with an acute heart attack, a little balloon blows up in a vessel, a stint is placed. Twelve years ago those stints were not around. They had never been placed into a coronary artery. How do you get to that point to where it is used in just about every hospital, every cardiology hospital in the United States of America? Well, the last phase of development is clinical trials.

That is why it is so important to me. And it is, in a very direct but also an indirect way, important to every single American, no matter what age you are because everybody at some point in their lives will be sick or will be ill. Anything that we can do as a Nation to lower the barriers between whether it is industry or our investigators or medical science and the delivery, the effective delivery of safe and effective procedures is something we need to work on. We started much of that work 3 or 4 years ago in modernization of the FDA.

I spent some time explaining this aspect of clinical trials to reinforce how critical it is that we do everything we can to lower the barriers to participation in clinical trials.

One thing we have to be aware of in terms of clinical trials is that we don't fully know what—I use the word ''incremental''—the increased cost, the incremental cost is when someone goes in to a clinical trial. As I mentioned earlier, usually you have one group of patients who did not get an intervention, one group of patients who did get an intervention, get that additional drug. You need to follow them over time and see what the incremental costs are of that clinical trial.

Mrs. MURRAY. Will the Senator yield for a question?

Mr. FRIST. I am happy to yield briefly for a question. My answer will be very short because I don't have enough time to finish.

Mrs. MURRAY. Mr. President, I appreciate the Senator yielding for just a quick question. Isn't it true that insurance companies, until recently, did pay for clinical trials, and it wasn't until we moved to the HMO era that we are now in that we are being denied access to those?

Mr. FRIST. Yes. I really appreciate the question because it shows why we are addressing this today. In part, it is

because we are just beginning to understand the real importance of clinical trials. We are just figuring out the cost. The other dynamic is just that.

We have insurance companies and managed care companies and private payers today who basically say: We are in the insurance business. Our job is to deliver health insurance. If an individual comes in and they are sick, my obligation, as a managed care company or as an HMO or a health insurance company, is to take that patient and cover them by the definitions of that contract.

The question they are asking us today, and need to ask us on the floor, is shouldn't that be the responsibility of the Federal Government? Why should I, an HMO, an indemnity plan, a private health insurance plan, be paying for research that has potentially nothing to do with that particular patient? Because this is a mandate, the underlying Dodd amendment is a new mandate.

What Senator MACK and I will propose is also a mandate. So both sides are going to be hearing it. They are basically asking: Why are you all of a sudden thrusting on me the responsibility that is yours, the Senate, the Federal Government, the NIH? Why aren't you using Federal money, taxpayer money to subsidize this research, which is very beneficial? Why are you putting that mandate on my shoulders, the private insurance company?

Now, the answer to that is twofold. We probably need to do a little of both. We need to have more appropriate public investment in the clinical trials and at the same time have the private health insurance company in some way subsidized.

The problem with that is, if we put this new mandate on the managed care companies and the HMOs, somebody has to pay for it. The Federal Government is not going to pay for it. Unfortunately, I think we need to go back and address this same issue in Medicare. The Federal Government has basically said that we, except through the NIH, are not going to. For example, in the Medicare system, the health care delivery system for seniors, we have not approached the issue of how we subsidize these clinical trials.

So the private sector is saying: Why are you making us pay for it, while you in the Federal Government, at least in Medicare, have not yet addressed that?

The response to that is, yes, but we have the National Institutes of Health. We need to continue investing in that, and they oversee, along with other public agencies, clinical trials.

The private sector says: Why us? What the private sector is going to do is say: I am in the business of taking care of the heart attack that I cover under contract. Why am I having to, under your mandate, to have this clinical trial on prostate surgery or prostate cancer treatment? Why are you forcing me to subsidize that?

We need to answer that question. The general public good and the great advances are the answer to that question, but then somebody has to pay for it.

The health insurance companies, what are they going to do? Whatever that incremental cost is, they are going to charge their very next person that they cover. So they are going to pass it back to the patients.

Then all of a sudden you have the patient come forward basically saying: I came in because of a heart attack. Why are you increasing my premiums and making me pay more every year to do general research that benefits everybody across the world? I just want a health care plan that pays for my own insurance.

We have to be able to determine what that additional cost of this mandate is, and that is very unclear today. We have to determine what that is. Then we have to explain to people why that is going to result in increased premiums that are passed on to the individual patients. That is sort of the big picture.

Let me go back to the Senator's question because it was a good question. Twenty years ago we didn't have many HMOs. Twenty-five years ago, we didn't have coordinated care plans, HMOs, PPOs, provider-sponsored organizations. All these are new entities. It used to be that private health insurance would be able to subsidize or cross-subsidize some of these clinical investigations—not a lot but some. That was at a time where there was more room to maneuver.

Now, with the scarcity of the health care dollar, they have been squeezed down, physicians have been squeezed down. You hear it all the time. People who are in our reception room and here to lobby us all the time say: We are being squeezed down. Managed care companies say: We are being squeezed down. Everybody recognizes that in terms of health care dollars, the demand is so huge.

Technology allows us such a great opportunity to deliver heart transplants, which I was able to do every week, or putting in heart valves or hip replacements in 95-year-olds, things that we couldn't do 30 years ago. The overall expense has caused a squeezing down on everybody. You hear private health insurance companies saying: No longer can we subsidize; no longer can we take a little money from here and subsidize this research out of the goodness of our heart because we are squeezed so far. And thus we come in with some sort of mandate which is going to end up being in this bill, and some say performed to encourage and promote the private sector. We need to address it in the public sector in Medicare where we haven't addressed it for the private sector in some way to participate in clinical trials.

Mrs. MURRAY. If the Senator will further yield, I understand that the Senator is a surgeon and has seen clinical trials and knows the benefit of them. I listened with respect to his arguments.

But in this amendment, we are simply assuring that the patients will get the best care. And if the best care for their particular condition is a clinical trial that will not only benefit themselves but the rest of the people with that condition as well—and NIH has paid for the vast majority of this. I understand from CBO that 90 percent of insurance companies have been paying for clinical trials. The amendment ensures that won't go away. We are seeing more and more HMOs look at their bottom line and that benefit is being taken away. We want to make sure the insurance companies continue to pay their part. Certainly, a patient who goes in cannot afford to pay for that clinical trial, but they have been paying premiums for years. Shouldn't that be part of what they expect when they pay a premium to an HMO?

Mr. FRIST. I will respond, through the Chair, to my colleague that the gist of her question is, shouldn't we allow what used to be done to continue to be done, and we should encourage that. The models of health care are changing rapidly. I hate to look back and say that because something used to be done, it should be done today. In this case, I am one who wants to promote the expansion of clinical trials as much as possible.

How much time do we have?

The PRESIDING OFFICER. The Senator has 6 minutes 38 seconds remaining.

Mr. FRIST. I yield myself 6 minutes. Please notify me when we have 30 seconds remaining.

The real issue—and the reason why I urge my colleagues to defeat this amendment, as written—is the following:

I have explained the difference between overall cost and incremental costs, and the cost of the clinical trial. Let me say that the data presented by Senator HARKIN is good data, but it always asks for what the end number is in science, how many cases the data is on. I didn't hear that; I didn't know how many. One of the charts was around 100, maybe 130 patients. You are looking at small statistical differences. We need more patients if we are going to be making policy on studies. That involved very few patients.

We had the opportunity in committee to look at a number of studies. There have been three completed studies—not ongoing but completed—all of which had some limitations. All three included just cancer patients, which is a very important group. We don't want to extrapolate cancer patients to artificial heart patients where they are putting in artificial hearts, cardiac valves, or stints. We have to be careful with that. The overall sample and size of the studies is very small.

On the other hand, the charts, in essence, are right. If you get into a clinical study, the medicine continues to be very good. Why? Because you have outside people watching what every move is, making sure every lab test is

justified. If you are going to do a lab test, it gives you the result; that is right. But there is an incremental increase in cost.

If you take two patients and you are studying them, you end up doing more testing. The side effect of the drug might be that it lowers one's blood test count, so then you have to test the hemateikon more. That increased cost is passed on to the patients in the private sector—not through Federal taxation going through Medicare and the subsidy coming down, but it is passed on by increased premiums.

We have to be able to explain to the patients, for the great public good, why they are having to pay more. I am saying basically that the science of knowing exactly what that cost is very young; it is in development. We should have 100 studies, not just 3, to be able to cite.

I think it is very important for us to continue as a body to encourage the gathering of that information and the academic study, careful study, through carefully controlled perspective trials, to determine what that cost is before we open the door broadly and pass that cost on to managed care companies, which on the very next day are going to put it on the backs of everybody who is listening to me speak today; that is, the patient—the patient who may have appendicitis 30 days from now, or a heart attack 60 days from now. Every day you are going to say tomorrow you are going to pay for this mandate we put on your managed care company.

In Medicare, which insures 36 million senior citizens and individuals with disabilities, we try to address it, and we are going to address it. But the reason we have not is we don't know what the cost will be. Where you have Medicare, you have a system going bankrupt over the next 15 years. We can't get together in this body, working with the President of the United States, to reform that in a sensible, modernized way. We just can't do it. We are not going to be throwing new mandates out there either—or we should not—which furthers that bankruptcy.

The question is, Where do we go from here? I think my objective is exactly the same as the principal sponsors of this amendment. There is one huge, gaping door there that I am most concerned about. I think the populations you have drawn from are probably appropriate, so we can get the data, the information to do this right. But basically the indication is that qualified individuals to whom this new mandate will apply in health care broadly—the indication is life-threatening or a serious illness. Now, having a category that broad in putting this mandate out on managed care, which is going to be passed on to patients—it has to be; there is nowhere else to pass it to; we are not taking it out of the Federal Treasury—before we do that, shouldn't we get a little more information and narrow the scope so we can learn and not make what could be a tragic mistake?

Saying that the people who are qualified is anybody who walks in and says they have a life-threatening illness, or anybody who has a serious illness, is very dangerous. If you are a patient and have appendicitis, that is a routine procedure and that is serious. Is it a life-threatening illness? No, but it is serious. As I go in as a patient under this new mandate, I might be able to say I want to be in a clinical trial.

Mr. DODD. Will my colleague yield?

Mr. FRIST. Let me finish my statement. What does that actually set into motion? I am not quite certain because we don't know exactly what the overall expense or cost range of those trials would be. So what I would like to see first would be an approach like the one of the Senator from Florida—to use the same overall indications but have the scope of a particular entity, instead of anybody who comes in and falls into the category of life-threatening or a serious illness because to a patient every illness is serious.

How much time remains?

The PRESIDING OFFICER. Thirty seconds remain.

Mr. DODD. Mr. President, I ask unanimous consent to have 1 minute to ask a question.

Mr. FRIST. The Senator would have to take it off the time of the bill.

Mr. DODD. Mr. President, I ask unanimous consent for 1 additional minute.

Mr. FRIST. On the time of the bill?

Mr. DODD. On our time, yes.

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

Mr. DODD. My question to my colleague and good friend from Tennessee is this: As we have written this amendment, there are two other conditions. It isn't just life-threatening or serious illness. There has to be no other standard, no other option available to the person other than the clinical trials. So that is one. And, two, there has to be a limited time. For instance, it can't just be someone who has cancer but in certain stages of cancer.

So I appreciate his point that it can be pretty broad. But what we have done with our amendment is say that nothing else exists out there to possibly treat you, No. 1; and No. 2, it has to be done in a limited amount of time. He may want to respond to that.

Mr. FRIST. Mr. President, I yield myself 3 minutes on the bill—not on the amendment.

The PRESIDING OFFICER. The Senator is recognized.

Mr. FRIST. Mr. President, I appreciate the Senator's clarification of that because it is important. The concept is basically that we can't create a door that is so broad that anybody can come in. If I need a heart transplant, is there any other therapy available? Probably not. Does that automatically qualify me for arranging a clinical trial? That can be dangerous. I can tell you that putting an artificial heart in can cost $100,000 or $150,000. I have put in these devices before.

We have to be very careful because to put a $150,000 expense into a policy that is translated directly down to the shoulders of patients—not the patient who needs the artificial heart but somebody else—can be dangerous.

I want us to work together. We can do that in the underlying amendment. We may not be able to go as broadly as we all would like to go until we get the appropriate information on the incremental cost and how much of a burden we are placing on society.

Again, I think our goals are very similar. I will refuse to move as far as the Senator on that concept in terms of life-threatening or serious illness, such as the example I just gave of the artificial heart, but I look forward to working with the Senator.

I again urge my colleagues to vote against this amendment with the understanding that the outline Senator MACK put forward as an amendment hits right at the principles of a mandate where we will support clinical trials without an undue burden on the backs of patients. That will be to the benefit of all Americans.

I yield 30 seconds initially to my colleague from Maine so that she may submit her amendment, and I yield the remainder of the time if that is appropriate.

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

The Senator from Maine is recognized.

AMENDMENT NO. 1241 TO AMENDMENT NO. 1239

(Purpose: To enhance breast cancer treatment)

Ms. SNOWE. Mr. President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Maine (Ms. SNOWE), for herself, and Mr. ABRAHAM, Mr. FITZGERALD, Mr. CRAPO, Ms. COLLINS, Mr. JEFFORDS, and Mrs. HUTCHISON, proposes an amendment numbered 1241 to amendment No. 1239.

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

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

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

Mr. FRIST. Mr. President, I yield 20 minutes, or whatever time is necessary, to the Senator from Maine.

The PRESIDING OFFICER. The Senator from Maine is recognized.

Ms. SNOWE. Thank you.

I thank Senator FRIST for his leadership on obviously what is a very challenging and very difficult issue.

I think even in spite of the debate that has occurred on some of these issues where there may be apparent differences on how to approach this problem, there is no disagreement on the fact that we need to bring much needed reform to the managed care system in America today.

Mr. President, I rise today to submit an amendment to the Patients' Bill of

Rights that will ensure that appropriate medical care—not a bureaucrat's bottom line—will dictate how long a woman stays in the hospital after undergoing a mastectomy.

This amendment that I am introducing, along with my colleague from Michigan, Senator ABRAHAM, and Senators FITZGERALD, CRAPO, COLLINS, JEFFORDS, and HUTCHISON, is based on bipartisan legislation that I was pleased to introduce at the beginning of this year with bipartisan cosponsors.

I have been in Congress for 20 years—10 of those years in the House when I served as cochairman of the Congressional Caucus on Women, which addressed issues that affected women and families in America on a bipartisan basis. Throughout that time, I fought long and hard to advance women's health issues, women's health research, and protection for patients who are facing life-threatening diagnoses of breast cancer.

I feel justified in saying that I come to this debate not only with strong feelings about the issue but with a long history of involvement and close familiarity with the problem. It is in that light, I believe, that the amendment I am submitting today, along with Senator ABRAHAM and my other colleagues, is the most effective approach to address the issue of those individuals who are faced with breast cancer.

Our amendment is straightforward. First, it says that the inpatient coverage with respect to the treatment of a mastectomy, regardless of whether the patient's plan is regulated by ERISA or State regulations—in other words, all plans will be provided for a period of time—will be determined by the attending physician in consultation with the patient as medically necessary and appropriate.

Second, it allows any person facing a cancer diagnosis of any type to get a second opinion on their course of treatment.

Imagine having a life-threatening disease and not having access to the best possible advice. A diagnosis of breast cancer is something that every woman dreads. But for an estimated 175,000 American women, this is certainly the fear that they have to realize. The fact is that one in nine women will develop this terrible disease during their lifetime, and for women between the ages of 35 and 54, there is no other disease which claims more lives.

So it is not hard to understand why the words, ''You have breast cancer,'' are some of the most frightening words in the English language, because for the woman who hears them, everything changes from that moment. No wonder the diagnosis is not only accompanied by fear but also by uncertainty:

What will become of me?

What will they have to do to me?

What will I have to endure?

What is the next step?

For many women, the answer to that question is mastectomy or lumpectomy.

Despite the medical and scientific advances made, despite advances in early detection technology, and more and more often the need for radical surgery, it still remains a fact of life that at the end of the 20th century these procedures can be the most prudent options in attacking and eradicating cancer found in a woman's breast.

These are the kinds of decisions that come with the breast cancer diagnosis. These are the kinds of questions women must answer. And they must endure some of the most difficult and stressful circumstances imaginable.

The last question a woman should have to worry about at a time like this is whether or not her health insurance plan will pay for appropriate care after a mastectomy. A woman diagnosed with breast cancer in many ways already feels she has lost control of her life. She should not feel as though she has also lost control of her own treatment. All too often that is exactly what happens.

Imagine a patient who just had one or both of her breasts removed in the wake of a cancer diagnosis, and she agrees in consultation with her physician that it would be best if she stayed in the hospital for another day or so. Maybe it is because she still needs to learn how to take care of herself. Maybe there are concerns about the possible complications, like infections or uncontrolled bleeding.

Let's remember that this is a very complicated surgical procedure we are talking about. What other reason is the decision based on than medical advice from doctors who are likely involved with hundreds of thousands of these kinds of operations? Yet in many instances, because of the decisions made by accountants and insurance actuaries—none of whom have ever witnessed such operations, let alone go to medical school—that same woman cannot afford to follow her doctor's advice. She is not covered by her plan because whoever wrote her plan already decided that she didn't need inpatient care. Instead, that charge for that extra day in the hospital will come out of her own pocket, and unless it is an awfully deep pocket, she is just as likely to take her chances at home. That is just plain unacceptable.

If we are talking about patients' rights, I can't think of a more appropriate place to start than right here. That is why I appreciate that my Democratic colleagues raised this vital issue. As I have said, no one is more concerned about this issue than I am.

I looked carefully at the amendment and watched the debate very closely. But when all was said and done on this issue, and despite the good intentions of the amendment, I could not support the amendment that was offered yesterday by our colleague, Senator ROBB. Let me tell you why.

The Robb amendment relied on the phrase ''generally accepted'' medical standard to instruct insurance companies as to what constitutes a ''medical necessity'' that requires coverage. What exactly does that mean, ''generally accepted'' medical standard? That is a good question.

The fact is that we are not exactly sure what it means. In fact, the problem is that it means different things in different places. Moreover, there has never been a consensus concerning the definition of ''medical necessity,'' though it has not been for lack of trying.

The most recent Federal attempt, as a matter of fact, was in 1993 when the Clinton health care working group tried and failed. But they didn't give up. Instead, they decided to leave the definition of this crucial term not to physicians and their patients but to a national administrative board.

Perhaps that working group would have been better served if they looked to 1989 when Medicare tried to define ''medical necessity'' and Medicare failed. Medicare failed. Why did it fail? Because terms like ''medical necessity'' and ''appropriateness'' cannot be defined for an entire nation, and they certainly can't be defined by Congress.

The standards change with time, they change with individual patients, they change depending on the illness or disease, and they should change because medicine is marching forward.

Likewise, trying to define ''generally accepted medical standard'' is like hitting a moving target, and a low target at that. ''Generally accepted medical practices'' will vary tremendously among communities, hospitals, and even among doctors.

Just look at the chart behind me that was used yesterday by my colleague, Senator FRIST. It is a good chart because I think it illustrates the point on the very treatment prescribed for breast cancer patients. In some cases they use ''lumpectomy'' more sparingly than they do ''mastectomy.'' It obviously varies across regions and States.

Looking at the percentages using lumpectomy versus mastectomy treatments, very few were performed in South Dakota; but in the Northeast, including parts of New York, there is a higher degree of the use of lumpectomy versus mastectomy.

Obviously, the treatment varies. Obviously, the treatment is complicated. It is a very complicated treatment and set of options for a woman facing a mastectomy. As the chart shows, in the United States of America, the treatments vary all across the land. We cannot prescribe the status quo; we cannot prescribe uniformity. We have to allow the doctors and patients to have the latitude to determine what is best for the individual patient. We hear over and over again that the patient has choices. Let the patient have choices. This is allowing the patient to have choices as to what is in her best interest.

This chart illustrates very graphically the differences and the variations across the country in mastectomy and

lumpectomy surgeries. What is generally accepted in one area is not generally accepted or performed in another area. That is the way it should be. Should we be telling a woman who can be treated with a smaller, less invasive and less traumatic lumpectomy, Sorry, in your community, the generally accepted medical standard is a mastectomy? Of course not.

And the reverse is true. Should a woman have a mastectomy without knowing that she can have a lumpectomy first, to determine whether or not it is necessary to go to the more invasive surgery?

How can we say what is generally acceptable for a 31-year-old athlete in Oregon is generally acceptable for a 78-year-old grandmother in Maine?

The phrase ''generally accepted medical standard,'' far from representing the cutting edge of medicine, is nothing more than the medical community status quo, a status quo that simply cannot keep up with the pace of medical science and new technologies.

What we are talking about in this amendment is offering the best practice, the best standards, the best quality care. Think how far we have come in the past decade. Mastectomies were once virtually the only option. Today, we have a whole host of alternatives available, depending on the woman's circumstance. If a mastectomy is a generally accepted medical standard, there are other options a woman may be missing out on in making her decision.

The web site of NIH shows a variety of options available to a woman to determine for herself, with her doctors, what is best, depending on the progress of her cancer. She could have a lumpectomy; she could have a segmental mastectomy, a modified radical mastectomy, or, if necessary, even a radical mastectomy.

The fact is, hardly a day passes when we don't hear of a promising new treatment or a research breakthrough. Parties need to be able to take advantage of these advancements now. They can't wait for generally accepted medical standards to catch up with the times. Under this amendment, they will not have to.

In contrast, my amendment dictates coverage in terms of medical standards. If a doctor and a patient agree on a course of treatment of care and an insurance plan refuses to allow that treatment, the patient has a right to appeal to an independent medical expert in that field of medicine. In turn, that expert can take into account all pertinent information in determining what is medically necessary and appropriate based on the relevant scientific and clinical evidence. That includes evidence offered by the patient and her doctor, expert consensus of peer review literature.

Not only does this put the patient first, but it also ensures we are not lowering the bar of coverage by handcuffing the physicians in their ability to employ the best strategy, the latest medical technology, with respect to their specific patient. If anything, this amendment raises the bar precisely because the ultimate decisions will be driven by physicians and patients, not lawyers and regulators.

Let me add another point. I heard over and over again that the language offered in the amendment yesterday was the language offered in my bill and the bill offered by Senator D'Amato in the last Congress. Let me state for the record, the D'Amato-Feinstein-Snowe legislation offered in the last Congress was legislation that said it was medically appropriate—medically appropriate. It did not use the definition of generally acceptable medical standards and practices. The legislation offered by myself and Senator FEINSTEIN uses the word ''medically appropriate.''

The point I am making is, all of the bills that have been addressed in recent years on the issue of breast cancer treatment and whether or not the length of stay is to be determined by the doctor and patient have been using the words ''medically necessary,'' ''medically appropriate,'' not defining ''medical necessity.'' This would be the first time we are dealing with a definition of ''medical necessity'' which heretofore has not been practiced by Medicare, by the President's health care group, when developing a health care plan, not by CHAMPUS, not by the VA, not by Medicaid, not by legislation introduced on a bipartisan basis over the last few years.

Finally, my amendment will also include the ability to provide full coverage for secondary consultations with a specialist whenever any type of cancer has been diagnosed or a treatment recommended. Imagine being given a life-threatening diagnosis and not being able to get another doctor's opinion. Patients cannot afford to forgo second opinions when it comes to cancer of any kind—from lung cancer, to leukemia, to breast cancer, to prostate cancer. Under this amendment, they will not have to. That is important because we all know, when it comes to cancer, time is of the essence and making the right decision in terms of treatment is paramount.

So often there are no second chances when it comes to taking the best course of action. Our amendment will allow the possibility of having that second opinion and making sure people are getting the right treatment so we can reduce senseless deaths resulting from false diagnosis, empowering individuals to seek the most appropriate treatment available.

The evidence for the need of this amendment is especially important when it comes to the so-called drive-through mastectomies. It is more than just allegorical, more than symbolism. We have heard time and time again antecdotal evidence that speaks for itself. Between 1986 and 1995, the average length of stay for mastectomies dropped from about 6 days to 2 to 3 days. Thousands of women across the country undergo radical mastectomies on an outpatient basis and are being forced out of hospitals before they or their doctors think is reasonable or prudent.

I recall the story of one woman from the State of Washington named Linda Schrier. Linda was a registered nurse who worked in the postoperative recovery room for 18 years before she underwent a mastectomy. Linda was doing well after the operation. The pain was under control. She opted to go home instead of staying overnight. Today, she believes that was a big mistake. When Linda woke up at home the next day without the benefit of the IV pain medication she had in the hospital, she was in excrutiating pain. She also had tremendous difficulty caring for her wound.

Keep in mind, this is someone who worked in the medical profession. Today, she feels, very strongly, based on her own experience as a nurse and as a patient, that no one should go home the day of their mastectomy. She also believes that no insurance company should tell a woman how long her hospital stay should be. It should be up to a woman and her doctor.

I could not agree more. I know we all could not agree more. This decision must be returned to physicians and their patients. All Americans who face the possibility of a cancer diagnosis must be able to make informed decisions about the appropriate and necessary medical care.

As we debate the Patients' Bill of Rights this week, let us not forget the women and men across the country who are battling cancer. Let's do the right thing for all of them.

I yield back my time.

The PRESIDING OFFICER. The Senator from Washington.

Mrs. MURRAY. Mr. President, I have a great deal of admiration for the Senator from Maine, Ms. SNOWE, who, in my time with her over the last several years in the Senate, has worked long and hard on behalf of women's health issues. I appreciate she is offering an amendment that we offered yesterday on this side which deals with the issue of drive-through mastectomies. The language is very similar to the language offered by Senator ROBB from Virginia, along with myself, Senator MIKULSKI, Senator BOXER, Senator LANDRIEU, and Senator LINCOLN. It was defeated on a 52-to-48 vote yesterday.

We would have been delighted to work with our colleagues if they wanted to talk with us about a word or two about which they were concerned. We were not given that opportunity. The amendment was simply defeated.

We stand very strong on this side that we need to make changes in the health care delivery system in this country so that the woman from the State of Washington the Senator from Maine talked about is not sent home after a radical surgery, a mastectomy,

to care for herself when she is unable to do so. The doctor and the woman should make the decision based on the best medical judgment, not based on the bottom line from an HMO. I agree entirely with the Senator from Maine.

Unfortunately, because it is offered in this way, what this amendment does is it gives us a Hobson's choice regarding women who have had a mastectomy because this amendment wipes out the amendment by Senator DODD on clinical trials that we have debated for the last several hours on this floor, where we have talked about the need for women with breast cancer or ovarian cancer, or the gentleman with multiple sclerosis or the man with heart disease, or the young child with diabetes, to have access to clinical trials so they can get the best medical research possible.

Organizations such as the National Coalition for Cancer Survivorship, Cancer Care Incorporated, Candlelighters, Childhood Cancer Foundation, Susan G. Koman Breast Cancer Foundation, National Alliance of Breast Cancer Organizations—and the list goes on—want the access to clinical trials that Senator DODD's amendment offers because those are the clinical trials that will assure that women, maybe, in the future, will not have to have a mastectomy.

I agree with the Senator from Maine. We want to make sure HMOs are not having drive-by mastectomies, where a woman is sent home. I commend her for the language of her amendment, except for the very first line, which cynically wipes out the clinical trials that Senator DODD has offered.

Mr. DODD. Will my colleague yield?

Mrs. MURRAY. I will be happy to yield.

Mr. DODD. Mr. President, if I may inquire of my colleague from Maine—I appreciate immensely what the Senator from Washington just said. It sounds to me what the Senator from Maine has offered is something with which I could certainly agree. I would add it to my amendment. There is no reason we ought to ask people to make a choice between a proposal dealing with breast cancer and a proposal dealing with clinical trials and prescription drugs.

So I make a request that this be added to the clinical trials amendment so we could achieve the goals of both dealing with the clinical trials issue and the issue the Senator from Maine has raised.

If it is appropriate, I ask unanimous consent the amendment by the Senator from Maine be added to the underlying Dodd amendment on clinical trials.

Mr. JEFFORDS. Reserving the right to object.

The PRESIDING OFFICER. The Senator from Vermont.

Mrs. MURRAY. Mr. President, I am reclaiming my time.

The PRESIDING OFFICER. Is there objection?

Mr. JEFFORDS. Reserving the right to object, I would like to point out——

Mrs. MURRAY. Mr. President, is this on my time? I do have the floor.

The PRESIDING OFFICER. The regular order is to object or not object. Is there objection?

Mr. JEFFORDS. Objection.

The PRESIDING OFFICER. Objection is heard.

Mrs. MURRAY. Mr. President, I am extremely concerned, as I am sure my colleague from Connecticut is as well, that an objection was heard and we were not able to just add this language directly to the underlying amendment on clinical trials, because what the Senator from Maine has now done is forced us into a vote where we would be voting against clinical trials in order for women not to have drive-through mastectomies. That is not a choice Senators ought to be having.

In addition, what it says to women across this country is you have a choice, a mastectomy or a clinical trial. That is not a choice we should be offering.

I really hope our colleagues on the other side of the aisle will reconsider their objection to this and we can work this out. The people of this country are watching this debate, asking whether or not we are going to move forward and give patients the ability to have the best care possible. If we can work out this amendment and add it to the clinical trials, we will have done the people of this country a service.

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

Mr. JEFFORDS. Mr. President, I yield myself 5 minutes off the bill time.

The PRESIDING OFFICER. The Senator is recognized for 5 minutes.

Mr. JEFFORDS. Mr. President, I want to explain where we are right now. This monstrosity, whatever you want to call it, of a procedure which was set up by the leaders in negotiating back and forth leads us into these kinds of situations. We, on the Republican side, are trying to end up with the best bill, and we are intending to do that. This provision, which is offered by Senator SNOWE, is responding, to the extent that we desire to do so, to the question which has been raised about mastectomies.

If anybody would try to explain, even to our colleagues, as to this chart we use on the parliamentary procedure, we could spend the rest of the week just talking about that. What we are doing now is taking care of the issue raised with respect to women's health and mastectomies. We have a good provision. That is recognized by the other side. It is a fine position. Everybody ought to adopt it. We hope you do. I hope we get 100 votes on this amendment. We are going to take up and the other side will have an opportunity to reinstitute clinical trials at some point. This is the process that has been set up. We are trying to improve our bill, and by doing that we are going to make sure we have the best provision possible dealing with women with breast cancer. That is what we are doing.

The fact we attached it to a provision on clinical trials is the way the game is working back and forth. But we all, each of us, want to end up with the best possible bill for our side. Right now I point out we will have an amendment on clinical trials. That will end up eventually being in our bill which will be voted on at the end. People may disagree with what we end up with on clinical trials. They may have their own version. We will have a good provision. What we are trying to do right now is to make sure the best possible policy is established for women with breast cancer. So I hope people will try to understand this somewhat convoluted process is going to confuse you all the way along. You have to wait until the end to see what the final product is.

I reemphasize what the Senator from Maine said, as to what the Republican bill is across the board, the whole bill. It is different with respect to the protections people receive. For the first time, the Republican bill will provide to this Nation a standard which is the ''best medicine'' standard. It does away with the multiple standards across this Nation, about what is generally practiced in the area. This will give us the opportunity for every woman and every man to be able to get the advice as to what the experts, by analysis of all the processes that have been used, is the best medicine.

That is why this bill does a job in an area which has not been discussed much but we should concentrate on, which is AHCPR. That is the acronym for the agency which has been set up to learn what all of those interested in health care from the beginning of these great discussions starting in 1994 say we need to determine: How do you determine what the best results are?

How do you determine what the best results are? You set up a system where you can get outcomes research throughout this country, reporting of what was tried and what worked and what did not work.

As a result of that, we now will be able to help physicians across this Nation, under certain circumstances when problems occur, to know, about these following systems and methods, whatever was used to try to cure this disease or whatever, that these are the ones that worked. So that individual, trying to find out what kind of care they ought to get, will have the ability to first appeal it internally. If the doctor will say, ''I do not believe what the HMO tells me I should do is the best medicine,'' they could do that review internally. If they are not happy with the internal review, then they ask for an external review. This external review person must be an expert in the area, an independent person, one who can be relied upon to give an independent judgment. If that individual says, ''No we think the best care would be this process which across the Nation

has worked the best,'' then the decision can be made. If the patient desires it, ''I want the one that has been best across the Nation,'' they can get it. That is what we are talking about.

Right now we are in a convoluted process where people are going to be knocking amendments out with an amendment that may even be in a different area, but in the final analysis when we get to it tomorrow night, we expect to have a bill which will provide the best possible health care to all Americans. It is a little confusing.

The PRESIDING OFFICER. The Senator's 5 minutes have expired.

Mr. JEFFORDS. I yield 5 minutes to the Senator from Maine off the bill time.

Mr. REID. I am sorry, I did not understand that, Mr. President. The Senator is yielding 5 minutes off what?

The PRESIDING OFFICER. Off the bill time. The Senator from Maine is recognized.

Ms. SNOWE. Mr. President, I thank Senator JEFFORDS for his comment and for yielding time.

I want to clarify a few points that were made earlier because I do think it is important it does not get lost in the debate.

The amendment I am offering is not the amendment that was offered yesterday. The language is not identical. I thought I had made that abundantly clear. It is different from the D'Amato-Feinstein-Snowe legislation passed in the last Congress. It is different from the Snowe-Feinstein legislation offered in this Congress. It is different from the Feinstein-Snowe legislation because medical necessity is not defined, and that is the issue.

Secondly, the Robb amendment did not have a second opinion for cancer patients. That is included in this legislation.

This amendment is offered to the Republican legislation; that is, the substitute that was offered by the minority leader. That is the process that has been developed on a bipartisan basis and on unanimous agreement. The Republican substitute does not have this language. The option was to offer this amendment at this point in time.

I should also make it clear the amendment that was offered yesterday by the Senator from Virginia was restated in the language that was already included in the Democratic legislation. So it is just restating a fact. We are in a position to offer this legislation to the Republican substitute, language that has not been included in the Republican substitute.

This is the process that has been agreed to. Therefore, that is why this amendment is being offered at this time. I had hoped we could have worked on it yesterday, but the Robb amendment was offered to the Democratic plan yesterday, and that was a second-degree amendment. We had no ability to perfect that amendment.

Mr. DODD. I ask my colleague——

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, I yield such time as the Senator may need.

Mr. DODD. Mr. President, before my colleague from Maine sits down, I know she cares about the clinical trials issue. She has one of the best bills on clinical trials, of which I am a supporter. What I have offered incorporates some of her ideas, some of Senator MACK's, and Senator ROCKEFELLER's ideas with the clinical trials.

I also agree with what my colleague from Maine is doing on mastectomies, on the breast cancer issue. I am perplexed a bit. We have a chance right now by taking the amendment of the Senator from Maine, of which I am supportive, and adding it to the clinical trials amendment, and we might just do something no one expects. We might actually do something in a bipartisan way on the Patients' Bill of Rights.

I do not understand why there is such objection to that. If we agree with Senator SNOWE and her amendment, if, by and large, we all agree on clinical trials, why does the Republican majority object to adding the Snowe amendment to the Dodd amendment, adopting both of them and moving on to the next amendment?

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

Mr. DODD. I will be happy to yield.

Mr. REID. It is true, is it not, I say to my friend from Connecticut, yesterday we had a drive-through mastectomy provision in the Robb amendment?

Mr. DODD. That is true.

Mr. REID. What I understand you are saying is, why don't we take that, which is in keeping with the amendment of the Senator from Maine, and——

Mr. DODD. I would take the amendment of the Senator from Maine, with all due respect to my colleague from Virginia.

Mr. REID. They are basically the same.

Mr. DODD. We agree on the clinical trials. We can put them together and move on to the next issue. That is what I recommend.

Mr. REID. Is it not true that the Senator from Connecticut asked unanimous consent that the clinical trials, which are so badly needed and on which we understand there is agreement, be accepted with the drive-through mastectomy?

Mr. DODD. I asked for that and objection was noted by the Republican majority.

Ms. SNOWE. I appreciate and applaud the leadership of Senator DODD on clinical trials, and I wholeheartedly agree——

Mr. JEFFORDS. I yield the Senator from Maine 5 minutes on the amendment.

Ms. SNOWE. I thank the Senator. It does obviously represent the legislation that I introduced on this issue. I appreciate the Senator's forceful advocacy. Obviously, the issue is concerning scope at this point in time. I might agree with him on what he is attempting to do, but obviously there is a big difference in our legislative approaches with respect to scope. There are differences. Perhaps that ultimately can be worked out on the whole issue of clinical trials, and I hope it is. I believe it is that important. We were left in the position, given the scenario that has been developed on both sides, because I think this is so important, of having to offer it at this point in time or I lost the opportunity. We think it is important to add this language to the Republican substitute. We lost an opportunity yesterday, to be honest with you, with the amendment that was offered to the Democrat's plan. We are left in this parliamentary process at this point in time.

Mr. DODD. If my colleague will yield, I gather it is not just her voice but obviously other voices here—the leadership. May I interpret that to mean that if I were to offer my clinical trials amendment as a freestanding proposal, I would then have her support of that proposal so we are not asking ourselves to make a choice between two items we like, and instead of adding one to another, we are substituting one for another; therefore, being put in a terrible parliamentary situation, unnecessarily, in my view. I am fearful if I offer my clinical trials amendment freestanding as to whether or not I will be able to have the Senator's support on that, maybe even as a cosponsor.

Ms. SNOWE. I will look at the language. I would certainly want to support it. I know it does not include FDA-sponsored trials. I cannot speak for everybody in this conference or in this Senate, but certainly it is something I could support and obviously do support, given the legislation I have introduced in this Congress. I will be more than happy to do that.

At this point, we have to address the issue of mastectomies. It is that important to this legislation. We lost an opportunity to improve upon the Robb amendment, because that was a second-degree amendment offered yesterday, and, obviously, that created another Hobson's choice.

Mr. DODD. Parliamentary inquiry.

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

Mr. DODD. Parliamentary inquiry.

Mr. KENNEDY. I yield the time necessary for the parliamentary inquiry.

Mr. DODD. Mr. President, am I allowed to withdraw my amendment?

The PRESIDING OFFICER. It would take unanimous consent.

Mr. DODD. To withdraw my amendment.

The PRESIDING OFFICER. That is correct.

Mr. DODD. I thank the Chair.

Mr. ROBB. Mr. President, will the Senator from Maine yield for a question with respect to the process?

The PRESIDING OFFICER. The Senator from Maine.

Ms. SNOWE. Do I still have the time?

Mr. JEFFORDS. Mr. President, I yielded the Senator from Maine 5 minutes.

The PRESIDING OFFICER. The Senator from Maine is recognized for 5 minutes.

Mr. ROBB. I thank the Chair, and I thank the Senator from Maine.

Yesterday, when we were debating the amendment I had the privilege of offering on behalf of myself and Senators MURRAY, MIKULSKI, BOXER, and others, we had no one from the other side of the aisle here to debate or discuss that during the entire period we were discussing that particular amendment. In a few minutes I am going to address the merits of what was said, but nothing was said, no engagement on the merits of the amendment that we offered was offered by anyone from the other side of the aisle. Was there a decision not to engage this side? Does the Senator know how to respond to that?

Ms. SNOWE. I was not aware of that. I was certainly not aware what was taking place on the floor. We were aware the Senator from Virginia was offering an amendment. I was aware, in fact, he was offering an amendment, but there was no strategy on this side to suggest we would not engage in that debate. I think there was some discussion on this side about the debate. I do not see that is a valid objection at all.

Mr. ROBB. I am only responding to the concern there was not adequate time for discussion. We were actively seeking engagement on this question, and it did not occur. I look forward to talking about the merits on my own time.

I thank you and I yield the floor.

Ms. SNOWE. Mr. President, I still have some remaining time.

I would like to make a point. I think the point is, there are substantial differences between the legislation offered by the Senator from Virginia yesterday and the legislation we are offering in this amendment. We are not defining ''medical necessity.'' As I indicated previously, there has been no other legislation on this issue that defines ''medical necessity,'' legislation that has been introduced on a bipartisan basis over the last few years.

That is going to take away from women the variety of treatments and prescriptions for breast cancer, as you can see what is illustrated on this chart. I think we ought to opt for the best treatment, the best practice, the best standard, and the best principles. No one else, no professional, no government agency, no private association with medical credentials has defined ''medical necessity'' because you can't.

Leave it up to the doctor and the patient. That is what we are asking with respect to women who have breast cancer. That is a huge difference between this amendment and the one that was offered yesterday. By the way, the language offered yesterday was already included in the minority's plan, so it did not have to be restated. I think we could have worked something out that we could have agreed to on a bipartisan basis, as we already have in legislation that has been introduced on this very issue.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. I yield 7 minutes to the Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized for 7 minutes.

Mr. ABRAHAM. I thank the Senator from Vermont. I think I will be finished in that time frame.

Mr. President, I would like to speak to the Snowe amendment substantively at this point. As I have a number of times over the past few years, I rise to join her in sponsoring an amendment to address the incidence of breast cancer in this Nation.

This year alone, 180,000 women will be diagnosed with breast cancer. Yet, in this Nation of vast medical resources a number of those women are being denied the best health care available. It is time we did something about it.

I have made increasing awareness and funding for breast cancer research a central part of my agenda since coming to the US Senate.

That is why I have fully supported the efforts of Breast Cancer Awareness Month, the Race for the Cure, and WeCan. This last organization, which stands for ''We Encourage Cancer Awareness Network,'' brings together people we are interested in cancer control and prevention in Michigan, with a focus on breast and cervical cancer.

Awarness is important. Breast cancer survival rates are much higher when the disease is diagnosed early.

That is why I have participated in a number of campaigns aimed at encouraging women to have regular mammograms. It also is why I fought the National Cancer Institute's short-lived recommendation against all women in their forties getting mammograms.

As I said, awareness is critical. But it is not enough. Research also is desperately needed to fight this deadly disease. That is why I have supported Defense Department research in this area and cosponsored an amendment to the Treasury-General Government appropriations bill in 1997 to authorize creation of a new stamp to fund breast cancer research.

Like awareness, research is critical. And like awareness, research is not enough. Women must be empowered to make the best use possible of existing research and technologies in fighting breast cancer. And that means putting health care decisions in the hands of patients and their doctors.

The Women's Health and Cancer Rights Act, which my colleague and I are offering as an amendment to the underlying bill, would empower women; it would help them take charge of their own medical care during the time of crisis surrounding a breast cancer diagnosis.

Our amendment would require all—and I mean every—group health plan to cover inpatient care following a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer.

The length of stay would be determined by the physician, in consultation with the patient, and would be based solely on what is necessary and appropriate for that patient.

There would be no minimum stay required, and outpatient treatment would also be covered if the patient and her doctor agree that that is the best course.

Under current law, insurers may have guidelines recommending that mastectomies be performed on an outpatient basis. But a mastectomy is, in fact, a complicated surgical procedure, one from which significant complications can arise.

Under these circumstances, sending a woman home immediately after a mastectomy may not be the right thing to do. The woman may not have the information she needs, or even the care she needs during this critical time.

We must see to it that doctors are not pressured by health plans to release mastectomy patients before it is medically appropriate.

Women suffer immense emotional trauma from mastectomies. They also suffer from scarring and may suffer from significant and even dangerous complications hours after surgery.

It simply is not appropriate, then, to have anyone other than the patient and her physician deciding when it is safe and proper for her to go home.

Our amendment does just that. It allows patients and their physicians to make the critical, life-changing decisions concerning how to treat breast cancer.

In addition to these provisions, our amendment would help patients diagnosed with cancers of all kinds by empowering them to seek second opinions.

Under the language of this amendment, patients diagnosed with any form of cancer by their primary care physician would be able to get a secondary consultation with a specialist. Group health plans would be required to include coverage for these visits.

Even if the specialist finds no cancer, the health plan would be required to cover that visit. And members of HMOs will still be covered if they go outside the HMO for their secondary consultation.

These provisions will defend a patient's right to a second opinion in addressing a cancer diagnosis. In a nation with the vast health care resources of our country, there simply is no excuse for not allowing patients to seek an independent second opinion when dealing with a cancer diagnosis.

This amendment would place these key health care decisions in the hands of patients and their physicians. It will put the priority back on patient care, where it belongs. It is an important element of our ongoing fight against cancer, and breast cancer in particular.

I urge my colleagues to lend their support for this important amendment.

I yield the floor.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I would like to yield myself 3 minutes.

Could I have the attention of the Senator from Michigan just for a moment?

I notice on page 3 of the amendment, talking about ''Inpatient Care,'' under the title ''In General'' it states:

. . . the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate. . . .

This is going to be universal. Why does the Senator from Michigan think we should protect a woman who has breast cancer and needs a mastectomy but not provide the same protection for a woman who has ovarian cancer and needs a hysterectomy. Why shouldn't we provide the same protection for someone who has brain cancer? Why do you believe this should be applicable to all HMO members—that a decision should be made by the doctor and the patient, using the best health guidelines—but not provide the same protections for these other diseases? What is the justification for this different treatment? Our bill does provide those protections.

These are in the findings, on page 3, under the ''Inpatient Care,'' ''In General.'' You provide:

. . . is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate. . . .

You do it for a mastectomy, a lumpectomy, and for a lymph node. Why do it universally for all HMOs for these three procedures yet not provide the same protection for women with ovarian cancer, brain cancer, or other illnesses? That is what we would like to know. Because our bill would provide protection for all of these illnesses; yours for just one. What is possibly the rationale and justification for that?

Mr. ABRAHAM. Mr. President, I will answer with respect to this—would it be on your time?

Mr. KENNEDY. Yes.

Mr. ABRAHAM. Obviously, a number of people have worked in this area of breast cancer treatment. I believe Senator SNOWE, who has been the foremost leader on this in the Senate on working on this issue, will probably comment on this as well. We are attempting to work on getting legislation which she has spearheaded in the Senate into this bill.

I have no idea what other Senators may come to this floor with, with regard to other forms of cancer or other types of diseases or other types of treatment. They may well come here with such areas that are specialty areas and offer similar amendments. I would defer to them to do that. This is an area we are working on which we think, in fact, is justified in this respect and which is consistent with last year's amendment on reconstructive surgery.

The PRESIDING OFFICER. The Senator's 3 minutes have expired.

Mr. KENNEDY. Mr. President, I yield myself 2 more minutes.

It isn't a question of the particular process or procedure. The amendment says ''as determined by the attending physician, in consultation with the patient, to be medically necessary.'' Why not use that standard on any of the other kinds of health care needs? Why apply this standard nationwide on the question of mastectomy and not provide it for protection of other areas health needs?

Mr. ABRAHAM. Which standard is that?

Mr. KENNEDY. As is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following a mastectomy, lumpectomy, or a lymph node dissection.

I am asking you, why can't you use that same protection: by the attending physician, in consultation with the patient, to be medically necessary, leaving it up to the doctor? That is what you do for these three procedures. You leave it up to the doctor.

Mr. ABRAHAM. Perhaps the Senator could direct the question to somebody who voted on the other side of that issue yesterday.

Mr. KENNEDY. That is what I am asking.

Mr. ABRAHAM. I voted yesterday, when we had the issue of medical necessity.

Mr. KENNEDY. Does the Senator agree——

Mr. ABRAHAM. That is how I voted yesterday. So perhaps the Senator should ask somebody who voted against it yesterday.

Mr. KENNEDY. Good. So if I understand—the Senator can obviously answer any way he wants to—you believe that decisions with regard to health care ought to be decided by the doctors and their patients?

Mr. ABRAHAM. That is how I voted yesterday.

Mr. KENNEDY. When we came to the scope amendment, would you agree then that we ought to apply whatever we are going to do with the 48 million self-insured to the other ⅔ of Americans left out under the Republican plan?

Mr. ABRAHAM. In general principle, I believe that these areas in which the Federal Government has not chosen to oversee, where the scope has already been provided to States to address—in my State, very aggressively—that we shouldn't preempt the significant progress that has been made in Michigan. I don't want to come to the floor to wipe out what I consider to be very effective patients' rights laws that my State has passed, which a scope amendment that would cover every single plan in every setting would have done in my State. There may be Members who have States that are in various ways deficient and ineffective. They may want to supersede what they have done. But this Senator chose not to, at least with respect to my State.

The PRESIDING OFFICER. The Senator's 2 minutes have expired.

Mr. KENNEDY. I yield myself 15 seconds.

There isn't a single State in the country that has that kind of protection. I know my friend from Vermont keeps insisting the State of Vermont does. We will give him that. But there isn't a single other State, if Vermont complies with those kinds of protections.

I yield 5 minutes to the Senator from California.

The PRESIDING OFFICER. The Senator from California is recognized for 5 minutes.

Mrs. BOXER. I thank the Chair.

Mr. President, I feel really bad about what is happening here. Every single amendment, the people lose and the HMOs win.

There is a cruel irony in the Snowe amendment, which the Senator from Connecticut tried to repair and could not. Let me tell my colleagues about the cruel irony of the Snowe amendment.

That amendment treats women who need mastectomies with dignity, and I am for that. That is why I supported the Robb amendment yesterday, and that is why I agree with the Snowe amendment. But let me tell my colleagues what else the Senator from Maine does that makes this a real cruel irony. At the same time she gives dignity to women who have to undergo mastectomies and gives them bed care, she strikes the Dodd amendment which would allow those same women to choose another option other than mastectomy by getting into a clinical trial.

To explain that specifically, I have a dear friend who I have known for many years. She was diagnosed with breast cancer. The doctor said: You have three alternatives: One, you can get into a clinical trial on tamoxifen; two, you can get into a clinical trial on a new drug called reluxifen; three, you can have a double mastectomy. My friend wanted to avoid the mastectomy. She is doing everything she can to get into a clinical trial, and she is reaching obstacle after obstacle after obstacle.

The Dodd amendment says, if someone is in need of a different type of therapy—and it is very tightly drawn—they have a right to get into that therapy.

What the Snowe amendment says to women is: Yes, my dear, if you need a mastectomy, we will treat you fairly. That is good. But, no, my dear, we cannot guarantee you the right to get into a clinical trial to avoid that amputation, as my friend from Maryland called it yesterday.

That is just one example, a personal example of someone I know. There is no reason we can't get around the parliamentary hurdles. We are good at

that. We know how to do it. As a matter of fact, I am going to make a unanimous consent request at the end of my remarks, I alert the Senator from Vermont, to solve our problem and to put the two together, the Snowe amendment and the Dodd amendment.

The Dodd amendment ensures that if your doctor says you need a certain type of drug to solve your health problem, your HMO cannot keep that prescription drug away from you by claiming it is not in their formula.

Here we have the Snowe amendment, which takes a giant step forward in the treatment of women with mastectomies but, at the same time, strikes the opportunity for women to get into clinical trials to get the drugs they need that are necessary to give them their health. This is a sad day.

What is the response from the Senator from Maine? Gee, I am sorry about this; it is parliamentary.

I am very sad. I have never seen the Senate be as partisan as it is on this issue. This is a sad, sad day. What happened to the days of Kennedy–Kassebaum? It wasn't that long ago that we worked together when we could agree. I think the American people are the losers, and women are the losers.

Yesterday, we had a situation on this floor—I have handed out on each desk an example of this—where Senator ROBB offered an amendment. Senator ROBB said that OB/GYNs want the right to be primary care providers. Senator FRIST stands up and says: They don't want to be primary care providers. He quoted a particular doctor and said this doctor, an OB/GYN, doesn't want to be a primary care provider.

That was false. That was false. I have the proof right on your desk. This doctor says:

> Senator FRIST's misuse of my statement in support of his position that OB/GYNs could not act as primary care physicians . . . is, to say the least, misleading and does an injustice to the true intent of my statements.

He supports OB/GYNs being designated as primary care providers.

Then a letter from the organization that says it is imperative that doctors who are OB/GYNs be primary care providers.

Let's stop the misstatements, and let's put together the Dodd amendment and the Snowe amendment.

As a matter of fact, I ask unanimous consent that S. 1344 and the Daschle substitute amendment be modified with language from the Snowe amendment No. 1241 prohibiting drive-by mastectomies and requiring coverage for second opinions, and this will keep the clinical trials and the drive-by mastectomies provision.

The PRESIDING OFFICER. Is there objection?

Mr. JEFFORDS. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. KENNEDY. Mr. President, I yield myself 20 seconds.

Under the Senate rules generally, as the Senator from California knows, if we were not forced into this agreement, the Senator from Connecticut could modify his amendment to include that. We have tried to get this legislation to the floor so that we could follow the historic rules of the Senate and were precluded from that, basically forced into this time element, voting Thursday evening. But we are getting very close to the point where we will not have the opportunity for having a full airing of these issues. We are getting very close to where some of us will believe that there has not been the full, complete fulfillment of the agreement. These issues may very well be left outstanding for future considerations.

We are getting very close to the point, Mr. President, where you have such a basic corruption of the rules. By denying what has historically been the rule—that would have permitted a Senator to modify an amendment prior to the time they get the yeas and nays—we are close to having a basic corruption of the rules. We had an agreement, and we are sticking with that agreement. Nonetheless, it will delay the Senate and frustrate, obviously, the opportunity for the good debate.

I yield 5 minutes to the Senator from Maryland.

Ms. MIKULSKI. Mr. President, we are at a fork in the road today. We are at a fork in the road to show whether we really are engaged in a debate over partisan politics or whether we are engaged in a debate over how we can best help patients in the United States of America.

I urge my colleagues, in the situation we now find ourselves, to put partisan politics aside and reach out to what is in the best interests of patients, what is in the best interests of the people of the United States of America. That is why I think the suggestion of taking the Snowe amendment and attaching it to the Dodd amendment would show the American people that in this debate, at this time, at this moment, we are willing to put patients above politics. That is what I hope we can do.

There is much to be commended in the Snowe amendment. It is a very good amendment. I congratulate the Senator from Maine on this amendment. I would so like to support it. Unfortunately, it knocks out the Dodd amendment providing patients with access to clinical trials.

The Senator from Maine has had a longstanding reputation of really being an advocate for providing access to clinical trials. I recall with great fondness our battles, going back to the days in the House of Representatives, when she and Congresswoman Schroeder cochaired the women's caucus. We fought to get women included in the clinical trials at NIH. The Senator from Maine and all others will recall when we were systematically excluded. We worked together on a bipartisan basis when she came to the Senate. Working with her, Congresswoman MORELLA, and Congresswoman Schroeder, we were able to literally call NIH's bluff on their shallow and unscientific reasons for not including women in clinical trials.

When President Bush appointed Bernadine Healy as head of NIH, Senator KENNEDY and I worked to establish the Office of Women's Health at NIH, and now women are included in the clinical trials. What a hollow victory it will be today if we deny them the access to the very clinical trials we fought so hard to open up for women.

I am sorry we have come to this. At this fork in the road, let's not make another fork in the road over partisan politics. We can show the American people that we really want to be concerned about patients. We have done it before. We have done it with the people in this room. Some of the greatest pleasures and joys of my life have been working on a bipartisan basis, opening up clinical trials and establishing quality standards for mammograms.

So I am going to offer one more opportunity, and I plead with my colleagues to allow this to happen. I want to have the Snowe amendment attached to the Dodd amendment.

Therefore, I ask unanimous consent that S. 1344, the Daschle substitute amendment, be modified with language from the Snowe amendment, No. 1241, prohibiting drive-through mastectomies and requiring coverage for second opinions.

The PRESIDING OFFICER. Is there objection?

Mr. JEFFORDS. Objection.

The PRESIDING OFFICER. Objection is heard.

Mr. JEFFORDS. Mr. President, I yield 1 minute to the Senator from Texas.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, I have to take exception to the comments that Senator KENNEDY made. I am not trying to get into an argument, but as anyone who has followed this debate knows, for 2 years we have offered the Democrats the ability to bring up their bill. Then we would bring up our bill and let the Senate choose. The Democrats dictated the format we are debating under, and they would not allow us to pass an appropriations bill until they got exactly the procedure they have today. Now that they have exactly the procedure that they dictated by holding the Senate up, they are unhappy with the procedure.

Might I also say, with all of these cries of partisanship, not one Democrat voted for any amendment offered by any Republican yesterday or Monday. Now, I don't understand bipartisanship as existing when Republicans vote to let the Government take over the health care system and to bring lawyers into the system rather than doctors but it is somehow not bipartisan when Democrats refuse to vote for our proposals. You can't have it both ways.

Mr. KENNEDY. I will use 30 seconds, Mr. President. The Senator had better get his facts straight. We have just offered to accept the amendment of the

Senator from Maine. Yesterday the Democratic leader offered to accept the Nickles amendment on deductibility. So the Senator is fundamentally and actually wrong.

I yield 5 minutes to the Senator from California.

The PRESIDING OFFICER. The Senator from California is recognized.

Mrs. FEINSTEIN. Mr. President, my heart is heavy because, as I believe the Senator from Vermont knows, I was the lead Democratic sponsor of the D'Amato bill on mastectomy and cancer rights in the last Congress. Then Senator SNOWE became the lead Republican author on it when Senator D'Amato left the Senate and I am the lead Democratic sponsor in this Congress. So I feel very strongly about this bill and the amendment before us.

But what I see in the tactics being used is of very deep concern to me. Yesterday, we saw the Frist language on medical necessity essentially wiping out the Democratic language requiring that medical necessity be based on generally accepted principles of medicine. Our amendment would have covered a hospital stay for mastectomy as well any other hospital stay, by simply giving the physician the responsibility to make the call on how long a patient should stay in the hospital.

Now we have these individual cases like hospitalization for mastectomy. It is a very strong case that the Senator from Vermont makes. I myself saw, in 1996, where a major HMO in California was doing a same-day mastectomy and women who had surgery at 7:30 in the morning were being pushed out on the street in the afternoon, not recovered from anesthetic, with drains in their body, not knowing where they were or how to care for themselves. That simply is not the good practice of medicine.

So I think all of us have resolved that we want to do something about this situation. But at the same time, you give us a Hobson's choice, and that is unfortunate because Senator Dodd's amendment, requiring plans to cover the routine costs of clinical trials, is a good amendment.

I am the vice chairman of a national cancer dialogue initiated by the American Cancer Society. President George Bush is the chairman. Not too long ago I had the pleasure of spending the day with President Bush on one side of me and Mrs. Bush on the other while I chaired a meeting of the cancer dialogue. One of the outstanding results of that particular day was strong support for more access to clinical research trials. The entire clinical trial research effort is not going to be successful unless there is more access to these trials, and particularly by the minority population where participation is very small, largely because managed care plans do not cover the non-research, routine costs of care.

Therefore, Senator DODD's amendment is timely, it is necessary, it is scientifically correct, it will help us speed these trials, add more trials, and it will mean a quicker cures for diseases if we pass the Dodd amendment.

The Hobson's choice, for those of us who have worked on this now for over 3 years, is that by voting for Senator Snowe's amendment, we negate the Dodd amendment. That is not right. It is not good medicine. It is not good politics.

I, too, join in complimenting my colleague and friend from California and the Senator from Maryland, both of whom spoke eloquently on this. Please, please, please don't do this.

Senator DODD asked that his amendment be modified to include the Snowe amendment in his amendment. Twice I heard the Senator from California and the Senator from Maryland propound a unanimous consent request. I am also going to do the same thing. Don't present this body with this kind of Hobson's choice. Both amendments are necessary. Don't wipe out the clinical trials coverage amendment while attempting to put in patient protections for cancer patients. The American public deserves to be able to participate in clinical trials which, after all, could save your life, save the lives of the women of America, and men, because breast cancer affects men too. My father-in-law died of breast cancer when my husband was 10 years old.

Please, don't do this.

I, too, propound a unanimous consent request. I ask unanimous consent that S. 1344, the Daschle substitute, be modified with language from the Snowe amendment No. 1241 prohibiting drive-through mastectomies and coverage for second opinions.

The PRESIDING OFFICER. Is there objection?

Mr. FRIST. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. JEFFORDS. Mr. President, I yield the Senator from Tennessee 5 minutes.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Mr. President, very briefly—I will not take 5 minutes—a number of issues have been discussed. Let me comment on a couple of issues.

The first has to do with some statements made by my colleague from California about obstetricians and primary care specialists; second, about clinical trials; and, third, scope.

I know my colleague from Texas has been waiting. I will conclude my remarks in 2 minutes, and then, hopefully, we can turn to her.

No. 1, do obstetricians want to be designated by their managed care companies to be primary care physicians? It sounds as if they do.

I have to say that if you are a primary care physician—that means if you are responsible for that managed care company, insurance, group, plan, or HMO—you are responsible really to become the gatekeeper. That means you have a specialist, obstetrician or gynecologist, who wants to be able to take care of the woman as a whole but doesn't necessarily want to take care of her ingrown toenails, appendicitis, headaches, or laryngitis.

That is the danger. It sounds good to say the OB/GYN is the primary care specialist for the patient. They are the primary care physician, the gatekeeper. That means the OB/GYN is going to be doing things that they are simply not trained nor want to do.

What women want in this country is to at any time be able to go to their obstetrician or gynecologist, whether it is an emergency or not, for routine care. That is what our bill does. That is what the American people want—to remove the barriers that exist today.

Yes, we need legislation. That is what our bill does. It drops that barrier so at any time a woman can go to, and be taken care of by, their obstetrician and gynecologist. It is in our bill.

The designation of ''primary specialist'' sounds benign. In truth, they are dangerous to the system. Obstetricians as a group may want it, and some may not.

I quote on behalf of 100 patients and provider groups, The Patient Access Coalition. They talk about these specialist amendments. They write to us very specifically:

> We do, however, wish to express concern about specialists being defined as primary-care providers.

It is very important that people do not come in and legislate and make them primary care providers. We want to remove the barriers to access to specialists. That is what we do.

No. 2, clinical trials. Again and again, the Dodd bill has some very good points in it. We are for clinical trials. We believe clinical trials should be part of the system, and I have spent most of the morning talking about that. But we don't know the overall cost. Before we know that cost, a managed care company is going to take care of that mandate from here, and they will put it on sick people who are getting sick and paying the tax. We don't have any idea what it is.

The amendment that will be offered tomorrow by Senator MACK looks at the cost issues. It has a mandate to cover clinical trials in an appropriate setting and in an appropriate way, but not in an irresponsible way.

We remove the Dodd language. We take what is very good in his amendment, and we will build on it and have a better amendment for the American people.

On the issue of scope in the underlying amendment about breast disease and cancer, the reason this scope is different from the other things is, they wanted to make this particular amendment consistent with the D'Amato approach from last year that had this with mastectomy and reconstruction of a breast—a procedure. What we did—and what was done by the Senator from Maine—was very specifically match that scope for this type of disease in a way that is consistent. That is why

that scope is different. They are exactly right. There is some difference there.

Those are the three points I wanted to make on that.

I yield the floor.

Mr. KENNEDY. Will the Senator yield for a question on my time?

Mr. FRIST. I would be happy to.

Mr. KENNEDY. Last year the Republican proposal had this measure. Most of us who followed the Patients' Bill of Rights understood the reason for this measure. It was to get the Senator from New York, who felt so strongly about this provision, to support the overall Patients' Bill of Rights. When the Republicans introduced their bill this year, the provision was kept out. Now they are trying to put the provision back in.

Mr. FRIST. Does the Senator have a question?

Mr. KENNEDY. I am asking, is that not correct?

Mr. FRIST. That is incorrect.

Does the Senator have another question?

Mr. KENNEDY. No.

Mr. FRIST. I yield the floor.

Mr. KENNEDY. I will take 1 minute.

The fact is, that is exactly what happened. That is exactly what happened. I will put in the RECORD within the next hour this bill that showed that they took the provision out of this year's bill. I will put in the RECORD the bill that had the provision, and then the bill that took out the provision. Now the Republicans are trying to put the provision back in again after they voted against the Robb amendment. They now have the willingness of the principal sponsor of the amendment to accept it.

Who is playing games around here?

Mr. President, I yield 5 minutes to the Senator from Virginia.

The PRESIDING OFFICER. The Senator from Virginia is recognized for 5 minutes.

Mr. ROBB. Thank you, Mr. President. I thank my distinguished colleague from Massachusetts.

I am pleased that the Senator from Tennessee is on the floor.

First, let me observe that I see a disturbing trend as we consider the basic proposal to grant patients' rights, however defined. Every time we have a Democratic amendment, we find some small objection to it, technical or otherwise, causing everyone on the other side to have to vote against it with the promise that tomorrow we will resubmit it with a word or two changed so it will be acceptable to our side.

If my observation is incorrect, I look forward to being corrected.

Yesterday the Senator from Tennessee, Senator FRIST, took the floor to say that he supported 98 percent of the amendment I offered on behalf of myself and Senators MURRAY, MIKULSKI, BOXER, and others, but he had just a couple of objections to it. He stated that the problems with our amendment were such that he had to urge all Members to vote against it and it could only be fixed with the alternative that Senator SNOWE and Senator ABRAHAM would cover today.

At the time my friend from Tennessee was speaking, I asked if he would yield for a question. He declined to do so. That is, of course, his right. But since my friend from Tennessee would not yield during yesterday's debate for a question on his claims, I want to take just a minute to correct the RECORD.

First of all, Senator FRIST said he had spoken with the chairman of the American College of Obstetricians and Gynecologists' Primary Care Committee, Dr. Robert Yelverton. My colleague said Dr. Yelverton told him that OB/GYNs would not qualify as primary care physicians. A number of OB/GYNs took exception to the claim of the Senator from Tennessee that Dr. Yelverton told him OB/GYNs are unqualified, including Dr. Yelverton.

I received a fax this morning from Dr. Yelverton which clarified these comments for me and for our colleagues. Let me read part of what he said.

He said:

I have never spoken directly to Senator Bill Frist (R-TN) or any member of his staff on the subject of OB/GYNs as primary care physicians or on any other subject. The quote that Senator Frist attributed to me on the floor of the Senate today came from an article in the June 13, 1999, edition of the New York Times.)

He goes on to say:

Senator Frist's misuse of my statement in support of his position that OB/GYNs could not act as primary care physicians because of the ''high standards'' that managed care organizations set for primary care physicians, is regrettably misleading to say the least, and does an injustice to the true intent of my statements.

Again, I am quoting Dr. Yelverton. He went on to say:

I personally supported then and I support now the amendment sponsored by ACOG to allow OB/GYNs to act as primary care physicians and to allow direct access for women's healthcare and did, in fact, spend a portion of this very afternoon e-mailing my senators and encouraging them to vote in support of the amendment.

Mr. President, I ask unanimous consent to have the doctor's letter be printed in the RECORD.

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

To Lucia DiVenere, ACOG Government Relations.

From Robert W. Yelverton, M.D., Chairman, Primary Care Committee.

I received your fax tonight and offer the following in response.

I have never spoken directly to Senator Bill Frist (R–TN) or any member of his staff on the subject of OB/GYNs as primary care physicians or on any other subject. The quote that Senator Frist attributed to me on the floor of the Senate today came from an article in the June 13, 1999, edition of the New York Times. The article may be viewed on the New York Times website (go to www.nytimes.com, then click on Health and Science). I was contacted by the article's author, Larry Katzenstein, and asked to comment on the impact of managed care on women's healthcare in this country. In my interview with Mr. Katzenstein, I discussed ''barriers'' that managed care organizations have raised against the efforts of OB/GYNs to become primary care physicians. The quote attributed to me by Senator Frist was from a non-quote in this article. I told Mr. Katzenstein that some managed care organizations have placed barriers consisting of such stringent (not ''high'' as Senator Frist stated) standards for their qualifications as primary care physicians that most OB/GYNs would not be able to meet them without further training.

One objective of my comments was to demonstrate that the College's interests were to allow OB/GYNs to provide women's healthcare to their patients unimpeded by the cumbersome requirements of managed care referral systems. Mr. Katzenstein's article did not emphasize to the degree it should have that these were barriers to OB/GYNs being designated primary care physicians—not ''high standards''—as has been discussed repeatedly in meetings of the Primary Care Committee. I went on to say to Mr. Katzenstein that the qualification requirements that some managed care organizations impose on OB/GYNs in certain instances exceed even those required of family physicians. He chose not to include that statement in his article.

Senator Frist's misuse of my statement in support of his position that OB/GYNs could not act as primary care physicians because of the ''high standards'' that managed care organizations set for primary care physicians, is regrettably misleading, to say the least, and does an injustice to the true intent of my statements.

I personally supported then and I support now the amendment sponsored by ACOG to allow OB/GYNs to act as primary care physicians and to allow direct access for women's healthcare and did, in fact, spend a portion of this very afternoon e-mailing my senators and encouraging them to vote in support of the amendment.

Please contact me at (813) 269–7752 after 9:00 a.m. tomorrow (Wednesday). I will be glad to discuss this matter with you at that time and will support any effort that you want to undertake to clarify this issue now on the floor of the Senate.

Mr. ROBB. Mr. President, the same doctor my colleague quoted said the Republican arguments against our amendment are off base. Contrary to the comments of the Senator from Tennessee yesterday, the American College of Obstetricians and Gynecologists endorses our amendment.

I ask unanimous consent to have printed their letter on this issue.

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

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS,
Washington, DC, July 12, 1999.

Hon. CHARLES S. ROBB,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR ROBB: On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing 40,000 physicians dedicated to improving the health care of women, I am pleased to offer ACOG's strong endorsement of the Robb-Murray Amendment to be offered during Senate consideration of managed care reform legislation this week. This amendment assures women access to obstetrician-gynecologists and the critical services they provide.

The Robb-Murray amendment allows women access to their ob-gyns in two important ways. First, it allows women to select a participating obstetrician-gynecologist as her primary care physician. Second, if a woman chooses a primary care physician of another speciality, this amendment allows her to have direct access to her ob-gyn provider without having to secure prior authorization or a referral from her primary care physician.

It is imperative that women's direct access to their ob-gyns not be limited by Congress' failure to classify ob-gyns as primary care physicians. Ob-gyns are often the only physicians many women regularly see during their reproductive years. Insurers often put barriers between women and their ob-gyns. The Robb-Murray amendment would allow them to choose the type of physician they want.

In addition, the Robb-Murray amendment makes clear that direct access to ob-gyn care is not at a managed care plan's option but rather a guarantee for women. The amendment also provides women access to all ob-gyn services covered by their health care plans, not just a subset of those services designated by the plan as routine. Ob-gyn providers would also be able to order appropriate covered follow-up ob-gyn care, including referrals for related care, without prior authorization.

Thirty-seven states have acted to address these issues, but these laws do not protect the many women enrolled in self-insured plans. The Robb-Murray amendment extends meaningful direct access to ob-gyn care to women in federally regulated plans. ACOG applauds your efforts in offering this important amendment for America's women.

Sincerely,

RALPH W. HALE, MD,
Executive Vice President.

Mr. ROBB. I ask my Republican friends: What are their objections to the proposal to allow women access to care that they want and need? How do those who voted against our amendment yesterday, which is so important to American women, justify doing so?

I want to clarify something my colleague from Tennessee said about our proposal to guarantee that doctors and patients—not insurance companies—decide how long a woman stays in a hospital after a mastectomy. Senator FRIST criticized a provision in our amendment that said physicians shall make decisions about the length of stay in a hospital in accordance with ''generally accepted medical standards,'' arguing this standard would be used in determining whether a woman has a mastectomy, a lumpectomy, or a lymph node dissection.

I want the record to reflect that our amendment said nothing of the sort. The Robb-Murray amendment simply said that after a woman has had one of these procedures, a doctor and patient can then decide how long a woman stays in the hospital. That is what the amendment actually said. Our Republican colleagues are simply wrong when they say that the amendment would somehow apply to the decision of the kind of surgical procedure a woman undergoes.

Mr. President, I know there is a broader issue being debated over the definition of ''medical necessity'' and whether or not this definition is problematic. But that debate has nothing to do with the amendment we offered yesterday. Our amendment specifically said that physicians would be empowered to overrule insurance companies only when deciding how long a woman stays in the hospital after a woman has had a mastectomy, a lumpectomy, or lymph node dissection. Their argument that our amendment had a broader application is simply without merit.

The Republican arguments in this case against the mastectomy portion of our amendment were off base. Their argument against guaranteeing better care by an OB/GYN has been discredited by the doctor whom they quoted yesterday.

I hope we can come to some truly bipartisan resolution of these issues. They are important. They are important to women. They are important to all of the people in this country who are not currently covered. To restrict the scope of this amendment in such a way that specifically excludes women from having direct access to the type of health professionals with whom they are most comfortable is unconscionable.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized for 5 minutes.

Mrs. HUTCHISON. Mr. President, it seems to me in watching the debate yesterday and today, both sides of the aisle want access to better care for every American who is in some form of an HMO or managed care plan. I think we should acknowledge that we do have different approaches on how to get there.

We can summarize the differences in three ways:

No. 1, we are looking at the costs. Many Members are concerned that if we raise the cost of a premium, a family has worse than a Hobson's choice as our colleagues have complained we are giving them with regard to floor debate. If the cost of health care rises too much, millions of Americans will have no choice at all when they lose their coverage. That has to be a consideration.

No. 2, on the issue of who defines the standards, our amendments and our underlying bill put the emphasis on the patient and the physician. They give the patient the right to have an internal appeal and then an external appeal to make sure they get the quality of care the physician believes is best for that patient.

No. 3, it is a matter of access to lawsuits. We have to make a fundamental choice: Do you want good care or do you want good lawsuits? That is going to make a big difference in the longevity of the HMOs and their ability to continue to give health care service.

Do we need better service? Absolutely. I don't know anyone who hasn't had a complaint about an HMO. That is why I think our approach of an internal review with a time limit, an external, binding review process, again with strict time limits, by medical experts outside of the HMO is far preferable to costly litigation that can take years to resolve.

This has been tested. It has been tested in my home State of Texas. We passed an internal and external review process in Texas that has worked for over a year. Part of it has been struck down by a Federal court because they said it was a Federal law that takes precedence over the State law. Some of it has been knocked out. But it was working, and, on a voluntary basis, still is. People were satisfied they had the right to a quick appeal to get the care they needed. About half of the appeals were won by patients and about half by the health insurance companies, which tells me it was probably a pretty fair system. Most people want to have the quality care and a fair, quick system to redress their complaints rather than the ability to sue. Our bill would establish a national system very similar to that passed in Texas, but without creating new incentives to sue.

Quality care is prospective; a lawsuit is retrospective. If a person wants good care, they are not as interested in a lawsuit later. They are interested in getting the access that the patient and the physician is seeking.

The Snowe-Abraham amendment is a good amendment. It does add to the Robb amendment from yesterday. I think it is a better approach. Our approach, saying we are not going to have any arbitrary time limits on how long a woman can stay in the hospital if she has a mastectomy or a lumpectomy, is a good approach. Everything I have read says the quicker a patient can go home and be cared for at home, the better off they are and the more likely they are to have a quick recovery. However, if you have a problem, a complication in your surgery, we don't want an artificial time limit on the length of the hospital. That is what the amendment of Senator SNOWE and Senator ABRAHAM provides.

Secondly, we have heard a lot of discussion this week about whether an OB/GYN would be primary care physician designee for a woman. The underlying Republican bill provides that both OB/GYNs and pediatricians will have direct access to a woman, in the case of the OB/GYN, or for the parent and the child, in the case of a pediatrician. That is very important.

We have direct access. It is unnecessary to go through a gatekeeper in the Republican bill to see an OB/GYN physician for an OB/GYN problem; nor does a child who needs to see a pediatrician have to go through a gatekeeper. I think that is very important.

I do know a number of women who only go to an OB/GYN and don't have regular checkups, although I have tried to talk my friends into getting regular physical exams. I think it is important to have a full checkup. Nevertheless, many women don't do it. So at the very least, our bill assures that they will have direct access to their OB/

GYN, without going through a gatekeeper.

We are approaching this from different standards, there is no question about that. I think our approach is better. They think their approach is better. But I think we need to argue these points based on the merits. I think the Snowe amendment is a good amendment.

The issue of clinical trials will come up again. I believe there should be access to clinical trials to be paid for by HMOs, I really do. There is going to be an amendment on that. It will be somewhat different in approach. Again, the difference is going to be on who defines and what the standards are, and I think Senator MACK will have a good amendment that will be better than the Dodd amendment. Just as Senator SNOWE's amendment and Senator ROBB's amendment are very similar, but the differences are real, I think people will be able to make a choice. I think we are going to provide a very strong women's health care amendment with the Snowe amendment that will strengthen women's ability to have direct access to their OB/GYN and have the care they need based on consultations with their physicians, not a Federal rule that would have a one-size-fits-all approach.

Mr. President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. How much time remains, Mr. President?

The PRESIDING OFFICER. The Senator from Massachusetts has 11 minutes 2 seconds.

Mr. KENNEDY. I yield 9 minutes to the Senator from Connecticut.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, let's make that 8 minutes; let me know in 8 minutes so my colleague from Nevada and anyone else can be heard on this. I don't think I need that much time.

Regarding this issue of clinical trials and the issue that has been raised by Senator SNOWE dealing with breast cancer, I guess you could divide the country into two groups. There are those who have had to deal with someone in their family who was dying or was threatened with death because of a serious illness, and those who have not been through it yet. You will; whether it is someone in your own family or a neighbor, someone you feel deeply about. Then you will understand, if you are not in the latter category, what my amendment tries to do. That is why I think it is so outrageous that on five different occasions in the last 2 hours, an effort to join together the Snowe amendment with the Dodd amendment has been objected to.

It is incredible to me that we are in the Senate dealing with two issues that cry out for a solution dealing with breast cancer and how women are treated by HMOs and hospitals and the right to get a clinical trial if you are dying. On five occasions in the last hour, a unanimous consent request has been made that would allow these two amendments to be joined, and I suggest be agreed to unanimously. And on five different occasions objection has been heard.

Someone may think they are scoring a political point here. Try to explain that to the people in the waiting room at a hospital in any State in the country at this very hour. Try to explain that to a family member who is looking at someone in a bed who is plugged into about 50 tubes. The doctors said: Look, there is only one way your husband, your wife, your child is going to survive and that is if you get into a clinical trial. That is it. And at 1:05 on this day, the 14th of July, we have a chance to do something about it and we are not going to do it because of gamesmanship, because someone may score a point. Instead of taking these two amendments and doing what any reasonable American would ask us to do—not Democrat, Republican, conservative, or liberal—we are not going to do it. Explain it to someone who says my family member needs clinical trials; my family member needs to get that breast cancer treated.

I have listened today to the most incredible arguments against this clinical trial amendment. I wouldn't mind if there were questions about facts, but it is just not factual. We limit clinical trials. Let me tell you how we do it. There are five conditions you must meet before you can qualify for a clinical trial.

Only those clinical trials sponsored by NIH, the Department of Defense, and the Veterans' Administration qualify. That is No. 1.

No. 2, there is no other standard treatment available anywhere in America for you. If there is, you do not get into the clinical trial. I am glad my colleague from Tennessee is here because he raised these issues earlier. If there is another standard procedure available to you, you do not get the clinical trial under my amendment.

No. 3, you have to be suffering from a life-threatening or serious illness.

No. 4, you have to have the potential to benefit from the trial that would be covered.

Last, you only get routine costs. My colleague from Tennessee said if you are going to get a heart, it is going to cost you a lot more because that is expensive. This amendment says no, no, no; only the routine costs are compensated by the HMO, not the device, not the prescription drugs—only the routine costs, under my amendment.

I beg the leadership on the majority side, let us take the Snowe amendment and take the Dodd amendment, if you will, on clinical trials, and let's move on to the next issue and say to the American public on this question we agree. Ironically, the trade association for the HMOs agrees. They have sent out bulletins saying to their own HMOs: We think you ought to have clinical trials and make them available to people. How ironic that we are about to vote down the right to have clinical trials which the HMOs think they ought to have.

I gather an amendment will be offered. ''Wait until tomorrow. There will be an amendment tomorrow.'' Let me predict what the amendment will do. It will provide clinical trials for cancer. You tell that to someone who has AIDS or someone who has Alzheimer's or Parkinson's disease. You tell that family: I am sorry, we think clinical trials are OK for cancer but not OK for the other illnesses. What is the logic in that?

I think we have narrowed this pretty well. You limit it to NIH, Department of Defense, Veterans'; no other standard treatment is available in the country; you have to be dying; and it has to be able to treat the covered problem you have, and you only pay for routine costs, not for the devices or the equipment.

I am preaching to the choir when I talk to my colleague from Maine. She has written a good bill. I mentioned it earlier. Senator MACK has been on this bill, Senator ROCKEFELLER, others have been involved on a bipartisan basis. So my appeal in the last remaining minutes of this debate on this amendment is that we drop the objections, the five objections that have been raised. The costs on this are negligible. The estimates are 12 cents per covered patient per month—12 cents.

In fact, Sloan-Kettering Cancer Institute and the M.D. Anderson Center, two of the finest in the world, in their report stated that they believe the costs are lower for the clinical trials than for the other procedures—actually a lower cost. So you have Sloan-Kettering and M.D. Anderson lowering costs of clinical trials on their analysis of our amendment. Lower costs, 12 cents a month, you pick it.

We have narrowed it tightly so you limit it, as limited as I know how to make it, to life threatening, no other standard procedure available to you. You have to use one of the only three, clinical trials sponsored by NIH, Department of Defense, Veterans'. How much more narrow can we get? There is only one of three or four ways that we get new products out to people. You test it in a lab first. Then you give it to animals. Then you have to have clinical trials. You have to have them. If you do not have the clinical trials, then you cannot get the product to people. So it is not just the patient today who needs it, who is lying somewhere wondering whether or not they can get their HMO to include a clinical trial, but future patients. If we do not have the clinical trials today, that future patient will not get that medicine or may be delayed in getting it.

Mr. President, there may be other issues which divide us. This one should not. This one should not divide us. Can we not, for 5 minutes——

The PRESIDING OFFICER. The Senator has 5 minutes.

Mr. DODD. I will take 30 additional seconds. Can't we find 5 minutes this week to come to an agreement on the Snowe amendment and the Dodd amendment and move on to the next issue? Do we really have to make this a huge battle and fight, where we go through a battle to say, no to one, yes to another, maybe tomorrow. This is not fair to the American public. They expect I think a little more from us than this.

Mr. President, I will try one more time—one more time, the sixth time.

The PRESIDING OFFICER. The Senator's 30 seconds have expired.

Mr. DODD. I ask for 30 additional seconds. I ask unanimous consent—this is the sixth time this will be made in the last hour—that S. 1344, the Daschle substitute amendment, be modified with language from the Snowe amendment No. 1241 prohibiting drive-through mastectomies and requiring coverage for second opinions be included in the Dodd amendment.

The PRESIDING OFFICER. Is there objection?

Mr. JEFFORDS. Objection.

The PRESIDING OFFICER. Objection is heard.

Mr. DODD. Mr. President, I am saddened by this objection. The American people ought to be deeply saddened by what they have heard on this issue in the last hour and half.

I yield the floor.

Mr. MURKOWSKI. Mr. President, I rise in strong support of the Snowe Amendment—an amendment to rid the tragic practice of drive-through'' mastectomies.

Mr. President, one out of nine American women will suffer the tragedy of breast cancer. It is today the leading cause of death for women between the ages of 35 to 54.

Alaskan women are particularly vulnerable to this disease. We have the second highest rate of breast cancer in the nation.

1 in 7 Alaska women will get breast cancer and tragically it is the Number One cause of death among Native Alaskan women.

We know that these deaths are preventable—and the key to prevention is early detection. It is estimated that breast cancer deaths can be reduced by 30 percent if all women avail themselves of regular clinical breast examination and mammography. I'm proud of the work that this body has done in the recent past to expand Medicare and Medicaid coverage for mammographies.

I am also proud of the efforts that my wife Nancy has done in expanding early detection efforts throughout Alaska. You see, Mr. President, for many Alaska women, especially native women living in one of our 230 remote villages, regular screening and early detection are often hopeless dreams.

For 25 years, my wife Nancy has recognized this problem and did something about it. In 1974, she and a group of Fairbanks' women created the Breast Cancer Detection Center, for the purpose of offering mammographies to women in remote areas of Alaska—regardless of a woman's ability to pay.

Now, the Center uses a small portable mammography unit which can be flown to remote areas of Alaska, offering women in the most rural of areas easy access to mammographies at no cost.

Additionally, the Center uses a 43-foot long, 14 foot high and 26,000 pound mobile mammography van to travel through rural areas of Alaska. The van makes regular trips, usually by river barge, to remote areas in Interior Alaska such as Tanana.

Julie Roberts, a 42-year-old woman of Tanana, who receives regular mammographies from the mobile mammography van, knows the importance of early screening:

There's a lot of cancer here (in Tanana)—a lot of cancer. That's why it's important to have the mobile van here . . . I know that if I get checked, I can catch it early and can probably save my life. I have three children and I want to see my grandchildren.

I am proud to say that the Fairbanks Center now serves about 2,200 women a year and has provided screenings to more than 25,000 Alaska women in 81 villages throughout the states. To help fund the efforts of the Fairbanks Center, each year Nancy and I sponsor a fishing tournament to raise money for the operation of the van and mobile mammography unit. After just three years, donations from the tournament have totalled over $1 million.

Mr. President, Nancy and I are committed to raising more funds for this important program so that every women in Alaska can benefit from the advances of modern technology and reduce their risk of facing this killer disease.

But, Mr. President, the fight against breast cancer does not end with detection of the disease. That is why I stand in strong support of Senator SNOWE's amendment. Her amendment will once and for all put an end to the practices of so-called drive-through'' mastectomies.

In too many cases women who survive the trauma of a mastectomy are being forced to get out of the hospital only hours after their surgery. How can medical care professionals allow this? Simply because many insurance companies demand that the procedure of a mastectomy be considered an out-patient service.''

Here's the horror that many insurance companies cause:

Nancy Couchot, a 60 year old woman had a radical mastectomy at 11:30 a.m. She was released from the hospital five hours —even though she was not able to walk or use the rest room without assistance.

Victoria Berck, had a mastectomy and lymph node removal at 7:30 a.m. Seven hours later, she was given instructions on how to empty two drains attached to her body and sent home. Ms. Berck concludes, No civilized country in the world has a mastectomy as an out-patient service.''

Mr. President, it's for these very reasons that I am in strong support of Senator SNOWE's amendment. Specifically, the amendment will require health insurance companies to allow physicians to determine the length of a mastectomy patient's hospital stay according to medical necessity. In other words, the bill makes it illegal to punish a doctor for following good medical judgment and sound medical treatment.

This amendment is important follow-up to legislation that I and many in this Body worked on worked on to ensure that mastectomy patients have access to reconstructive surgery. Prior to our efforts in last year's Omnibus bill, scores of women were denied reconstructive surgery following mastectomies because insurers have deemed the procedure to be cosmetic'' and, therefore, not medically necessary.

Mr. President, far too often breast cancer victims, who believe that they have adequate health care coverage, are horrified when they learn basic and sound medical practices are not covered in their health plan.

Mr. President, these issues are not partisan issues. We may have our differences regarding managing and financing health reform, but I think we all endorse accessible and affordable health care that preserves patient choice and physician discretion. Cancer does not look to see the politics of its victims.

Mr. KENNEDY. Mr. President, earlier I said that I would enter into the RECORD the fact that last Congress, the majority's version of the Patient's Bill of Rights included a mastectomy provision that was quite similar to the provision offered by Senator ROBB yesterday and by Senator SNOWE today. Yet, this mastectomy provision was conspicuously absent from the majority's bill this year. Drive-through mastectomies were discussed during committee markup but were not added back. In fact, the majority rejected an amendment by Senator MURPHY to end drive-through mastectomies. Now, in response to popular pressure, the majority is offering the Snowe amendment on mastectomies as a way of undermining our attempt to provide coverage for patients in clinical trials. I ask unanimous consent that the table of contents and relevant pages of the Republican bills from the last Congress and from this Congress be printed in the RECORD.

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

S. 2330, JULY 20, 1998

* * * * *

Subtitle C—Women's Health and Cancer Rights

SEC. 531. SHORT TITLE.

This subtitle may be cited as the ''Women's Health and Cancer Rights Act of 1998''.

SEC. 532. FINDINGS.

Congress finds that—

(1) the offering and operation of health plans affect commerce among the States;

(2) health care providers located in a State serve patients who reside in the State and patients who reside in other States; and

(3) in order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in 1 State as well as health plans operating among the several States.

SEC. 533. 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 the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by sections 111 and 302, is further amended by adding at the end the following new section:

''SEC. 715. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the surgical treatment of breast cancer (including a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer) is provided for a period of time as is determined by the attending physician, in his or her professional judgment consistent with scientific evidence-based practices or guidelines, in consultation with the patient, to be medically appropriate.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician in consultation with the patient determine that a shorter period of hospital stay is medically appropriate.

''(b) RECONSTRUCTIVE SURGERY.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall ensure that, in a case in which a mastectomy patient elects breast reconstruction, coverage is provided for—

''(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

''(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

''(3) the costs of prostheses and complications of mastectomy including lymphedemas;

in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 1999;

whichever is earlier.

''(d) NO AUTHORIZATION REQUIRED.—

''(1) IN GENERAL.—An attending physician shall not be required to obtain authorization from the plan or issuer for prescribing any length of stay in connection with a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

''(2) PRENOTIFICATION.—Nothing in this section shall be construed as preventing a group health plan from requiring prenotification of an inpatient stay referred to in this section if such requirement is consistent with terms and conditions applicable to other inpatient benefits under the plan, except that the provision of such inpatient stay benefits shall not be contingent upon such notification.

''(e) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

''(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to individuals to encourage such individuals to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

''(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; and

''(5) subject to subsection (f)(2), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

''(f) RULES OF CONSTRUCTION.—

''(1) IN GENERAL.—Nothing in this section shall be construed to require a patient who is a participant or beneficiary—

''(A) to undergo a mastectomy or lymph node dissection in a hospital; or

''(B) to stay in the hospital for a fixed period of time following a mastectomy or lymph node dissection.

''(2) COST SHARING.—Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

''(3) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

''(g) PREEMPTION, RELATION TO STATE LAWS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to preempt any State law with respect to health insurance coverage that—

''(A) relates to hospital length of stays after a mastectomy, lumpectomy, or lymph node dissection;

''(B) relates to coverage of reconstructive breast surgery after a mastectomy, lumpectomy, of lymph node dissection; or

''(C) requires coverage for breast cancer treatments (including breast reconstruction) in accordance with scientific evidence-based practices or guidelines recommended by established medical associations.

''(2) APPLICATION OF SECTION.—With respect to a State law—

''(A) described in paragraph (1)(A), the provisions of this section relating to breast reconstruction shall apply in such State; and

''(B) described in paragraph (1)(B), the provisions of this section relating to length of stays for surgical breast treatment shall apply in such State.

''(3) ERISA.—Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.''.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 note) is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for reconstructive surgery following mastectomies.''.

(c) EFFECTIVE DATES.—The amendments made by this section shall apply with respect to plan years beginning on or after the date of enactment of this Act.

SEC. 534. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.), as amended by section 303(a), is further amended by adding at the end the following new section:

''SEC. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a

group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the surgical treatment of breast cancer (including a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer) is provided for a period of time as is determined by the attending physician, in his or her professional judgment consistent with scientific evidence-based practices or guidelines, in consultation with the patient, to be medically appropriate.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician in consultation with the patient determine that a shorter period of hospital stay is medically appropriate.

''(b) RECONSTRUCTIVE SURGERY.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall ensure that, in a case in which a mastectomy patient elects breast reconstruction, coverage is provided for—

''(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

''(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

''(3) the costs of prostheses and complications of mastectomy including lymphedemas;

in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the enrollee upon enrollment and annually thereafter.

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 1999;

whichever is earlier.

''(d) NO AUTHORIZATION REQUIRED.—

''(1) IN GENERAL.—An attending physician shall not be required to obtain authorization from the plan or issuer for prescribing any length of stay in connection with a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

''(2) PRENOTIFICATION.—Nothing in this section shall be construed as preventing a plan or issuer from requiring prenotification of an inpatient stay referred to in this section if such requirement is consistent with terms and conditions applicable to other inpatient benefits under the plan, except that the provision of such inpatient stay benefits shall not be contingent upon such notification.

''(e) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

''(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to individuals to encourage such individuals to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

''(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; and

''(5) subject to subsection (f)(2), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

''(f) RULES OF CONSTRUCTION.—

''(1) IN GENERAL.—Nothing in this section shall be construed to require a patient who is a participant or beneficiary—

''(A) to undergo a mastectomy or lymph node dissection in a hospital; or

''(B) to stay in the hospital for a fixed period of time following a mastectomy or lymph node dissection.

''(2) COST SHARING.—Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

''(3) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

''(g) PREEMPTION, RELATION TO STATE LAWS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to preempt any State law with respect to health insurance coverage that—

''(A) relates to a hospital length of stay after a mastectomy, lumpectomy, or lymph node dissection;

''(B) relates to coverage of reconstructive breast surgery after a mastectomy, lumpectomy, or lymph node dissection; or

''(C) requires coverage for breast cancer treatments (including breast reconstruction) in accordance with scientific evidence-based practices or guidelines recommended by established medical associations.

''(2) APPLICATION OF SECTION.—With respect to a State law—

''(A) described in paragraph (1)(A), the provisions of this section relating to breast reconstruction shall apply in such State; and

''(B) described in paragraph (1)(B), the provisions of this section relating to length of stays for surgical breast treatment shall apply in such State.

''(3) ERISA.—Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.''.

(b) EFFECTIVE DATES.—The amendments made by this section shall apply to group health plans for plan years beginning on or after the date of enactment of this Act.

SEC. 535. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.

(a) IN GENERAL.—Subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–51 et seq.), as amended by section 303(b), is further amended by adding at the end the following new section:

''SEC. 2753. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER.

''The provisions of section 2707 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the date of enactment of this Act.

SEC. 536. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

(a) IN GENERAL.—Subchapter A of chapter 100 of the Internal Revenue Code of 1986 (relating to group health plan portability, access, and renewability requirements) is amended by inserting after section 9803 the following new section:

''SEC. 9804. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the surgical treatment of breast cancer (including a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer) is provided for a period of time as is determined by the attending physician, in his or her professional judgment consistent with scientific evidence-based practices or guidelines, in consultation with the patient, to be medically appropriate.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician in consultation with the patient determine that a shorter period of hospital stay is medically appropriate.

''(b) RECONSTRUCTIVE SURGERY.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall ensure that, in a case in which a mastectomy patient elects breast reconstruction, coverage is provided for—

''(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

''(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

''(3) the costs of prostheses and complications of mastectomy including lymphedemas;

in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as

may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 1999;

whichever is earlier.

''(d) NO AUTHORIZATION REQUIRED.—

''(1) IN GENERAL.—A, attending physician shall not be required to obtain authorization from the plan or issuer for prescribing any length of stay in connection with a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

''(2) PRENOTIFICATION.—Nothing in this section shall be construed as preventing a plan or issuer from requiring prenotification of an inpatient stay referred to in this section if such requirement is consistent with terms and conditions applicable to other inpatient benefits under the plan, except that the provision of such inpatient stay benefits shall not be contingent upon such notification.

''(e) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

''(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to individuals to encourage such individuals to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

''(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; and

''(5) subject to subsection (f)(2), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

''(f) RULES OF CONSTRUCTION.—

''(1) IN GENERAL.—Nothing in this section shall be construed to require a patient who is a participant or beneficiary—

''(A) to undergo a mastectomy or lymph node dissection in a hospital; or

''(B) to stay in the hospital for a fixed period of time following a mastectomy or lymph node dissection.

''(2) COST SHARING.—Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

''(3) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

''(g) PREEMPTION, RELATION TO STATE LAWS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to preempt any State law with respect to health insurance coverage that—

''(A) relates to a hospital length of stay after a mastectomy, lumpectomy, or lymph node dissection;

''(B) relates to coverage of reconstructive breast surgery after a mastectomy, lumpectomy, or lymph node dissection; or

''(C) requires coverage for breast cancer treatments (including breast reconstruction) in accordance with scientific evidence-based practices or guidelines recommended by established medical associations.

''(2) APPLICATION OF SECTION.—With respect to a State law—

''(A) described in paragraph (1)(A), the provisions of this section relating to breast reconstruction shall apply in such State; and

''(B) described in paragraph (1)(B), the provisions of this section relating to length of stays for surgical breast treatment shall apply in such State.

''(3) ERISA.—Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.''.

(b) CONFORMING AMENDMENTS.—

(1) The heading for subtitle K of such Code is amended to read as follows:

''Subtitle K—Group Health Plan Portability, Access, Renewability, and Other Requirements''.

(2) The heading for chapter 100 of such Code is amended to read as follows:

''CHAPTER 100—GROUP HEALTH PLAN PORTABILITY, ACCESS, RENEWABILITY, AND OTHER REQUIREMENTS''.

(3) Section 4980D(a) of such Code is amended by striking ''and renewability'' and inserting ''renewability, and other''.

(c) CLERICAL AMENDMENTS.—

(1) The table of contents for chapter 100 of such Code is amended inserting after the item relating to section 9803 the following new item:

''Sec. 9804. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for reconstructive surgery following mastectomies.''.

(2) The item relating to subtitle K in the table of subtitles for such Code is amended by striking ''and renewability'' and inserting ''renewability, and other''.

(3) The item relating to chapter 100 in the table of chapters for subtitle K of such Code is amended by striking ''and renewability'' and inserting ''renewability, and other''.

(d) EFFECTIVE DATES.—The amendments made by this section shall apply with respect to plan years beginning on or after the date of enactment of this Act.

SEC. 537. RESEARCH STUDY ON THE MANAGEMENT OF BREAST CANCER.

(a) STUDY.—To improve survival, quality of life and patient satisfaction in the care of patients with breast cancer, the Agency for Health Care Policy and Research shall conduct a study of the scientific issues relating to—

(1) disease management strategies for breast cancer that can achieve better patient outcomes;

(2) controlled clinical evidence that links specific clinical procedures to improved health outcomes;

(3) the definition of quality measures to evaluate plan and provider performance in the management of breast cancer;

(4) the identification of quality improvement interventions that can change the process of care to achieve better outcomes for individuals with breast cancer;

(5) preventive strategies utilized by health plans for the treatment of breast cancer; and

(6) the extent of clinical practice variation including its impact on cost, quality and outcomes.

(b) REPORT.—Not later than January 1, 2000, the Agency for Health Care Policy and Research shall prepare and submit to the appropriate committees of Congress a report concerning the results of the study conducted under subsection (a).

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S. 326, JUNE 17, 1999

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TITLE I—PATIENTS' BILL OF RIGHTS

Subtitle A—Right to Advice and Care

Sec. 101. Patient right to medical advice and care.

''SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

''Sec. 721. Patient access to emergency medical care.
''Sec. 722. Offering of choice of coverage options.
''Sec. 723. Patient access to obstetric and gynecological care.
''Sec. 724. Patient access to pediatric care.
''Sec. 725. Access to specialists.
''Sec. 726. Continuity of care.
''Sec. 727. Protection of patient-provider communications.
''Sec. 728. Patient's right to prescription drugs.
''Sec. 729. Self-payment for behavioral health care services.
''Sec. 730. Generally applicable provision.

Sec. 102. Comprehensive independent study of patient access to clinical trials and coverage of associated routine costs.

Sec. 103. Effective date and related rules.

Subtitle B—Right to Information About Plans and Providers

Sec. 111. Information about plans.
Sec. 112. Information about providers.

Subtitle C—Right to Hold Health Plans Accountable

Sec. 121. Amendment to Employee Retirement Income Security Act of 1974.

Mr. JEFFORDS. How much time do I have remaining?

The PRESIDING OFFICER. Nine minutes, 6 seconds.

Mr. JEFFORDS. I yield myself 3 minutes.

Mr. President, I have listened to the very excellent debate of my good friend from Connecticut, and it sounds very compelling. It is with some difficulty that I have to remind those across the aisle that we tried last year and we tried this year to have a face-off with the two bills: You put the best bill forward you have, we will put the best bill forward we have, we will allow amendments back and forth, 20 to a side, something like that. No, they did not want that. Why? They figured they would lose. We had a better bill. We have a better bill now.

No. 1, this bill, after the vote, assuming we win on the vote, the Senator from Connecticut will have the opportunity, the minority will have the opportunity to offer their provisions on clinical trials again. We will have several opportunities to do that. We are not cutting off the opportunity for that one to be reexamined.

What we are saying is, right now, we want to make sure we clear up the problems with respect to mastectomies and want to make sure this body will have an opportunity to, once and for all, bring back the so-called amendment of Senator D'Amato to make sure all women in this Nation have an opportunity for the best possible care for the very difficult problems of breast cancer.

We are ready to do that. There will be other votes. We will have more votes, I do not know, 5, 10 more votes between now and the time this debate ends. Right now, we want to have the vote on our amendment which, under this convoluted process we were talked into by the minority, which is very confusing—and maybe they want it that way—creates a mess for the public and even us as Members to understand what the process is or what is going to happen next or how we are going to end up.

I want to let everyone know I am sincerely in favor of good clinical trials, and I am sincerely in favor of taking care, as we would right now, of the problems of the mastectomies and also OB/GYN. We will be doing that. Since I am the one who is objecting, I want everyone to know that is my job as leader on the floor. I do not want it to be utilized as some way I am against these things personally.

I yield 2 minutes to the Senator from Tennessee.

Mr. FRIST. Mr. President, again I stand as an advocate for clinical trials and say at the end of the next 48 hours, we are going to have a very good amendment that will be added to this bill which will address the issue of getting clinical services to people earlier by lowering the barriers to get into clinical trials with a mandate on managed care, HMOs that will be very effective, that will be accountable, that will be affordable, and that will get things to people quickly.

Let me go back to the examples. It is so hard. You use an example and somebody plays off it. Artificial hearts are expensive. A clinical trial opens up. It is life-threatening; there is no alternative. Two patients: one dying of cardiomyopathy. The patient will hardly last 2 weeks. You put in an artificial heart to see if it works. The patient dies 2 weeks later. It is terrible. The artificial heart in the other patient keeps him alive and 2 weeks, 3 weeks has a stroke to the brain. He has a massive stroke and stays in the hospital for a week, 1 month or 2 months. He takes hematinics. He has about $4,000 to $5,000 of testing every year. There are 15 people or so monitoring that patient for the next week, 3 weeks, 6 weeks, or 8 weeks. Two different patients: the intervention, the artificial heart you introduced as part of the clinical trial, and this patient dies. The incremental cost, the difference between these two is the hospitalization for 3 weeks, 4 weeks, or 8 weeks and the medical care.

Again, the incremental cost you are going to make the managed care plan pay—since everybody is bashing managed care, that seems to be OK—but remember, all the managed care plan does is pass that cost on to the people who are sick. You have sick patients, whose premiums go up, who pay this bill. It is unintended. I know that is not what you meant, but by using life-threatening or serious illness where there is otherwise no alternative, using the example you introduced, which I refuted—I am going to throw it right back at my colleague—it is very complicated. We need to stay sharp and focused and pass a sharp bill.

The PRESIDING OFFICER. The Senator's time has expired. Who yields time?

Mr. JEFFORDS. Mr. President, I yield the Senator from Maine such time as we have remaining.

Ms. SNOWE. How much time remains?

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

Ms. SNOWE. Mr. President, I want to make a few points to wrap up. I applaud the leadership of Senator DODD with respect to clinical study trials. Obviously, I could not agree with him more on this issue.

This is an issue that will be addressed further in this debate, as it should. But the Senator is frustrated, and if other Senators are frustrated at the process, then we all have a collective responsibility to make sure it does not happen again. We cannot pretend we do not know how we got here. It is unfortunate we have a Hobson's choice today, but we had a Hobson's choice yesterday when it came to mastectomies when the amendment was offered by Senator ROBB to the legislation that already had the identical language. I had planned to offer this legislation well before the recess because I wanted to improve upon the Republican legislation on managed care. I thought it was absolutely essential.

The Senator from Massachusetts asked, why did we just identify mastectomies and women with breast cancer? I say to the Senator, why? For the same reason the Senator singled out mastectomies in his own legislation and Senator ROBB singled it out in his amendment that he offered yesterday. Because we have an identifiable problem with drive-through

mastectomies and HMOs. That was the genesis of the legislation to begin with when former Senator D'Amato had introduced that legislation with Senator FEINSTEIN and myself several years ago. I introduced the same legislation this year with Senator FEINSTEIN for that very reason, because there has been a problem with managed care and drive-through mastectomies.

We have all heard the horror stories. That is why this legislation was developed. That is why I am offering this amendment to the Republican legislation, because it does not have that language.

Some suggest there is some partisan political ploy. I will compare my credentials on bipartisanship with anybody across the aisle. We have worked on a bipartisan basis on issues concerning women's health since I came to the Congress 20 years ago. I would have hoped yesterday we would have had the opportunity to work it out rather than having to vote on an amendment that included language that was already in the Democratic bill.

We should have been working together, but now we are having to address the issue of defining ''medical necessity'' that no other legislation, no board, no governmental agency, no association has defined. It is going to limit the treatment that is offered to women when it comes to breast cancer. That is a fact.

So the choice is, are you going to get the best care, the best treatment, the best principles when it comes to breast cancer? Or are you going to lower the threshold and say: Well, everybody offers this, no matter what, when there are other options? There is better science developing all the time, and it could be available to a woman who has breast cancer.

Those are the choices. That is why we are at this point. I just say to everybody in this Chamber, if we want to avoid this kind of contrivance when it comes to this amendment process, then I suggest it is the responsibility of each of us to make sure it does not happen, so that we get the very best legislation, that we can walk across the aisle, rather than being constrained by the parliamentary procedures that we confront today.

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

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada has 1½ minutes.

Mr. REID. I will take 2 minutes off the bill in addition to that.

Mr. President, the statements of the Senator from Vermont and my friend from Maine basically are cynical and very unreasonable. We have given the majority the opportunity to vote on drive-through mastectomies and also to maintain clinical trials. We could do that by voice vote. We could save a lot of time. The decision has been made by the majority to make sure that we do not have the opportunity to pass the clinical trials aspect of this bill.

They are always promising they are going to come back with something else a little better later. The fact of the matter is, this is not a Hobson's choice. What they are attempting to do is cynical and unreasonable.

Senator LOTT said this morning in his opening statement, Republicans have a medical doctor to support their positions. And I have the greatest respect for the junior Senator from Tennessee. The fact is, with his medical knowledge, though, he should relate the facts. And the fact is, on page 8341 of the CONGRESSIONAL RECORD of July 13, 1999, Senator FRIST said, among other things, ''Let me share with Members what one person told me. Dr. Robert Yelverton, chairman of the American College of Obstetricians and Gynecologists.' . . .''

Fact: My friend from Tennessee never spoke to Dr. Yelverton.

Fact: Dr. Yelverton, even if he had spoken to him, disagrees with statements made by Senator FRIST about him.

I ask unanimous consent to have printed in the RECORD page 8341 of yesterday's RECORD. I also ask unanimous consent to have printed in the RECORD a memorandum to Lucia DiVenere from Dr. Yelverton, wherein that memorandum states:

Senator Frist's misuse of my statement in support of his position . . . is regrettably misleading . . . and does an injustice to the true intent of my statements.

Further, I ask unanimous consent to have printed in the RECORD a letter to Dr. FRIST, dated July 14, 1999, from Dr. Hale, executive vice president of the American College of Obstetricians and Gynecologists.

That letter, in part, says:

The American College of Obstetricians and Gynecologists and Dr. Yelverton fully support efforts in Congress, including the Robb/Murray amendment, which would enable obgyns to be designated as primary care providers. A recent . . . survey found that nearly one-third of all ob-gyns in managed care plans are denied the opportunity to be designated as primary care physicians. Ob-gyns are often the only health care provider many women see through their [entire] adult lives and are best suited to understand and evaluate the health care needs of their patients. . . .

We also strongly endorse the Robb/Murray amendment's provision that would require managed care plans to allow women direct access to the full array of covered ob-gyn services under the plan.

While the amendment failed yesterday on a 48 to 52 vote, we are hopeful the Senate will take up this important issue again. Dr. Yelverton and I urge you to vote in favor of these important policies.

I would hope my friend, Senator FRIST, and the other Republicans would take this to heart. I believe we need to review some of the votes taken yesterday.

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

EXCERPT FROM RECORD OF JULY 13, 1999

Mr. FRIST. In the Kennedy-Robb amendment is the issue of access.

Again, my colleagues on the other side hit it right on the head: Women today want to have access to their obstetrician. They don't want to go through gatekeepers to have to get to their obstetrician or gynecologist. That relationship is very special and very important when we are talking about women's health and women's diseases.

In the Kennedy-Robb amendment, the language is that the plan or insurer shall permit such an individual who is a female to designate a participating physician who specializes in obstetrics and gynecology as the individual's primary care provider.

It is true that in our underlying bill we don't say the plan has to say that all obstetricians and gynecologists are primary care providers. That is exactly right. The reasons for that are manyfold.

Let me share with Members what one person told me. Dr. Robert Yelverton, chairman of the American College of Obstetricians and Gynecologists' Primary Care Committee, stated:

The vast majority of OB/GYNs in this country have opted to remain as specialists rather than act as primary care physicians.

He attributes this to the high standards that health plans have for primary care physicians, saying:

None of us could really qualify as primary care physicians under most of the plans, and most OB/GYNs would have to go back to school for a year or more to do so.

You can argue whether that is good or bad, but it shows that automatically taking specialists and making them primary care physicians and putting it in Federal statute is a little bit like taking BILL FIRST, heart and lung transplant surgeon, and saying: You ought to take care of all of the primary care of anybody who walks into your office.

DOCTORS YELVERTON, LERNER, FALLIERAS, KILBRIDE, MARSTON, JAEGER, MINTON & BROWN,
Tampa, FL, July 13, 1999.

To: Lucia DiVenere, ACOG Government Relations.

From: Robert W. Yelverton, M.D., Chairman, Primary Care Committee.

I received your fax tonight and offer the following in response.

I have never spoken directly to Senator Bill Frist (R–TN) or any member of his staff on the subject of OB/GYNs as primary care physicians or on any other subject. The quote that Senator Frist attributed to me on the floor of the Senate today came from an article in the June 13, 1999, edition of the New York Times. The article may be viewed on the New York Times website (go to www.nytimes.com, then click on Health and Science). I was contacted by the article's author, Larry Katzenstein, and asked to comment on the impact of managed care on women's healthcare in this country. In my interview with Mr. Katzenstein, I discussed ''barriers'' that managed care organizations have raised against the efforts of OB/GYNs to become primary care physicians. The quote attributed to me by Senator Frist was from a non-quote in this article. I told Mr. Katzenstein that some managed care organizations have placed barriers consisting of such stringent (not ''high,'' as Senator Frist stated) standards for their qualifications as primary care physicians that most OB/GYNs would not be able to meet them without further training.

One objective of my comments was to demonstrate that the College's interests were to allow OB/GYNs to provide women's healthcare to their patients unimpeded by the cumbersome requirements of managed care referral systems. Mr. Katzenstein's article did not emphasize to the degree it should have that these were barriers to OB/GYNs

being designated primary care physicians—not ''high standards''—as has been discussed repeatedly in meetings of the Primary Care Committee. I went on to say to Mr. Katzenstein that the qualification requirements that some managed care organizations impose on OB/GYNs in certain instances exceed even those required of family physicians. He chose not to include that statement in his article.

Senator Frist's misuse of my statement in support of his position that OB/GYNs could not act as primary care physicians because of the ''high standards'' that managed care organizations set for primary care physicians, is regrettably misleading, to say the least, and does an injustice to the true intent of my statements.

I personally supported then and I support now the amendment sponsored by ACOG to allow OB/GYNs to act as primary care physicians and to allow direct access for women's healthcare and did, in fact, spend a portion of this very afternoon e-mailing my senators and encouraging them to vote in support of the amendment.

Please contact me. I will be glad to discuss this matter with you at that time and will support any effort that you want to undertake to clarify this issue now on the floor of the Senate.

———

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS,
Washington, DC, July 14, 1999.

Hon. BILL FRIST
Washington, DC.

DEAR SENATOR FRIST: As Executive Vice President of the American College of Obstetrics and Gynecologists (ACOG), I feel it necessary to clarify ACOG's position on the Robb/Murray amendment to allow women in managed care plans direct access to ob-gyn care. I've also attached a memo from Dr. Robert Yelverton, Chairman of ACOG's Primary Care Committee, correcting your misuse of his statements in a June 13 New York Times article.

ACOG and Dr. Yelverton fully support efforts in Congress, including the Robb/Murray amendment, which would enable ob-gyns to be designated as primary care providers. A recent ACOG/Princeton Survey Research Associates survey found that nearly one-third of all ob-gyns in managed care plans are denied the opportunity to be designated as primary care physicians. Ob-gyns are often the only health care provider many women see throughout their adult lives and are best suited to understand and evaluate the health care needs of their patients. While not all ob-gyns may choose to accept a PCP designation, all ob-gyns should have the opportunity to be designated as a woman's PCP under managed care.

We also strongly endorse the Robb/Murray amendment's provision that would require managed care plans to allow women direct access to the full array of covered ob-gyn services provided under the plan.

While the amendment failed yesterday on a 48 to 52 vote, we are hopeful the Senate will take up this important issue again. Dr. Yelverton and I urge you to vote in favor of these important policies.

Sincerely,

RALPH W. HALE, MD,
Executive Vice President.

Mr. KENNEDY. Mr. President, do we still have a minute and a half on the amendment?

The PRESIDING OFFICER. The time on the amendment has been consumed.

Mr. KENNEDY. I yield myself 1 minute off the bill.

The PRESIDING OFFICER. The Senator has that right.

Mr. KENNEDY. Mr. President, I ask unanimous consent to have printed in the RECORD a letter from the National Partnership for Women & Families and a letter from the National Breast Cancer Coalition. Both of these organizations support the Dodd amendment, and they urge opposition to the Snowe amendment because it strikes the underlying Dodd amendment on clinical trials.

The letter from the National Partnership for Women & Families says:

It is essential that women and families have access to clinical trials. We oppose any effort to deny such access.

I ask unanimous consent that both these letters be printed in the RECORD.

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

NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES,
Washington, DC, July 14, 1999.

Hon. EDWARD M. KENNEDY,
U.S. Senate,
Washington, DC.

DEAR SENATOR KENNEDY: The National Partnership for Women & Families urges you to oppose the pending Snowe amendment because it strikes the underlying Dodd amendment on clinical trials. It is essential that women and families have access to clinical trials. We oppose any effort to deny such access.

Sincerely,

JUDITH L. LICHTMAN,
President.
JOANNE L. HUSTEAD,
Director of Legal and Public Policy.

———

NATIONAL BREAST CANCER COALITION,
Washington, DC, July 14, 1999.

Hon. THOMAS DASCHLE,
U.S. Senate, Washington, DC.

DEAR SENATOR DASCHLE: On behalf of the National Breast Cancer Coalition (NBCC), I want to express our deep concern about the fact that a choice has to be made between the length of hospital stay and the clinical trials amendments. If a choice must be made, NBCC's priority is access to clinical trials.

As you know, NBCC is a grassroots advocacy organization made up of more than 500 organizations and tens of thousands of individuals working since 1991 to eradicate this disease through advocacy and action.

While it is important for doctors and patients to make decisions about how long women should stay in the hospital following a mastectomy, an even more important amendment is Senator Dodd's access to clinical trials amendment. Clinical trials provide the best evidence of whether an intervention will work. Without them, we will never know how to prevent breast cancer, how best to treat it, or how to cure it-and our demands for ''quality care'' will have no meaning.

NBCC truly appreciates Senator Snowe's support of breast cancer issues. Unfortunately, under these circumstances we believe the length of hospital stay amendment should not be supported in lieu of ensuring access to the lifesaving therapies in clinical trials.

Thank you for your leadership. We look forward to working with you to get this important patient protection, and a comprehensive and enforceable ''Patients Bill of Rights'' enacted into law. Please do not hesitate to call me, or NBCC's Government Relations Manager, Jennifer Katz if you have any questions.

Sincerely,

FRAN VISCO,
President.

Mr. JEFFORDS. Mr. President, I ask unanimous consent that Senator MURKOWSKI be added as a cosponsor to the Snowe amendment.

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

Mr. JEFFORDS. Mr. President, I ask for the yeas and nays on the Snowe amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 1241. The yeas and nays have been ordered. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

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

The result was announced—yeas 55, nays 45, as follows:

[Rollcall Vote No. 203 Leg.]

YEAS—55

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

NAYS—45

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

The amendment (No. 1241) was agreed to.

Mr. FRIST. Mr. President, I remove to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from South Dakota.

AMENDMENT NO. 1242 TO AMENDMENT NO. 1239

(Purpose: To ensure that the protections provided for in the patients' bill of rights apply to all patients with private health insurance)

Mr. DASCHLE. Mr. President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from South Dakota (Mr. DASCHLE), for himself, Mr. KENNEDY, Mr. REID, Mr. DURBIN, Mr. WELLSTONE, Mr. WYDEN, Mr. REED, Mrs. MURRAY, Mr. CHAFEE, and Mrs. FEINSTEIN, proposes an amendment numbered 1242 to amendment No. 1239.

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

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

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

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. LEAHY. Mr. President, will the Senator yield for a unanimous consent?

Mr. KENNEDY. Yes. I yield for that purpose.

Mr. LEAHY. I thank my friend from Massachusetts.

PRIVILEGE OF THE FLOOR

Mr. President, I ask unanimous consent that Rebecca Pastner of my staff be given the privilege of the floor today during votes.

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

Mr. KENNEDY. Mr. President, I yield myself 7 minutes.

All patients, regardless of where they live or how they purchase their insurance, deserve to know that their health plan will cover the benefits they need when they are ill or injured.

When we say ''all,'' we mean all.

That is a fundamental principle of HMO reform. But it is a fundamental principle that is ignored in the Republican minimal alternative.

The amendment that Senator DASCHLE, I, and others are offering makes clear that every provision of the Patients' Bill of Rights should apply to all 161 million Americans with private insurance coverage.

No patient should be turned away at the emergency room door, denied access to the specialist they need to save their life, or be told that they will not get the prescription drug they need to treat their illness because they live in Mississippi instead of Massachusetts or in Oklahoma instead of Ohio.

No child or parent or grandparent should be denied the medical care they need because they happen to work for a small business instead of a large corporation or because they are a teacher in a public school instead of an executive on Wall Street.

Of the 161 million Americans with private insurance, only 48 million are covered under the Republican plan; 113 million Americans are left out or are left behind. The Republican plan limits protections to those who receive their coverage from an employer who self-insures their health plan rather than purchasing an insurance policy.

Only the largest corporations self-fund their insurance plan. However, many employees of even the largest employers get their coverage through an fully-funded health plan. These employees would not be protected by the Republican bill.

What an incredible irony. Much of the public desire for patient protection legislation comes from the concern about the abusive practices of HMOs. But virtually no one enrolled in an HMO is covered by the Republican bill because HMOs are rarely part of self-funded arrangements.

These reforms are supposed to protect patients against HMO and insurance company abuses. But people with coverage from insurance companies and HMOs are not protected by the Republican bill.

Nothing more clearly demonstrates that the Republican bill is an industry protection act, not a patient protection act.

It is no wonder insurance companies support the Republican bill. It is no wonder that over 200 groups of doctors, nurses, patients, and advocates for women, children, and families oppose the Republican bill.

The ''dishonor role'' of those left out under the Republican plan is long.

We are talking about 75 million Americans who work for businesses that purchase insurance. We are talking about 15 million Americans who are small business men and women, self-employed salesmen, home day-care workers, early retirees, farmers, or others who purchase their own insurance instead of receiving it through their employer.

We are talking about 23 million schoolteachers, police officers, librarians, nurses, and other employees of State and local government.

Why are these people excluded?

This chart indicates exactly the point that we are making.

The Republican bill covers 48 million people. These are the people who receive health insurance through self-insured employer plans. These are the plans in which the company self-insures and, therefore, pays for the various medical treatments.

It doesn't cover the 75 million persons whose employers provide coverage through an insurance policy or HMO even though approximately 85 percent of the 75 million are enrolled in HMOs. It doesn't cover the 23 million State and local government workers. It doesn't include the people buying individual health insurance policies. Those are the very small businessmen, the farmers, and others.

Why are these people excluded, even though the Republican plan in the House of Representatives includes most of these individuals?

Mr. SARBANES. Will the Senator yield?

Mr. KENNEDY. I yield for a question.

Mr. SARBANES. As I understand this, we are dealing here with a Patients' Bill of Rights which is designed to, in effect, curb some of the practices of the HMOs. The proposal from the other side of the aisle by our Republican colleagues does not cover the bulk of the people who are in HMOs, is that correct?

Mr. KENNEDY. It covers virtually none of the people who are in HMOs.

Mr. SARBANES. What is the purpose of their exercise? It is a pretense, is it not, to assert some sort of Patients' Bill of Rights to deal with problems people are having with HMOs and then not to cover the very people who are in the HMOs? That is a pretense, is it not?

Mr. KENNEDY. I believe it is.

This chart clearly reflects the point the Senator has made. The 48 million who are covered are covered through self-funded plans. The largest group of persons receiving health care through HMOs are the 75 million where the employer purchases coverage through an insurance policy or an HMO; about 85 percent of the 75 million are enrolled in HMOs. This bill does not cover them.

This bill doesn't cover State and local workers, and it does not cover people buying individual policies.

The bill supported by the Republicans, which is a bill allegedly dealing with the problems occurring in HMOs, covers few if any of the members of Health Maintenance Organizations.

Is it any wonder the insurance industry is supporting their particular proposal and is opposed to the proposals we have supported? Isn't it understandable that the major medical groups and professions, the doctors and nurses who are concerned about managed care abuses—who understand the abuses happen to those with employer-provided plans, State and local government plans, and individual plans—uniformly support our legislation?

Mr. SARBANES. I did a fast calculation. As I calculate, more than 70 percent of the people who we are concerned about with respect to how they get their health care and the practices which are followed are excluded—not included, excluded—from the Republican proposal.

Mr. KENNEDY. The Senator is correct. That is why this debate has been rather empty until now. We heard much stated by the principal supporters of the other side's bill about all the benefits of the Republican bill. Now we have found out that the benefits do not apply to two-thirds of all those with insurance coverage, and most of those it may protect are not enrolled in HMOs.

(Mr. GREGG assumed the Chair.)

Mr. BIDEN. Will the Senator yield?

Mr. KENNEDY. I yield.

Mr. BIDEN. In my State, the vast majority of the people who have insurance work for Dupont, General Motors, Chrysler, the major pharmaceutical firms such as Zeneca and Hercules. Do you mean all those people—and they all have employer-provided health care—are excluded from coverage in the Republican bill?

Mr. KENNEDY. Not knowing whether those particular programs are self-funded offhand, it would be difficult to respond concerning particular companies.

However, only the larger companies self-fund. They are the only companies that have the resources to self-fund. It is generally the major companies and

corporations that have the adequate resources to self-fund health coverage.

The people buying individual policies are the farmer, and the small shopkeeper. It is the men, women and children on Main Street who are not protected under the Republican plan.

When we talk about State and local government employees, we are talking about policemen and firefighters putting their lives on the line every day, their spouses, their children, their parents. They are the State and local government employees. About 75 percent are covered by an HMO—they are getting no protections under the Republican plan.

I am reminded by my staff that 89 percent of the people in Delaware who have privately purchased health insurance will not be covered under the Republican plan.

Mr. BIDEN. Eighty-nine percent?

Mr. KENNEDY. 89 percent will not be covered by the proposal. We have a breakdown for each State. In Delaware, it is 89 percent not covered by the Republican proposal. The protections they are talking about doing, or will do, will not cover 89% of the people in Delaware, with the exception of the amendment of the Senator of Maine that has just been adopted, which is universal. That is another issue we will come back to.

Mr. SARBANES. Will the Senator yield?

Mr. KENNEDY. I yield.

Mr. SARBANES. As I understand the Senator's chart, there are 15 million people buying individual policies. Under the Republican proposal, they will not be covered, is that correct?

Mr. KENNEDY. The Senator is correct.

Mr. SARBANES. There are another 23 million people, State and local government workers, as I understand it, under the Republican bill, who will not be covered, but they will not receive any protections with respect to the practices of the HMOs, is that correct?

Mr. KENNEDY. The Senator is correct.

Mr. SARBANES. Furthermore, there are another 75 million people whose employers provide coverage through an insurance policy or an HMO, 75 million, and those people will not be covered, is that correct?

Mr. KENNEDY. The Senator is correct.

Mr. SARBANES. That is a total of 113 million people not covered.

As I understand it, the only people covered in this Republican proposal are 48 million people covered through a self-funded employer plan, which is less than 30 percent of the total number of people about whom we should be concerned.

Mr. KENNEDY. The Senator is quite correct.

That raises the question about supporting that plan. It is a legitimate question—whether we ought to be representing to American families that we are doing something to protect them when we are not, we are failing. By failing to provide universal protection, if the Republican proposal comes before the Senate and Members support it, we are failing 70 percent of the American people.

It is a fraud to represent that we are providing them with protections when we are not. This is why I think we are putting the Senate to the test this afternoon. We are testing the seriousness Members have for ensuring that whatever is passed will apply to everyone in this country who has insurance.

Mr. SCHUMER. Will the Senator yield?

Mr. KENNEDY. I yield.

Mr. SCHUMER. Does the Senator have information on what percentage are covered in New York?

Mr. KENNEDY. The answer to that is, yes, we do. Mr. President, 79 percent of those who are insured in the State of New York will not be covered. There are 10,300,000 individuals who are covered with privately purchased insurance, and the number of persons not covered under the Republican bill is 8,101,000, practically 80 percent. Four out of five of the citizens of New York will not be covered under the Republican program unless this amendment is accepted.

Mr. SCHUMER. And, further asking a question, that means that four out of five would not get emergency room coverage; four out of five would not get the right to specialists; four out of five would not get the extended appeals, the independent appeals; four out of five would not have any right to sue.

So this amendment that the Senator from Massachusetts is offering is probably, I would guess, the most important amendment because every other amendment is dependent on it. No matter how good an amendment you agree to, if the amendment of the Senator from Massachusetts is not agreed to, it does not matter to most Americans because they simply will not be covered. We would be voting for a bill that would do one-fifth as much, at best, as a proposal that would cover everybody. Am I correct?

Mr. KENNEDY. The Senator is quite correct. It is the difference between substance and process. You can have the greatest substance in the world, but if you control the process, you can limit it and restrict it in such a way to preclude people from being protected. That is exactly what is happening here.

Mr. SCHUMER. Right.

Mr. KENNEDY. Even the underlying substance of the Republican proposal we believe has fallen short in the areas mentioned by the Senator from New York. We are going to try, during the latter part of the afternoon, tonight, and tomorrow, to continue to address those inadequacies, and hopefully we will have some support.

Mr. SCHUMER. One final question. This chart would indicate it all. It is 48 million/161 million. Under our proposal, the Democratic proposal, 161 million Americans are covered for emergency room, for specialists, for independent review, for the right to sue. And, at best, even if all the other amendments are agreed to, under the Republican proposal under 48 million would be covered?

Mr. KENNEDY. The Senator is quite correct. On the other side of the room—I am glad to see our two colleagues. We are missing some of our other colleagues for this debate on a matter of such great importance.

I rarely see, and I ask my other colleagues how many times have they seen, legislation written that effectively excludes 72 or 73 percent of all Americans but meets American's needs? Yet we effectively exclude 72 or 73% of Americans who need these protections. This, I think, makes the proposal fraudulent in its representation to the American people.

Mr. SARBANES. Will the Senator yield further?

Mr. KENNEDY. Yes.

Mr. SARBANES. I think the Senator from New York has again emphasized an extremely important point. People watching this debate have to understand, we have had these amendments arguing about what practice should be covered—what practice should be covered. So we have an important difference there. But the fact of the matter is, under the Republican proposal, no matter what practice is covered, it is only going to reach less than 30 percent of the people.

For the remainder, the other 70 percent, the 113 million, this debate for them is completely irrelevant because they are not going to be covered at all. So all of this other argument about whether you cover this procedure or that procedure—which I think are extremely important arguments in and of themselves, and important issues—but unless we deal with this issue of coverage, which is the sharpest contrast between the two proposals, well over 70 percent of the people are simply going to be left out altogether. Is that not correct?

Mr. KENNEDY. The Senator is correct. But let me mention an additional fact you will hear from the other side. They will say: We want to cover these 48 million individuals, but the States are covering all the others; therefore, you have an empty argument, Democrats have an empty argument.

Do you know the answer to that? There is no State in this country that provides all the protections provided in the Democratic proposal—not one State. There is no State in the country that guarantees pediatric specialty care for children who may have cancer or other kinds of serious illness—not one.

You can pick and choose and find out that there are 18 States that have require some type of external appeal; almost all reject the kinds of appeal the Republicans have, the self-serving appeals where the HMO appoints the reviewer. They can fly-speck all afternoon and say we have this here and

this here, but there is not a State that provides all the protections we provide.

I ask any of my colleagues who are on their feet if they differ with the concept that we ought to provide a basic floor of protections for all Americans. Then, if the States of New York, California, Massachusetts, or Maryland want to build on those protections, we may do so. This is the model used in the bipartisan legislation Senator Kassebaum and I sponsored which passed the Senate that allows employees to move from job to job while retaining health care coverage. We follow that pattern very closely with this legislation. We follow the same type of model—a federal floor—in COBRA legislation. We follow the same model for mental health programs.

We have followed that model with bipartisan support on 10 different programs, and I will have them printed in the RECORD this afternoon, and yet we have the Republicans saying no to the model on this legislation.

Why? The answer is, the insurance companies will not let them. That is the answer. There is no other answer. We challenge our Republican friends. They are not here. We challenge them. How do you justify following the same type of process and procedure we have used in 10 different programs that have bipartisan support and yet now saying no, no, no, we are not going to do it on this bill? Can they give me an answer? Can they give us a clear answer on why they will not do that?

I do not know. I think it is important, however, in giving a complete answer to the Senator, to at least know what they are saying and how inaccurate and implausible their explanation is.

Mrs. BOXER. Will the Senator yield for a question?

Mr. KENNEDY. I see my friend and colleague from Massachusetts.

Mr. KERRY. Mr. President, I ask my colleague from Massachusetts, who I think has hit the nail on the head when he talks about what the insurance companies will allow or not allow, for the average American listening to this, the immediate question is—it seems incomprehensible—how can we not be covered if that is the purpose of the bill?

The Republicans are going to hide behind a number of false arguments. I wonder if my colleague would share with us what the reality is of the cost, because the Republicans are going to hide behind the notion that somehow what the Democrats want to do, which is cover more Americans, is too costly, and they will bring out the old Harry and Louise chart again and try to confuse Americans about what will happen.

Will my colleague share with us and with the American people what the real costs are of what the Democrats are talking about doing?

Mr. KENNEDY. Mr. President, we have put into the RECORD the letter from the General Accounting Office that said it is 4.8 percent over 5 years. That figure was used by the majority leader, Senator TRENT LOTT, on ''Meet The Press.'' He basically subscribed to that cost over a period of 5 years.

If you take the average program, it averages about $2,000 for an individual; $1,000 for a child; about $5,000 for a reasonably good family plan. Maybe it is somewhat more costly in the Northeast than it is in the South. If you look at a 5 percent cost, it would be $250 over 5 years; that is $50 a year. If you look at the percentage paid for by the worker, it is typically about 20%. If you do that for 12 months, do that over 1 year, it is less than $2 a month, it is a Big Mac.

I see a number of my colleagues. I think all of them would agree, every time we talk about family and medical leave we get a study done by the Chamber of Commerce. When we talk about minimum wage, we get those studies that are done by the restaurant association on the increase in the minimum wage. They talk about the escalation of costs and how it is going to put everybody out of business. The studies about cost used in this debate are studies that are bought and paid for by the insurance companies—bought and paid for by the insurance companies.

We have heard from our Republican friends for months and years, as the President of the United States said yesterday: We always rely on the CBO figures. Now we have a CBO figure, and they do not like it.

Their second point is that all those people are going to lose their health insurance. The fact is that the individuals and groups which have fought for expansion of health insurance coverage for years support our bill. Now we have the insurance industry saying pass this bill because it is going to mean the loss of health insurance coverage. That is poppycock. That is wrong.

The facts, again, is that the General Accounting Office—and I have put in the RECORD the particular provision—has said there may very well be an expansion in total coverage because there will be good benefits and good protections.

The line I like is the one that was stated so well by our good friend from Maryland earlier today at a press conference: Around here it used to be when you bought insurance, it was what you were buying, what you could expect; what you paid for is what you were going to get. Now when you give your money and buy insurance, it is what the insurance company is prepared to give you.

That is what has happened in the United States of America. It is what the insurance company is going to give you. As a result, it fails to give adequate coverage to those children and women, the disabled and people who have bought the insurance and deserve appropriate coverage. That is what is happening.

When they talk about costs, I wish they at least had the decency to address who picks up the cost when people fall through the cracks? It is charity care in the States. It is taxpayers who pick up the costs.

What about the cost of all that advertising we see every day? Mr. President, the profits of the top 10 HMOs total $1.5 billion. There are tens of millions of dollars spent for CEO salaries. Who is paying for all that? That is going to result in higher premiums for American workers, and that is what they should be outraged about.

I will take a couple more questions, and then I will be glad to yield the floor. Can I finish with my colleague?

Mr. KERRY. One further question, if I may. We have talked about some other States. In the State the Senator and I represent, Massachusetts, it is my understanding that 77 percent of the privately insured would not be protected under the Republican plan.

Mr. KENNEDY. That is my understanding as well, 3 out of 4.

Mr. KERRY. How can you describe the rationale for the Republicans coming to the floor and saying that, in fact, they are offering Americans a Patients' Bill of Rights?

Mr. KENNEDY. I find that has been the question for a long time. We had hoped to work in a bipartisan way as we did to get coverage for 5 to 10 million children with the Republicans on our committee. We had hoped to work in a bipartisan way as we did with Senator Kassebaum to allow health insurance to become more portable. We are hopeful of working some of the privacy issues out in a bipartisan way. Yet when it comes to the Patients' Bill of Rights, the wall came down. The insurance companies said absolutely not, not an inch.

I was listening to my colleagues say this is a regrettable situation; I wish we could get together. The insurance companies will not let them get together with us. They will not let them. This bill has been bought and paid for by the insurance industry; no question about it.

I yield to the Senator from North Dakota.

Mr. DORGAN. I appreciate the Senator yielding. I was standing here listening and thinking of Mark Twain. He was asked to engage in a debate at one point. He said: Fine, as long as I can be on the opposing side.

They said: We haven't told you what the subject is.

He said: It doesn't matter. Being on the opposing side doesn't require preparation.

There is no preparation here. We do not have a Republican on the floor at the moment. I am sorry, Senator JEFFORDS is here.

You can fill in the blank. It would not matter if you talk about managed care, minimum wage, clean air. You can talk about Medicare, you can talk about child labor laws, and there will be the same folks coming to the floor saying: It is not the Federal Government's responsibility; let the States do it.

The Senator from Massachusetts made the point that most of the people are left out of the Republican plan. If people wonder if it is us against them, here is a USA Today editorial. It says: ''100 million Reasons GOP's Health Plan Fails.''

That is how many people the proposal will leave unprotected. Judging from the health insurance reform package announced this week by Senate Republicans, at least the title is correct. The proposal is called the ''Patients' Bill of Rights,'' and if you are waiting for this perfunctory plan to protect you, you'll need to be patient indeed. Many of the plan's key protections are restricted to the 51 million Americans who get their insurance through self-insured plans, subject to Federal regulations, but another 100 million or so whose health plans are subject to state regulations are excluded.

The same editorial points out, as the Senator from Massachusetts has, that most of the States do not have these protections.

These folks who come to the floor and say the States already have the protection—access to nonnetwork providers, 35 States do not have that. I just do not understand. Instead of coming to the floor and being honest and saying: We have no interest in this bill, all we want to do is obstruct, we have no interest in passing anything similar to that. Instead of doing that, they come with all these fuzzy shells. You wrap a package. It looks to be the same package that is sitting across the desk, but it has nothing in it. That is what is happening. Amendment after amendment is an empty shell, a package with nothing in it.

USA Today says it right: ''100 Million Reasons GOP's Health Plan Fails.''

Isn't it the case, I ask Senator KENNEDY, because of this every single health organization in this country opposes the Republican plan and supports the Democratic plan? Is that not the case?

Mr. KENNEDY. The Senator is correct. Generally around here it is a pretty good test to take a piece of legislation and ask who is supporting it and who is going to benefit. That is not a bad test for the American public: Who is supporting the legislation—which groups, which people—and who is going to benefit.

What you find out is that our plan has the support of every health professional and every patient group. They are the ones supporting our bill.

Who is opposing it? The insurance industry. Who is supporting the opposition program? The insurance industry.

As this debate goes on and we get involved in technicalities, people ought to know at the bottom line of each and every one of these issues who supports our plan. On the OB/GYN issues, the medical professionals support our proposal in spite of the misrepresentations put forth in this Chamber.

That is what is happening. The reason for that, as the Senator understands, is we have worked this out with consumers and health professionals. We tried to find out what is needed from the consumers—the people who have suffered—and also the health professionals who have tried to protect the consumers. We were out there listening.

I will take these last two and yield the floor.

Mrs. BOXER. I have two quick questions. One involves the largest State in the Union, and that is the State I represent. This is really key. We have 33 million people living in California. How many of them, percentagewise, will not be covered by this Republican plan?

Mr. KENNEDY. It just so happens I have that information: 18 million privately insured persons, 18.6 million; 14,477,000, 77 percent of the people of California will not be covered if our amendment is not successful—77 percent of the people in California.

Mrs. BOXER. I think it is very important that the people in my home State understand that the Republican plan does not do anything for very many of them.

The second question I have deals with children. As the Senator from North Dakota pointed out, we do have national laws. This is one Nation, under God, indivisible, and we do have national laws. I find it unbelievable that colleagues on the other side—a couple came over and said: States are taking care of all these issues.

I want to talk about children. Every Senator in this body I know cares about kids. I know they care about kids. They care about their own kids, their grandkids, and the kids they represent. I ask my friend to elaborate on this. If we can have child labor laws which say you cannot hire a child, you have to wait for a certain age, and when you do, there are certain rules that apply, should we have a national law that protects every child in this country so if that child comes down with a cancer, they are not told by their HMO: Go see a general surgeon; you don't need a pediatric surgeon?

I know my friend has had experience with this. Can he talk just a moment about why the Democratic plan is for the children of this country and the Republican plan is a sham?

Mr. KENNEDY. As the Senator knows, the kinds of protections for children are included, including the preventive programs, specialty programs, the clinical trial programs, and the specialty care programs. Our good friend, Senator REED, is one of our real experts on these issues. The range of different protections and guarantees is out there for children. That is why every child's health group supports our program.

But let me mention something of interest that is on point. The Senate has just accepted the amendment of the Senator from Maine on the issue of mastectomies. In her amendment it says:

[I]n order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in 1 State as well as health plans operating among [all] States.

So perhaps we could find a distinction. I know the Senator believes strongly that is the kind of coverage we should have for women. But could the Senator possibly explain to me how we could justify supporting that particular provision and not say we need similar protection for children? Are we missing something on this? They will say: We will do it for this.

Right above that it says:

[H]ealth care providers located in a State serve patients who reside in the State and [also] patients who reside in other States. . . .

What they are acknowledging is, people move from State to State, so they are going to provide for them.

It talks about the amendment covering all health plans. What is the rationale? Can the Senator tell me?

Mrs. BOXER. The only rationale I could find—I was here when my friend asked Senator ABRAHAM the same question—this Republican plan has been pieced together. It makes no sense. It is a political response, I believe, to the Democratic proposal. They looked at this issue, and they said: OK, when it comes to mastectomies, we'll make our plan apply to everybody.

But, by the way, if you get ovarian cancer, under the Republican plan you do not get the benefits. If a man gets prostate cancer, he doesn't get the benefits. If you are a little child and you have a rare form of cancer, like one of my constituents, Carley Christie—and there were only a couple doctors who knew how to handle it—you are out of luck.

They say leave it to the States? Fine. If the States want to do a good job, we are happy. We are just setting a floor in this bill, as the Senator from Massachusetts points out.

So I can only respond by saying their approach is pieced together. It is a political response to a real issue. They are doing the least they can do to try to say, with a straight face, they have done something. The bottom line is, their bill is hollow, and if my friend's amendment does not pass, it will make virtually no difference to most of the people in this country.

Mr. KENNEDY. I finally yield to the Senator.

Mr. WELLSTONE. I was going to hold up my own chart, but I would rather ask the Senator from Massachusetts, could you just give me the figures?

Mr. KENNEDY. You have your Minnesota figures there.

Mr. WELLSTONE. I enjoyed when you said: I just happen to have figures here.

Mr. KENNEDY. As the Senator well knows, the State of Minnesota has 3,400,000 privately insured persons and 1,986,000 not covered. So you are going to have some 58 percent—58 percent will not be covered.

Mr. WELLSTONE. The reason I asked my colleague for those figures is, that is over half the State's population.

Minnesota does better than some other States in terms of the number of families that would be covered under the Republican plan because we have more people who are self-insured.

But let me just be clear about this. The Senator from Massachusetts has made it clear that our amendment provides basic protection for every family in the country. We want some kind of floor. Any State that wants to do better, any State that wants to do better by way of protecting children, more access to specialty services, stronger consumer protection, can do so. But this amendment is an amendment to make sure that every family in the United States of America has some basic protection. Is that correct?

Mr. KENNEDY. The Senator is correct.

Mr. WELLSTONE. Let me just ask the Senator from Massachusetts one more question to finally put this debate in sharp focus—if we are going to have a debate. I do not know that we will.

Do you believe there is some correlation between the fact that the plan we now have on the floor of the Senate, the Daschle-Kennedy Democratic plan, altogether covers an additional 113 million people and the Republican plan only covers 48 million people altogether? The Republican plan provides as little coverage as possible to people. Is that why all the consumer organizations, all the provider organizations, doctors and nurses, support our plan and the insurance industry is the only interested party that supports the Republican plan? Do you believe there is any correlation on this whole question of how many people are covered?

Mr. KENNEDY. I think the Senator is correct in his statement. It is basically because the industry is putting its profits ahead of the protection of the patients.

We had reaffirmation yesterday, in an indirect way, with the publication of an article in the medical journal JAMA, that says the for-profit HMOs provide a good deal less service for the coverage of individuals than those which are not-for-profit. It is, I think, a kind of intuitive, self-evident factor that this is taking place.

I would be glad to yield time.

Mr. WELLSTONE. I would like to take 3 more minutes if I may.

Mr. KENNEDY. I am advised by my friend and colleague, 2½ minutes.

Mr. WELLSTONE. That is fine. That is all we have left?

Mr. REID. We have 7 and a half minutes.

Mr. WELLSTONE. I will do it in 1 minute. Then I will pass it on to others.

Let me just finish my line of questioning by saying here on the floor of the Senate that one of the things I have been most interested in as a Senator from Minnesota is reform and how to revitalize democracy, how to make sure that the Government belongs to the people, how to make sure that the Senate belongs to the people.

I really do believe that this vote on this amendment about whether or not we are going to cover all the families in our country and provide them with some basic protection, so that they can make sure they themselves and their loved ones receive the care they need and deserve, is a test case as to whether or not we have a system of democracy for the many or democracy for the few.

This vote ultimately is about more than health care. This is a vote about whether the Senate belongs to people in Minnesota and people in Massachusetts and people in New York and people in North Carolina or whether it belongs to the insurance industry. It is that simple.

I hope every citizen will hold all of us accountable for how we vote and whom we represent and for whom we fight.

I yield the floor.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. On behalf of Senator KENNEDY, I yield 2½ minutes to Senator DORGAN.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. REID. Could we change that to 2 minutes.

The PRESIDING OFFICER. The Senator from North Dakota is recognized for 2 minutes.

Mr. DORGAN. Senator KENNEDY has been talking about the issue of the number of Americans who would be covered under these two competing proposals. The point I have made in the past in quoting the USA Today editorial is the same point that a number of us have made: The fact is, our opponents' plan does not cover most of the American people. They say: Well, the States provide protection for those their bill leaves out. But the facts do not bear that out.

My preference would be that if they do not want to legislate in the area of health care, just say that. Do not make a pretense of coming over here and saying, we support all these issues, we support each and every one of them but then vote against the kinds of reforms that will really accomplish them.

My understanding is that the amendment we just agreed to by Senator SNOWE on the issue of breast cancer covers everyone in the country. Why cover all Americans on just that issue? Apparently you are willing to provide some protection for everyone on only that one issue but you are unwilling to cover everyone when it comes to all of the other issues. I do not understand that.

I wish I had the time to again show you the pictures of real victims of our current system to illustrate that this debate is not about theory; it is about real people. Unfortunately, I do not have the time. But this debate is about what kind of treatment patients will get in a health care system that in some cases—not in all, but in some cases—has put profits ahead of patients' medical needs.

Some in this Chamber say these stories don't matter. We stand with insurance companies. We stand with profits, and we don't believe patients need protection.

Others of us believe very strongly that it is time to provide the kinds of protections on a uniform basis that patients ought to expect when they purchase insurance or when they receive insurance through their employer.

Again, to those who have spent this week fuzzing up this debate, if you don't like the Federal Government legislating in this area, just say that. Don't bring a bunch of empty vessels to the floor of the Senate and then pretend they do something because you know better.

The PRESIDING OFFICER. The Senator's 2 minutes has expired.

PRIVILEGE OF THE FLOOR

Mr. REID. Mr. President, I ask unanimous consent that Joshua Segall, an intern in the office of Senator PAUL WELLSTONE, be granted the privilege of the floor today.

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

Mr. REID. How much time does the minority have?

The PRESIDING OFFICER. The Senator has 6 minutes.

Mr. REID. Mr. President, I yield 2 minutes to the Senator from New York and, following that, 2 minutes to the Senator from Massachusetts.

The PRESIDING OFFICER. The Senator from New York.

Mr. SCHUMER. I thank the Senator from Nevada.

There are two crucial numbers to look at as we debate this entire bill: 48 and 161—48 million Americans covered by the Republican plan, 161 million Americans covered by the Democratic plan. We are saying 70 percent of all Americans will get no protection.

Do we say 70 percent of all Americans are not covered by minimum wage? Do we say 70 percent of all Americans are not covered by Social Security? Do we say 70 percent of all Americans do not get child labor laws applied to them, do not get the Clean Air and Clean Water Acts applied to them? I have never heard anything such as this in my life—take a proposal needed by all people and arbitrarily say 30 percent of Americans will be covered and 70 percent of Americans will not.

This vote on the amendment of the Senator from Massachusetts will be the most crucial vote in the entire debate, because it will determine, do we really wish to cover all Americans.

Should only 30 percent of Americans get the right to emergency room care? Should only 30 percent of Americans get the right to see a specialist? Should only 30 percent of women get to treat an OB/GYN as their primary care specialist? Who would agree with that?

Anyone who votes against the amendment of the Senator from Massachusetts, anyone who votes for the Republican plan is arbitrarily, unfairly,

and inhumanely cutting off 70 percent of all Americans.

The cost: $2 a month. The cost argument is bogus.

The real issue is, who will be covered and who will not be. Under this plan, we cover 161 million; they cover 48 million.

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

Mr. SCHUMER. Nothing more must be said.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KERRY. Mr. President, this is, indeed, the most important vote with respect to this issue. I congratulate my colleague from Massachusetts for his extraordinary leadership in putting this issue before the American people.

It is extraordinary to me; in the years I have been in the Senate, I think this is perhaps the single most contradictory, craven moment, in some regards, before the Senate. To come to the Senate and suggest you are going to have a Patients' Bill of Rights that in State after State after State leaves out 77, 80 percent, 89 percent of the American people is a contradiction on its face that denies any kind of reasonableness. I think most people in America will understand that our colleagues on the other side of the aisle have spent more time and energy protecting the right to bear arms than the right for citizens to get decent medical care.

What will happen in this legislation if the Republican charade passes—and they have the votes—is, once again, the American people will be left behind and business—and business only, the bottom line—will be the victor.

They are going to suggest there are costs, there is administrative overhead. We are going to go through the whole ''Harry and Louise'' thing again. Literally millions of dollars are being spent to scare Americans and confuse them.

When it is convenient for the Republicans, they love the Congressional Budget Office. The Congressional Budget Office provides the best figures, the most neutral and independent assessment of expenditures. But here, the Congressional Budget Office comes out and says the real costs of this are only 3 to 13 cents per month per beneficiary. There isn't an American I know who wouldn't pay 3 to 13 cents to have the decent kind of coverage and the protections they need in order to guarantee that coverage in a health care system that has run amok.

The PRESIDING OFFICER. The Senator's time has expired. Who yields time?

Mr. KENNEDY. Mr. President, how much time remains for each side?

The PRESIDING OFFICER. The Senator from Massachusetts has 2 minutes, and the Senator from Tennessee has 15.

Mr. KENNEDY. I yield 2 minutes to the Senator from Illinois.

Mr. DURBIN. Mr. President, this amendment really gets to the heart of the debate: how many Americans will we leave behind when it comes to reforming our health insurance protection.

Senator KENNEDY and Senator DASCHLE offer an amendment which will reform health insurance plans across the country. The Republican side of the aisle would leave behind 113 million Americans. They argue that these families should not be protected by a national standard. Just by accident of birth or residence, some people would be disqualified.

Who are we talking about? We are talking about people such as the self-employed, small businesspeople, and farmers, those who have a tough enough time securing health insurance. They pay higher premiums for it, and they are not in a good position to really bargain when it comes to buying their health insurance.

This amendment gets to the heart of which party and which approach really care for American families and the challenges they face. I support Senator KENNEDY and Senator DASCHLE in this effort.

I just left the chatroom right off the floor of the Senate, where people have been, through the Internet and by telephone, calling in from across the United States. I think many people on the Republican side of the aisle have not really taken into consideration how important this issue is to Americans. They can vote with the insurance industry, and a Republican majority can defeat us on these amendments, but eventually they will have to go face the same families who I have spoken to and who write to my office—families who worry on a daily basis about whether their doctors are making medical decisions or the decisions are being made by insurance company professionals.

This amendment, which is about protecting all insured Americans, is one I am proud to support. The idea of picking and choosing the winners and losers across America is inconsistent with the policy that we should have coming out of this Chamber.

I hope a handful of Republican Senators will come forward and join the minority on the Democratic side and enact a bipartisan approach that is sensible.

The PRESIDING OFFICER. The Senator's time has expired. Who yields time?

Mr. FRIST. Mr. President, I yield myself 2 minutes, followed by Senator GRAMM for 10.

The issue we are talking about is an amendment which came on the floor about 50 minutes ago. We are currently looking very carefully at that amendment. It is the first time we have seen the amendment. It comes down to a critically important issue, and that is one of scope.

We have a Patients' Bill of Rights. We have spent much of yesterday and the day before and this morning on what those rights should be. Are they consumer protections? Are they patient protections, gag clauses, access to specialists, access to emergency rooms, poststabilization in emergency rooms, continuity of care? We have talked about the issues of the internal and external appeals process. All are very important.

Now we turn to this underlying discussion of scope. We have heard again and again that our bill excludes a large number of people. No. 1, the whole information section of our bill applies to all 124 million people, the information to understand what is in that insurance policy, in that contract.

On the whole issue of genetic discrimination, something the other side has not even mentioned, again we apply it to all 124 million people. Why? Because it has not been adequately addressed in the United States of America today because projects such as the human genome project are just coming on line. Yet in advance we want to make sure that an insurance company does not use a predictive test in some way to either exclude somebody or raise policies.

No. 3, the internal and external appeals process, the whole accountability process, grievance procedures, inside, outside, applies to all 124 million people.

The issue which has been discussed over the last 40 to 45 minutes is that of the 48 million people who are uncovered today by State plans, cannot be regulated by State plans. It is to those 48 million people that we address the patient protections of gag clauses, access to emergency rooms, continuity of care, poststabilization in the emergency room. That is the focus. In our bill, internal and external appeals covers everybody; discrimination, everybody; information, everybody; recover the uncovered, regulate the unregulated.

I yield 10 minutes to the Senator from Texas.

Mr. KERRY. Mr. President, will the Senator from Texas yield before starting?

Mr. GRAMM. Mr. President, we have now listened to the minority use up their time. I think it is time for us to speak. So with all due respect, I didn't ask for them to yield on their time. I don't yield on my time.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. GRAMM. Mr. President, we have heard, for the last hour, in almost tearful terms, our colleagues talk about how in the amendment they now have before us ''we are down to the heart of what separates the two parties.''

Well, I don't know whether it is the heart, or the lungs, or the liver, but we are sure down to what separates the two parties. Our colleague from Massachusetts has a sign that talks about how we are not protecting Tennessee. That is interesting because Tennessee protected itself by electing one of the Nation's premier physicians to represent them in the Senate and to become the Nation's foremost spokesman

on health care. Yet Senator KENNEDY believes he is somehow here to protect the people of Tennessee. I don't think they elected Senator KENNEDY. I think they elected Senator FRIST. I think they elected him because he does represent their views.

What is in this amendment that is supposed to be the heart of what defines the two parties? Well, it is very interesting. It is about two things. No. 1, they want to raise taxes about $5 billion. That does define the difference between the two parties. Whether it is the heart of the difference, or some other body part, I don't know. But the first thing that is different—and they are speaking in such passionate, tearful tones about it—is they want to raise taxes by $5 billion on this amendment.

So to take them at their word, if you want to know the difference between the two parties, the difference between the two parties is that they, by their own words and deeds and amendments, are the party that wants to raise taxes in the Senate. The tax burden is at the highest level in American history, but it is not high enough to suit them. They want $5 billion, and they want to take it $50 per household in America, and they want it in this amendment. That is the first thing they say defines the heart of the difference between the two parties.

The second thing they say defines the heart of the difference—and I agree with them—is that when they read the Constitution, they quit reading too soon because what the Constitution says in the tenth amendment is that those powers not specifically delegated to the Federal Government are reserved for the States and for the people.

Why is that relevant? Why it is relevant is, despite all the efforts to confuse people, under existing law, the States regulate insurance. There is a Federal statute that carves out between 40 and 50 million insurance policies where the companies actually underwrite the policies—a law called ERISA—where the Federal Government in these circumstances established its primacy and its jurisdiction so that the State legislature of Tennessee, and the State legislature of Texas, and the State legislature of all the States in the Union are prohibited from legislating in these ERISA plans where the company assumes liability for the insurance.

What we have done in our bill is, where the States can't reach, we have passed a bill that guarantees patients' rights, including the one right the Democrats preclude. The Democrats will let a patient look in the phone books' Blue Pages and call the Government if they are unhappy with an HMO, and they will let them look under ''attorneys'' in the Yellow Pages and hire an attorney if they are unhappy with an HMO; but the Democrats don't give them the freedom to fire the HMO. We give them that freedom.

Now, we have written a bill that is aimed at dealing with the part of this problem that comes under the Federal Government. Our Democrat colleagues are very unhappy because they want a national health plan. They believe Senator KENNEDY and President Clinton know everything there is to know about health care, that Dr. FRIST knows nothing about health care, and they would like to write health care policy for Texas.

Now, they want to do it without the inconvenience of having to move to Texas, pay taxes in Texas, and run for office in Texas. They want to assume that if you are elected to the Senate from Massachusetts, that allows you to tell people in Tennessee how insurance ought to be regulated, and that allows you to tell people in Texas how things ought to be. Now, Texas has already passed a comprehensive patients' bill of rights, but that doesn't stop those elected to the Senate from some other State from the right to come in and say to Texas: You don't know what you are doing, you don't know anything about health care, and you don't care about the people of Texas.

Having been elected in Massachusetts, they care about people from Texas; but they believe the people in the senate and the house of the Texas Legislature are somehow deficient in caring to suit them. So the second thing they differ on is that while States throughout the Union have tried to tailor their programs to meet their individual needs, the Democrats would have us say: Take everything Texas has done, everything Maine has done, everything the 43 States have enacted, and the other States that are about to act, and throw it in the trash can because all wisdom emanates from Washington.

So this ''heart'' of the difference between the two parties that we have been listening to for an hour really boils down to two differences. They want to raise taxes by another $50 per family on the amendment they just offered and they want to say to States: We are going to take away from you a right that has been historically guaranteed under Federal law and under the tenth amendment to the Constitution, which allows States, in the area of insurance where they regulate, to state their own policy, to decide what kind of policies they want operating within their own State borders.

Our colleagues have decided taxes are too low and that we don't have enough Federal regulation. So what they would do is attempt to substitute Federal mandates for what our Texas Legislature has decided, which would be dictated and enforced by Federal bureaucrats.

With all due respect, who is doing a poorer job than HCFA in regulating health care in America? Who is doing a poorer job than we are doing at the Federal level?

Our approach is an approach which says where we have responsibility, where only we can deal with a problem, we have put together a comprehensive program that makes sense. Granted, we didn't do a public opinion poll; we didn't get together focus groups and try to say if you ran a 30-second TV ad on this subject, would people tend to agree with it? We have Dr. FRIST. We have SUSAN COLLINS. We have JIM JEFFORDS. We sat down for over a year with people who knew something about the problem and we wrote a bill we believe people will be glad we wrote 10 years from now. But the reality is that there are two differences Democrats want to highlight today. There are two things they claim represent the heart of what separates the two parties.

They believe taxes ought to be higher. So they raise taxes by $5 billion with this amendment.

Second, they don't believe that Maine ought to set its health policy. These people in Maine don't understand health, and they don't care about people in Maine. Only people in Massachusetts care about people in Maine. Only people in Massachusetts care about people in Texas. And we don't understand it.

They are right. We don't understand it. We don't accept it. We reject it.

If the best they can do in telling us what is right with them and what is wrong with us is that they want higher taxes and they want to tell every State in the Union how to run health care, they are going to be in the minority a very long time.

I reserve the remainder of my time.

Mr. KERRY. Mr. President, will the Senator yield for a dialog?

The PRESIDING OFFICER. Who yields time?

Mr. JEFFORDS. Mr. President, I yield 10 minutes to the Senator from Wyoming.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. KERRY. Mr. President, I believe I asked a question.

Mr. GRAMM. The Senator has no time.

Mr. ENZI. Mr. President, I ask unanimous consent that I not be interrupted.

The PRESIDING OFFICER. The regular order is that the time shall be controlled by the managers, and time has been yielded to the Senator from Wyoming.

Mr. KERRY. Parliamentary inquiry, Mr. President.

Mr. GRAMM. Could we have regular order, Mr. President?

The PRESIDING OFFICER. The Senator is unable to propound a parliamentary inquiry. Time has been yielded to the Senator from Wyoming.

PRIVILEGE OF THE FLOOR

Mr. ENZI. Mr. President, I ask unanimous consent that Patrick Thompson, my HELP subcommittee staff person, and Mark Battalini, my legislative fellow, be granted floor privileges during debate on S. 1344, the Patients' Bill of Rights.

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

Mr. ENZI. Mr. President. I rise in opposite to this amendment. Among the handful of principles that are fundamental to any true protection for health care consumers, probably the most important is allowing states to continue in their role as the primary regulator of health insurance.

This is a principle which has been recognized—and respected—for more than 50 year. In 1945, Congress passed the McCarran-Ferguson Act, a clear acknowledgement by the federal government that states are indeed the most appropriate regulators of health insurance. It was acknowledged that states are better able to understand their consumers' needs and concerns. It was determined that states are more responsive, more effective enforces of consumer protections. And, as if we need to re-learn this lesson yet again, it is usually for the best when we let each state respond to the needs of its own consumers. State legislatures are watching, wondering how far we are going to dip into their authority.

As recently as this year, this matter of fact was re-affirmed by the General Accounting Office. GAO testified before the Health, Education, Labor, and Pensions Committee, saying, ''In brief, we found that many states have responded to managed care consumers' concerns about access to health care and information disclosure. However, they often differ in their specific approaches, in scope and in form.''

Wyoming has its own unique set of health care needs and concerns. But, despite our elevation, we don't need the mandate regarding skin cancer that Florida has on the hooks. My favorite illustration of just how crazy a nationalized system of health care mandates would be comes from my own time in the Wyoming Legislature. It's about a mandate that I voted for and still support today. You see, unlike in Massachusetts or California, for example, in Wyoming we have few health care providers; and their numbers virtually dry up as you head out of town. So, we passed an any willing provider law that requires health plans to contract with any provider in Wyoming who's willing to do so. While that idea may sound strange to my ears in any other context, it was the right thing to do for Wyoming. But I know it's not the right thing to do for Massachusetts or California, so I wouldn't dream of asking time to shoulder that kind of mandate for our sake when we can simply, responsibly, apply it within our borders.

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

As consumers, we should be downright angry at how some of our elected officials are responding to our concerns about the quality of our health care and the alarming problem of the uninsured in this country. It is being suggested that all of our local needs will be magically met by stomping on the good work of the states through the imposition of an expanded, unenforceable federal bureaucracy—kind of a one-size-fits-all plan. It was complicated before.

This is an overlay of how the plan will work under the Democratic plan. It is considerably more complex and considerably tougher to deal with. It is being suggested that our local needs would be magically met by stomping on the good ground of the States that have kept it simple and have the bureaucracy already in place.

It is being suggested the American consumers would prefer to dial a 1–800 number to nowhere versus calling their State insurance commissioner, real people who can be talked to each time you call. You don't have to repeat the same ground to bring them up to speed on where the problem is, and chances are because they know you they will get it solved right away. They are the people you meet in the grocery store after church on Sundays.

As for the uninsured population in this country, carelessly slapping down a massive new bureaucracy on our states does nothing more than squelch their efforts to create innovative and flexible ways to get more people insured. We should be doing everything we can to encourage and support these efforts by states. We certainly shouldn't be throwing up roadblocks.

And how about enforcement of the minority's proposal?

One of the findings of the amendment reads as follows, ''It would be inappropriate to set federal health insurance standards that not only duplicate the responsibility of the 50 State insurance departments but that also would have to be enforced by the Health Care Financing Administration (HCFA) if a State fails to enact the standard.''

That is a name you hear thrown around a lot because HCFA has some problems. HCFA is as much as 10 years late in sending out some notices which they need to send. They are already overburdened. If you don't believe me, talk to the people who are working with home health care, another area of health that is very important. They will tell you how HCFA is able to solve their problem. They are going out of business because of HCFA.

In other words, not only is it being suggested that we trample the traditional, overwhelmingly appropriate authority of the states with a three-fold expansion of the federal reach into our nation's health care, they want HCFA to be in charge. HCFA, the agency that leaves patients screaming, has doctors quitting Medicare, and, lest we not forget, is the agency in charge as the Medicare Program plunges towards bankruptcy.

And you want to give them all of this now, too?

I could go on at length about the very real dangers of empowering HCFA to swoop into the private market with its embarrassing record of patient protection and enforcement of quality standards. For example, it took ten years for HCFA to implement a 1987 law establishing new nursing home standards intended to improve the quality of care for some of our most vulnerable patients. According to the General Accounting Office, HCFA missed 25 percent of its implementation deadlines for the consumer and quality improvements to the Medicare Program which were required under the Balanced Budget Act of 1997.

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

To me, the message is pretty clear. Expanding the role of the Federal Government well beyond its lawful authority would be a big mistake.

The scope of Federal authority under the Employment Retirement Income Security Act, ERISA, with regard to the regulation of health care, is well understood. Duplicating, complicating, and ultimately unraveling 50 years of State experience and subsequent action makes no sense. For those of my colleagues who think no one is bothered by that, I and 117 million Americans currently protected by State health insurance beg to differ.

Our Federal responsibility lies with those 48 million consumers who fall outside the jurisdiction of the State regulation. That is our scope. That is our charge. That is what the States are politely reminding Members of now. If we go through with this, they may remind us less politely.

In March of this year, the National Association of Insurance Commissioners implored Members to not make a mess of what they have done for health care consumers, saying:

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

I am stunned that their pleas is so easy for some to ignore.

I yield the floor.

Mr. JEFFORDS. I yield 10 minutes to the Senator from Maine.

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

Ms. COLLINS. Mr. President, I start by commending the Senator from Wyoming for his excellent statement. He has provided Members with a very clear explanation of the issue that is before the Senate.

I am disappointed to hear my friends and colleagues from the Democratic side of the aisle once again completely disregard and, indeed, belittle the tremendous efforts that the 50 States have made to protect health care consumers. It is disappointing to once again hear Senator KENNEDY completely ignore the good work of the States in this area.

The health committee bill builds upon the good work that the States have undertaken to protect health care consumers. Our legislation provides the key protections that consumers want, without causing costs to soar so high that we add to the growing number of uninsured Americans. We would apply the protections responsibly where they are needed.

Current Federal law prohibits States from acting to regulate and to provide consumer protections in self-funded plans. They are covered by Federal law, by ERISA, which specifically prohibits the States from acting in this area.

The States have had the primary responsibility for regulation of health insurance since the 1940s, more than 50 years. I served for 5 years in State government as commissioner of a department that included the Bureau of Insurance. I know how hard the civil servants at the Bureau of Insurance worked to protect Maine consumers. I know Maine health care consumers who are having problems with their insurance companies' coverage or have a dispute would rather call the Bureau of Insurance in Gardiner, ME, than have to go through the maze of the ERISA office in Boston. That is what this debate is about.

The fact is, the States have done a good job of responding to the needs and concerns of their citizens. In fact, every single State has debated and enacted legislation to protect health care consumers. That has been totally ignored by our friends on the other side of the aisle.

This chart shows the enormous number of State laws regulating health insurance. There are more than 1,400 State health insurance mandates—more than 1,400. Every single State has enacted legislation to protect health care consumers by mandating either specific coverages or specific procedures. It is not as if the States have ignored this responsibility. In fact, they have acted far ahead of Washington. They have acted without any prod from Washington. They have acted responsibly and swiftly—indeed, much more quickly than we have—to protect their consumers.

The next chart shows State laws protecting parties are extremely common. This chart demonstrates 47 States have passed laws prohibiting gag clauses that restrict communications between patients and their doctors. This is something I think every single Member of the Senate can agree on: Gag clauses should be prohibited. Mr. President, 47 States have acted to do just that; 50 States have consumer grievance procedure laws; 28 have external appeals; 36 have direct access to OB/GYN; 40 States have provisions dealing with access to emergency rooms.

The States have acted. They have acted in a way to tailor their laws to the problems within their particular State. These problems vary from State to State. We have rural States such as those represented by my friend from Wyoming which do not have a high penetration of managed care. Therefore, imposing all these burdensome new regulations is not necessary. In other States where managed care represents a high degree or a high concentration of the coverage provided, there may be a need for many more State laws.

The point is that the States have acted. They have acted without any mandate or prod from Washington, and they have acted in a way so as to tailor their laws to their marketplace. One size does not fit all. We do not know what is best for every State-regulated plan. What may be appropriate in one State may not be necessary in another.

A State that has been mentioned today, Florida, provides for a direct access to a dermatologist. That is because Florida has a very high rate of skin cancer. That mandate makes a great deal of sense in the State of Florida. It does not make much sense in many northern States where other problems occur and need to be addressed.

That is why the National Association of Insurance Commissioners, which is a bipartisan group, supports the approach that we have taken in our health committee bill. In a March letter to the chairman of the health committee, the NAIC pointed out:

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

The letter continues:

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

That is precisely the approach taken in our Republican bill. We recognize the States cannot protect those health care consumers who are covered in self-funded ERISA plans. That is why we need to act on the Federal level. That is why we need to pass health care protections to reach those consumers whom the States cannot protect.

We received a letter today from the Republican Governors' Association. I ask unanimous consent to have that letter printed in the RECORD following my remarks.

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

(See Exhibit 1.)

Ms. COLLINS. Let me quote from the letter because I think it captures the issue before the Senate.

> As Congress begins debate on managed care reform legislation, we would like to emphasize our confidence in states' achievements in managed care and ask that any legislation you consider preserve state authority and innovation. We applaud the Republican Leadership's efforts to complement the states' reforms by expanding managed care protections to self-insured plans without preempting state authority.
>
> Historically, regulating private insurance has been the responsibility of the states. Many, if not all of the ideas under consideration now in Congress, have been considered by states. Because the saturation of managed care is different throughout the nation, each state has its own unique issues relative to its market place. We have concerns about the unintended consequences of imposing one-size-fits-all standards on states which could result in increasing the number of uninsured and increasing health care costs.
>
> As Governors, we have taken the reports of abuses in managed care seriously and have addressed specific areas of importance to our citizens.

That is exactly the issue before us. We do need to act to protect those consumers who are beyond the reach of State regulation. We do not and should not act to preempt the good work done by our States.

Another issue that is before us, raised by the Kennedy one-size-fits-all approach, is what if a State has made an affirmative decision not to act in one of the areas which Senator KENNEDY would impose upon that marketplace? What if the legislature, perhaps even a legislature controlled by the Senator's own party, has reached the decision that a particular mandate is not appropriate for that State and would increase health care costs?

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

Ms. COLLINS. Mr. President, I yield the floor. I know there are others waiting to speak. I reserve the remainder of my time.

EXHIBIT 1

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

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

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

Historically, regulating private insurance has been the responsibility of the states.

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

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

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

Sincerely,

FRANK KEATING,
Governor of Oklahoma,
Chairman.
ED SCHAFER,
Governor of North Dakota,
Vice Chairman.
DON SUNDQUIST,
Governor of Tennessee,
Chairman RGA Health Care Issue Team.

Mr. JEFFORDS. Mr. President, I rise to alert those who followed the minority's debate earlier. It was not only confusing but most inaccurate as to scope. The Democrats claim: ''The Republican plan would only apply to 48 million Americans.''

This is accurate for one aspect, but it ignores many extremely important provisions. Further, charges regarding actions by the insurance industry were not only inaccurate but totally baseless.

Let me set forth what the scope of the protections actually is.

The Republican plan contains nine major patient protection provisions. One of the nine major components has six new access standards to ERISA for the 48 million in self-insured plans that State consumer protection standards cannot reach.

These include: the prudent layman's standard for emergency care; a mandatory point of service option; direct access to OB/GYNs; direct access to pediatricians; a continuity of care provision; and a prohibition of gag rules.

The majority of Americans already enjoy these protections, since most of the states have already adopted these standards through their regulation of health insurance companies.

The other major components of the Patients' Bill of Rights provide significant new protections for millions of Americans. Of these, some provisions are not even included in the Democratic bill. The provisions include:

1. A new health plan comparative information requirement to benefit all 124 million Americans covered by group health plans under ERISA;

2. Grievance procedures and internal and external appeal rights for all 124 million Americans covered by group health plans under ERISA;

3. Providing all 140 million Americans covered by group and individual health plans with new rights that will prevent discrimination based on predictive genetic information; and

4. Benefit all 270 million Americans by providing a stronger emphasis on quality improvement in our health care system with a refocused role for AHCPR.

The GOP plan creates new enforceable federal health care standards to cover those 48 million of the 124 million Americans covered by ERISA plans that the states, through their regulation of private health insurance companies, under the McCarran-Ferguson Act of 1945, cannot protect. We feel that it would be inappropriate to set federal health insurance standards that not only duplicate the responsibility of the 50 state insurance departments—but, that we know from a new GAO report won't be enforced.

The Democrats, by contrast, would set health insurance standards that duplicate the responsibility of the 50 state insurance departments and mandate that HCFA enforce them if a state decides not to adopt them. Building a dual system of overlapping state and federal health insurance regulation is in no one's best interest.

The federal regulators at HCFA have faced an overwhelming new set of health insurance duties under HIPAA. In the five states that have failed to or chosen not to pass the legislation required by HIPAA (California, Massachusetts, Michigan, Rhode Island, and Missouri), the HCFA is now required to act as insurance regulator for the state HIPAA provisions.

A GAO report that I released found that HCFA officials have confessed that their agency has thus far pursued a ''minimalist'' approach to regulating health insurance standards under HIPAA, and they attribute its limited involvement to a lack of experienced staff, as well as uncertainly about its actual regulatory authority.

There is a related concern that HCFA cannot fulfill its responsibilities for administering the Medicare program. At a July 16th, 1998 House Ways and Means hearing, HCFA's administrator stated that she intended to postpone the development of a Medicare prospective payment system for outpatient hospital care and home health services; the consolidated billing for physician and other Medicare part B services in nursing homes; and a new fee schedule for ambulance services. Delaying the implementation of these mandates will result in many home health providers and other providers not receiving the reimbursement that they deserve. It will put many home health agencies in the position of having to chose between turning Medicare patients away and insolvency.

Given HCFA's demonstrated inability to carry out its current responsibilities under both HIPAA and BBA, we believe it would be irresponsible to promise the American people that they will be able to receive new federal health insurance guarantees and then rely on HCFA to enforce these rights when we know they can't do the job.

Our proposal, by keeping the regulation of health insurance where it belongs—at the state level—provides the American people with a real Patients' Bill of Rights that they know from their personal experience will be enforced. The principle that the states should continue to regulate the private health insurance market, and that Congress should only set health care standards in those areas where the states have been preempted, guided the design of the six access standards in the Republicans' Patients' Bill of Rights because we know it works.

The PRESIDING OFFICER. The majority has 18 minutes remaining. Who yields time?

Mr. JEFFORDS. I yield 10 minutes to the Senator from Nebraska.

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

Mr. HAGEL. Mr. President, there is no issue more important to the American people than ensuring quality health care for themselves and their families. We all agree on that. It is the great common denominator in our society.

All of us in this debate, my Democratic colleagues and my Republican colleagues, want to help the people we serve. We want every citizen to have access to good, affordable health care. As a member of the Republican Health Care Task Force, I am very proud of the bill the Republicans have brought to the floor, the Patients' Bill of Rights Plus.

I think it is important that we focus on the completeness of what this bill is about, what it would do. This bill would increase the quality of health care, the accessibility of health care, and the affordability of health care for millions of Americans. Our bill protects 48 million Americans whose health care plans are not now covered by existing State regulations. Specifically, it provides the following:

Guaranteed access to emergency room care; health plans would be required to use the prudent layperson standard for providing in-network and out-of-network emergency care.

No. 2, guaranteed access to the doctor of your choice. Under our bill, these health plans must provide point-of-service and continuity-of-care options that allow persons to see physicians outside of their health care network.

No. 3, access to medication. Health plans would be required to provide access to noncovered drugs in cases where they are medically necessary and appropriate.

No. 4, our plan provides access to specialists, and no gag clauses that restrict doctors from discussing treatment options with their patients. Health plans would be required to ensure that patients have access to covered specialty care within the network or, if necessary, through contractual arrangements with specialists outside

the network. If the plan requires authorization by a primary care provider, then the plan must have a defined referral and authorization process. Moreover, under our bill providers are given the unfettered right to discuss all treatment options with their patients.

No. 5, guaranteed access to an OB/GYN specialist. Health care plans would be required to allow direct access to obstetricians/gynecologists and pediatricians without the need for referral or the plan's prior authorization.

No. 6, timely appeals by patients who believe they were improperly denied coverage. This is a key part of our bill. Our bill would allow timely review of a patient's claim by medical experts not affiliated with the plan. In emergencies, the review would be within 72 hours. The decision of the outside review panel would be binding. This way, a sick or hurting patient gets the matter resolved now, quickly, rather than languishing in court proceedings for years in a typical lawsuit.

No. 7, it guarantees consumers access to plan information. Our bill requires all group health plans to provide consumer information about what is covered, what is not covered, how much they will have to pay in deductibles and in coinsurance, and how to appeal adverse coverage decisions.

No. 8, it protects patients from being discriminated against on the basis of genetic information. This is a very big part of why our bill is better. The Democrats do not cover this. Our bill expressly prohibits all health care plans and health insurers from collecting or using predictive genetic information about a patient or their family to deny insurance coverage or set premiums. The Democrats' bill has no such prohibition.

No. 9, changes in the Tax Code to make health care coverage more affordable and increase the number of people with health insurance. Isn't that what we are about—bringing more people on our health rolls; making quality, accessible health care affordable? If we want to help increase access to health care, one thing we could do is change the Tax Code. The self-employed ought to be able to deduct 100 percent of premiums for themselves and their families. Our Patients' Bill of Rights Plus does exactly this.

Our bill would give all Americans the opportunity to open a medical savings account, an MSA, to save for their health care needs. Many Americans work for employers who do not now offer health insurance, and they must pay for it out of their own pockets. An MSA would be a tremendous benefit for these individuals and would greatly expand the number of individuals with coverage for their health care needs. According to the General Accounting Office, nearly one-third of the participants in the MSA pilot program authorized by Congress a couple of years ago had been uninsured before utilizing these tax-free accounts.

It is also time to enact full tax deductibility for premiums that cover long-term care. The average annual cost of caring for a person in a nursing home is $50,000. Stories, of course, are legion of people exhausting their access and resorting to Medicaid to pay for nursing care. We address this issue in our bill.

What does the Republican bill not do? There are several important things that the Republican Patients' Bill of Rights does not do. Let's start with liability. The Republican bill achieves the proper balance between legal rights and affordability. Our bill would preserve one of the most important rights patients already possess, and that is the right to file a class action injunction to get coverage. The class action is one of the strongest protections of patient rights under ERISA.

You cannot sue your way to better health care. Let me say it again. You cannot sue your way to better health care. Rare are the patients who can afford a legal challenge against a big, well-financed insurance company. Mr. President, 22 States including Nebraska, my State, have already refused to expand liability and open up the opportunity for countless, endless lawsuits.

The Democrat bill would make employers liable for medical malpractice. That is an incredible thing. Their bill would make the employer liable for medical malpractice. Patients could sue the employer. I cannot think of a more certain way to drive up both the cost of health insurance and the number of uninsured. Small businesses are especially vulnerable. One huge claim could wipe them out completely. It is no surprise that in a verified recent poll of small businesses across this country, 57 percent of small businesses said they would drop their health coverage rather than expose themselves to ruin under the provisions of the Democrat health proposal.

The scope? Our bill does not unnecessarily duplicate State regulations, which adds more Federal Government mandates and increases costs. We do not need more Federal mandates. We do not need more Government mandates. We need more options for the patients and better health care. Our bill targets the 48 million Americans who have self-funded insurance policies. Democrats, including Vice President GORE in a recent CNN interview, and Senators, my friends on the other side of the aisle, have accused the Republican Senators of ignoring the roughly 100 million Americans insured in other ways.

If the Republican Patients' Bill of Rights is so good, my friend Senator KENNEDY asks, then why doesn't the GOP offer it to everybody? The answer is quite simple: Not everybody needs what we are offering. State laws and insurance regulations protect the rights of patients in all other plans but not necessarily in self-funded plans. We protect the people who need the protection. The Democrats duplicate the plans and protections already available under State laws.

Cost: Our focus should be on providing access to quality, affordable health care for more Americans. We heard a lot on the floor in the last few days about quality and access, but we have heard very little about affordability, who can afford health care, especially from those on the other side of the aisle who want to talk about this. Pricing people out of health insurance systems is no way to improve access.

The rate increases that would hit individuals would also hit employers. Dramatic hikes in health care costs cost employees their jobs, and what are we doing for America when we throw people out of work?

Back when I had a real job—and I did have a real job once; I was a small business owner—I remember poring over numerous health insurance plans to determine which were the best, which could I afford for my employees. I have yet to meet a small business owner who does not want to give their employees health insurance.

In conclusion, as I said at the outset of my remarks, there is no issue more important to more Americans than ensuring quality health care for themselves and their families, but in an effort to improve health care, it makes no sense to drive up costs and leave millions of Americans without health insurance.

I look forward to the passage of the Republican bill, the Patients' Bill of Rights Plus, and as one of the architects, one of the Senators who helped write it, I am very proud of it.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. CRAIG). The Senator's 10 minutes has expired. Who yields time?

Mr. NICKLES. Will the Senator yield me 1 minute?

Mr. JEFFORDS. I yield 1 minute to the majority whip.

The PRESIDING OFFICER. The majority whip, the Senator from Oklahoma.

Mr. NICKLES. Mr. President, for the information of our colleagues, we are going to be voting on this amendment probably in another 10 minutes. I urge my colleagues to vote no for all the reasons that have been so amply discussed by my colleague, Senator HAGEL, just a moment ago, and Senator COLLINS earlier, Senator GRAMM, Senator ENZI, and others.

They are exactly right. We should not have ''one size fits all'' or ''Government knows best.''

There are a couple other reasons why they should vote against the KENNEDY amendment. It is a big tax increase. I look at page 14, section (H) and there is a tax increase, a tax increase that boils down to about $3.5 billion over the next 10 years. Section (I) on page 14 is a tax increase that is $1.2 billion over 10 years. Section (J), page 16, another tax increase of $288 million over 10 years. If you add all that together, this amendment we will be voting on increases taxes by $5 billion. I urge my colleagues to vote no on this amendment.

I thank my friend and colleague from Vermont. I compliment him for his outstanding leadership.

Mr. JEFFORDS. I yield 5 minutes to the Senator from Pennsylvania.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized for 5 minutes.

Mr. SANTORUM. I thank the Chair.

Mr. President, I, too, congratulate all those who have spoken. I do not want to repeat what has been said. They said it well. In the Republican bill we are not leaving 100 million people uncovered. The fact of the matter is, the States that have the authority under the law, under the Constitution, and under the McCarran-Ferguson Act, to regulate insurance do the job and do it very well.

What this is all about, in my mind, is arrogance. This is about people walking around in Washington, DC, thinking: This is the center of the universe, and unless we decide what is best for all of you, you cretins out there in central Pennsylvania or in Wyoming or in Tennessee, you folks just do not understand what we, the enlightened in Washington, know what is best for you. So we are going to impose on you, State legislators, insurance commissioners, what we think you should be doing, even though you have gone through the process, an exhaustive process.

Pennsylvania went through an exhaustive debate in the House and the Senate and with the Governor on what kinds of patient protections they were going to provide for the people who were covered by State insurance, those 100 million people who are ''uncovered.''

For the people in Pennsylvania, rest assured, there was a fine Patients' Bill of Rights passed by the Pennsylvania Legislature and signed by Governor Ridge. In fact, I spoke with the sponsor of that bill over the weekend. He came up to me and said: Rick, please, please, don't pass a bill that is going to wipe out what we so carefully crafted that we believe is in the best interests of Pennsylvania.

Dr. Tim Murphy, the sponsor of the bill in the Pennsylvania Senate, someone who I think cares deeply about the concerns of children and concerns of the well-being of Pennsylvanians, said: Please, don't undermine what we have done. Don't put a layer of bureaucracy, the Health Care Financing Administration, overseeing the kinds of patient protections we have passed in Pennsylvania. Please, let us do what we do well, and if there are problems, we will deal with them, we will come back, and we will revisit this issue—just like the issue here is not over. But give us some credit that we know what is going on in our own States. We care about the people in Pennsylvania more than Senators from California or from Louisiana or from Massachusetts. We care about our people because they are our constituents.

We see a lot of examples of arrogance in Washington, of the ''we know best'' attitude in this town. This is an amendment that says: Washington knows best. What goes on in State capitals is irrelevant because they do not really care about their constituents. If I am in Massachusetts, I care more about what goes on in Pennsylvania than the Governor or the State legislators, State senators.

That is ridiculous. The fact of the matter is, the States are engaged actively. Frankly, they are much more active than we have been in the Congress. They have been actively engaged in dealing with the problems in their States, and we should let the States do what they do best, and we should do—and the Republican bill does—what only we can do, and that is to regulate ERISA plans, with patient protections and, I add, a lot more.

The one thing that really sort of irks me about this whole debate is that it is not just about protecting rights with HMOs. What our bill does is much broader and deals with issues of quality and choice, giving people alternatives to HMOs, not just locking them in and trying to fix something that may or may not be broken.

We say you can fire an HMO, go somewhere else, and get health care in a different way. The Democrats will not let you do that. We do.

We provide tax breaks for the self-employed which, again, increases access to the system. They do not. We have not only quality assurance; we have choice; we have access. The thing we do not do—and I am very proud we do not—we do not drive up cost and drive people out of the insurance market. They do.

On all four counts of what health care reform is supposed to be about—choice, quality, access, and cost—we are the winners, not the other side.

The PRESIDING OFFICER (Mr. CRAPO). The time of the Senator has expired. The Senator from Vermont has 2 minutes remaining.

Mr. JEFFORDS. Mr. President, I yield back the remainder of my time and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

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

The PRESIDING OFFICER. The Senator has that right.

Mr. KENNEDY. I have listened with a good deal of interest to our colleagues on the other side complaining. They want it both ways. On the one hand, they are supporting covering 48 million Americans and leaving out 113 million Americans—so they are covering some Americans—but they are not covering all Americans. Then they are troubled, evidently, because they are covering some Americans. Many of our colleagues on the other side, as we have just heard, do not think there ought to be any kind of protection for the American citizens, that we ought to just leave this up to the States.

My response is, the law of the jungle may be good in the jungle, but we do not accept that in the United States, when people are being exploited by the private sector. In this case, the insurance industry refuses to provide the protections for women and children in our country. The insurance industry refused to provide protections for workers in our country.

That is basically the fact of it. We hear repeatedly, mistakenly, that the States have provided protections. I will include in the RECORD the Families USA analysis of the various States.

An examination of state legislation in 13 areas of basic managed care consumer protections finds that no state has all 13 on the books. . . .

I ask unanimous consent to have that analysis printed in the RECORD.

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

[Press Release from Families USA Foundation]

DESPITE STATE MANAGED CARE LAWS, MOST PEOPLE STILL GO UNPROTECTED

FAMILIES USA RELEASES COMPREHENSIVE REVIEW OF STATE MANAGED CARE LAWS

(Washington, DC) An examination of state legislation in 13 areas of basic managed care consumer protections finds that no state has all 13 on the books according to a new report released today by the national consumer group Families USA.

Hit & Miss: State Managed Care Laws examines state laws for a number of patient protections including the right to independent eternal appeals when health care services are denied, access to emergency room coverage, the right to sue health plans for wrongful denials of care, and the establishment of state funded consumer assistance programs. (See table 1, attached, for a list and explanation of the protections studied in the report.)

The study reveals that only one state, Vermont, had passed 10 or more of the protections, 16 states enacted 5 to 9 of the basic protections, 33 states had passed only 1 to 4 of the protections and South Dakota had passed none. (See table 1 attached.) The report also reveals that, despite state legislation on managed care, many consumers are not protected by those laws.

According to the report, one in three people with employer-based coverage are in self-insured health plans and are not covered by state consumer protection laws. The federal Employee Retirement Income Security Act (ERISA) exempts self-insured employer plans from state health insurance laws. Approximately 51 million Americans are not covered by any of the managed care consumer protection laws in their state because of ERISA.

''Not only do managed care consumer protections vary greatly from state to state,'' said Ron Pollack, executive director of Families USA, ''but even with laws on the books, many consumers who get their coverage from their employer are not protected because of ERISA. Only a federal patients' Bill of Rights would ensure consumer protections for all Americans who receive employer provided coverage.''

Other key findings of the report include:

The requirement of disclosure of treatment options and protection advocacy (that is a ban on ''gag rules'') has been passed by the most states—45 states and the District of Columbia.

Thirty-one states and the District of Columbia have passed laws requiring health

plans to pay for emergency room care when a person believes he or she is experiencing a medical emergency.

Only 15 states have passed laws establishing an independent external appeals process for consumers who believe they have been wrongfully denied care.

Eight states have passed laws requiring plans to have a procedure to allow individuals to obtain prescription drugs that are not on the managed care plan's list or ''formulary.''

Of the 13 key protections studied, the establishment of independent consumer assistance programs and changes in liability laws had been passed by the fewest states.

Vermont is the first and only state to pass a law that provides funding for an independent statewide consumer assistance program.

Two states, Texas and Missouri, passed laws that open the door so that consumers can hold their health plans accountable through litigation. This issue is still being debated in the courts.

While the ERISA statute preempts state insurance laws for people in self-insured plans, the statute goes even further in preventing Americans from suing their health plan for damages in the event of wrongful denials of care. The study found that 83 percent of Americans who get their health care from their employer, 124 million people, cannot hold their health plans liable for their denials of care because of ERISA preemption of state laws relating to grievance resolution. Public employees (state and federal workers) are not preempted.

''ERISA—which was intended to protect employees in pensions and health plans—has become a protective shield for managed care plans even when they wrongfully deny care, either through negligence or malicious indifference,'' added Judy Waxman, director of government affairs at Families USA. ''Health plans have no accountability for their decisions to deny needed care and treatment. This lack of meaningful remedies invites abuse.''

Current proposals in Congress address many of the protections studied in the new Families USA report. The Patients' Bill of Rights introduced by Senators Daschle and Kennedy and Representatives Dingell and Gephardt would establish all 13 of the protections studied. The House Republican proposal, which is not yet in legislative form, would address from two to four of the issues. (See table 2 attached.)

''The American public has said very clearly that they want managed care protections, but because of ERISA they are denied the protections passed by their state,'' added Pollack. ''Because of the federal ERISA law, this issue can not be left up to the states. Federal protections are needed to ensure all Americans get fair treatment from their managed care plans.''

CONSUMER PROTECTIONS EXAMINED IN HIT & MISS

The 13 areas selected for special analysis in Hit & Miss were chosen for a combination of reasons. First, they are important rights to help ensure that health plan enrollees get the care promised by their plans. Second, these rights are sufficiently specific and understandable that consumers can assess their significance. And third, these rights provide good illustrations of the diverse state-by-state approaches to regulating managed care. The 13 protections are:

the right to go to an emergency room, and have the managed care plan pay for the resulting care, if a person reasonably believes he or she is experiencing an emergency;

the right to receive health care from an *out-of-network provider* when the health plan's network of providers is inadequate;

the right of a person with a serious illness or disability to use a *specialist as a primary care provider*;

the right of a seriously ill person to receive *standing referrals to health specialists*;

a woman's right to gain direct access to an *obstetrician or gynecologist*;

the right of a seriously ill patient or pregnant woman to continue *receiving health care for* a specified period of time *from a physician who has been dropped* by the health plan;

the establishment of a procedure that enables a patient to obtain specific *prescription drugs that are not on a health plan's drug formulary*;

the *right to appeal* denials of care through a review process that is external to, and independent of, health plans;

the establishment of *consumer assistance, or ombudsman,* programs;

prohibitions against plans' use of so-called ''gag rules''—rules that prevent physicians and health providers from fully disclosing treatment options to patients;

prohibitions on plans' reliance on *inappropriate financial incentives* to deny or reduce necessary health care;

the establishment of state *laws* that prevent plans from *prohibiting participation in clinical trials*; and

the establishment of state laws enabling enrollees to sue their health plans when they improperly deny care.

TABLE 1.—HIT AND MISS: STATE MANAGED CARE LAWS

[The variability of State managed care consumer protection laws, as of July 14, 1998]

States	E.R. services	Access to providers				Continuity of care	Prescription drug access	Appeals procedures	Consumer assistance	Patient-provider relationship		Clinical trials	Liability
	Prudent layperson standard	Referral to out-of-network providers	Specialists as primary care providers	Standing referrals to specialists	OBGYN direct access	When physicians leave plan	Access to non-formulary prescriptions	Independent external reviews	Independent ombuds programs	Disclosure of treatment options	Prohibit physician financial incentives	Clinical trials	Right to sue health plans for damages
ALABAMA			•	•									
ALASKA										•	•		
ARIZONA								•		•			
ARKANSAS	•				•	•	•			•			
CALIFORNIA	•			•	•		•			•	•		
COLORADO	•	•			•	•				•			
CONNECTICUT	•				•			•		•			
DELAWARE					•					•			
DISTRICT OF COLUMBIA	•									•			
FLORIDA		•		•	•	•		•	•	•			
GEORGIA	•				•		•			•	•	•	
HAWAII	•							•		•			
IDAHO	•				•					•	•		
ILLINOIS					•								
INDIANA	•	•	•		•	•	•			•			
IOWA	•									•			
KANSAS				•		•				•	•		
KENTUCKY	•	•								•			
LOUISIANA	•				•					•	•		
MAINE	•	•			•					•			
MARYLAND	•				•			•		•	•	•	
MASSACHUSSETTS										•			
MICHIGAN	•							•		•			
MINNESOTA	•			•	•	•		•		•			
MISSISSIPPI					•								
MISSOURI	•	•	•	•		•	•	•		•			•
MONTANA		•			•					•	•		
NEBRASKA	•				•					•	•		
NEVADA	•									•	•		
NEW HAMPSHIRE										•			
NEW JERSEY			•		•	•				•	•		
NEW MEXICO	•	•	•	•	•			•		•	•		
NEW YORK	•	•	•	•	•	•				•			
NORTH CAROLINA	•	•			•					•			
NORTH DAKOTA										•			
OHIO	•	•	•	•			•			•	•		
OKLAHOMA										•			
OREGON	•				•		•			•			
PENNSYLVANIA	•		•	•	•	•		•		•	•		
RHODE ISLAND								•		•	•	•	
SOUTH CAROLINA	•				•								
SOUTH DAKOTA													
TENNESSEE		•	•	•	•	•		•		•			
TEXAS	•	•	•		•	•		•		•	•		•
UTAH		•								•	•		
VERMONT	•	•	•	•	•	•	•	•	•	•	•		
WASHINGTON	•				•					•			
WEST VIRGINIA	•				•					•	•		
WISCONSIN	•									•			

TABLE 1.—HIT AND MISS: STATE MANAGED CARE LAWS—Continued

[The variability of State managed care consumer protection laws, as of July 14, 1998]

States	E.R. services	Access to providers				Continuity of care	Prescription drug access	Appeals procedures	Consumer assistance	Patient-provider relationship		Clinical trials	Liability
	Prudent layperson standard	Referral to out-of-network providers	Specialists as primary care providers	Standing referrals to specialists	OBGYN direct access	When physicians leave plan	Access to non-formulary prescriptions	Independent external reviews	Independent ombuds programs	Disclosure of treatment options	Prohibit physician financial incentives	Clinical trials	Right to sue health plans for damages
WYOMING										•			

TABLE 2.—BASIC CONSUMER PROTECTIONS: STATE LAWS AND FEDERAL PROPOSALS

Managed care consumer protection	Number of States *	Gingrich Plan	Daschle/Kennedy Dingell/Gephardt	Nickles Plan
Emergency Room Access	31	•	•	❩
Access to Out-of-Network Providers.	15		•	
Specialist Can Be Primary Care Providers.	10		•	
Standing Referrals to Specialists.	12		•	
Direct Access to Obstetricians and Gynecologists for Women.	31	?	•	❩?
Continuity of Care When Physician Leaves Plan.	14		•	❩?
Access to All Prescriptions Drugs.	8		•	
Independent External Review of Complaints.	15	?	•	?
Independent Consumer Assistance Program.	2		•	
Disclosure of Treatment Options Required.	45	•	•	❩
Prohibit Financial Incentives to Deny Care.	19		•	
Access to Clinical Trials	3		•	
Right to Sue for Damages	2		•	

? Details of the proposal are too sketchy to determine whether the proposal meets the standard.

* None of these laws apply to people in self-insured ERSIA plans (one in three Americans who have employer-based coverage).

• Applies to all consumers with employer-provided health coverage.

❩ Only applies to consumers in self-insured ERISA plans (one in three Americans who have employer based coverage).

Mr. KENNEDY. Vermont has 10 out of the 13, but no State has all 13. These are basic and fundamental standards that can be built upon. If Texas wants to do more, so be it. If Pennsylvania wants to do more, so be it. But these are the most basic and fundamental protections. That is what this legislation is all about. These are basic kinds of protections which, in most instances, have been included in the protections of the Federal employees, who include every Member of this body.

I have been so interested in listening to this debate about how we do not want the Federal Government having anything to do with health care. The Federal employment insurance has 11 million members. Every Member of this body has an opportunity to go in there and check a little box and say: We don't want the Federal employment protections. We don't want that. We want the private sector. Yet very few Members of this body have done that.

Eleven million Federal employees have these protections. It is so nice to hear: Well, we're glad to have protections for our children. We refuse to provide them for other people's children.

You don't hear anyone suggesting we are going to give up our Federal employees' health care. We should not say, when we provide this kind of protection for our children that we are going to provide the protection for other people's children. That is the heart of this issue.

I yield myself another minute off the bill.

I have included in the RECORD an analysis of which States provide these 13 basic protections and which States do not. They are rather basic and fundamental protections. They are protections concerning emergency care, OB/GYN care, access to clinical trials, access to specialists, ensuring adequate accountability, and eliminating the financial incentives that lead to denying people quality health care.

For all those who say they do not want these protections, I do not know what their States are like. I do not know the last time they talked to their insurance commissioners. I doubt if there is anyone in this body—1 more minute—anyone in this body who could call their insurance commissioner this afternoon and not hear scores of complaints. That is what is happening, maybe not in the Senate, but all across this Nation.

This amendment will make an important difference in terms of protection.

I reserve the remainder of my time.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I yield myself such time as I need off the bill.

The PRESIDING OFFICER. The Senator is recognized.

Mr. NICKLES. Mr. President, I am glad my colleague is sitting down. We might need Dr. FRIST on the floor.

Mr. KENNEDY. Could the Senator yield, on my time, on that issue?

Mr. NICKLES. I am happy to yield.

Mr. KENNEDY. We couldn't see a specialist like Dr. FRIST under the Republican bill. I am glad to use him if I need him. I thank the Senator.

Mr. FRIST. He is here.

Mr. NICKLES. Mr. President, just a couple comments on the underlying amendment. I am always kind of amazed with the philosophy of saying, well, millions of people are not protected, as if the States have not been doing a good job. It is as if saying to the States: We don't care what you have done, it is not good enough. Senator KENNEDY has decided you haven't done good enough. HCFA should be running your health care plans. States need not apply. States, don't bother. We know better. The Federal Government knows better. HCFA, the Health Care Financing Administration, basically should be running your health care plans. We don't care what you have done, States. We don't care if 42 States have already passed a health care bill of rights or 50 States already have consumer grievance procedures or 47 States already have a ban on gag clauses. We are going to pass things that supersede what you have done. We know what is best.

The Health Care Financing Administration has done a crummy job, frankly, in administering rules dealing with home health care. We have home health care problems all across the country. A lot of it is because of HCFA. Or HCFA is getting information out to Medicare—which we passed in the Balanced Budget Act of 1997. They are supposed to give seniors information. They have not done it. Yet we are going to transfer the entire regulatory authority of all the health insurance plans of America over to this governmental agency? To a bunch of bureaucrats thinking they can do a better job than all the States? I do not think so.

If people are somewhat familiar with the labyrinth of regulations dealing with insurance plans, if we pass the Kennedy bill, as now proposed, the amendment that is before us, this is the kind of regulatory scheme we are going to have.

You talk about duplication, you talk about confusion, you talk about almost an impossibility if the State has a plan—wait a minute, do we comply with Federal regulations dealing with the bill of rights or do we comply with the State, or do we comply with the State ban on gag clauses or ours? Somebody says, well, if there is confusion, we will have HCFA decide. HCFA will decide, the Government will decide, the Federal Government will decide.

I urge my colleagues to vote no on this amendment. In addition, I would like to let my colleagues know there is $5 billion worth of new taxes in this amendment that is before us. If you want to increase taxes by another $5 billion, vote in favor of the Kennedy amendment. I urge my colleagues to vote no on this amendment.

Mr. KENNEDY. I yield myself 1 minute.

Mr. President, what about the bureaucrats in the insurance industry who are denying coverage for children in these emergency rooms? What about the bureaucrats who are denying women the right to be able to be in the clinical trials? What about those? This isn't HCFA. The Senator from Oklahoma knows this.

When the General Accounting Office recommended they get additional resources for HCFA, they led the fight against giving them resources to enforce the Kassebaum-Kennedy legislation. Go back and look at the RECORD, I say to the Senator. You know that.

I am not interested in going back and forth on this issue. But I daresay the

bureaucrats in the insurance industry are the ones about whom people are most concerned. Americans know what the insurance industry is doing. They are looking at the bottom line. I think maybe HCFA has its problems—maybe they made some mistakes—but, by and large, they are dedicated men and women who are committed to public service who are trying to do a decent job. It is easy to beat up on employees, Government employees, but for my money, they do a great job.

The PRESIDING OFFICER. The time of the Senator has expired. All time has expired on the amendment. The question is on agreeing to amendment No. 1242. The nays and nays have been ordered. The clerk will call the roll.

The assistant legislative clerk called the roll.

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

The result was announced—yeas 48, nays 52, as follows:

[Rollcall Vote No. 204 Leg.]

YEAS—48

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

NAYS—52

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

The amendment (No. 1242) was rejected.

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

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

The motion to lay on the table was agreed to.

AMENDMENT NO. 1239, AS AMENDED

The PRESIDING OFFICER. The question is on amendment No. 1239 as amended.

The amendment (No. 1239), as amended, was agreed to.

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

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

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Maine.

AMENDMENT NO. 1243 TO AMENDMENT NO. 1232

(Purpose: To expand deductibility of long-term care to individuals; expand direct access to obstetric and gynecological care; provide timely access to specialists; and expand patient access to emergency medical care)

Ms. COLLINS. Mr. President, on behalf of myself, Senator HUTCHINSON, Senator FRIST, Senator JEFFORDS, Senator GRASSLEY, and Senator GRAMS, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Maine (Ms. COLLINS), for herself, Mr. HUTCHINSON, Mr. FRIST, Mr. JEFFORDS, Mr. GRASSLEY, and Mr. GRAMS, proposes an amendment numbered 1243 to amendment No. 1232.

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

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

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

The PRESIDING OFFICER. The Senator from Maine.

Mr. KENNEDY. Mr. President, may we be in order. The Senate is not in order. The Senator is entitled to be heard. We have had a good debate over the course of the day. Members have been attentive. We would like to make sure that the good Senator has the attention of the membership.

The PRESIDING OFFICER. The Senator is correct. Will the Senate come to order.

The Senator from Maine.

Ms. COLLINS. I thank the Presiding Officer. I thank my friend and colleague from Massachusetts.

Mr. President, on behalf of myself, Senator HUTCHISON, Senator FRIST, Senator JEFFORDS, Senator GRASSLEY, and Senator GRAMS, I have sent to the desk a four-part amendment.

We explained in producing our health committee bill that two of our goals were to expand access to health insurance and also to provide important consumer protections to those individuals who are insured in self-funded plans that the States cannot reach, cannot regulate, and that come under Federal jurisdiction. The amendment which I and my colleagues have proposed seeks to advance both those goals.

The legislation would permit individuals who purchase long-term care insurance that is not subsidized by their employer to deduct 100 percent of the cost of that coverage.

That is the first part of the amendment.

The second part of the amendment includes the access to emergency services provision which Senator HUTCHINSON and Senator FRIST have been working on. We believe it strengthens those provisions. It includes some of the language which Senator GRAHAM of Florida had offered yesterday, but that has been refined. It takes a somewhat different approach.

The third part of this amendment includes language developed by Senator FRIST dealing with timely access to specialists. Senator FRIST will explain that provision in more detail.

The fourth provision in this amendment has been developed by Senator JEFFORDS dealing with access to OB/GYNs. It is an attempt to improve upon and strengthen the health committee legislation.

I am not going to address the provisions that deal with long-term care insurance. Most Americans mistakenly believe that either Medicare or their regular health insurance policies will cover the costs of long-term care should they develop a chronic illness or a cognitive impairment such as Alzheimer's disease.

Unfortunately, far too late, far too many Americans discover their families do not have the coverage they need until they are confronted with a difficult decision of placing a frail parent or loved one in a long-term care facility and face the shocking realization they will have to bear those enormous costs themselves. With nursing home costs ranging from $40,000 to $70,000 a year, a chronic illness requiring long-term care can easily bankrupt a family. It can also result in the taxpayer eventually having to pick up the costs through the Medicaid program. Concerns about how to finance long-term care will only multiply as our population ages and is at greater risk of chronic illness.

By the year 2030, the demographics of 32 States will resemble those of Florida today. The number of people over age 65 will nearly double. Moreover, the fastest growing segment of our population are Americans who are age 85 and older. These older Americans are at least five times more likely to reside in a nursing home than people who are age 65.

Americans should obviously think about and plan for their future long-term care needs as they plan for their retirement or purchase life insurance to protect their families. Private planning for long-term care through the purchase of long-term care insurance will not only provide families with greater financial security, but it will also ease the growing financial burden on Medicaid and strengthen the ability of that program to serve as a vital safety net for those Americans most in need.

Moreover, private long-term care insurance policies provide Americans with much greater choice in the type of services they can receive. While government programs predominantly pay for nursing home stays, private long-term care policies provide a wide variety of services, ranging from personal assistance with activities of daily living such as bathing or eating or dressing, to 24-hour skilled nursing assistance. Many policies also cover assisted living.

In addition, policies often cover home care, adult day care, and respite

care, giving seniors greater flexibility and enabling them to retain the dignity of choice and to have the most appropriate care in their senior years.

The Health Insurance Portability and Accountability Act of 1996 made long-needed changes in our Tax Code to give long-term care insurance essentially the same tax treatment as other health insurance. As a consequence, long-term care insurance premiums are now deductible for those employers who choose to offer the coverages of benefit and also are excludable for taxable income for the employee. Moreover, premiums for long-term care insurance are treated as a medical expense for the purposes of itemized deductions for medical expenses and are also partially deductible for self-employed individuals.

The amendment I am introducing today will expand the tax deductibility of long-term care insurance to encourage and to help more Americans to purchase it. In this regard, I want to acknowledge the leadership of Senator GRASSLEY as chairman of the Aging Committee on which I am privileged to serve. Senator GRASSLEY has been a long-time advocate of expanding the tax deductibility for long-term care insurance.

The legislation I am proposing will permit individuals who purchase long-term care insurance on their own, without any kind of subsidy from their employer, to deduct 100 percent of the cost of that insurance. Providing additional financial incentives for individuals to plan for their own future long-term care needs is particularly important in order to encourage younger people to purchase the coverage.

By encouraging individuals to plan now for retirement through the purchase of long-term care insurance, not only are we helping to ensure their future financial security; we are also giving them the peace of mind knowing that should they develop a chronic illness, should they become ill with Alzheimer's disease, for example, they will be covered by private insurance. Moreover, the insurance will ensure that they receive the choice of care they need and on their own terms.

Finally, encouraging individuals to plan and prepare for their future long-term care needs will help strengthen and preserve the financial solvency of the Medicaid program. This is an idea that I hope will have the support of colleagues from both sides of the aisle. I encourage all of my colleagues to join me in this effort to make this critical coverage more affordable to millions of Americans.

I yield such time as he desires to my colleague from Arkansas for an explanation of the emergency care provisions of this amendment.

Mr. HUTCHINSON. I applaud the Senator from Maine for her outstanding leadership on this legislation and particularly for this amendment and the tax provisions which I believe are going to provide significant tax relief. The Joint Committee on Taxation estimates that 3.8 million taxpayers benefit from this provision on long-term care. It is an important provision. Senator COLLINS and Senator GRASSLEY have been great leaders in pushing for this. I applaud their efforts.

I will briefly address the provisions in this amendment regarding access to emergency services, an issue we debated at some length yesterday. I think the provisions in this amendment adequately and significantly improve the Republican bill and address the concerns that have been expressed.

Let me compare briefly the Kennedy bill and the Republican bill in this area. Both bills, with the adoption of this amendment, will eliminate prior authorization for visiting the emergency room. This was included in the committee bill as it came out. We reaffirmed that in the amendment. It eliminates the need for the requirement for prior authorization, something that is obvious, something that is common sense. If you have an emergency event, you don't want to get preauthorization before you go to the emergency room. We eliminate that requirement for prior authorization. For policies that have it, we prohibit that.

Both bills require coverage for medical screening exams and stabilization services under the prudent layperson standard for emergency.

That language, that provision, is included in both the Democrat bill and the Republican bill. Both bills, with the adoption of this amendment, will ensure that patients will not have to pay more for emergency services provided by an out-of-network provider than an in-network provider. Many of the stories and examples we have heard on the floor of the Senate regarded individuals who had to pass by an emergency room when something tragic occurred, drive across town to find a provider that was in the network. That should never happen. It should not ever be required. No one should bypass an emergency room that is close to them because they are afraid of having to pay a penalty or pay a higher copay because that emergency room is not in the network. So we would prohibit that kind of differential. The Democrat bill has that provision. With the adoption of this amendment, we would prohibit that. You would go to the closest emergency room.

Both bills, with the adoption of this amendment, would provide the coverage of poststabilization services. The Republican amendment will do the following. It will require coverage of services to maintain the stability of the patient, those services which are related to the emergency condition, treatment related to the emergency condition, provided in the emergency room, and under the condition that the health plan has been contacted by the nonparticipating provider regarding approval for such services.

If the plan has not responded within 1 hour—this is exactly what is required under Medicare—to arrange for transfer, discharge, or for further care at a nonnetwork facility, the plan continues to be liable for the care needed to maintain stability and those conditions related to the emergency situation.

So we believe this is very strong language. It provides the kind of protections we need for poststabilization services. What it does not do—and this is the difference, this is the distinction—it does not allow someone to go into the emergency room with a genuine emergency and then ask for treatment of a condition totally unrelated to the emergency event. If you go in and you have a knee injury because of a fall and then, after you have been stabilized, you tell the doctor you have not had your heart checked and you haven't had an x ray and you want this done or that done, on conditions totally unrelated to the emergency event, that should not be required to be covered by the insurance policy.

We clarified what we believe was ambiguous language, where there had been abuses, to ensure that in fact treatment has to be related to the emergency event.

I think it is a very strong provision, and I urge my colleagues to support the overall amendment and this provision regarding access to emergency services.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I commend the efforts of the Senator from Arkansas. He has worked very hard on this issue. What he and the Senator from Tennessee have developed clearly strengthens the bill reported by the HELP Committee. I think it is an excellent refinement, and I commend him for his efforts.

I now yield such time as he may need to the Senator from Tennessee to explain the access to specialists provisions in the amendment.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Mr. President, I thank the Senator from Maine for laying out so well what this amendment is all about.

The amendment has four parts: Long-term care deductibility, which has been spelled out. The Senator from Arkansas has just laid out the second portion of this amendment on access to emergency services, something he and I have worked on very closely that I think really pulls together so much of the debate over the last 3 days and demonstrates we are working together to improve the underlying legislation as we go forward. Another demonstration of that is the third component, the access to specialists, which I will outline. Then I will turn to the Senator from Vermont to discuss the fourth component on access to obstetricians and gynecologists—again, an issue that has been on the floor again and again and again.

I think overall this amendment demonstrates our very sincere effort to

work together as we go forward, taking ideas, bringing ideas forward, and improving this bill as the day develops.

Under access to specialist, we do four things:

No. 1, we ensure timely access to specialty care. ''Timely'' is the key word. Timely is important. I will come back to why it is important and what we do.

No. 2, we expand the provision to ensure access to primary care subspecialists. It is an expansion to the underlying provision, but again I think it is one that is very important to clarify the intent to which I believe both sides agree.

No. 3, the third component of the access to specialists is that we acknowledge, in very specific language, that a specialist could be the patient's case manager. That is important. It is very important to understand what a case manager is, and I will come back to that very briefly.

The fourth point I want to make in describing my aspect of this amendment is that there are concerns that referrals do not require a treatment plan to be in place.

No. 1, timely access to specialty care. This amendment is necessary to improve the underlying bill. It does so by requiring the plans to ensure ''timely''—it is in the bill—access in accordance with the surrounding medical circumstances in the case. That is very important.

It is important to me as a physician, to patients, and to doctors because the last thing in the world we want to do is have something on the books that says you have access to a specialist, which we have in our bill, but to have a plan be able to delay in some way, or say, yes, the provisions are there; we are going to work on it. So we want to put a temporal component in it to make sure you have timely access, that you can see that specialist in a timely way so you get that care when you actually need it. Therefore, we have timely access.

Why is it in the Patients' Bill of Rights? Basically to guarantee to the patients, to assure the patients, the plan has to respond in a way that meets the circumstances of their particular care—appendicitis, heart disease, lung disease; that they will have a timely response to that with a specialist.

No. 2, we expand the provision to ensure access to primary care subspecialists. Again, this is something very close to me. Again we focus on access because that is what patients want. They don't care what titles these people have, but what they say is: If I need a cardiologist, I can get to a cardiologist; I can get to a heart transplant surgeon. I want to make sure that care is there. So we remove the barriers. We do not try to dump people into categories and give them labels.

There are some subspecialties within primary care that are actually subspecialties under primary care, and we want to make absolutely sure, because for those individuals it is critical that they are involved in chronic care—we want to make sure it is very clear. We want to reach out and expand that amendment to include that definition of specialty care to include both primary and specialty health care professionals who are appropriate to the patient's condition. If you have heart disease, it needs to be a cardiologist. If you have cancer, it needs to be an oncologist.

A typical example to bring this home is a cardiologist. I am a heart transplant surgeon. We also have cardiologists. I operate on patients. Cardiologists are the medical end of the study of the heart. To become a cardiologist, you go through training to become an internist, or internal medicine. Internal medicine is considered a primary care specialty. But a subspecialty of internal care medicine is cardiology. You may go for 3 or 4 years of internal medicine training, which is a primary care field; then you go ahead and do a subspecialty of internal medicine, and that is cardiology, an additional 2 or 3 years.

I want to make clear that we are talking about access, we are talking about the subspecialties underneath the primary care of internal medicine. This amendment ensures that access.

No. 3, I want to make sure, what this amendment does is it acknowledges that many times the treating specialist could be the patient's case manager, the person who is coordinating that care. Therefore, our amendment adds the words ''case manager'' where information may be required to be communicated to a patient, to a patient's primary care provider, in the creation of a whole section called Treatment Plan. Both the Democratic bill and the Republican bill have a section called Treatment Plan. This also applies to obtaining an adequate number of referrals.

The fourth point: The Republican bill follows the recommendation put forth by the President's own quality commission, the commission we referred back to that was in effect for about a year and produced a document. Under their section, Access To Specialists, they use the word ''authorization.'' I quote from that:

> Authorization when required should be for an adequate number of direct access visits.

I wanted to actually take that language and put it in our bill.

> Authorization when required should be for an adequate number of direct access visits.

Again, that is from the President's commission, his quality commission. What we have done there is follow their recommendations. What our amendment does is revise and amend and improve that recommendation to clarify that a treatment plan is not required to obtain an adequate number of referrals. We need to make very clear that the treatment plan does not have to be the provision in order to get an adequate number of referrals. It is a necessary clarification because the underlying bill simply states that a plan may require the specialist to put together a treatment plan in consultation with the patient and primary care provider or case manager, but we do not require or expect that a treatment plan will be required or necessary for every patient.

I have spoken long enough on this whole issue of access to specialists. The timely component, the case manager component, the access to subspecialists, and adequate number of direct visits are very direct components. I yield the floor.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I commend the Senator from Tennessee. As the Senate's only physician, he brings a unique perspective and a very useful perspective to these important health care issues. He has been a leader in working to improve still further on the work that was done in the HELP Committee.

The task force has been working on this issue for some time. We first started working on the issue in January of last year. We met every week for many months. That is an indication of our determination to produce a balanced bill that will really make a difference to millions of Americans.

Our efforts did not cease. Once we went to the HELP Committee, we continued our work, and we are continuing our work today. That is why we have come up with this amendment to further strengthen and improve the legislation reported by the HELP Committee.

I yield as much time as he would like to the chairman of the HELP Committee, the Senator from Vermont.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. Mr. President, women have special health needs that require the expertise of practitioners trained in obstetrics and gynecology. We must offer them the best means to provide for their preventive women's health needs, as well as access to an obstetrician to ensure a safe pregnancy and delivery of healthy children. Under our bill, direct access for women to routine gynecological care will be ensured. Obstetrical care and needed follow-up are also ensured without requiring preauthorization by the plan. For coordination of care, providers may be asked to provide on a continuing basis the medical treatment plans in order to allow for good coordination of a woman's health care needs.

In Vermont, legislation has ensured that women have direct access for their obstetrical and routine gynecological needs in order to facilitate optimal care. Vermont's law however does not cover 42 percent of women in Vermont who are in self-insured group health plans. Our bill will ensure that all women in Vermont will be guaranteed direct access for their preventive women's gynecological health needs, as well as obstetrical care.

I do not support the Democratic bill that requires health plans to designate their practitioners specialized in obstetrics and gynecology as primary care providers. This provision in the Democratic bill would force practitioners specialized in obstetrics and gynecology to practice primary care, independent of whether they feel qualified or have the desire to do so. Some obstetricians and gynecologists may be adequately trained and experienced in primary care medicine as well as their specialty. In those special cases, the plan will be able to review their competency and comfort level, and determine if women in the plan would be well served to be able to designate them as their primary care doctor as well. We must protect our women's health care needs to the same degree as we protect our men's, and ensure that women are being cared for by the people best trained to do so.

I want to ensure that women's health care needs are met the best possible way. We will do so by requiring direct access in self-ensured group health plans for obstetrical and routine gynecological services to practitioners specialized in these areas. We will also expect the same degree of training for the providers looking out for the overall health needs of women, by not assuming that all obstetricians and gynecologists are as well trained in primary care as providers who have had focused training and practice experience in providing for the total general health. I strongly urge my colleagues to ensure that the best health care needs for women is met. This will be done by supporting our bill.

I reserve the remainder of the time and yield the floor.

Mrs. BOXER. Mr. President, I wonder if the Senator will yield for a question.

Mr. JEFFORDS. On your time.

Mr. REID. Mr. President, I yield the Senator from California up to 5 minutes.

Mrs. BOXER. I am very interested in the comments by the Senators who support this amendment because if one reads their bill, first of all, they say women deserve OB/GYN care, and they are right. That is why Senator ROBB offered his amendment to cover all the women in America.

I ask my friend from Vermont: How many patients are covered by this amendment?

Mr. JEFFORDS. As we are going along here, we have two different approaches, and the approach we take is that we are trying to help those women who are primarily under ERISA prohibitions——

Mrs. BOXER. I am just asking the Senator if he can tell us how many women are covered, just the number.

Mr. JEFFORDS. I can give you a number.

Mrs. BOXER. Perhaps I have the answer to the question.

Mr. JEFFORDS. Somewhere around 20 million.

Mrs. BOXER. Twenty million.

Mr. JEFFORDS. There are 48 million. It is higher. Somewhere in that area. From 20 to 48.

Mrs. BOXER. I say to my friend, 50 million are left out. I say to my friend, the vast majority of women are left out. In the last amendment by Senator SNOWE, the one good thing she did is cover all the women in terms of her amendment that dealt with mastectomies. We are facing an amendment, whereas the underlying bill will guarantee—that is the Democratic bill—all women these protections, this only applies to a very small percentage of the women. Let's make sure people know this is a sham.

Mr. DORGAN. Will the Senator from California yield for a question?

Mrs. BOXER. I will be happy to yield.

Mr. DORGAN. I wonder if the Senator will include in her question why a proposal would have been offered by one Senator, Senator SNOWE, that covers all the women. With respect to mastectomies, but the proposal offered on OB/GYN leaves out up to 50 million women.

Mrs. BOXER. It would leave out about two-thirds. My friend is correct. I wonder, I say to my friend, what his response is. I was asked that question by Senator KENNEDY. The only thing I can come up with is politics. The heat was on on the mastectomy issue, the light was on, so they covered everybody. Now on this other amendment, they do not cover all the women.

If my colleagues will turn to page 8 of this bill, I say to my friend from Maine and my friend from Vermont, if they will read the way they have structured this, it says:

> A group health plan described in this paragraph may treat the ordering of other care that is related to obstetrics or routine gynecological care.

''May treat.'' It does not say they have to. This, I say to my friends, is a sham proposal. It does not do anything for the women of this country. It leaves out two-thirds of the women, and it leaves it up to the health plan if they are going to give this kind of care.

Let me tell my colleagues specifically what I mean. Yes, they provide access for routine gynecological care. Suppose you finish your checkup, everything is fine and a month later you find a lump in your breast. You cannot go to that OB/GYN, except if the Democratic bill passes because we give direct access to women and make OB/GYNs the primary health care provider.

In the debate yesterday, the Senator from Tennessee stood on this floor and said the OB/GYNs do not want to be primary care providers. That was an untruth. We have a letter on the desks from the organization that represents them, and the gentleman who was cited on the floor of this Senate said it was a misrepresentation; they support the Democratic proposal. They want to be primary care providers.

So we have an amendment here that purports to help women, but, A, it does not help the vast majority of the women in this country; B, it undermines the Democratic bill, which says you can go to your OB/GYN any time you want without having to go through a gatekeeper; and, C, it does not treat women the way they ought to be treated.

So I would call on my colleagues to support the underlying Democratic bill.

Mr. DORGAN. Will the Senator yield?

Mrs. BOXER. Yes.

Mr. DORGAN. Instead of saying this helps women, this amendment should be characterized as saying it helps some women but not most women. Would that be accurate?

Mrs. BOXER. I would say some women just a little bit. Not as much as they say.

The PRESIDING OFFICER. The Senator has used 9 minutes.

Mr. REID. Mr. President, I would like to direct a question to the manager of the bill, the Senator from Vermont. There is a provision in your bill—by the way, let me, for everyone, just explain. Because of the way we were forced to debate this issue, we have been unable to look at this amendment. We just got this amendment. What happens in the ordinary course in the Senate is if somebody offers an amendment, under normal conditions, we would ask for a quorum call so we could take a look at the amendment before the debate started. We cannot do that. Our time is running as we speak. So we are trying to work our way through this amendment they have jammed in here at the last minute without giving us any notice as to what was going to be in it.

But my question to the Senator from Vermont is, there is a provision—in fact, it is the first provision in the bill—that includes long-term care insurance. Would the Senator from Vermont tell the minority how much this is going to cost and from where the money comes?

I would like the RECORD to note the dull silence.

Mr. DORGAN. Will the Senator yield while waiting for an answer?

Mr. REID. Yes.

Mr. DORGAN. I think there are two other questions on that point: Not only how much does it cost, but because this is a tax provision, is it not the case that this clearly is a blue-slip provision? A tax provision cannot start in the Senate.

Mr. REID. Will the Senator explain what this means to the people watching?

Mr. DORGAN. Constitutionally you must not start a tax provision in the Senate; it has to originate in the House. Second, is it offset? If so, how would one pay for this tax incentive? I think those questions should be asked as well. I wonder if we could get an answer to that.

Mr. REID. I would ask, through the Chair, the manager of the bill to answer those questions, if he would,

please. We have just received a copy of the amendment from the pages a couple minutes ago.

Mr. JEFFORDS. I will defer to the distinguished Senator from Oklahoma.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Let me make a couple comments on the bill in general. I am assuming I am on our time.

The PRESIDING OFFICER. Yes.

Mr. NICKLES. How much time remains on the amendment?

The PRESIDING OFFICER. The majority has 23 minutes 6 seconds; the minority has 42 minutes 45 seconds.

Mr. NICKLES. Mr. President, one, I understand some of my colleagues made the statement, what about a blue slip? If we pass a tax cut, won't the House of Representatives automatically blue-slip it? For those people who are not aware of what that means—and probably a lot of people watching do not have the faintest idea what that means and what that has to do with health care—the idea of a blue slip is that the Constitution of the United States says: All revenue measures must originate in the House. If the Senate originates a tax cut or revenue measure, the House can refuse to take it. They can blue-slip it and not have it go anywhere. We do not plan on having that on this particular bill. We have seen it before.

I might mention, in the unanimous-consent agreement that was agreed to, that outlined the procedures for the bill. We agreed:

> That following passage of the bill, should the bill upon passage contain any revenue blue slip matter, the bill remain at the Desk; that when the Senate receives the House companion bill, the Senate proceed to its immediate consideration; that all after the enacting clause be stricken, the text of the Senate-passed bill be inserted in lieu thereof, and the bill, as amended, be passed; and that the Senate insist on its amendment and request a conference with the House, all without any intervening action or debate.

What that means is, obviously, we knew in the Senate bill it was our intention to deal with tax issues because we want to increase access; we want to improve access; we want to increase the number of people who are insured. Unfortunately, our colleagues' bill, the Democrat bill, the Kennedy bill, will increase the number of people who are uninsured. It is estimated by people to increase the number of uninsured by 1.8 million, maybe 2 million people who would lose their insurance. We don't want to do that.

I stated on the floor of the Senate, maybe 2 years ago, that whatever we did we should do no harm, we should not increase health care costs, and we should not increase the number of uninsured. We should be doing just the opposite. We should be increasing the number of insured.

In the amendment the Senator from Maine has offered, we have given a tax credit for people with long-term health care, a provision I believe and I hope and expect will improve the access to long-term health care, which is a problem for millions of Americans. That will improve it dramatically. It will be a very positive change.

I compliment my friend and colleague from Maine for basically saying: We want this in our bill. Long-term health care is a very significant problem. There are a lot of people going into nursing homes and they are going bankrupt or their families are going bankrupt trying to take care of loved ones in nursing homes.

Shouldn't we do something to address that? In the Tax Code we have incentives to help with health care, rather significant incentives. Large corporations get to deduct 100 percent. Unfortunately, the self-employed only get to deduct 45 percent. We have already addressed that. That was one of the amendments we agreed to yesterday, allowing 100-percent deductibility for the self-employed. That is a positive change.

This change, as offered by our colleague from Maine, and others, is a very positive change saying, let's give a tax deduction for people in purchasing long-term health care coverage so they will not be so dependent on their kids or their grandkids, in some cases, or other family members, so they can start working on preparing for their later years and making that available for them now. That will improve their quality of health care now, or they will be ready for it now. Most people do not do that. Most companies do not do it. Most plans do not do it. We want to encourage it. We want to jump start it. We want to make it a common option, a common fringe benefit that, frankly, right now is not there. Most people do not have it, do not think about it until it is too late, until a loved one goes into a nursing home or maybe a loved one has a real problem with Alzheimer's or something, and the expenses are very large.

So the provision my friend and colleague, Senator COLLINS, has offered allows individuals with no employer subsidy to deduct 100 percent of the cost of long-term care insurance and allows long-term care benefits to be offered through a cafeteria plan.

The estimated cost—I think somebody asked that—is $5.4 billion over 5 years and would benefit an estimated 3.8 million taxpayers. I make that clear.

One of my colleagues said: How is it paid for? How are you going to pay for it? What is your intention on how to pay for it?

We actually do intend on having some offsets. We have not introduced those yet. We will at the appropriate time.

I have been somewhat critical and maybe have had a little fun with my colleague, Senator KENNEDY, because he had some tax increase in some of the provisions including Superfund and others. I do not think Superfund belongs in this bill. We do plan on having some offsets at the appropriate time. We do not have to, under this UC, have them in the bill at this point or else my colleague could make a point of order on it. That is not allowed in the unanimous consent agreement that was already reached by both sides, and so I just mention that.

But at the appropriate time we expect to have an offset. Even if we did not have an offset, the bill would not pass the Senate; it would be held at the desk until we received the appropriate vehicle from the House of Representatives.

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

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I think this is an interesting argument, to say the least. We have, on this side, striven, worked very hard to make sure there are some benefits for long-term care. It is great that there is some acknowledgement they want to do that, but in this age of frugality, it is interesting that the majority is willing to spend $5.4 billion with no offset. Anything we have set forth in this bill had offsets. We looked at the Superfund as an appropriate offset, and the only complaints we heard were from the majority in this regard. In short, it appears that we have, as the Senator from California pointed out, a provision to help women that really doesn't help women. Helping the women which is about 20 million women, is not mandatory. The HMO could do it if they want to. It is permissive. It is like having nothing.

We have learned from a letter from the President of the American College of Obstetricians and Gynecologists that at least a third of the women who want to go to a gynecologist in these HMOs are refused. This amendment, the little bit that we have been able to see in the last few minutes, it is clear, has no substance. It is a sham. It is a phantom.

It is, as I pointed out in my opening statement, a game that I first learned when I went to New York, the shell game. Every time you look under one of these shells that the majority gives us, it is empty. There is nothing there. You keep looking, hoping that one of the times you are going to pick up a shell and there is going to be something of substance. This amendment that we have been able to see, again, is similar to the rest of the game that has been played here the last 3 days.

The shells appear. We anxiously pick one of them up. And just like the street game in New York, they are empty.

Mr. DORGAN. I wonder if the Senator will yield for a question?

Mr. REID. I am happy to yield.

Mr. DORGAN. This all reminds me of that old moonwalk that you have seen people do, where they look like they are walking forward, but, in fact, they are making no progress. A famous singer used to do that moonwalk. That is what I see on the floor of the Senate.

We offer a proposal that has the support of virtually every health organization in this country and every consumer and patient group in this country.

Mr. REID. My only correction is, not virtually every group. Every group.

Mr. DORGAN. Every group. And the proposal deals with care by specialists, emergency care, OB/GYN. It covers the vast array of the American people.

Then we have amendment after amendment that is kind of like decoration. It is kind of like the paint and the chrome and the hood ornaments to try to dress things up and make it look like it is something, but it is a vehicle without an engine.

The engine is what we have produced on the floor in terms of a bill that says we are going to do something real for patients who are not getting the health care they need. So we will give them some protection.

The response we get is to come out here with some empty vessels and some dressing up of some empty vessels saying: We share your concern and so here is how we address it.

On the issue before us, isn't it the case that when someone stands up and says: Women have a right to get treatment by their OB/GYN, except when they offer the proposal, it is a right for only some women, but a right that will be denied to most women? Isn't that the case?

Mr. REID. And a right that doesn't mean anything. It says that the group health plan described in paragraph 2 may treat the ordering of other care, ''may treat.'' That says, as my friend from Massachusetts has talked about for 3 days, if the insurance company decides it is good for them; right? What are they going to decide is good for them? The bottom line, what is going to give the HMOs another top $10.5 billion in profits.

Mr. DORGAN. One additional question: Wouldn't it be the case that if the Senator from Nevada brought to the floor a tax proposal, or a spending proposal for that matter, that costs $3 or $5 billion, our friend would chase you off the floor and say: If you are bringing something to the floor that is not paid for, come on, that violates all the rules of the Senate?

Yet we just heard from our friend from Oklahoma that this provision provides tax incentives. It is going to cost billions of dollars. How are you going to pay for it? Well, we don't pay for it in this bill, but we have an intention to pay for it at some point along the way.

Do you think our friend from Oklahoma would let you get by with that, bringing a provision to the floor that says we are going to have a tax incentive and you are not going to pay for it, but you will come up with an answer later?

Mr. REID. I say to my friend from North Dakota, maybe it is going to be paid for the same way as the huge cuts that American veterans are getting. It could be paid for the same way: Cut them some more, as the budget that passed this body that not a single Democrat voted for.

Mr. DORGAN. Talking about health care.

Mr. REID. I am talking about health care for veterans. Maybe that is where we could get part of it, cut them some more, the veterans.

Mr. DORGAN. Obviously, the Senator is talking about the budget that was passed by the Senate on a partisan basis. I did not support that. It is not the right approach to have substantial veterans' health care cuts. The Second World War veterans are reaching a time when they need maximum health care that was promised them. The right approach is not to cut veterans' health care. The need is to increase it. Getting back to the point, we have an amendment that was offered, which we had not previously seen, that suggests it will provide some protection. In fact, it denies that protection to the majority of the American women. It doesn't guarantee it, in any event, and provides tax cuts that are not paid for.

Mr. REID. I say to my friend, it guarantees them that they may, if the insurance company or HMO decides they want to give it to them, get it. It is permissive. That is what it does. It guarantees nothing.

Has my friend from Florida—again, we have had little opportunity to look at this—has my friend from Florida, who has done such an outstanding job in previous days talking about our second amendment that we offered on emergency medical care, had an opportunity to look at their provision in this amendment, beginning page 15?

Mr. GRAHAM. I say to my colleague, the answer is, briefly, yes. I have a couple of questions. Maybe I could engage in a dialogue with Senator HUTCHINSON on these matters.

Mr. REID. I yield my friend from Florida 3 minutes for this question so that we leave the Senator from Massachusetts ample time. If you need more time, we will consider it. Three minutes to the Senator from Florida.

Mr. GRAHAM. That depends on how long it takes to respond to the question. I will get started

As I said last night, there were two principal differences between the Republican and Democratic emergency medical care provisions. The first of those was the question of, if your child has a 103-degree fever and needs to go to an emergency room, and the closest emergency room is one that doesn't belong to your HMO, but you are taken there anyway, can you be required to pay higher charges for that closest emergency room as opposed to taking him to the more distant hospital that belongs to your HMO's network?

What had concerned me was the language in the original Republican bill. I am looking at subpart (C), section 721, Patient Access to Emergency Medical Care, in the original Republican bill. On page 5, lines 5 through 18, is the outline of the uniform cost-sharing provision. I had read the equivalent language in the amendment which appears on page 18, line 13 through line 2 on page 19. I have tried to read them, and I believe the language is verbatim the same.

This is what the committee report which was issued by the Committee on Health, Education, Labor, and Pensions and signed by all of the Republican Members said about that language:

> Plans may impose cost sharing so long as it is uniformly applied to similarly-situated individuals and to all benefits consisting of emergency medical care. The committee believes that it would be acceptable to have a differential cost sharing for in-network emergency coverage and out-of-network emergency coverage, so long as such cost sharing is applied consistently across a category.

The language is verbatim in the amendment as it was in the original Republican bill. So can I assume that that committee language, which interprets what section (B)(1) on page 5 of the original Republican bill, lines 5 through 18 meant, is the same thing that the verbatim language in your amendment says?

(Mr. ABRAHAM assumed the Chair.)

Mr. HUTCHINSON. I respond to the Senator from Florida by, first of all, complimenting him for his concern and interest in this issue and for, I think, pointing out clearly some improvements that were needed in the committee bill. I do not believe it was the intent of the committee to allow a differential in cost sharing for out-of-network providers.

Mr. GRAHAM. Would the Senator look at page 29 of the committee report, the first full paragraph?

Mr. HUTCHINSON. I have looked at that. I cannot explain that language, but I believe a clarification was necessary. We have made that clarification in the amendment.

Mr. GRAHAM. Then why is the amendment—what concerns me is that the amendment has, word-for-word, much of the same language as contained in the underlying Republican bill to which this paragraph relates.

Mr. HUTCHINSON. I say to the Senator, the change in the amendment is in in-network uniform cost sharing. That was the intent to be permitted. The amendment, on page 19, on out-of-network care, makes it abundantly clear that such differentials in going to an emergency room that may not be in the network and requiring a penalty, requiring an additional copayment because you went to an out-of-network, would not be permissible.

Mr. GRAHAM. That language is also verbatim in the underlying Republican bill. There is a paragraph in the committee report that interprets that, as well. That says:

> The committee adopted an amendment offered by Senator HUTCHINSON, adding a new paragraph (2) to Section 721(b)—

Which is the same language in the amendment—

clarifying that plans may not hold a participant or beneficiary liable for any additional charges—

That is not the issue of copayments or deductible; that is additional charges. This is what we used to refer to as double billing.

—from a nonparticipating provider who has provided emergency services for the participant or beneficiary. In many communities, plans and MCOs typically contract with specific providers and hospitals. However, an individual as a prudent layperson may seek services at the nearest facility, depending on the severity of the symptoms. It is the committee's intent to ensure that individuals acting under the prudent layperson standards are not held liable financially for exercising this right when they seek care at a non-network facility.

That refers to the double billing; that is, if you go to a nonparticipating emergency room, they can't charge you more. But the issue—

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

Mr. GRAHAM. The subject of subparagraph 1 is the issue of whether they can charge you a different copayment or deductible; that is, if my standard deductible, if I go to an in-network emergency room, is, let's say, 20 percent, can I be charged a 70-percent copayment because I am going to an out-of-network? That is what both subparagraph 1 and the paragraph on top of page 29 of the committee report refers to. They are two significant and different concepts.

Mr. REID. Mr. President, on our time, I say to my friend from Florida, he has answered his own question. The fact of the matter is, they have copied the old stuff from the old bill. They have changed nothing. They have packaged it in this fancy package with all these ribbons and bows, as the Senator from North Dakota said. As I have said, we have this shell game being played. We pick it up and there is nothing under it.

I respect and admire so much the Senator from Florida, who is an expert in emergency room care. He has given a number of dissertations on the floor that have been outstanding. I say that sincerely. Obviously, he understands this issue much better than some who have tried to speak on this issue.

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

Mr. REID. I yield the Senator another minute.

Mr. GRAHAM. If we both have the same objective, which is to ensure that a family with a child with a 103-degree temperature won't be at an economic disadvantage by going to the nearest emergency room—if our desire is to encourage that, let's not be vague about it. Let us not leave this ambiguous.

Mr. HUTCHINSON. Will the Senator yield?

Mr. REID. On your time?

Mr. GRAHAM. No one is served by ambiguity.

Mr. HUTCHINSON. I don't think it is ambiguous at all. There has been a misunderstanding of the language in the amendment.

Certainly, there can be a differential in a network plan between going to an emergency room and going to a provider other than an emergency room. That is what is clear both in the bill and in the amendment. If you will listen to the language of the out-of-network case, I think it is as unambiguous as any language can be:

The plan shall cover emergency medical care under the plan in a manner so that, if such care is provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider.

I believe that is as clear and unambiguous as language can be. It was our intent that you should not have any incentive to drive across town while your child or your spouse is in jeopardy, that you should be able and would be able to go to the closest emergency room without incurring additional costs. That is what the amendment does, and that is what I think should be done.

Mr. GRAHAM. Here is the problem. I am a court or I am an administrative agency trying to apply this law. I have exactly the same language in this amendment as was reported by the Senate committee of jurisdiction. That committee issued a report that, in very unambiguous language, specifically interprets these words to mean that you can't be charged more if you take your kid to the closest emergency room that doesn't happen to be a part of a participating network.

Now, you have said, Senator FRIST has said, and I think everybody agrees, that we don't want that to be the result. So why don't we get a set of words that removes any ambiguities so that no one, a year from now, can go back to this same report and read what the committee allegedly meant as applied to the Senate words. It is not a complicated concept to articulate. We ought to do it.

Mr. FRIST. Mr. President, I yield myself 2 minutes. To clear this up, the three of us have had discussions. The issue in the underlying bill was not clear. The question was raised two or three nights ago by the Senator from Florida that there is a potential barrier there that we need to clarify, to make sure you can go to the closest emergency room, that there is not an economic barrier there, believing you are going to be charged more if that is an out-of-network provider or participant.

I agreed on the floor openly two or three nights ago. The committee report I disagree with, he disagrees with it, and Senator HUTCHINSON disagrees because it says—I don't have the exact words, but it implies they are allowed to charge more out-of-network. Therefore, agreeing with that, we have come up with this wording, which is as clear as we can make it. I want to make sure the RECORD is clear that I agree with the Senator from Florida and with Senator HUTCHINSON, and this is our best effort to be as clear as we can, and that the language in the committee report is inconsistent with the amendment on the floor.

I yield the floor.

Mr. GRAHAM. I don't mean to be repetitive, but my concern is that the language in the amendment is exactly the language that is in the underlying bill to which that committee report was written.

PRIVILEGE OF THE FLOOR

Mr. DORGAN. Mr. President, I ask unanimous consent that Marc Schloss be allowed privilege of the floor.

Mr. REID. Mr. President, I yield 5 minutes to the Senator from Rhode Island to talk about the provision in this amendment dealing with specialists.

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

Mr. REED. Thank you, Mr. President. I thank Senator REID for yielding.

This amendment contains many elements, one of which is apparently an attempt to provide access to specialty medicine and specialists. But it is an attempt that I think falls far short of the mark.

If you look at the definition of specialty care, it means, according to the legislation, someone who has ''adequate expertise.'' I don't know of any medical professional who would define themselves as a specialist using that terminology—it seems oxymoronic—''adequate expertise.''

It also says ''age appropriate expertise.'' That is one of the crucial issues we must address. It is one of the critical differences between the Democratic proposal and the Republican amendment that is before us today, because in our proposal we specifically guarantee access to pediatric specialists. For example, these are individuals who we hope have more than ''adequate expertise.'' These are individuals who have been recognized by their colleagues as in fact highly qualified, highly specialized practitioners of medicine.

Their amendment is somewhat illusory. It talks about specialists. But then it just says to the insurance company that if you can find someone with adequate expertise, you can call him or her a specialist. And with respect to age, it doesn't have to be a pediatric specialist; it can just be someone who has, as I quote, ''age appropriate expertise.''

What does this mean? Someone who 2 years ago saw a 12-year old or a 13-year old—the individual might, in fact, be a cardiologist, or a nephrologist, but saw the child a couple of years ago—is that ''age-related expertise?''

That is not what I think we have to ensure in this legislation. We should be able to guarantee to every parent that if their child is seen by a general practitioner—a pediatrician, we hope, in the case of a child—and that child needs a consultation, or referral, to a pediatric specialist, that is what will

happen. Sadly, this legislation falls far short of that. We must do that.

I just spent several hours on Monday at the Providence, RI, General Hospital. I met with pediatricians and pediatric specialists. They all told me the same thing. They have a lot of difficulty getting referrals in managed care to pediatric specialists. They sometimes might be offered a referral to an adult specialist. But there is a difference. I think anyone with any knowledge of the medical profession—in fact, far more than I—would identify and recognize immediately that a pediatric cardiologist and a pediatric nephrologist are in a different subset of specialties from what you find at the adult level.

Our legislation guarantees this type of elasticity to the family.

The other chorus I heard from listening to these practitioners is the fact that the primary care physician in the pediatric field today are overwhelmed because they are seeing children—particularly in the context of some of these attention-deficit disorders—and they are in five or six different types of medicines that they don't see frequently or commonly in their practice. They need to get a referral to a specialist in child psychiatry, for example, or someone who has much more expertise. And, once again, without hard, iron-clad guarantees of access to pediatric specialists, this will not happen. It is not happening now.

I seriously question the effectiveness of this particular language when it comes to doing what we think can and must be done; that is, to have, particularly with some of the children—I have made this point time and time again—to have children be with pediatric specialists and not just with people with ''adequate expertise,'' not just someone who may have seen a few children a few years ago but recognized pediatric specialists.

I continue to hammer away at this issue of children because typically they are so poorly served in managed care in regard to access to specialists. For one reason, there is a very small volume of chronically ill children who need this access. As a result, managed care panels seldom will employ these pediatric specialists.

For this reason, and for the reasons from the other side, my colleagues, I think this amendment falls far short of what we need to do. I strongly urge its rejection and acceptance of the Democratic alternative.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I yield 3 minutes to the Senator from North Carolina.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Mr. President, I say to my colleagues and to the Senator from Tennessee that I suffer from the disadvantage of having seen this amendment only for a short period of time, as my other colleagues have. But just in that short period of time, I have found what appear to me to be—and I am perfectly willing to listen to an explanation—three gaping holes in this amendment, particularly as it relates to the issue of specialty care. I think our amendment completely closes those holes.

Hole No. 1: Even though the bill provides for timely specialty care in accordance with the exigencies of the case of access to primary and specialty care specialists—that on the surface sounds wonderful—here is the problem. There are three huge holes in that provision.

No. 1, the plan can still do anything it wants to control costs, which means the plan can have a provision that essentially wipes out access to some particular specialty, or some particular kind of specialty care, in order to control costs. All they have to do is justify it on that basis, which is to control costs.

So they can essentially eliminate the value and substance of this provision by simply saying, as they do every day now: We are doing this on the basis of cost. That is the reason the HMO is doing this. We have to do it for cost control—so they can keep kids from seeing specialists and so they can keep adults from seeing specialists. And their justification is, they are controlling costs.

Huge gaping loophole No. 2: They can still condition access to a specialist in a treatment plan, which means the HMO can provide a treatment plan that is completely contrary to what the medical professionals taking care of the patient believe the patient needs to see in terms of a specialist.

If that treatment plan—written by the health insurance company, written by the HMO—is inconsistent with what the doctor is doing in taking care of, for example, a young child whom he believes he needs to see in terms of a pediatric specialist, then the right to see a pediatric specialist is gone.

So we already have two huge gaping holes:

No. 1, the HMO can keep people from seeing specialists by just saying, we are controlling costs. That is as simple as that. It is over. Control is in the hands of the health insurance company.

No. 2, if they say we have a treatment plan that is different from what the treating doctors say the child needs, they can keep the child from seeing a specialist, completely eliminating the right.

And the killer is gaping hole No. 3, particularly working in combination with the other two, which is, there is no right to an external appeal.

The result of this is, if the HMO says, we are not going to let you see a specialist because of cost, we are not going to let you see a specialist because we have a treatment plan that is inconsistent with what the treating doctors say, the patient is completely out of luck. They can't do a single thing about it. They have no right to an external appeal. They are completely stuck. The power remains entirely in the hands of the HMO and the health insurance company.

It doesn't cure it in any way because of the extraordinary problems we have with access to specialty care today.

Thank you, Mr. President.

The PRESIDING OFFICER. Who yields time?

Mr. JEFFORDS. Mr. President, I yield 5 minutes to the Senator from Minnesota.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. GRAMS. Thank you very much.

Mr. President, I rise to lend my voice in support of Senator COLLINS' amendment regarding deductibility for long-term care insurance.

I know some of those on the other side call this a sham-type proposal. But to the minority, a lot of times a sham, or empty vessel, or a shell game, if the Government doesn't do it, or buy it, or provide it somehow, if you encourage personal responsibility, if you encourage individuals to buy in the private sector, that doesn't count. The Government is left out.

I think by offering this amendment—by offering the tax incentives—to try to level the playing field between big employers, self-employed, and employees who do not have coverage, and giving them this incentive, many will take the option to buy this long-term insurance because they will have more access and because it will be more affordable.

That is the heart and basis of this amendment.

As Senator COLLINS mentioned, the long-term care provision of this amendment was contained within the Health Care Access and Equity Act which I introduced last month. I am pleased the Senate will get a chance to vote on this issue because it is such an important issue for today's seniors and tomorrow's retirees.

Mr. President, it is estimated that, in the history of the world, half of the people who have ever reached age 65 are alive today. As the baby boom generation ages, the population of those over age 65 will increase quicker than at any time in history. The increase in the aged population brings with it a number of complex and vexing issues, one of which is long-term care.

The Health Insurance Portability and Accountability Act tinkered slightly with the issue of long-term care insurance, but we need to meet the issue head on rather than skirt the edges.

I have believed we should encourage individuals to save for their retirement needs and, for a number of reasons, usually cost, long-term care insurance is often overlooked during retirement planning. Unfortunately, I think this often leads to individuals spending themselves down to poverty and relying on Medicaid in order to pay for long-term care.

Again, the heart of this amendment is to encourage people when they are

planning for those years to also include long-term care to protect their estate, to protect their heirs.

By allowing individuals to deduct the costs of long-term care insurance, we can prevent many of our elderly from impoverishing themselves in order to receive long-term care.

I also wanted to express my appreciation to Senator HUTCHINSON for his work on the prudent layperson language which is so important to all of our constituents.

As many of my colleagues know, I have been working on emergency medical services issues for the past 3 years and believe this provision will not only help patients in their time of emergency, but it will help our EMS providers continue to offer the most advanced emergency care in the world. This will help do that.

Finally, Mr. President, I'd like to express my appreciation to the physician Senator from Tennessee for not only his work on the access to specialists provision, but also his work throughout this debate providing a voice of experience and reason.

Again, I would urge my colleagues to vote for this much needed tax relief for long-term care insurance.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Before my friend from Minnesota leaves the floor, I am curious as to how you are going to pay for the $5.4 billion that the long-term care would cost. Where would that money come from?

Mr. GRAMS. We have discussed that. I believe Senator NICKLES has today talked about that. We do have provisions that will be offered.

The plan is there. Don't think Republicans would offer this without a plan to go along with it.

Mr. REID. What is the plan?

Mr. GRAMS. As Senator NICKLES said, it will be offered.

Mr. REID. He said it would be offered later.

Mr. GRAMS. It will not come out of the Superfund money, I assure you of that.

Mr. REID. What other ideas do you have as to where it would come from?

Mr. President, I yield 4 minutes to the Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I appreciate the chance to speak about the pending amendment, particularly about the specialty care provision of the pending amendment.

I read it recently, but I think there are some serious concerns that need to be addressed. The Senator from North Carolina has raised them. I know others have as well.

As I understand the amendment now, there is no provision in it to restrict an HMO from charging additional for a patient if they need to go outside the plan to get specialty care. One of the things we have tried to do in the amendment we drafted on specialty care is to ensure not only that a person has the right to specialty care but that they cannot be charged whatever the HMO determines in additional charges they want to tack on in order to get that access.

I think this is important. Clearly, if a person has signed on to a health care plan, they expect to be able to access the care they need without incurring additional costs, particularly when there is no restriction in this legislation or this pending amendment, that I am aware of, which would in any way restrict the amount of the additional cost that might be added. That is a very real concern which I think we have to bear in mind.

Another concern is, the amendment we intend to offer on specialty care tries to specify that if a person has a chronic illness that requires the care of a specialist, that specialist could be designated as the primary care provider. For example, someone who is diabetic and who needs to see a specialist, an endocrinologist—which I believe is the specialty that is focused on dealing with the problems of diabetics—a person could have that endocrinologist designated as their primary care physician so they could go directly to that person and not have to go through a primary care provider in each case.

As I read this amendment, it says nothing in this section shall be construed to prohibit a plan from requiring the authorization of a case manager—that is, the person working for the insurance company—or the primary care provider each time you go to see a specialist.

I think that is another defect in the bill, as I understand it. Now, I could be corrected on any of this if the author of the amendment can point to other language that I am not aware of.

The third point I want to make is the same question the Senator from North Carolina raised. He referred to it as ''gaping hole No. 3.'' That is the question about what do you do when the health maintenance organization says no, we will not allow you to access a specialist. That is a real-life circumstance that many people face.

In the amendment we intend to offer, we provide if you are denied access to a specialist, you can get an independent reviewer to review that decision on a very timely basis and then abide by that decision. There is nothing in the pending amendment I can see that would provide for any such appeal if the HMO turns down a patient's request for specialty care.

We had a very good opportunity earlier today to hear from a mother of a 4-year-old boy about the problems she encountered in trying to get access to specialty care for him. That circumstance is one that many people face. She was delayed and delayed and delayed by the health maintenance organization constantly saying they would not allow her to see anyone but her primary care physician for the various ear infections her 4-year-old son was having because they believed those should be treatable by that primary care physician. After more than 2 years of being delayed, she finally did get access to a specialist. The specialist did a surgical operation which corrected the problem.

Unfortunately, because this situation existed at this time in her son's life, her son now has a speech impairment and is having to go through therapy for that. Again, she is encountering problems getting access to that speech therapy for her son through the HMO.

I don't believe the specialty care provision in this amendment that is pending solves the problem for most Americans.

I yield the floor.

Mr. JEFFORDS. I yield 5 minutes to the Senator from Iowa.

Mr. GRASSLEY. Mr. President, I am pleased to support Senator COLLINS' amendment that addresses several important areas. In particular, I am glad to support the provision to allow a 100% above the line tax deduction for the long-term care insurance.

As chairman of the Special Committee on Aging, addressing the challenges of long-term care have been high on my list of priorities. During the past two years, I've heard firsthand from individuals and family members about the financial challenges that go along with managing long-term care needs, such as those associated with Alzheimer's Disease.

In too many cases, families experience financial devastation when faced with long-term care needs. Unfortunately, many families do not plan for costs associated with long-term care. And many families are mis-informed about what Medicare and Medicaid cover in respect to long-term care.

Today's average cost of nursing home care is about $40,000 a year. When individuals are faced with a chronic or disabling condition in retirement, they often quickly exhaust their resources. As a result, they turn to Medicaid for help.

In fact, the care for nearly 2 out of every 3 nursing home residents is paid for by Medicaid. As many seniors realize too late, Medicare does not cover long-term care costs.

I introduced legislation last Congress and again this Congress to provide an incentive for individuals to plan and prepare for long-term care cost. Like the provision in Senator COLLINS' amendment, my bill will allow Americans—who do not currently have access to employer subsidized long-term care plans—to deduct the amount of such a plan from their taxable income.

This encourages planning and personal responsibility by helping to make long-term care insurance more affordable for middle class taxpayers.

Longer and healthier lives are a blessing and a testament to the progress and advances made by our society. But Americans must be alert and prepare for long-term care needs. The role of private long-term care insurance is critical in meeting this challenge. Over the past ten years, the

long-term care insurance market has grown significantly. The products that are available today are affordable and of high quality.

As policy makers, our job is to develop policies for public programs that can deliver efficient and cost-effective services. Yet, equally important is the role of private long-term care financing. We must take steps to inform Americans about the importance of planning for potential long-term care needs. And, in turn, we should provide incentives now for the families to prepare financially for their retirement.

The PRESIDING OFFICER. Who yields time?

Mr. JEFFORDS. Mr. President, I yield the Senator from Maine such time as she may take.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I ask unanimous consent that the Senator from Michigan, Mr. ABRAHAM, be added as a cosponsor to the pending amendment.

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

Mr. JEFFORDS. Mr. President, I yield to the Senator from Tennessee as much time as he may desire.

Mr. FRIST. Mr. President, how much time remains?

The PRESIDING OFFICER. The Senator from Vermont has 7 minutes; the Senator from Massachusetts has 10 minutes 40 seconds.

Mr. FRIST. Mr. President, a number of issues have been raised again. I appreciate the debate. I think it has been very good on a number of these issues, some of which we have talked about in the past and some of which have come up on the floor. It is difficult, with the amendments being presented, to know exactly what to address and what not to address. Those of us who have been looking at this for the last year, and through the Health, Education, Labor, and Pensions Committee, have looked at a number of these issues. Let me comment.

The allegation has been made the Republican bill does not assure access to specialty care. The fact is the following: The Republican bill guarantees access to specialists. Period. Section 725 states that plans ''shall ensure access to specialty care when such care is covered under the plan.'' We brought up again and again that the problem with the Democratic bill is that it guarantees that 1½ million Americans, if it were adopted, would not have any health insurance at all and, therefore, would not have access to specialty care.

No. 2, we have heard that under the Republican bill there is no guarantee a child with cancer will have access to a pediatric oncologist. That came up earlier in the debate. The Senator from Rhode Island brought it back up, so let me just clarify what we have done. Again, it has been a process, as we talked again and again about that.

The Senator from Rhode Island says we need to specifically say ''appropriate pediatric expertise.'' We talked about it in the committee. The reason we use the words ''age appropriate expertise'' instead of just pediatric, which is much more narrow than ''age appropriate expertise'' is because it includes pediatrics but it also includes a terribly important part of our population and that is the geriatric aspect of health care.

We are going to have a doubling of the number of seniors over the next 30 years in this country. We have to write this legislation for today and 10 years from now and 20 years from now. By using the words ''age appropriate expertise'' instead of the very narrow construction of ''appropriate pediatric expertise,'' we include the geriatrician, both of today and the future, as well as the pediatrician; on either end of the spectrum. That is the intent. That is the way it is written. That is the way it is spelled out very clearly in the committee language in the report.

Going through, we have heard again and again: Under the Republican bill, patients could be charged more for out-of-network specialty care, even if the plan is at fault for not having access to appropriate specialists.

Again, let me read from the committee report, on page 33, because some people have not gone back to read the original committee report which is the intent behind the language. We say:

> . . . the committee intends that when the plan covers a benefit or service that is appropriately provided by a particular type of specialist not in the network, the benefit will be provided using the ''in-network'' cost-sharing schedule.

I want people to understand that. It is on page 33 of the committee report, for people to refer back to that.

I heard again and again: The Republican bill will not allow patients to appeal a denial of access to a specialist, to make that appeal to an independent reviewer. The fact of the matter is the Republican bill provides the right to an independent, external review by a medical expert when the access to a specialist is denied on the basis that care is not medically necessary or not medically appropriate.

So, again, let me summarize for, I think, the Senator from Rhode Island. The ''pediatric expertise'' I have explained to be more ''age appropriate expertise.'' The Senator from North Carolina listed three gaping holes which I simply contend are not gaping holes.

I have not addressed one. The first was the plan can do anything to control costs. That was his point No. 1. Let me say that what we have used in the bill is, in fact, almost the exact words out of the Democratic bill. He is referring to the rule of construction under the timely access provision, section 104. Basically, we lifted—used the exact same wording as the rule of construction. It goes something like:

> Nothing in this paragraph shall be construed to require the coverage under a group health plan of particular benefits or services or prohibit a plan from including providers . . .

And it goes on forward.

With that, I will simply refer him to the rule of construction on page 34 and 35 of their bill, of the underlying Kennedy bill, because that is where we took that rule of construction, about not requiring coverage.

The second so-called hole was the treatment plan issue and the limitation. Again, from your bill, if you look at page 12 where we say we require a treatment plan, your bill requires the same sort of treatment plan as what we actually required. Again, you can be critical of it in our plan, but explain why it is in your plan on page 12.

The third is this right to appeal. It is very important to deal with that right to appeal. Saying there is no right to appeal is, basically, absolutely false. We have obtained a legal opinion on this to make absolutely sure. If required, the treatment plan is required—what they told me, it is to be an element of medical judgment; that is, is it medically necessary or not necessary, which takes it in the realm of medical judgment. If that is the case, there can be an appropriate request for an external appeal, where you have a medical physician, independent reviewer, have the final say as to whether or not that coverage is there.

That is about 9 or 10 of the complaints that have been discussed over the course of the day.

Senator BINGAMAN mentioned cost sharing. Again, I would refer him to page 33 of the report where we talk about in-network cost sharing.

His second point where the specialists have to be primary care physicians, I have gone on and on about this. I just disagree. Specialists today—a heart transplant surgeon does not need to be designated a primary care physician from an access standpoint when you have removed the barriers, and that somebody does have access, as guaranteed in the bill.

I see there to be no reason why you designate a heart transplant surgeon to be a medical specialist. We just disagree. I yield the floor.

The PRESIDING OFFICER. Time has expired on the time of the Senator from Vermont. Who yields time? The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I want to go over where we are in the debate. The amendment that has been proposed by our Republican colleagues covers, as close as I can figure, four different areas: One is the tax credit of long-term care. It is being defined. We have asked the Treasury Department to look at that because many of us are interested in the long-term care issue. We have not heard back from the Treasury Department. Time has expired on this particular amendment.

There is also the issue of changes to the OB/GYN provision and whether this is a change which gives the protections to women which we have included in our legislation. The provisions have

been examined by various OB/GYN specialists. We will include in the RECORD the inadequacies of those particular provisions in achieving the objectives described on the floor. The OB/GYN specialists find the language included in that amendment fails. That will be available to the Members.

Third is the speciality issue. Our good friends, the Senator from New Mexico and the Senator from Iowa, as well as the Senator from Rhode Island and the Senator from North Carolina, and others will address in greater detail the issue of specialists.

I want to make a brief comment in response to the particular proposal of the Senator from Tennessee. In reading through the language—and it is important to read the language, as the Senator has said—it says:

Nothing in this section shall be construed to prohibit a group plan from requiring that speciality care be provided pursuant to a treatment plan so long as the treatment plan——

Is developed by the specialist. On page 12, it says:

. . . appropriate to the conditions of the participant or beneficiary, when such care is covered under the plan, such access may be provided.

''When such care is covered under the plan'' makes the provision meaningless because the care is covered only if authorized by the gatekeeper. It says when the care is covered, but it does not say it has to be covered.

Then it says:

Such access may be provided through contractual agreements with specialized providers outside the network.

That is optional. You can read all the lines you want about age-appropriate speciality if they include it in the plan, but if you start right out and say it is not included and is optional, it is meaningless. That is not only my opinion, but it will be gone into to some degree by others.

I listened to my friend and colleague from Tennessee say the issue is appealable. Why not write that in the bill? We wrote it in. Why leave any question? Why does he have to quote a letter from some law professor? I have a letter from a law professor that says it does not. Why not just write it in the bill?

I hope there will be some kind of response. I will be glad to yield for a minute. We wrote in our bill that it is appealable if a specialist such as a pediatric oncologist or necessary specialist is denied. Why isn't it included in the Republican plan? It is not.

We will have an opportunity to debate that issue.

I do not want to get off message, but I hope our good friend from Oklahoma, as well as our good friend from Texas, will now look at what the Republican bill is costing.

This is what the Republican bill is costing. According to joint tax, it is $1 billion for patient protections; 100 percent deductibility for small business is $2.9 billion; liberalized MSA, $1.5 billion; flexible spending account is $2.3 billion. That adds up to $7.7 billion. Long-term care is $5.4 billion. That is $13 billion—$13 billion for the Republican plan.

I hope we do not hear any more about the cost of the plan with no offsets. I hope we can get rid of that argument. It has taken us 2½ days. Under CBO, ours is $7 billion. The Republican plan with this will virtually be doubled. I hope we are going to be free of that argument. We want to focus on what we are interested in, and that is the Patients' Bill of Rights.

We are going to have an amendment when I yield back the time in just a moment. I want the membership to understand, this amendment will not be targeted to OB/GYN. It will not be targeted to long-term care. It will not be targeted to emergency room care, though there are many different provisions in that with which we take issue, which our friend from Florida has pointed out. This will only be targeted to the provisions of the Republican amendment on speciality care.

Our amendment is accepted and those who will put forward and present it are Senator BINGAMAN, Senator HARKIN, Senator EDWARDS, and others will debate that for the next 50 minutes. It will only be amending that particular provision. We will have an opportunity to make a judgment on the rest of the provisions later, depending upon what happens on this.

We are limiting this debate to what we have always wanted: a debate on the Patients' Bill of Rights, and that is, protecting people from the abuses of HMOs. Long-term care is not a part of that provision, although it was brought in and that is important. We do not believe it belongs on this, but it is here.

Many of us are unprepared to make a judgment on that since we just found out about that particular provision. We will be interested in what the offsets are going to be.

The next proposal will be the amendment that will be offered by the Senator from New Mexico which will be targeted to speciality care. We are protecting patients, and we insist they get the specialty care we believe is so essential.

Mr. President, I yield back the remainder of my time.

Mr. GREGG. Will the Senator yield for a question prior to yielding back his time?

Mr. KENNEDY. Not at this time.

The PRESIDING OFFICER. All time is now yielded back on the Collins amendment.

AMENDMENT NO. 1245 TO AMENDMENT NO. 1243

(Purpose: To guarantee access to specialty care)

Mr. KENNEDY. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Massachusetts [Mr. KENNEDY], for Mr. BINGAMAN, for himself, Mr. HARKIN, Mr. DODD, Mrs. MURRAY, Mr. REID, Mr. EDWARDS, Mrs. BOXER, Mr. DURBIN, Mr. GRAHAM, Mr. KENNEDY, Mr. DASCHLE, Mr. FEINGOLD, Mr. ROCKEFELLER, Mrs. FEINSTEIN, and Mr. REED, proposes an amendment numbered 1245 to amendment No. 1243.

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

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

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

Mr. KENNEDY. Mr. President, I am going to yield the floor. If the Senator has a question, I will be glad to yield for a minute to respond. I want to have our colleagues talk about this amendment.

Mr. GREGG. I can respond on our time relative to this amendment. I will do it then.

Mr. KENNEDY. Fine. I did not want to be discourteous to the Senator. I yield 7 minutes to the Senator from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico is recognized for 7 minutes.

Mr. BINGAMAN. I thank the Chair, and I thank the Senator from Massachusetts for yielding this time.

Mr. President, this is a very important amendment. This is the amendment that I believe is the most significant for many Americans in this entire debate. This is the amendment that relates to the question of whether they are going to have access to speciality care as part of their arrangement with their health maintenance organization.

Often, if speciality care is denied or if access to speciality care is delayed for a substantial period of time, it can involve a real health risk and even death for a patient. This is not an insignificant matter. This is a very important matter which is essential we deal with if we are going to put in place some protections for patients in this legislation.

The amendment that Senator KENNEDY has sent to the desk on my behalf establishes, first of all, a general right to speciality care if it is medically necessary. If a plan cannot provide such care within its own network, then it must allow the patient who needs that care to go outside the network at no extra cost to the patient. This is in sharp contrast to the amendment we were talking about before which the Senator from Maine sent to the desk. In that case, there was no restriction on the HMO in its ability to charge additional amounts to the patient if they went outside the plan.

We provide that no additional charges can be imposed. This is a procedure which is in place in many of our managed health care plans, but unfortunately not in all. What we would do is say that this is a basic right that people in this country are entitled to if they have health care through health maintenance organizations.

The second thing this amendment does is it allows people who have a

chronic or a serious ongoing illness that requires specialty care to receive that care either through a standing referral to a specialist or by designating a specialist as their primary care provider.

This is very important. This is an important protection for disabled people, for individuals with serious chronic illnesses, such as diabetes. In my comments a few minutes ago, I referred to the fact that a person with diabetes clearly needs access to a specialist on an ongoing basis. They receive most of their care from a specialist who understands their condition, and that specialist is in the best position to coordinate their care.

The plan which the Republican Members offered a few minutes ago does not guarantee access to that specialty care without additional cost. It does not guarantee access to that specialty care for all patients. And it does not guarantee access to that specialty care on an ongoing basis with that specialist being designated as a standing referral or as a primary care provider.

So there is a very great difference between what we are offering in this second-degree amendment and what was earlier discussed.

This amendment I think is absolutely crucial for people who suffer from these ongoing chronic diseases. This is an issue which we heard very dramatically described earlier this morning in a press conference that occurred outside the Capitol.

We had a woman attend who talked about the problems—she is a nurse herself, so she knows a great deal about providing medical care to individuals—and she talked about the problems she and her husband had in gaining access to specialty care for their young child, their 4-year-old son Matthew. What she said I think rings true to a lot of Americans.

Let me just go briefly through her story. She talked about Matthew having a significant speech delay that had been directly linked to his repeated ear infections. She said for the first 2 years of his life Matthew suffered 14 ear infections. In most cases this is a normal childhood illness that is treatable by antibiotics, but in the case of Matthew it was not a normal childhood illness.

The doctor who treated Matthew repeatedly used antibiotics instead of granting the request, which the parents made, for a referral to an ear, nose, and throat specialist. As a nurse, this mother, Beth Gross, knew the risks of the chronic condition. She grew frustrated at how a simple surgical procedure called an ear tube placement could have immediately corrected this problem, and eventually her frustration grew to a level where she made the decision to change her primary care physician.

She called the insurance company at that point. She said when she explained the dilemma she was in, she was outraged by the response she received from the insurance company.

This is a quotation from her statement. She said:

> We could not get a referral for Matthew because it was their policy [the policy of the insurance company] to impose monetary sanctions on the physician for giving a referral for something that he is able to treat.

It was the view of the insurance company that he was able to treat this. They were going to impose monetary sanctions on him if there was a referral made. On that basis, they would not allow the referral. So she had to fight for another year to get the referral that Matthew needed.

By that time, Matthew was 18 months old and was still not speaking. Although she had changed doctors, she could not change insurance companies. When they finally did see the specialist they needed, the specialist immediately knew the right procedure and performed it to correct the problem. So Matthew finally did receive this ear tube surgery that he desperately needed. After that, his hearing cleared up; the problem was solved.

Unfortunately, though, if Matthew had only been treated earlier he would have been able to avoid the speech problem he now has as a 4-year-old. She said in her statement:

> Now our family must work to correct his speech problem. Our insurance company has changed since then, but it has been another fight with another HMO to cover speech therapy. They denied coverage for that service until the National Patient Advocate Foundation stepped in and won that battle for Matthew.

We have a serious problem in gaining access to specialty care in the case of many of these HMOs. The amendment we have prepared has the support of a tremendous number of groups: The National Alliance for the Mentally Ill, the Patients Access Coalition, the Religious Action Center of Reform Judaism, the Coalition of Cancer Organizations, the Oncology Nursing Society, the American Thoracic Society, and on and on.

So there is a very long list of organizations that believe very strongly we need to have this protection built into the law. I believe very strongly in that.

When I travel through New Mexico and talk to people about their health care problems, of all the issues that I am told about, probably this issue of gaining access to specialty care is the most significant.

People are very concerned that if a circumstance befalls them or their child or their parent, they will be denied access to specialty care unless we do something to ensure that that access is there. The amendment we are offering will provide that access. It will ensure that access is there. It is a basic right that we ought to ensure.

Let me mention one other thing because I think this is a point that was made several times this morning.

We spend billions and billions of dollars in this country, and we vote for those dollars right here on this Senate floor, to support the very best medical research in the world. At the National Institutes of Health, I think their budget this year is somewhere in excess of $13 billion. We do have the specialists that the rest of the world envies. People come here from all over the world to gain access to these specialists.

The PRESIDING OFFICER (Mr. SMITH of Oregon). The Senator's time has expired.

Mr. BINGAMAN. Unless we put some of these protections in the law, we are denying our own citizens, in many cases, access to the specialists their tax dollars have paid to train in the specialty care their tax dollars have gone to develop. So we need to put these protections into place. The great research and the great health care that is developed at NIH needs to get to the patient, and that is what this amendment will try to do.

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

Mr. BINGAMAN. I very much hope that all Members of the Senate will support this amendment.

I yield to the Senator from Nevada the remainder of my time and yield the floor.

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

Mr. REID. I yield 7 minutes to the junior Senator from Iowa.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, this is an extremely important issue that Senator BINGAMAN has come up with. I am proud to be a cosponsor of the amendment with him. I will just read the list of additional cosponsors: Senators DODD, MURRAY, REID of Nevada, EDWARDS, BOXER, DURBIN, GRAHAM of Florida, KENNEDY, DASCHLE, FEINGOLD, ROCKEFELLER, FEINSTEIN, and REED of Rhode Island.

This is an important issue. I have worked, as Senators know, for a long time on issues dealing with disabilities, people with disabilities in this country. This is an extremely important issue for people with disabilities and people with long-term chronic health conditions such as cancer and others. The Bingaman amendment would ensure access to specialty care would be guaranteed to individuals in a group health plan so they have access to the specialty care they need. The inability to access specialists is the No. 1 reason people give for leaving HMOs. When I hear criticism of managed care from my constituents, it almost always involves some sort of problem with access to specialists.

Senator BINGAMAN has articulated the differences in the bill. I want to review them again so people have a clear understanding of what the Bingaman amendment does.

First, the amendment guarantees patients access to specialists who are qualified to treat their conditions. If the specialist in the plan's network cannot meet a patient's needs, this amendment allows the patient to see a specialist outside of the HMO's network at no additional cost.

For example, there are several rare and deadly forms of cancer that strike children at an early age. Pediatric oncologists often have advanced skills and technical knowledge that general oncologists do not possess. We have to make sure the parents of these kids can gain access to such specialists, even if the plan they have doesn't have pediatric oncologists in its network. We have to ensure they can get these without additional cost. The Republican proposal fails to provide this basic protection.

Secondly, our amendment allows a specialist to be the primary care coordinator for patients with disabilities or life-threatening or degenerative conditions. For example, imagine a woman with severe heart disease who also has diabetes and hepatitis. She recently had heart surgery and wants her cardiologist to coordinate her care. The Bingaman amendment would allow her to have her cardiologist as her primary care coordinator, who would then coordinate her care under a treatment plan in collaboration with her internist, endocrinologist, gastroenterologist, and the health plan.

Again, the Republican proposal fails to provide this logical protection. According to their version of patients' rights, a patient with a serious illness could be required to entrust important decisions to a primary care doctor who has no knowledge of the specific disease the patient may have. If someone has a chronic or degenerative illness or disability, it is only logical to have a specialist who understands those special needs to coordinate the patient's care.

The third element of this amendment provides for standing referrals for people who need ongoing specialty care, which enables them to go straight to the specialist instead of jumping through hoops time after time after time with primary care doctors or insurance companies.

Here is a true story: A San Diego woman with paraplegia wanted a standing referral to a rehab specialist, but her HMO primary care physician refused that. After she developed a severe pressure wound, something a rehab doctor would have caught and treated, her primary care physician still refused a referral. Eventually this woman had to undergo surgery and spent a year on her back in the hospital with round-the-clock nursing care. Later the HMO's medical director was quoted as saying, managed care ''doesn't accurately meet the needs of the special patient.''

Again, the Republican proposal fails to provide this commonsense protection. According to the Republican's version of patients' rights, a patient receiving ongoing care from a specialist would have to go back and go back and go back to her or his primary care doctor whenever he or she needed to visit the particular specialist.

From anyone's point of view, this does not make sense. By requiring a patient with an ongoing medical condition to continue to go back time and time again to a primary care doctor, every time they need to be treated by a specialist, inhibits the process of making the patient well.

Some people say our amendment would create onerous new burdens on plans. In fact, many plans already allow specialists to be primary care coordinators, and they let people have standing referrals. In addition, the numerical estimates don't factor in the importance of Americans' trust in the health care industry. The patients' rights we are legislating on will build consumer trust in the health care industry and consumer satisfaction. I believe that is in the best interest of our entire health care system.

Most importantly, when you step back and consider the policy of the Bingaman amendment, it is very simple: Insured Americans should get access to specialty care when and how they need it. They shouldn't be charged a single dime more than what they bargained for—nothing more and nothing less.

A lot of organizations support this amendment, including the American Academy of Pediatrics, the Consortium for Citizens with Disabilities, and the Patient Access Coalition.

I encourage my colleagues to join in supporting the Bingaman amendment.

Mr. REID. Mr. President, I yield 7 minutes to the Senator from North Carolina.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Mr. President, first, I join my colleagues, Senators BINGAMAN and HARKIN, in support of their amendment. I strongly support it. They have made great cases for it.

There is another issue I will address that goes to this amendment but also goes to the amendment presently pending from the other side which deals with issues of specialty care, emergency room care, and OB/GYN care. I want the American people who are listening to this debate to listen carefully to what I am about to say.

There is a huge, fundamental issue we are debating in the Senate this week. That issue is, are health care decisions going to be made by doctors and patients, or are they going to be made by insurance companies and HMOs.

Every provision that has passed and has been proposed, including this amendment presently before us, leaves power in the insurance company. It leaves power in the HMO. The arguments we hear that these bills are true patient protections are entirely circular.

If the American people believe insurance companies and HMOs should continue to make all the decisions, should continue to have control of the process, then they should support what our colleagues on the other side have been supporting. If they believe there needs to be a change in that system, then they should support what we are proposing and supporting.

The very simple reason—it is easy to understand—why their bills change nothing about the present system is because there is no way to enforce them. They allow appeals only on the issue of what is medically necessary. It is the only thing that is appealable. What is medically necessary is determined by the HMO and the health insurance company. They write in the contract what is medically necessary. So no matter what we do in the Senate, no matter what we pass, so long as the insurance company and the HMO can define what is medically necessary—and we have seen some ludicrous definitions discussed on the floor, including, for example, that it shall be in the sole discretion of the HMO and health insurance company to determine what is medically necessary, which means they can do anything they want, since that is the only thing that is appealable and, therefore, the only thing that is enforceable—the HMO has total control over this process. The patient has no power whatsoever.

To me, it is as if having a law saying you can't steal money from people but not having a court system to enforce it, not having a police force to enforce it. So when somebody steals something from you, you say: Wait a minute, you can't do that. That is against the law. And the person who has just stolen from you says: So what? What are you going to do about it?

What we have done is left the power entirely in the hands of the HMO to determine what is medically necessary and, as a result, to determine what is appealable. The only enforcement that any patient has is the appeal, which means the health insurance company has total control of the entire process.

This argument is completely circular. It makes no difference what we pass. We can pass anything—OB/GYN reform, emergency room reform, specialists reform. It doesn't matter. The health insurance company gets to determine what is medically necessary. The health insurance company gets to determine, therefore, what is appealable.

Those things have already passed, before this debate that is going on right now.

The bottom line is this: Patients have no power; they have no ability to enforce anything. As long as the health insurance company maintains control over the appeal and grievance process, as long as they maintain control over the only enforcement mechanism that exists, we have no police, we have no court, we have no way to hold the HMOs accountable.

When we finish the debate this week, and whatever passes here, HMOs are going to have a field day. They are going to go back with their teams of lawyers, and they are going to write contracts that completely protect them from any patient ever being able to appeal anything. That is all they

have to do. There is nothing in anything we have passed thus far that will prevent them from doing that. They can write their contracts any way they want. They get to decide what is medically necessary. What I have just talked about applies to everything; it applies to everything that has passed thus far.

I will say what my colleagues have said. If what I am saying is not true, why don't we simply say, for example, in the amendment that is presently pending from the other side, which deals with OB/GYN, emergency room care, specialist care—why don't we put one sentence in that says: Any denial of services under this amendment shall be subject to independent appeal and review.

That is all it would take. Then it is enforceable. Then you have police and a court system. But when that doesn't exist —and it doesn't exist, in my opinion, for a reason, in that amendment. I might add, that it is clearly stated in the amendment that Senator BINGAMAN has just offered. There is a direct, independent appeal if the HMO denies service.

It is very simple. It is a question of who has power. The way we live in the health care system in this country, the power rests with the HMO and the health insurance company. I hoped that the debate on the floor this week would be about how we can go about shifting that pendulum so we put more power in the hands of patients, more power in the hands of doctors, that we would pass some thoughtful, moderate legislation that would move the pendulum back to the middle.

Unfortunately, as long as there is no way to enforce it, as long as the HMO can write the contract any way they want, they can define medical necessity. They define the appeal process and, therefore, they can eliminate the right to enforce anything. The power rests entirely with the HMO and entirely with the health insurance company, which is where it is today, and that is what I believe we need to do something about.

Mr. JEFFORDS addressed the Chair.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. I yield myself such time as I may consume.

I have listened to the Senator, and I guess he has not been listening to the debate because the very argument he made, which has been made before—and we spent the time of this body going through the law, going through the definitions, going through the committee reports—is 100 percent wrong. The patient is in control. The patient has the right, first of all, to an internal review. First of all, the standard is not just necessary; it is necessary and appropriate.

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

Mr. JEFFORDS. Let me talk first and then I can yield. I want to inform you because, obviously, you are talking from a poor base of information, so there is no sense discussing it until I explain to you what is in the bill.

First of all, we have established for the first time in this country the right of patients to be able to get the necessary and appropriate health care that they deserve and are entitled to under their plan. That is why we have set up an internal review process first, which can be appealed within the HMO. And then if care is not given to the patient that the patient thinks is appropriate and necessary, there is an external review. That external review is made by someone outside of the HMO who is a qualified individual, knowledgeable on the subject, with the authority to overrule the HMO.

So how can the Senator get out of that the fact that they have no rights, when for the first time we give them rights? We give much more rights than your bill does to ensure that people in these HMOs have the absolutely necessary and appropriate care that they are entitled to.

So I hope that we will not continue to hear this repetition of things that are not true. Yesterday, the Senator from Pennsylvania came and read this to all of you. He read all this, which explains and details this and gives you exactly what the process is. And now you turn around and say it doesn't exist. It does exist.

Mr. EDWARDS. Will the Senator yield for a question? I request permission to ask the Senator a question.

The PRESIDING OFFICER. Does the Senator yield?

Mr. JEFFORDS. Yes, I yield for a question.

Mr. EDWARDS. Mr. President, I have two questions.

First, let me ask the Senator, is it his understanding that the insurance company, the HMO, writes in the contract what the definition of what medically necessary is?

Mr. JEFFORDS. Yes, but that is appealable.

Mr. EDWARDS. Is it the Senator's understanding that what is appealable is based upon the insurance company's definition that is contained in the contract?

Mr. JEFFORDS. No, that is not correct.

Mr. EDWARDS. Can he show me that in any bill, in anything we have passed——

Mr. JEFFORDS. We have read it to you.

Mr. EDWARDS. Let me finish the question. I don't mean to interrupt you. Can he show me anyplace, in anything we have passed, where we have put any confines, any kind of restrictions on how the HMO or health insurance company can define what is medically necessary? Can he show me anything to prevent them from defining what is medically necessary any way they want?

Mr. JEFFORDS. They can do that, but it will not be legally binding. The patient will have an appeal because in the law it says it must be necessary and appropriate care that must be provided. They cannot define necessary. They cannot define appropriate. That is a standard which we established after evidence as to what the best care is that should be available to them. The provisions are in the bill.

Mr. EDWARDS. I am reading from your bill, page 173, where it says what is appealable is what is medically necessary and appropriate ''under the terms and conditions of the plan.''

Mr. JEFFORDS. Mr. President, I want to continue this only if it is on the Senator's time. I don't have the ability——

Mr. REID. Mr. President, I yield such time as the Senator from North Carolina needs to finish his statement.

Mr. EDWARDS. I am reading from your bill, where it specifically says what is appealable is what is medically necessary and appropriate ''under the terms and conditions of the plan''—under the terms and conditions of the plan written by the health insurance company. Your own bill specifically says that the only thing that is appealable is what the insurance company's written plan says is medically necessary. How does that change the power from the insurance company having total control over the enforcement mechanism?

Mr. KYL. Mr. President, will the Senator from North Carolina yield?

Mr. JEFFORDS. We are getting into a lengthy dissertation. I think the Senator is reading from the old bill, which is a starting problem.

Mr. EDWARDS. I respectfully suggest that what I am reading from is the actual bill.

Let me ask the Senator one last, simple question. If what he is saying is true, is the Senator willing to put in the amendment presently before us OB/GYN care, specialty care, and emergency room care? On those three provisions, is he willing to put in a specific provision that says denial of any of those services is directly appealable to an independent body? Would he be willing to do that?

Mr. JEFFORDS. It is unnecessary. It is already in the bill.

Mr. EDWARDS. Is the Senator not willing to do it?

Mr. JEFFORDS. We have legal opinion given to us to exonerate.

Mr. EDWARDS. What is the right to do it?

Mr. JEFFORDS. We believe what we have is absolute protection for the patient. Not only that, it establishes a new national standard, which yours does not. You are using generally acceptable practices, which is a much lower standard. We establish a higher standard that every patient is entitled to the best medical care which is necessary and appropriate. That is a new standard. That is why the doctors are concerned, because they are going to have to reach a new standard.

Mr. EDWARDS. On my time, I am only asking the Senator, if that is true,

why does he have any objection to a simple sentence in this amendment that says denial of services under any of those areas is directly appealable to an independent body? Does the Senator object to that?

Mr. JEFFORDS. It is already in the bill, so why should I need to put it in?

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, we have gone over this before. Senator KENNEDY made the same offer. Our legislation says that anything, as set forth by the Senator from North Carolina, is appealable. It is as simple as that. It is appealable. They are depending on a legal opinion from some insurance lawyer. We are not willing to do that. We want appealable as part of the legislation. They are unwilling to do that for obvious reasons, because their legislation is dictated by the insurance companies.

I also say that the majority leader today bragged about one of his Members. I would like to brag about one of our Members.

We have JOHN EDWARDS, a new Senator from the State of North Carolina, who has represented the injured, the maimed, and the wrongfully killed for many years. He is one of the prominent attorneys in the United States. He is one of the finest representatives of protecting the rights of the oppressed and injured.

That should be spread across the RECORD of this Senate.

We have heard some people boasting about Members on the other side. We have one of the finest lawyers in America, now a Member of the Senate. We are very proud of that.

I think he has made a very clear case that the reason they are unwilling to agree to his simple words ''it is appealable'' is that they don't want it appealable. They know it is not appealable.

Mr. President, will the Chair indicate to the Senator how much time the minority has left on this amendment?

The PRESIDING OFFICER. The minority has 26 minutes 11 seconds remaining.

Mr. REID. I yield 5 minutes to the Senator from Rhode Island.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Thank you, Mr. President.

I rise in strong support of the Bingaman amendment and the Harkin amendment and all my colleagues who are supporting it.

This amendment is particularly responsive to the needs of children in the health care system. That is why it has been endorsed by the Children's Defense Fund.

We find when we look at the access to pediatric specialists that children don't have that kind of adequate access. As a result, they are the ones who will suffer the most, I believe, if we do not have strong, explicit language giving the right to access to pediatric specialists.

There was a survey done in 1992 by Pediatrics magazine. This survey indicated that of the pediatricians who were asked, 35 percent represented that they thought their patients' health outcome was severely upset by denial of access to a pediatric specialist. They found that this practice was all too common. For children, in particular with chronic illnesses, they must seek specialists. It must be clear. It must not be some type of very ambiguous language, as we find in the Republican version of the legislation.

Let me suggest another area when it comes to children where access to specialists is difficult. I have a letter from Paul L. Schnur, who is president of the American Society of Plastic and Reconstructive Surgeons. He points out that approximately 7 percent of American children are born with pediatric deformities and congenital defects such as birthmarks, cleft lips, cleft palates, absent external ears, and even more profound facial deformities. Yet, even in these compelling circumstances, he reports that it is very difficult to get a referral from a managed care plan to a specialist, and it is probably even more difficult to get a referral to a pediatric specialist.

Of the surgeons who indicated they had trouble getting referrals, 74 percent had patients denied coverage for initial procedures and 53 percent had patients denied coverage for subsequent procedures.

What you see is, access to specialists is difficult for children. Access for pediatric specialists is extraordinarily difficult for children. And unless we do something about this, we are going to find the situation where children will again and again be shortchanged by the managed care system.

The Republicans have said, listen, we have some in here who say it is ''age specific.''

We have a great deal of respect and esteem for our colleague from Tennessee, who is a physician. I suspect if he were making these decisions about referrals to specialists, he would be sensitive to ''age specificity.'' But that is not who makes these referral decisions. It is attorneys, reviewers, bureaucrats, and technicians. And, frankly, when they see ''age specific,'' they are going to say: Well, you know, we don't have a pediatric specialist on our panel. But that is OK, because we can find somebody who perhaps saw a child in the last year or two, and that is ''age specific'' enough for us.

This whole approach is an invitation, once again, to the HMO to make up the rules and then make those rules work against the interests of their patients, and particularly I am concerned that they will work against the interests of children.

There has been some various research done about managed care plans throughout the country. But I received some firsthand information from a doctor in Los Angeles who is conducting a very interesting program. It is Dr. Craig Jones. He is at the UCLA Medical School. He has developed a ''Breathmobile program.'' This program goes right to the schools in Los Angeles, and they deal with the No. 1 environmental illness affecting children, and that is chronic asthma.

Dr. Jones has treated lots of children. He has had a great outcome. But they collected data. The startling thing about their data is that a child in managed care gets the same kind of treatment for severe asthma as a child without any insurance. If they look at the numbers, there is no difference, because a child in managed care doesn't get the referral to a pulmonary specialist or a respiratory specialist. They get—like every other child who shows up in the emergency room—a little bag with an inhaler, and some medicine, and are told to go home.

We can do better, and we must do better. But we will not do better until health care plans are required to make references to specialists and, in the particular case of children, pediatric specialists. I have said this over and over again, but it still remains true. There is a difference between an adult oncologist and a pediatric oncologist. I don't think anyone in this body would dispute that.

One other final point, if I may make it, is that when you go around and look at how physicians are categorized and how specialists are categorized, you are not going to find an ''age appropriate'' specialty. You are not going to find someone who says, I am qualified ''age appropriate.'' They are pediatricians, neurologists, and a whole host of people who have special qualifications. We have to work with those categories and not some vague, disingenuous category which will be severely distorted by the insurance companies.

I urge passage of the Bingaman amendment.

Mr. BINGAMAN. Mr. President, the amendment that myself, Senator HARKIN, and many of my colleagues are offering today guarantees American families the right to access medical specialists. Our amendment is fair. It is what working families pay for each month, and very simply put; this amendment can literally save lives.

Let me briefly outline the fundamental components of this amendment.

First, our amendment says that if you pay for health insurance, you are guaranteed the right to see a specialist if medically appropriate.

Second, if a plan cannot provide such care within its network, it must allow the patient to go outside the network to an institution or individual competent to provide the care, at no cost to the patient beyond what would be required if the patient were treated in network.

Third, this amendment allows people with chronic or serious ongoing illnesses that require continued specialty care to receive that care either through a standing referral to a specialist or by designating the specialist as their special care coordinator.

The current requirement that patients must go back to a primary care doctor whenever they need to see a specialist or when additional care is ordered is at best an inconvenience, and at worst, a real detriment to timely, appropriate medical services. This is especially critical for the disabled and for people with chronic disorders and serious or complex medical conditions.

Our Republican colleagues have said that they cover access to specialists in their bill. In fact, their bill does not guarantee access to specialists. Under their bill, patients could actually be charged more for out-of-network specialty care—even if the plan is at fault for not having access to appropriate specialists within the plan.

Our amendment will have a profound effect on the lives of American children and the families who care for them.

For example, our amendment would allow a child with leukemia to go directly to a pediatric oncologist instead of being hauled from doctor to doctor.

A sick child should not have to go through such an additional ordeal. This makes perfect sense to me and the American people overwhelmingly agree. People who are fighting to stay healthy should not have to battle their HMO as well.

This amendment has other common sense effects. The access provisions in this amendment, when combined with a right to a meaningful and speedy independent appeal, will help minimize the need for litigation by helping ensure patients get the benefits they need from appropriately qualified providers in a timely fashion. The guaranteed right to have access to a specialist should not be a controversial issue. This is a simple matter of allowing working Americans to get what they pay for—the best medical health care available.

Mr. President, I believe this amendment is fair. The current system wasn't fair for Henry, a 40-year-old man from Albuquerque, New Mexico who had what the doctors refer to as ''lymphocytic lymphoma'' a form of cancer.

Henry was not responding to conventional therapy and quickly required a specialized procedure. This was not an experimental procedure and he would most certainly die without it. His doctor immediately applied for the referral.

Since there were no facilities for such a procedure in Henry's managed care network, his doctor requested a referral to a specialist out of network, a right he would have guaranteed under our amendment.

Even knowing exactly what kind of speciality procedure was necessary, where that specialist was, and that time was critical, the managed care company held multiple meetings which dragged on for more than a year.

Under our amendment speciality care is guaranteed to be available and accessible because we recognize the importance of providing timely, appropriate medical services.

A final meeting was held between Henry's doctors and the managed care company personnel. During that meeting, the managed care company required that Henry's doctor explicitly relate descriptions of what would happen to Henry without the referral for the necessary procedure.

Henry's doctor writes:

I had to sit in front of this patient and his wife and explain in graphic detail just exactly how he would die, how that would be, and how little hope there actually was that anything else would occur.

Henry's doctor continues, ''Henry had been pretty strong until that time, but this broke him and after that point he lost any spirit to fight.''

After one year of requests and delays, the managed care company did, in fact, approve the referral, but by that time Henry's condition had deteriorated and it was too late. Henry died.

In a final, sad epilogue to this story, the managed care plan is on record as having approved the referral to the specialist for the procedure.

We are fortunate to live in a country that has seen so many medical advances. We all have family or friends who have benefited from the knowledge and expertise of specialists. Blocking access to these health care professionals is wrong and it is well past time to address this issue.

Mr. President, I ask unanimous consent to have printed in the RECORD letters in support of the amendment from the American Academy of Pediatrics, the Children's Defense Fund, the American Academy of Physical Medicine and Rehabilitation, the National Breast Cancer Coalition, Consortium for Citizens with Disabilities, the National Association of People with AIDS, the Oncology Nursing Society, and the National Multiple Sclerosis Society.

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

AMERICAN ACADEMY OF PEDIATRICS,
Washington, D.C., July 12, 1999.

Hon. JEFF BINGAMAN,
U.S. Senate,
Washington, DC.
Hon. TOM HARKIN,
U.S. Senate,
Washington, DC.

DEAR SENATORS BINGAMAN AND HARKIN: On behalf of the 55,000 physician members of the American Academy of Pediatrics, I am writing in support of your amendment to guarantee that managed care enrollees have access to appropriate providers of care.

In many ways, children differ from adults. They have a wider spectrum of disorders and much of their care is more complex than similar care in the adult patient. Also, because children are rapidly developing, they often require more comprehensive services in order to promote appropriate development. Physicians who are approximately educated in the unique physical and developmental issues surrounding the care of infants, children, adolescents, and young adults should provide their care.

Your amendment would ensure access to specialty care, including, in the case of a child, pediatric medical subspecialists and pediatric surgical specialists. The Academy strongly believes that pediatric-trained physician specialists should have completed an appropriate fellowship in their area of expertise and be certified by specialty boards in a timely fashion if certification is available. These practitioners should also be engaged actively in the ongoing practice of their pediatric specialty and should participate in continuing medical education in this area. This is a critical guarantee for the pediatric population.

The Academy also agrees that an efficient process for approving referrals to pediatric specialists, in- and out-of-plan, should be developed and publicized widely to plan members. In some instances, this might include the provision of standing referrals for children with certain health care needs. Your amendment would make this possible.

Additionally, we support proposed arrangements to allow a specialist to serve as primary care provider in certain cases. Though the role of the ''gatekeeper'' should be assumed by the primary care pediatrician (i.e., the physician who assures that all referrals are medically necessary), this function might be transferred to a pediatric specialist team for certain children with complex physical health problems (e.g., those with special health care needs such as cystic fibrosis, juvenile rheumatoid arthritis, etc.) if the specialist assume both responsibility and financial risk for primary and specialty care.

Finally, we strongly support the ability of a beneficiary to go out of network, at no additional cost, if the plan has not contracted with appropriate specialty providers or they are not available. For children in need of specialty care, this protection is crucial. Because children tend to be generally healthy and a majority of them do not require specialty services, in some areas and/or within some plans, pediatric medical subspecialists and pediatric surgical are not available. This should never, however, be an excuse to force a family to take a child to a lesser-qualified provider.

If we can be of assistance or provide additional information in support of your efforts, please do not hesitate to contact us.

Sincerely,

GRAHAM NEWSON,
Director, Department of Federal Affairs.

CHILDREN'S DEFENSE FUND,
Washington, DC, July 13, 1999.

Hon. JEFF BINGAMAN,
U.S. Senate,
Washington, DC.

DEAR SENATOR BINGAMAN: I am writing to let you know that the Children's Defense Fund supports the access to specialty care amendment that you and Senator Harkin plan to offer during the Senate debate this week on the Patients' Bill of Rights. As you know, the mission of the Children's Defense Fund is to Leave No Child Behind® and to ensure every child a Healthy Start, a Head Start, a Fair Start, a Safe Start, and a Moral Start in life and successful passage to adulthood with the help of caring families and communities. Your amendment will ensure that families and their children in managed care get access to needed specialty care to help those children get the healthy start in life that they deserve.

Children with special health care needs often need out-of-network specialty care. Cost cutting and profit maximizing managed care decisions all too frequently serve as a bar to access to specialty care for these children. Also, when these children receive ongoing specialty care treatment, they should be able to designate their specialists as their primary care providers.

Your amendment will guarantee that children will get access to the specialty care they need and ensure that children in managed care have the opportunity to grow and

develop. Without such protection, children will suffer harm that is unconscionable. Thank you for taking a leadership role in raising this important amendment for consideration by the Senate. We look forward to implementation of meaningful managed care reform that includes these important specialty care provisions.

Sincerely,

GREGG HAIFLEY,
Health Division Deputy Director.

AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION,
Chicago, IL, July 13, 1999.

DEAR SENATOR HARKIN AND SENATOR BINGAMAN: The American Academy of Physical Medicine and Rehabilitation, representing 6,000 physicians who provide comprehensive rehabilitation services to people with physical disabilities, strongly endorses your amendments to assure direct access to specialists for people with disabilities who need specialty care and others who may have ongoing specialty care needs.

While S. 326 includes a provision on access to specialty care, it does not assure access for it does not enable a person with a condition requiring ongoing specialty care, such as spinal injury, brain injury or stroke, to have direct access to a specialist. Primary care providers are empowered to continue as gatekeepers in such cases under S. 326. Your amendments would authorize standing referrals to specialists or allow a person with conditions such as spinal injury to utilize a specialist as the care coordinator. Your amendments would therefore assure direct access to the specialist while S. 326 would not.

Sincerely

JOHN MELVIN, President,
American Academy of Physical Medicine and Rehabilitation.

NATIONAL BREAST CANCER COALITION,
Washington, DC, July 13, 1999.

Hon. JEFF BINGAMAN,
Hon. TOM HARKIN,
U.S. Senate, Washington, DC.

DEAR SENATORS: On behalf of the National Breast Cancer Coalition (NBCC), I am writing to thank you for your leadership in offering the access to specialists amendment to the ''Patients' Bill of rights'' being debated in the U.S. Senate this week. NBCC is a grassroots advocacy organization dedicated to eradicating breast cancer through action and advocacy. Formed in 1991, the Coalition now has more than 500 member organizations and tens of thousands of individual members. NBCC seeks to increase the influence of breast cancer survivors and other activists over public policy in cancer research, clinical trials, and access to quality health care for all women.

As you know, NBCC believes that this amendment is an essential component of a meaningful patients' bill of rights. By offering this amendment and making it a priority, you highlight the importance of ensuring that individuals in group health plans have access to the specialty care they need.

We appreciate that your amendment includes standing referrals that would allow patients to go straight to their oncologist instead of jumping through hoops with primary care doctors or insurance companies. This direct access is extremely important for women who are fighting for their lives against breast cancer.

We look forward to working with you to get this important patient protection, and a comprehensive and enforceable ''Patients' Bill of Rights'' enacted into law. Please do not hesitate to call me, or NBCC's Government Relations Manager, Jennifer Katz, if you have any questions.

Sincerely,

FRAN VISCO,
President.

CONSORTIUM FOR CITIZENS WITH DISABILITIES,
Washington, DC, July 9, 1999.

Re CCD strongly supports the Bingaman/Harkin amendment on access to specialists.

Hon. JEFF BINGAMAN,
U.S. Senate,
Washington, DC 20510

DEAR SENATOR BINGAMAN: We are writing as Co-Chairs of the Health Task Force of the Consortium for Citizens with Disabilities (CCD) to express our strong support for the amendment you intend to offer along with Senator Harkin to ensure appropriate access to specialty care during the upcoming debate on the Patient's Bill of Rights. CCD is a Washington-based coalition of nearly 100 national organizations representing the more than 54 million children and adults living with disabilities and their families in the United States.

Ensuring that people with disabilities and others with complex medical conditions can designate a specialist as the primary care provider (PCP) is among the most necessary new patient protections, along with the right to go out of network for specialty care when such specialty care is not readily accessible within the network. Most people with disabilities live with extremely complex conditions and getting access to appropriately trained providers with the knowledge and skill to treat their condition can have an enormous impact on their health status. When persons are treated by providers without the expertise or experience with their particular condition, many people unnecessarily become further debilitated, their capacity to function independently is often diminished, or their quality of life could be substantially eroded.

The Republican Leadership's reform plan clearly fails Americans who may ever need access to a specialist. Consider, for example, a person with a neurological condition. Under the Republican Leadership's proposal, a health plan could refuse to allow the patient to designate a qualified neurologist as their primary care provider. Or, the health plan could restrict the patient's access to a limited number of specialty visits—even when the nature of the condition clearly justifies the need for on-going specialized medical treatment. Any legislation that purports to protect patients, but doesn't give them the basic right to be seen by appropriately trained providers does not deserve to be enacted—and does not address the widespread concerns of the American people.

The CCD Health Task Force is pleased that you will offer an amendment that will ensure that people whose health condition warrants it are guaranteed that their health plan must enable them to seek the specialty care they require. This amendment addresses the dual issue of access to a specialist as a primary care provider and access to out-of-network specialists when such specialty care is not available within the health plan's network.

The CCD Health Task Force is grateful for your leadership on this critical issue and we look forward to working with you and your staff to ensure that this amendment is adopted.

Sincerely,

JEFFREY CROWLEY,
National Association of People with AIDS.
BOB GRISS,
Center on Disability and Health.
KATHY MCGINLEY,
The Arc of the United States.
SHELLEY MCLANE,
National Association of Protection and Advocacy Systems.

THE NATIONAL ASSOCIATION OF PEOPLE WITH AIDS,
Washington, DC, July 9, 1999.

Re NAPWA strongly supports the Bingaman Harkin amendment on access to specialists.

Hon. JEFF BINGAMAN,
U.S. Senate, Washington, DC.

DEAR SENATOR BINGAMAN: I am writing on behalf of the National Association of People with AIDS (NAPWA) to express our strong support for the amendment you intend to offer along with Senator Harkin to ensure appropriate access to specialty care during the upcoming debate on the Patient's Bill of Rights. NAPWA serves as a national voice for the nearly one million people living with HIV and AIDS in the United States. We advocate on behalf of all people living with HIV in order to end the HIV pandemic and the human suffering caused by HIV and AIDS.

Ensuring that people living with HIV and AIDS and others with complex medical conditions can designate a specialist as the primary care provider (PCP) is among the most necessary new patient protections, along with the right to go out of network for specialty care when such specialty care is not readily accessible within the network.

In recent years, medical advances and the development of highly active antiretroviral therapy (HAART) have given hope to hundreds of thousands of people living with HIV in the United States. This new drug therapy has been successful in preventing or slowing HIV progression for many people. Making appropriate treatment decisions, however, is incredibly complex. If we were to look only at the complexities involved in devising a medication regimen, there are numerous factors to be considered. Most current antiviral combinations involve taking at least three medications. Some of them produce certain types of side-effects more commonly than others. Some must be taken with food, while others must be taken without food. Some medications develop resistance in ways that if you become resistant to one drug you could become resistent to all of a particular class of drugs—and this impacts decisions about which drugs you should take first and which ones you should reserve in case your treatment regimen begins to fail.

Keeping up with the latest research, working with patients to devise a regimen to which they can adhere, and monitoring HIV progression is very complex. Unless providers have the training and spend time treating many people living with HIV, they cannot treat them well. Shouldn't people have a right to designate a primary care provider that has the training and expertise to treat them effectively? I am glad you think so. Unfortunately, the Republican Leadership proposal would not give America's health care consumers that right. Shouldn't a person be guaranteed that if their health plan does not have the in-network specialists they need, they can go out-of-network, and the health plan will pay for such care? I think this is common sense. And I think the American people think that is what health care is supposed to be all about.

I am hopeful that you and Senator Harkin will prevail in convincing a majority of your colleagues to support ensuring access to specialists. Now that our nation's scientists have delivered us medications that provide hope to people living with HIV until a cure is found, Congress needs to take the next step and make sure that heartless managed

care does not deny people the specialty care that can help to keep them alive.

Sincerely,

. CORNELIUS BAKER,
Excecutive Director.

ONCOLOGY NURSING SOCIETY,
Pittsburgh, PA, July 13, 1999.

Hon. JEFF BINGAMAN,
U.S. Senate,
Washington, DC.

DEAR SENATOR BINGAMAN: The Oncology Nursing Society (ONS) is the largest professional oncology group in the United States and is composed of over 29,000 nurses dedicated to improving the care of oncology patients and oncology health services. We endorse the Harkin-Bingaman amendment to assure that managed care plans do not discriminate among providers, such as the care provided by a nurse practitioner. We urge the Senate to pass provisions to allow for the non-discrimination of providers in managed care plans.

This amendment is extremely important to patients in managed care, especially in rural and underserved areas, such as New Mexico. Many areas in this country do not have enough physicians to adequately care for patients in our growing health care system. Many private and managed care plans do not allow nurse practitioners to be reimbursed for their services, thus preventing them from being full partners in our health care system.

Advanced practice nurses, such as nurse practitioners, provide competent and needed health care resources and information, particularly to the under-served. In one study in Tennessee, it was shown that nurse practitioners provided more care to women and to young clients than physicians. It has been shown that nurse practitioners provide more teaching and counseling services, smoking cessation counseling, weight reduction counseling, as well as nutrition counseling than other providers. These are valuable and needed services to improve many patient's overall health and ultimately reduce future health care costs.

Nurse practitioners are well prepared to care for the health care needs of patients. Nurse practitioners are well-educated to provide health care services. Most nurses entering advanced degree programs already have a wealth of experience in their planned specialty even before entering the advanced educational programs to prepare them as a nurse practitioner. As our population ages, more individuals will have cancer, and the majority of nurse practitioners working with oncology patients have many years of experience as oncology nurses. This type of specialization and care for patients with cancer must be supported. Also, as health care moves from hospital-based care to more care given in out-patient settings, nurse practitioners will become more needed to fill the growing gaps in health care resources. It is of outmost importance that they are recognized and receive reimbursement for their health care services.

The Oncology Nursing Society fully endorses the Harkin-Bingaman amendment to provide for the non-discrimination of providers in managed care. We urge the Senate to pass this amendment.

Sincerely,

ROBERT STROHL, RN, MN, AOCN,
President.
PEARL MOORE, RN, MN, FAAN,
Chief Executive Officer.

NATIONAL MULTIPLE SCLEROSIS SOCIETY,
New York, NY, July 13, 1999.

Hon. Jeff Bingaman,
U.S. Senate, Washington, DC.

DEAR SENATOR BINGAMAN, The National Multiple Sclerosis Society is pleased to support the Bingaman/Harkin amendment (access to specialists) to the Patient's Bill of Rights legislation pending in the Senate. Passage of patient protection legislation is one of the top public policy issues for the National Multiple Sclerosis Society. The MS Society supports legislation that would assure the right to quality medical care for all people, including those with chronic illnesses such as MS.

Our top priority for patient protection legislation is access to specialists. The Society supports legislation that:

Provides for direct access to a specialist when there is a life-threatening or chronic illness;

Provides for standing referrals when a patient regularly needs to see a specialist, thereby eliminating unnecessary delays;

Allows an individual with a life-threatening or chronic illness to choose a specialist as primary care physician.

We commend your continued leadership in the managed care reform debate and look forward to working with you on the common goal of getting the best medical care possible for patients. Please let us know what we can do to help persuade your colleagues to pass comprehensive bipartisan managed care reform legislation.

Sincerely,

MIKE DUGAN,
General, USAF, Ret.,
President and CEO.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. KYL. Mr. President, let me begin by complimenting Senator JEFFORDS, the chairman of the committee, for the work the committee has done, and all of the members of the committee, in bringing forth this legislation. I make a point to those who might be watching, this debate, frankly, is not quite as cut and dried, as black and white, as people on both sides of the aisle are attempting to make it. This is a complicated issue. I want to compliment some of my friends on the Democratic side for insisting the issue be brought before the Senate for debate.

There are, indeed, situations around this country in which some HMOs have abused their position. In order to cut costs—which we all would like to see—some HMOs have denied the highest-quality care to people under their care. That is something about which we all should be concerned.

Just as much, we need to be concerned about how much it will cost to fix the problem. If it costs too much, the cost of insurance escalates too high, too many people will no longer be able to buy the insurance that is offered.

We have to be very careful that in working out a solution to what is, in fact, a real problem, we don't go too far. That is where the differences of opinion are. They should be considered reasonable differences between reasonable people. But I fear that too much of the debate has been characterized by finger-pointing and by both sides characterizing the other side's ideas as absolutely off the wall, or that no one could possibly ever think such a thing could solve the problem, when, in reality, there are some common answers and there are some good ideas on both sides.

One of the problems Senator EDWARDS was referring to a moment ago was a problem during the external review process and what would be included in that external review process. There is going to be a change made by Senator ASHCROFT and myself that I am sure will be fully acceptable to the Senator from North Carolina. It accepts part of the definition he and others have offered with respect to what ought to be considered. Specifically, among the factors to be considered are not just what the HMO writes as its ''practice guidelines or definitions,'' but also ''recognized best practice'' and ''generally accepted medical practice.'' I know the Senator would be pleased with that.

The fact of the matter is if we continue to talk about this we are going to be able to come to some common agreement about what will make this work. We have to be careful it doesn't end up costing so much that it drives people off of insurance plans.

I will talk about that for a moment. David Broder, a respected columnist, wrote on April 7 in the Washington Post that the cold truth about health care raises this critical policy issue which is the irrefutable link between health care premium increases and the number of Americans without insurance. He said as we debate these various proposals, we have to keep this linkage in mind.

My colleagues on the other side are quick to point out their bill could improve health care, but they are not so quick to admit it will raise costs. That is the problem. If it raises costs too much, some employers will stop offering health insurance as a benefit. That will make insurance unaffordable for more Americans. Obviously, that means people are worse off, not better off.

Here are some statistics I think we should keep in mind. The Lewin Group, a very respected consulting group, said for each 1 percent of premium increase, an additional 300,000 citizens will lose their insurance; 300,000 people will lose their insurance for every 1 percent premium increase.

The Barents Group, another respected entity, projects a 5-percent premium increase would cause 1.6 million Americans to become uninsured. It further points out the increase would force employees who already have insurance to pay an additional average of $935 per household in out-of-pocket expenses. Most families are not going to be able to afford that.

The Congressional Budget Office has concluded the bill offered by our colleagues on the other side of the aisle, the Daschle-Kennedy Democratic proposal, would increase premiums by 6.1

percent. That is the Congressional Budget Office. That is not a biased insurance company study. By these projections of these specialty groups, this would result in almost 2 million more uninsured nationally.

In my own State of Arizona, over 34,000 people who are currently insured would be uninsured as a result of the increased premium costs, if the Democratic proposal were to pass. That is why some of the people on this side of the aisle are so concerned about what is being done. Yes, there is a problem, but the physician's first rule of thumb is to do no harm. We are concerned on this side that the proposal of the Democrats is so costly that it would, in effect, remove 3 million people from the insurance rolls. That is a worse result than is currently the case.

We believe, and David Broder concluded in his column, by correctly pointing out, that additional benefits for those with insurance are less vital than providing access to basic care for the uninsured. This is one of the reasons why we have provisions in our bill which would provide more of an opportunity for people to actually get insurance and why we think the Democratic version of this bill is just too expensive.

What does the Congressional Budget Office score the Republican bill as costing? Less than 1 percent. That is why we believe ours is a better approach. We would not preempt the laws of 50 States, as would the Democratic bill.

Here are some of the things the Republican bill would do:

First, we make health care more affordable for the self-employed by letting them deduct 100 percent of their health premiums in the year 2000, 3 years ahead of schedule.

We give more patients more control over their medical care and make it more affordable by expanding access to medical savings accounts. These MSAs can provide coverage for a lot of Americans who currently are not covered.

We require the health plans actually provide the benefits that have been promised.

We require the health plans provide care based on the best scientific information available.

We require the health plans provide patients with access to their medical records and ensure that the medical information will only be used to provide better care, not to increase their premiums.

We require the health plans provide reasonable access to specialists such as OB/GYNs and pediatricians without the need for referral.

We require them to remove so-called gag clauses. I worked on that with my colleague, RON WYDEN.

We require they be held accountable through the appeals process. This is where I refer back to the colloquy Senator JEFFORDS and Senator EDWARDS had a moment ago. It is true that HMOs write their contracts. They are the ones that write the contract. They can't force any employer to contract with them. This is a matter of bargaining. It is a matter of competition. It is a matter of what they cover. Once a contract has been written and an employer has bought that contract and provided coverage to his employees, the question then is in any given case whether or not a particular procedure may be medically necessary.

What we provide in our legislation is a two-step process by which this matter can be reviewed. It is by an independent party with the external review. Not by the HMO, not by somebody the HMO picks; rather, it is by an independent external medical reviewer, someone who has expertise in the area in which the diagnosis is involved.

This has to be done on an expedited basis so if there is a concern about time, the care can be provided in a timely way.

Senator ASHCROFT and I will be proposing two changes to the language which I think solves two big problems. The first is the problem Senator EDWARDS raised. We add to the factors that the external review specialist has to consider not only the party's records and the evidence submitted by the plan and the guidelines offered by the plan but also the external review expert would have to examine the recognized best practice and generally accepted medical practice as part of the consideration of what is appropriate in any particular case. It wouldn't be bound by any of these specifics but would have to consider these factors.

Another thing we have added, and I think it is very important, in the event for some reason the HMO would decide, even though it had been ordered by the external reviewer to provide a certain procedure or care, should it decide not to do so, then in that case we have provided a new process whereby the patient will be able to go to some other physician or some other provider and have that care provided by the other provider and bill the HMO that refused to follow the recommendation or the order of the external reviewer. So in no case should there be a situation where after the expert external review process takes place and a particular procedure has been ordered, in no case should the party be denied that care.

There is one final thing I want to say. There has been a lot of finger-pointing about HMOs, about doctors, and so on. I think it is important to recognize that HMOs have provided an important contribution to reducing costs and providing quality care to the citizens of our country. It is equally important to note that physicians have done a tremendous job in working under the conditions that were unfamiliar to them—the conditions of managed care—which require them in many cases to submit their diagnosis, plans, and care plans to someone else for review, something they are loath to do. And in many cases they have been overruled with respect to the care they would like to provide. The physicians are not just out to put money in their pockets. They are guaranteed only a certain amount by these HMOs, and it is a less and less amount each year. They are concerned for the good of their patients. I do not think we ought to be constantly pointing our fingers at doctors as if they are somehow the problem. Physicians are fighting for their patients, for the kind of care they think their patients need.

When a group such as the American Medical Association, for example, lobbies legislation, they are trying to do what they think is right for the good of their patients. Even though I do not support the legislation they have been sponsoring primarily, I am going to be the first to defend the physicians of this country, and specifically the American Medical Association, for doing what it thinks is right.

So I urge my colleagues, as we trade charges back and forth, that we just lower the rhetoric a little bit, recognize there is a problem to be solved, recognize that both sides of the controversy have something important to contribute, and try to come together with an idea that will solve the problem at an affordable cost.

That is what I think the Republican bill does. I again commend Senator JEFFORDS and his committee for coming forth with this legislation.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I yield 5 minutes to the Senator from California.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, I have been keeping score of these votes, where the HMOs are in every single vote. It may not be an All-Star game, but 7–0, HMOs over patients, that is where we are. Every single amendment they have won on their position, and the vote on every single amendment has basically been party line. To me, it is a sad day in this greatest of all deliberative bodies to have such partisan voting.

I wanted to mention a couple of things to the Senator from Arizona before he leaves the floor. In his opening he was very gracious. He said: Yes, it is true, some HMOs have made mistakes in their zeal to cut costs. I think he was very accurate in the way he talked about it.

The Republican bill—and this is such an irony—does not even cover HMOs. It covers only the 48 million people who essentially have self-funded plans. So the Republican bill doesn't even reach to the people in this country who utilize HMOs.

Mr. KYL. Will the Senator yield on that?

Mrs. BOXER. On your time I will be happy to.

Mr. KYL. Mr. President, I ask Senator JEFFORDS for 30 seconds, if I could?

Mr. JEFFORDS. I yield 30 seconds.

Mr. KYL. Is the Senator from California aware the external review process and internal review process, the appeal process we have been talking about, applies to all people, to HMOs, too, not just the ERISA plans?

Mrs. BOXER. Yes. I will take this on my own time. As Senator EDWARDS pointed out, it is a meaningless situation which I hope the Senator is going to correct. We talked about correcting it after the Senator from Vermont said it is perfect. Now we hear there is an amendment coming. Good, we are looking forward to seeing it.

But the basic bill, as Senator KENNEDY has pointed out, does not cover the vast majority of the people. Take the Collins amendment. The Collins amendment does not cover the vast majority of women in its provisions, or the vast majority of patients. Mr. President, 77 percent of the people in California are not covered by the basic bill. If you look at the whole Nation, it is about 70 percent or so. So it is 7–0, and we have many more amendments to go. I do not have much hope this is going to change. That is why I have this little flip chart. But we are hoping for something better in the later innings.

Let me say to my friends who support the Collins amendment, do not be fooled. You better look at this letter that just came in from the American College of Obstetricians and Gynecologists. Let me tell you what it says.

This amendment is an empty promise to the millions of women enrolled in managed care plans, covering only one in three women in ERISA-regulated plans. . ..[It erects] new barriers to follow-up care for both ob and gyn services.

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

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

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS,
Washington, DC, July 14, 1999.

Senator TRENT LOTT,
Majority Leader.

Senator THOMAS DASCHLE,
Minority Leader.

DEAR SENATORS LOTT AND DASCHLE: The American College of Obstetricians and Gynecologists, representing the nation's 39,000 obgyns and the women they serve, does not support passage of Amendment 1243 to the Patients' Bill of Rights, offered by Senator Collins. This amendment is an empty promise to the millions of women enrolled in managed care plans, covering only one in three women in ERISA-regulated plans.

While this amendment supposedly addresses the weaknesses in the Majority's managed care reform bill, it takes away as many protections as it provides. It removes barriers to access to obstetrical care while erecting new barriers to follow-up care for both ob and gyn services. While under this amendment, health plans would be required to provide direct access to the full range of initial obstetrical services, plans would still be able to limit direct access to needed gynecological care. The amendment would also weaken access to follow up ob and gyn care if a problem is identified in a routine or periodic visit. Indeed, by changing ''shall'' to ''may'' the follow up care provisions does no more than restate current law.

We continue to look forward to working with both sides of the aisle, but are disappointed that this amendment offers women less than half a loaf of needed protections.

Sincerely,

RALPH W. HALE, M.D.,
Executive Vice President.

Mrs. BOXER. Mr. President, this debate is very interesting, but it is very sad because we, on our side of the aisle, are offering amendments to try to correct real problems that are happening to real people. On the other side, we get empty promises. Not my words, the words of the OB/GYNs: Empty promises, sham, shells, but nothing real. So it is 7–0.

I rise also in support of a very fine amendment. I rise in very strong support of Senator BINGAMAN's amendment on specialists.

I want to tell you about one of my constituents, Carley Christie. I met her dad a long time ago. These are his words:

Carley was 9 years old when she was diagnosed with malignant kidney cancer: When the HMO insisted we trust our daughter's delicate surgery to a doctor with no experience in this area, we were forced to find an expert and pay for it ourselves.

Mr. President, $50,000 Mr. Christie had to come up with. He said:

You only get one chance at removing a Wilms' tumor correctly and successfully to ensure the highest probability of survival in children, and we weren't going to take that chance with our daughter's life because the HMO wanted to save money.

And he goes on to say:

Congress must close the ERISA loophole and hold health plans accountable for cost-cutting decisions that result in patient injury.

These are the words of a dad, a loving dad. We have a lot of loving dads in this institution. We have a lot of loving granddads in this institution. One is on the floor right now, the Senator from Utah.

I have to tell you, we have to start acting to help loving moms and dads such as this because we are not doing that.

I ask for 30 additional seconds.

Mr. KENNEDY. I yield the Senator from California 30 seconds.

Mrs. BOXER. We are not acting on behalf of loving dads such as Harry Christie. We are turning our backs on them and we are acting in favor of the HMOs against the patients, against the Carley Christies, against the Harry Christies. It is wrong and we ought to change and we ought to support the Bingaman amendment and get on the right track.

I yield the floor.

Mr. KENNEDY. Mr. President, I yield 30 seconds to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, the Bingaman amendment offered by the Senator from New Mexico, I began speaking about it, the Senator from California spoke about it, Senator REID spoke about it, but I have not heard one word on the other side about the Bingaman amendment that allows people to go outside their plan to get specialty care, as Senator BOXER just mentioned. Not one word from the Republican side about this amendment.

What is it? Are they going to support it? Are they going to oppose it? What are they going to do? Not one single word about it.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. I yield 15 minutes to the Senator from Utah.

Mr. HATCH. Mr. President, we are nearing the end of debate on legislation that is, unquestionably, one of the most important measures to be considered in the 106th Congress.

We have heard the horror stories about denials of coverage for certain treatments. We have heard about the bureaucratic nightmares suffered by family members who have a simple question: Why can't the insurance companies understand a family's anxiety as well as they understand the costs of diagnostic tests or the arcane science of filling out forms?

As a matter of fact, our constituents may be surprised to know that many of us have also experienced the bureaucratic two-step, many of us have also sat on ''hold'' trying to get past an automated switchboard.

Our colleagues on the other side of the aisle have made it seem that we are completely oblivious to the health care needs of the American people.

On the contrary, we are well aware of the public's frustration and of the need for effective legislation to ensure that those individuals enrolled in managed care plans are provided quality health care.

Over the past several years, numerous hearings have been held in both the Senate and the House of Representatives, exposing story after story about individuals who had complaints about their managed care plans.

The National Association of Insurance Commissioners (NAIC) recently published figures that, in 1998, more than 35,000 health insurance complaints were made to state insurance departments.

According to an article in the February edition of the Employee Benefit Plan Review magazine, ''consumer complaints about health insurers and HMOs are surging.'' The article goes on to say that ''these complaints encompassed matters such as health care claim denials, disputed claims, slow payments by health insurers, and premium-related matters.''

But the article also reports that insurance commissioners in 12 states where the data were collected ''doubt the rise implies a deterioration in care but rather that the numbers reflect greater public readiness to fight HMOs, and encouragement by states for consumers to file complaints.''

Enrollees in managed care plans are not likely to acquiesce and abide by

coverage decisions as final—when their lives are at stake. That is why we are here today and that is why the Senate is now poised to take significant action in addressing this issue for the American people.

The question before the Senate this week is not so much will we pass a patients' bill of rights measure—and I hope and believe that we will—but rather what kind of patients' rights bill will the Senate pass and send over to the House of Representatives for consideration?

All of us in this Chamber know very well there are numerous competing bills that have been introduced over the years that provide a variety of legislative remedies to address these concerns. In many respects, these bills have common components intertwined with similar and, in some cases, identical provisions.

It is my understanding that there are presently 47 various bills that have been introduced in the Senate and House this year alone which are designed to provide patient protections to managed care enrollees.

Clearly, we are all concerned. But, for Congress to act and pass responsible and workable legislation, we must come together in a bipartisan fashion and put forth the best bill for the American people. We have done this many times on health care legislation in the past, and there is no reason why we cannot succeed again today and do what is right for the country.

I have joined 49 of my colleagues in sponsoring one of the proposals currently under consideration, S. 300, the Patients' Bill of Rights Plus Act of 1999. This legislation, along with its companion bill, S. 326, represents a balanced approach at addressing the concerns over managed health care.

This bill is sound public policy that avoids unnecessary and costly federal mandates that would ultimately undermine the affordability and availability of health insurance to millions of Americans.

S. 326 was considered in the Senate Health, Education, Labor, and Pensions Committee, where extensive hearings were held affording an opportunity for all points of view to be heard on the various provisions of the legislation.

The HELP Committee reported S. 326 on March 18, 1999, and I want to commend Senator JEFFORDS and the members of the HELP Committee—Senators FRIST, COLLINS, GREGG, and others—for their work on this legislation.

S. 300 is identical to S. 326 except that it contains important tax provisions that will make health insurance more affordable for those who either do not have insurance, or are paying high premiums for such coverage out of their own pocket.

For instance, pursuant to the Title V provisions of S. 300, self-employed taxpayers would be permitted a 100 percent deduction for health insurance premiums. This provision would be effective beginning next year thereby easing the financial burden for self-employed individuals.

Moreover, S. 300 removes the current law provisions restricting Medical Savings Accounts, or MSAs, to employees of small employers and self-employed individuals, making MSAs far more generally available to individuals than they are today. This legislation also eliminates the existing 750,000 policy cap on the number of taxpayers who can have MSAs as well as the cap placed on Medicare+Choice MSA plans.

I would emphasize that a December 1998 report from the General Accounting Office concluded that 37 percent of those individuals who enrolled in MSAs were previously uninsured. Clearly, with greater availability and flexibility in the MSA design, these plans will attract even more of the uninsured.

These tax provisions will provide much needed reforms in tax-based assistance to those individuals without employer-subsidized insurance. They also will help millions of employees and business owners in obtaining coverage.

Today, however, the pending bill is S. 1344, championed by Senator KENNEDY and my colleagues on the other side of the aisle. For months, we have heard from a number of our colleagues on the Democrat side about their desire to bring their bill to the floor for a vote. I am glad they got their wish, although I happen to believe that Senator LOTT was quite generous in agreeing to this debate before we had even finished the appropriations bills. So, I hope we will hear no more about the majority's unwillingness to have this debate.

So, tomorrow, with the roll call of the clerk, we will decide which approach to managed care reform will be in the best interest of our constituents. So I encourage the American people to listen carefully to this debate. I encourage them to listen with discernment. They will have to separate a lot of fact from fiction and a lot of reality from rhetoric.

Let me see if I can shed some light on the fundamental differences that distinguish the Republican bill from the bill being advanced by Senator KENNEDY and President Clinton.

Contrary to the allegations made by some of my colleagues, the Republican bill that was reported by the HELP Committee—S. 326—is not the insurance industry's bill. In fact, the insurance industry's idea of a bill is no bill at all. Officials from the insurance and managed care industry tell me they not only oppose the Democrats' bill, S. 1344, but they also oppose the Republican bill, S. 326.

S. 326 would, in fact, impose a number of new rules on group health plans relating to access to care, scope of coverage, disclosure of plan information to enrollees, and appeals of claim denials.

Our Democrat colleagues assert that our bill is limited in scope and that it does not apply to all enrollees in ERISA plans. That simply is not true. Our bill includes many important features that will provide patient protections for enrollees in self-insured ERISA plans, about 48 million people.

However, our bill also provides protections to all ERISA enrollees, or 124 million people, regarding the critically important issues relating to an internal and external appeals process, patient information disclosure, and on discrimination in underwriting based on genetic information.

On the surface, the Democrats' criticism of our bill sounds credible. But the fact of the matter is that states have historically regulated the insurance market for those individuals not in self-insured ERISA plans. Why should Congress now suddenly preempt these regulations and impose a whole new series of costly federal mandates on plans that are already state regulated?

In Utah, there are currently 21 state mandates on fully insured health insurance plans. Let me just highlight some of these rules:

Direct access to OB-GYNs was adopted in 1995.

The ban on the so-called gag clause was adopted in 1997.

We have rules on drug abuse treatment, alcoholism treatment, maternity stays, coverage for optometrists, nurse midwives, podiatrists, psychologists, chiropractors, and well-child care.

Why does the Congress need to duplicate and preempt what the states are already doing? And perhaps the single most driving reason why we should not impose these rules on all health plans is that the Health Care Financing Administration would ultimately regulate this whole program. Frankly, I have more confidence in our state legislature and governor in deciding what is best for Utah.

I mean, if you think health insurance is complicated and bureaucratic now, just wait until HCFA is second-guessing everything from Washington, D.C. HCFA is that federal agency that administers Medicare and Medicaid—both of which have regulations that are the size of the New York City telephone directory.

Mr. President, our constituents will benefit absolutely nothing if we merely transfer regulatory power from states to the federal government. On the contrary, they will suffer even more frustration since decisionmaking is more remote in terms of both distance and impact.

Under the Republican bill, those plans which historically have been subject to state insurance regulation will remain subject to state law.

This is consistent with the McCarren-Ferguson Act of 1945 which essentially codified the states traditional role in regulating the insurance industry. This is a wise policy that has worked well in many sectors including life insurance, automobile insurance, business casualty insurance, as well as health insurance.

All of these areas are important, and thank goodness we don't hear cries to federalize matters like car insurance.

The McCarren-Ferguson Act embraces the important principles contained in the 10th Amendment to the Constitution, which reserves to the states all governmental functions not specifically assigned elsewhere in the Constitution to the federal government. Elected state and local officials can weigh unique state and local conditions. As well, state and local officials can be held politically accountable for their decisions concerning state and local matters—including insurance regulation.

So, while it may be true that health care is a vitally important matter, it does not necessarily follow—as my colleagues across the aisle apparently believe—that we should rush headlong into federalizing every aspect of health care delivery. The Congress wisely rejected this type of misguided thinking in 1994 when the public registered its adamant opposition to the Clinton/Kennedy/Gephardt health care reform bill.

I do not think my friends on the other side of the aisle really mean to send the message that only the federal government can tackle ''important'' matters and that states and local governments are okay to handle the insignificant, less important issues. If that isn't the height of federal elitism, I don't know what is.

From the beginning of our nation it has been left to the states to regulate the licensure of doctors and nurses. What is more important to the integrity and performance of the health care system than the credentialing of health care professionals? Do my colleagues want to take that over as well?

Don't be fooled by the false argument that if something is not federally controlled and regulated by Washington that somehow that it will be second-rate.

The Republican bill recognizes the traditional role of the states in the health insurance arena. By and large our states do a first-rate job with the responsibilities assigned to them under the Constitution and by law. States have done a good job in regulating the insurance industry—a task assigned to the states back in 1945 by the McCarren-Ferguson Act.

This is not to say that every aspect of the insurance industry should be beyond some reasonable federal requirements. The bipartisan Health Insurance Portability legislation is one example where we all worked together to fashion a narrow, targeted, and effective set of federal rules that apply to health insurance.

The challenge for legislators is to evaluate carefully which particular issues require national rules and which issues are best left to the states. In this regard, I must highlight the Republican bill's treatment of one of the most important aspects of this legislation—dispute resolution.

Under our bill, the important appeals process protections, which are the fundamental heart of this debate, apply to all ERISA plans. The Republican bill revises and improves the existing internal appeals provisions and adds new external appeal and nonappealable grievance procedures. And, as under current ERISA law, the claims procedures apply to both self-insured and fully-insured group health plans.

I would add that the issue of ensuring a patient's right to an appeals process, for both internal and external review, is one of the central issues in the patient protection debate. Under the Republican bill, health plans are required to issue an internal coverage decision within 30 days after the date on which the request for review is submitted. The notice of the decision must be issued no later than 2 working days after the decision is made.

For matters in which a patient's life or health is in jeopardy, a plan's decision must be made within 72 hours after a request for review is submitted. A notice of that decision must be made within that 72 hour period.

Moreover, the review is to be conducted by an individual with appropriate expertise who was not involved in the initial determination. Appeals involving issues of medical necessity or experimental treatment are to be conducted by physicians with appropriate expertise.

With respect to appeals for external review, the Republican bill requires that after a patient's internal appeal is denied, he or she can then submit a written request for review which must be submitted within 30 days after the date of the internal review decision. Within 5 working days after the receipt of a request for review, the plan will select an external appeals entity that will designate external reviewers.

These entities could include an independent expert in the diagnosis or treatment under review, or certain state or federally authorized or privately accredited entities using appropriate credential experts.

In addition, external reviewers are required to make an independent determination and consider all appropriate and available information on the patient. The review must be conducted no later than 30 working days, or earlier, after either the date on which a reviewer is designated, or all necessary information is received. And, finally, the decision of the external reviewers is binding on the health plan.

With respect to the consumer protection standards, our bill provides for the following:

Our bill requires that a group health plan ensure that enrollees have access to specialty care when covered by the plan.

Our bill would require a plan to provide coverage for emergency medical care, including severe pain, without prior authorization by applying the so-called prudent layperson standard to medical screening.

Our bill would permit individuals, with their providers consent, to continue a covered course of treatment for up to 90 days when a contract between a group health plan and health care provider is terminated.

Our bill would permit women to obtain gynecological and obstetric care from a participating OB-GYN specialist without prior authorization by a primary care provider.

Our bill would permit a child to obtain pediatric care from a participating pediatric specialist without prior authorization by a primary care provider.

And, under our bill, a plan could not impose a prohibition or restriction on advice by a health professional for medical care or treatment. In effect, our bill prohibits the imposition of the so-called gag rule.

With respect to the issue of information disclosure by managed care plans, S. 326 requires new information collection and reporting requirements relating to benefits, access to specialty care, coverage of emergency services, advance directives, prior authorization rules, appeals and grievance procedures and a list of specific prescription medications included in the formulary of each plan.

And, on the controversial issue of drug formularies, both physicians and pharmacists must participate in the development of a drug formulary, and a plan must have a process to allow physicians to prescribe drugs that are not listed on the formulary.

Finally, I want to commend my colleague, Senator FRIST, for his principal role in developing the provisions for a comprehensive independent study of patient access to clinical trails and for developing the provisions to improve medical outcomes research.

Senator FRIST is the only physician in the Senate and, quite frankly, I'd much rather have his advice and expertise in developing this legislation than the input of attorneys who had helped shape the Democrats' bill.

Mr. President, for anyone to describe S. 326 as ineffective and not doing much to help patients, I would respectfully submit that they simply have not read the bill.

S. 326 will help people. It will help those people who most need our help: those people who are enrolled in health plans that are not regulated by the states.

This legislation strikes an appropriate balance between ensuring patient protections without imposing excessive and costly new federal mandates on the private sector.

In that respect, let me also add one other point: I was not particularly enamored with S. 326 when I first read it. It contains numerous federal mandates which, historically, I have opposed.

I find it particularly troubling that the federal government will impose these mandates on the private sector because this action will drive-up the costs of health insurance which may ultimately lead to employers dropping health insurance altogether.

And I can assure you that comments from the business community about dropping health insurance altogether are not idle threats. The one issue I hear most often from employers, especially from small and middle size companies which comprise most of the businesses in Utah, is the rapidly escalating costs associated with providing health insurance to employees.

Employers want to provide their employees with comprehensive health insurance plans. In fact, in order for them to compete in today's competitive marketplace for talented and skilled help, they must offer employees decent health insurance coverage.

I recently received a letter from one of my constituents who owns and operates a small company. Ms. Hydee Willis owns a small business called ''Creative Expressions'' in Murray, Utah. She wrote to me and said:

I am a woman owned business person—fought through the ranks over the last 18 years of being in business [and] of fighting the entire stigma a woman in business [has] in this country. I have struggled with the intense feelings of inadequacy and helplessness as I lost employee after employee to larger companies able to offer wonderful benefits.

She further states:

After weeks of research and many agents, we finally found a plan that gave our employees at least part of what they wanted. Yesterday, the final program papers were put on my desk and a check was being requested by the insurance agent. My heart sunk. To insure 13 people, basic health coverage with $250 individual deductible, my costs are $3,700 per month per employee or $44,400 per year.

Moreover, she writes that the employees' share of the premium was equally staggering with ''one manager with a family of five having a bill of $458 per month.''

Ms. Willis will ultimately pay the price for the federal mandates imposed under any legislation passed by the Senate. And so will her employees.

Here is where the rubber meets the road. Here is where all of our platitudes about quality collide with issues of access and affordability. Here is where reality should set in for my colleagues who are advocating on behalf of the Clinton administration's proposal.

While I have admitted my concerns about the Republican bill, at least, the increase in premiums will be .04 percent annually. Under the Democrat plan, the increase in premiums will be 6.1 percent annually. The former may be manageable; the latter will undoubtedly have serious repercussions.

Mr. President, we simply cannot ignore the fact that whatever legislation we pass here in the Senate this week will ultimately be paid for by employers and employees alike. The federal government is certainly not going to pay for this; the American people—employers and employees alike—will pay for it, and that is precisely the reason why I oppose the Democrats' bill.

Too many federal mandates will only mean no patient protection because no one will be able to afford health insurance. Who is left to protect when employers drop health coverage altogether because they and their employees can no longer afford it?

In fact, we are already seeing an average premium increase this year of approximately 10 percent. With the 6.1 percent premium increase that the Congressional Budget Office estimates as the cost of the Democrats' bill, you are conceivably looking at a 16 percent increase in health insurance premiums—in just one year!

That is not the kind of legislating I believe the vast majority of my constituents in Utah would support. Nor would most Americans.

Even the letters I've received from my constituents who support the Democrats' bill are sensitive to the unintended financial consequences that passage of a misdirected and overly broad bill will have on health insurance affordability.

Another area where there is wide disagreement between the Republican plan and the Democrat plan is on the issue of expanded litigation.

The core of this debate is the critical issues associated with the expansion of health plan liability for coverage decisions and to allow tort actions for wrongful death and personal injury under state malpractice laws. Under the Republican plan, when patients are denied medical treatment or benefits, they have the right to a second opinion from a trained medical professional.

Under the Democrat plan, when patients are denied medical treatment or benefits, they have the right to see a lawyer. Am I missing something here? If I have a medical condition, I want the services of a medical professional. Why is it that the first thing the Clinton administration thinks of is going to court?

However, as a former medical malpractice attorney myself, I fully understand and appreciate how trial lawyers will benefit from the expanded litigation provisions in the Democrats' bill. It would be a bonanza for trial attorneys.

The expanded liability provisions in S. 1344 are, by far, the most costly component of their bill. Expanded liability would increase costs by eroding the ability of a health plan to contain costs and provide quality care. It will also compel health plans to allow for coverage of defensive medicine practices, or the inappropriate and even unnecessary medical care to protect themselves from liability.

Earlier this year, the Health Care Liability Alliance sponsored a briefing identifying the impact of the current health care liability system on health care costs and access issues. At that briefing, former Attorney General Dick Thornburgh provided an overview of the current state of affairs in our nation's legal system with respect to health care liability.

Mr. Thornburgh stated, ''We've got plaintiffs' lawyers raking in millions in contingency fees while the clients they represent settle for pennies on the dollar. This is increasingly becoming the case in class action lawsuits.'' He further states, ''there are estimates that lawsuit abuse is costing the U.S. economy as much as $150 billion each year! And, there is the social cost to society with the impulse to settle every squabble with a subpoena.''

In addition Mr. Thornburgh says,

Few areas provide such ample evidence of a legal system run amok than the area of medical liability. Compared to lawsuit abuse in other sectors of the economy and society, the litigation explosion in the health care area is, if anything, more damaging precisely because health care means so much not only to patients involved, but to all of us who—as potential patients—count on a vital, vibrant health care system to give us the best care that medical science can provide.

Under the Democrats' bill, ERISA would be amended to expand state tort liability to health plans—and to employers. Interestingly, with respect to the practice of medicine, ERISA currently does not preempt state law malpractice claims against medical professionals for providing substandard care. A patient can sue an ERISA plan for medical malpractice.

In addition, there has been a clear trend in recent years in federal court decisions that managed care organizations are held ''vicariously liable'' for the malpractice of health providers.

With respect to denied benefits, ERISA already provides for a ''full and fair review'' of disputed claims. If the result of the benefit plan's internal appeal process is not satisfactory to the patient, then ERISA provides patients with a right to judicial review in either federal or state court, and the court may award attorneys' fees, court costs, the benefits denied, and ''other equitable relief'' as needed.

In lieu of expanding health care litigation, the Republican bill provides specific internal and external appeals rights that would apply to all 124 million Americans covered by group health plans under ERISA.

It seems to me to make better sense to provide an appeals mechanism that is timely and responsive to those individuals who seek a remedy on matters involving benefit coverage or denial.

The Republican bill will achieve that objective.

I have heard from many Utahns who voice strong opposition to expanding liability to both health plans and employers. Our objective is to ensure patients obtain the necessary treatment they need. I say to my colleagues on the other side, the ability to sue will not help those who face life threatening diseases.

Malpractice claims take an average of 16 months to file and 25 months to resolve. And, as the record clearly shows, the contingent fee system promotes an aggressive trial bar that dramatically inflates medical malpractice claims.

I would add that even the President's own Advisory Commission on Consumer Protection and Quality in the

Health Care Industry did not recommend expanded liability for health plans as the commissioners agreed that such a recommendation would have serious consequences within the industry as well as for employees who would likely see the costs of their premiums increase dramatically.

Furthermore, plaintiffs receive only 43 percent of their tort awards—the other 57 percent goes to the trial lawyers.

We need a workable system that establishes specific time frames to ensure patients have an effective appeals process to address disputes.

The Employee Retirement Income Security Act of 1974 has served this country well over the last 24 years by enabling employers to provide health care coverage and other benefits that meet the needs of their employees and families. Approximately 124 million Americans are enrolled in health care coverage through their employers under ERISA.

Health care coverage for these people will clearly be threatened by opening up the floodgates to expanded litigation and shifting millions of dollars away from the provision of health care to the pockets of trial attorneys.

The Republican bill provides an expeditious remedy under which patients can appeal decisions. In my opinion, the appeals mechanism in our bill is far preferable than handing these matters over to the courts and to trial lawyers. I might also speculate that resources not spent on lawsuits could be spent more productively on behalf of patients.

Mr. President, as I have listened to the debate on patients' protection legislation, I am struck by the emotion and intensity that this issue holds for many of my colleagues in the Senate. This is a deeply personal issue for all of us because it literally affects the lives of people. At the end of the day, isn't that the reason why we are here? We are here to help our constituents and, indeed, to help all Americans.

I had hoped this debate would have produced more consensus. I believe there is probably more agreement on these issues than is apparent by this week's debate. I support the Republican leadership bill because it provides a balanced approach at addressing the complex and emotional issue of patient protection.

It's not a perfect bill and, for that matter, neither is the bill offered by the Democrats. But we have an obligation to the American people to do what is reasonable and responsible.

I want the American people to know that we in the U.S. Senate are dedicated to providing access to the highest possible quality care at an affordable price to everyone across the country. For my part, I will continue to fight for increasing access to health care to the medically uninsured. It is troubling to me that 43 million Americans do not have health insurance coverage.

But, I am afraid that the Clinton administration proposal violates the Hippocratic oath to do no harm. Accordingly, I urge my colleagues to support the Republican bill for the good of their constituents, and for the good of the American people.

Thank you Mr. President.

Mrs. MURRAY. Mr. President, my colleagues have clearly spelled out the intent and necessity of this amendment so I will not take much time to go through its benefits. I came to the floor simply to urge my Republican colleagues to really think about how much more protection this amendment provides their constituents than their bill does.

The so-called access to speciality care provisions in the Republican bill are nothing more than a statement on the importance of speciality care. They do not guarantee the care; they simply reiterate current insurance practices.

During committee consideration of this legislation, a similar amendment was offered to ensure access to specialists and to ensure that patients could designate a specialist as their ''care coordinator.'' During that debate in committee, we heard a great deal about training and experience. We were told how an oncologist was a trained specialist in treating cancer regardless of the age or gender of the patient. We were told a neurologist was a trained specialist regardless of the age or gender of the patient. We were told the training was the same and practice experience was not important.

I find this hard to believe, I ask my colleagues again: is there a difference between treating a child with cancer and treating an adult? Are the treatment regimes for a 3-year-old with a brain tumor the same as those for a 50-year-old? I doubt it. It seems likely to me that a cancer treatment regime for a 50-year-old could kill a 3-year-old. That treatment could render the child disabled or seriously impair his or her developmental progress.

I urge my colleagues to talk to people at their children's hospitals, to their pediatricians, to their ob/gyns and to their cancer specialists. I have. And what I heard was that patients need to see the specialists most qualified and trained to deal with them and their specific illnesses.

If your child had a brain tumor, would you want to be told there are no pediatric neurosurgeons or pediatric oncologists in your network, but that on page 215 of your physician directory you will find a list of the oncologists approved by the plan? I certainly wouldn't. I would want a specialist trained in pediatrics.

The Republican bill does not allow for access to speciality care. It is that simple. You can say it does and in fact some of my colleagues may hope it does, but it does not. I can assure my colleagues that the language in both the bill and the committee report will allow plans—not your specialist—to make the final determination on access and treatment.

Here is what the committee report says:

> This section would NOT prevent a plan from requiring that the specialists adhere to a treatment plan if it: (1) is developed by the specialist in consultation with the patient and the patient's primary care provider; (2) is approved by the plan; and (3) meets the quality assurance and utilization review standards of the plan.

What does this mean?

It means that if the patient is lucky enough to get a specialist, that specialist—who is a trained and qualified doctor—could be required to meet the plan's treatment standards. So maybe you could see a specialist, but you might not be allowed to be treated by one.

Yesterday we offered the Robb/Murray amendment to allow women direct access to their ob/gyns. It was defeated.

Today we are offering a broader amendment in the hopes of giving all insured Americans the hope that they can get the best care possible for their sick or injured child. If we do not adopt this amendment, once again the patient loses and the insurance company wins.

I urge my colleagues to support this amendment and yield back my time.

Mrs. FEINSTEIN. Mr. President, today I want to talk about the importance of patients being able to see medical specialists. I support the Bingaman amendment to the HMO bill before us.

As co-chair of the Senate Cancer Coalition, I am keenly aware of the importance of being able to see a doctor that has the expertise to properly diagnose and treat illnesses, particularly a complex or difficult-to-diagnose illness. There are hundreds of medical conditions that probably require a specialist and sooner or later we all have to visit with one—whether it be a dermatologist, a cardiologist, or an oncologist, to name a few.

For cancer, here's how the American Cancer Society has expressed it:

> Diagnosing and treating cancer is complex, multi-stage process often involving many visits with an oncologist or other specialist. Timely referrals are critical. However, according to a poll [March 1997] by the Commonwealth Fund, 8 of 10 physicians in managed care plans report ''somewhat or very serious problems with being able to refer patients to specialists of their choice.'' This same poll also found that 22 percent of physicians with more than half of their patients in managed care plans say they have a direct disincentive to refer.

The amendment before us would:

Require plans to refer patients, who have conditions requiring treatment by a specialist, to specialists in a timely manner. If a qualified specialist is not available in the plan, it requires the plan to cover services provided by the outside specialist at no additional cost to the patient. If a qualified specialist is available in the plan, it requires the patient to pay any costs over what the plan would pay;

Require plans to permit patients to designate specialists as their primary

care physician, when the patient has a life-threatening, degenerative, or disabling disease requiring specialized care over a prolonged period of time, such as cancer or heart disease. The specialist would coordinate the patients' overall care; and

Require plans to give patients with a condition requiring ongoing care, a standing referral to the specialist so that patients do not have to obtain a separate referral for each visit.

We need to pass this amendment guaranteeing access to specialists because we have heard story after story about managed care plans refusing to let sick people see a specialist and using financial incentives to, for example, punish doctors who refer to specialists. A study reported in the November 19 New England Journal of Medicine found that 57 percent of physicians said they felt pressure from managed care plans to limit referrals.

Sick people need specialized care. This amendment addresses the concerns of many doctors and patients who have shared their experiences with me. Specialists, from neurologists to pediatric nephrologists, report that plans regularly deny referrals for their specialized expertise. Even more troubling, these specialists report that they often still find themselves called for advice in these complicated cases without the benefit of ever having seen or examined the patient.

Here are some examples:

Dr. Jack Thomas, of Long Beach, California, in a Los Angeles Times article on May 13, 1999 said that one patient was ''in severe pain for several weeks while awaiting orthopedic consultation'' and that urgent consultation with gynecology was not approved after a two-week wait for another patient who continued ''to experience severe dysfunctional uterine bleeding.''

When the list of providers for the HMO did not have any physicians skilled in the treatment of brain tumors with which her daughter Sarah had been born (and as had been recommended by a neurosurgeon), Brenda Pederson, of San Mateo, California reports that her HMO told her ''we're not giving you second best, we're giving you what's on the list.'' Patients such as Sarah should not be limited to who is ''on the list,'' but should be able to go the doctor her mother and her doctor believe has the expertise to treat the illness.

Dr. Jack Shohet, Director of Neurology, University of California, Irvine, has said, ''Delay of referral is very common in the area in which I practice.'' He gives the following example: A 48-year old woman presented to her primary care provider about 6 months before seeing Dr. Shohet, with complaints of an ear ache. She was treated with multiple courses of antibiotics over 5 months by her primary care physician. The primary care physician noted a large mass in her auditory canal and biopsied it. It was positive for squamous cell carcinoma. He then referred to her Dr. Shohet (who is out of network) for therapy. By this time, she had a fungating mass with metastasis and cancer and spread in her neck. She had to have an operation which necessitated sacrificing her hearing. He says, ''One wonders how extensive her disease would have been 5 months earlier had she been referred early on to a qualified specialist.''

Denial of care is the biggest ethical concern to a majority of younger physicians, according to the August 1998 California Physician.

Having a standing referral to a specialist for ongoing care is important too. Patients should not have to continually return to their primary care provider for a referral when they have found a specialist who can treat that illness. California has a state law allowing enrollees who require continuing care to have standing referrals to specialists.

Writing to me in March of this year, a constituent who has battled chronic disease for twenty years requiring multiple surgeries noted, ''I cannot underscore the incredible waste of time it is for patients with Crohn's disease to have to see two doctors for every visit to the gastroenterologist!!'' This bill requires a standing referral to specialists for persons who require ongoing care from specialists so that patients can get the care they need in a timely manner.

Care by specialists benefits patients with chronic disease. Analyzing data about asthma patients in a major California HMO (Health Net), a report in the March 9, 1998 Archives on Internal Medicine concluded ''asthma specialists provided more thorough care than did primary care physicians.'' A 1997 study from the Mayo Clinic notes that ''outcomes, coordination, and patient satisfaction are superior when specialists have a central role'' in the management of chronic rheumatic and musculoskeletal diseases.

Specialists' care is good business. Providing access to speciality care makes good business sense. Citing its ''market-driven design'' including use of focus groups, Blue Shield of California has been offering direct access to speciality care since 1998. Its ''Access Plus'' plan allows patients to go directly to a specialist for a fixed, $30 copayment per visit. In the May/June 1999 issue of Health Affairs, Blue Shield senior managers Kathleen Richard and Ken Wood report that the health plan is the fastest growing HMO in California. They also report that patient satisfaction has increased by 50 percent.

And how much did this new program cost? Blue Shield found that the actual cost of the direct access program was much, much lower than even they themselves had forecast—fully 75 to 90 per-cent less than what they had anticipated.

Providing prompt, continued access to specialists can also result in cost savings in a managed care environment. Dr. Roland Blantz who heads the Division of Nephrology at the University of San Diego noted in a visit to our office a seven-year Kaiser study in the Los Angeles area which showed highly significant savings when patients were referred to kidney specialists for evaluation and treatment of elevated creatinine levels.

Our California experience shows that access to specialists can improve patients' health and increase plan satisfaction while keeping costs down.

Delayed care hurts. The bill requires that plans provide timely referrals to specialists who are available and accessible. A December 1998 General Accounting Office report on specialty care found that heart attack survivors who were seen regularly by cardiologists have better compliance with medications, by a factor of almost 50 percent, over treatment by generalists. Having to wait weeks or even months to get an appointment with a specialists from an HMO is a frequent complaint.

Mary Schriever of Cypress, California tried to get a referral from her HMO for psychiatric care for her son Bill who had performed self-mutilation on his arms by burning and carving himself. After two refusals over 18 months, they paid themselves for him to see a counselor. But even as his behavior deteriorated more, their further attempts to obtain the help of a specialist continued to be rebuffed. It was only in jail, after he was taken into custody by the police, that he finally saw a physchiatrist. Before being released and after a fight, he died of a brain hemorrhage.

Some have said, HMOs are fine—until you get sick.

A recent survey by Franklin Health entitled ''Facing Serious Illness in America'' and published on May 17, 1999, found that ''fully 6 out of 10 Americans believe that the current system is profoundly inadequate when it comes to dealing with medical catastrophes'' and that 93 per-cent of those surveyed believed that it is very important to have the right to choose one's own doctor regardless of plan.

Patients should not have to fight for their health care. This amendment will ensure that when people are really sick and need to see experts, they can. They will be able to use often what little energy they have when ravaged by serious illness to obtain the specialized care they need to make important decisions at such critical times.

I hope my colleagues will join me in passing this amendment.

Mr. GRAHAM. Mr. President, I rise today in strong support of this amendment to ensure that managed care enrollees have access to specialists.

Specialists are an integral part of our health care network. As a result, access to quality specialty care can often be a matter of life and death. In a recent Harvard study, 56 percent of doctors cited the bureaucracy involved with referrals to specialists as one of

their top three problems with HMOs. In addition, 40 percent of doctors felt limited by managed care companies from referring patients to appropriate specialists.

No managed care issue has raised more concern among consumers and providers alike than access to specialty care; especially the issue of having specialty physicians acting as primary care providers. Mr. President, you can imagine what a challenge this is for individuals with chronic or disabling conditions.

My own daughter has been in the position where she needed a specialist to coordinate her care. She had triplets a few years ago, and her medical needs were not unlike many young mothers in similar situations. I am convinced that my daughter's health would have been seriously compromised if she had been denied access to a multiple birth specialist. Multiple birth pregnancies are often high risk, but because she had the proper care, I can now gladly say that I am the proud grandfather of three beautiful girls.

The language in this amendment would ensure that if an individual has a condition or disease of sufficient severity and complexity to require treatment by a specialist, and the benefit is provided under the plan, then the plan shall make or provide for a referral to a specialist who is able to provide the treatment for such condition or disease.

The rigid restrictions by some HMOs on who can and cannot serve as a primary care physician are another obstacle to access to specialty care. In fact, several states (Indiana, Kentucky, New Mexico, Pennsylvania, New Jersey, New York and Texas) allow an enrollee with chronic health problems to select a specialists, such as a neurologist, a mental health provider, or a cancer specialist as their main health care provider.

A recent Families USA report—''HMO Consumers at Risk—States to the Rescue''—cites far too many cases where a patient's care was compromised because their primary care physician lacked the expertise to deal effectively with their particular chronic condition.

I cite the case of Ms. N., a 51-year-old woman with multiple sclerosis (MS). Although her primary care physician agreed that she had MS, he would not refer her to a neurologist. He said that since MS cannot be cured, a specialist could do her no good.

In another situation, an eight-year-old boy was not allowed to visit his cystic fibrosis (CF) care center for routine checkups even though regularly scheduled visits to a CF care center are essential to treatment. His primary care physician did not believe that aggressive treatment was appropriate, as patients with cystic fibrosis do not have a ''good prognosis.''

Every Member of this body would demand the best care for their child. If a specialist was best suited to provide that care, then every one of my colleagues would insist that their child receive that care regardless of cost and coverage. Why not guarantee this same right to the rest of the American people?

In addition, a recent survey by the National Coalition for Cancer Survivorship stated that oncologists should be the primary managers of care for individuals with cancer. To support their argument they cited factors such as: the complexities of treating cancer; their specific knowledge of long-term and late effects, rehabilitative services, pain management and hospice; and the importance of early detection and treatment for survivors who have an increased risk for second malignancies.

With regard to out-of-network specialists, the Republican bill lacks basic protections to ensure that patients can see doctors qualified to treat their condition. For example, a child with diabetes should be able to receive care from a pediatric endocrinologist. However, if there is no pediatric endocrinologist available in the network to provide care for the child with diabetes, the family should be able to seek care from an out-of-network physician at no addition cost.

We must ensure access to qualified specialists, outside of the network if necessary, and without high out-of-pocket expenses for enrollees who are forced to go outside the plan to be treated by the needed specialist.

The Republican bill also fails to hold a plan responsible for not having an adequate network of specialists. In fact, Sec. 725 in the Republican bill states that ''such access may be provided through contractual arrangement with specialized providers outside the network of the plan.''

Beneficiaries should not have to suffer because of their health plans' inadequacies. They should receive the care they need by the most appropriate health professional. The Republican bill's guarantee to specialists is weak and does not even guarantee that children can see pediatric specialists.

Finally, the legislation we are considering today only provides access to specialists for only 48 million Americans with private insurance. It leaves out the 113 million individuals who choose to enroll in managed care plans.

Plans should provide patients with an adequate network of physicians, and when they fail to do so, should allow the beneficiary to step out of the network at no extra charge. We must protect our frailest and sickest patients. Individuals with life-threatening and disabling conditions should be allowed the use specialists—the best source of information and care for specific and advanced diseases—to coordinate care.

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

Mr. JEFFORDS. I yield myself 5 minutes.

The PRESIDING OFFICER. The Senator is recognized for 5 minutes.

Mr. JEFFORDS. I appreciate the tremendous effort the Senator from Utah has made in this debate. I think he has hit upon the critical issue. We must remember, all of us, every time we do make changes which result in increased costs, people become uninsured. That is the advantage of the Republican package and why it is so much better than the Democratic package.

If you want to keep score, as my friend from California wishes to do on victories here, they will have 1.8 million victims from their cost increases; we will have about 240,000. And who are those victims? They are the working poor. They are the ones those of us who are compassionate always feel sorry for. We ought to be spending our time and ability to increase their capacity for health care, not throw them off the plans. That is the difference between the two bills in the final analysis when you come down to it; and that is, we will not make the working poor suffer more and throw 1.8 million people off of the rolls of the insured. So keep that in mind when you think about which bill you want to vote for. Because, to me, that is the top concern.

In addition to that, we also create a standard, a higher standard for all Americans with respect to what they should get from health care and from the HMOs, et cetera; and that is, to get away from the old standard where you did not have to worry about the changes in the medical profession or what advantages would be accomplished. With all of the work we are doing now in the outcomes of research to determine what works and what does not work, that is going to be available to us. It is available now, but as we move forward it is going to be more and more available.

We demand that the doctors must give the best health care, not just something that happens to be generally practiced in the area.

So we have two huge advantages with the Republican bill. I hope Members will keep that in mind as we move forward in the process.

I yield the floor.

Mr. KENNEDY. I yield the Senator from Iowa 15 seconds.

The PRESIDING OFFICER. The Senator from Iowa is recognized for 15 seconds.

Mr. HARKIN. Mr. President, we are considering an amendment by Senator BINGAMAN to allow people with chronic illnesses, people with disabilities, to go outside the plan and get the specialty care they need; yet, again, not one Republican will get up and even talk about it. Not even one Republican will get up and talk about it.

Mr. KENNEDY. Mr. President, I yield 2½ minutes to the Senator from New York.

The PRESIDING OFFICER. The Senator from New York is recognized for 2½ minutes.

Mr. SCHUMER. I thank the Senator from Massachusetts.

As the Senator from Iowa noted, no one seems to be debating this amendment. Everyone seems to be debating

other parts of the bill. There is a very simple reason why. Our bill says, when your primary care physician says you need a certain specialist, you will get one. Their bill says, when you need a certain specialist, maybe you will get one if the HMO says you can.

Let me tell you a story about a young woman in my State, a nurse, in her prime of life, 24 years old, a good athlete. She had a health care plan from her father because he was a lineman for the phone company. She developed a tumor on her femur. She went to her primary care physician. He said: This is dangerous. You need an oncological orthopedic surgeon. Her HMO said: No, no, no. You can use an ordinary orthopedic surgeon. The primary care physician said: No. You need an oncological orthopedic surgeon. This is a very difficult tumor.

But they were not a rich family. When the HMO said no, she went and had the operation from the orthopedic surgeon. Guess what. The tumor grew right back. She went back to the HMO. She said: I did what you said. I went through a painful operation. Now let me go to the specialist my primary care physician says I need. They said no again. She went on her own, paid $36,000 out of her pocket. It cured the tumor, but now she can hardly walk.

When she went to the HMO and said, please, pay for this, they said, no, no, no. Under the Democratic bill, Debra Bothe would not have had to go through this. She would have had the specialist she needed. She would be walking today. Her family would not be totally out of money today. Under the Republican bill, nothing would have changed.

That can be repeated in story after story, in anecdote after anecdote, on factual basis after factual basis. If you need a specialist, if you are deathly ill—I ask the Senator if I could have 30 seconds?

Mr. KENNEDY. I yield the Senator 30 seconds.

Mr. SCHUMER. If you are deathly ill, and your physician says you need a certain specialist, do you want the Democratic bill that says you get one or the Republican bill that says maybe you will get one, if your HMO allows you to?

I say to my friend, the Senator from Vermont, that is what working families want and need—this kind of bill, this kind of proposal, not a proposal that is toothless and sides with the insurance companies time after time after time.

I thank the Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I yield myself such time as I might use.

We are coming into the final moments before we will vote on this amendment. I will take at least these final moments to point out where we are.

Primarily, what we are talking about are the protections that have been included in our Patients' Bill of Rights. No matter how many times our Republican friends say they are shocked, shocked to discover the deficiencies in their amendments and promise to do better, their new product is just the same old, tired, flawed proposal in fancy dress. The problem is a simple one: Insurance companies don't want real protections, so Republicans won't produce them.

We have two different proposals on emergency care, two different proposals on OB/GYN care, and another proposal in terms of specialty care this evening—all changes, alterations, in terms of their original proposal. No matter how many times they alter or change, they still do not meet the basic standard and test of providing that the medical professions make the judgment of what is in the interest of that patient, not the insurance company.

Access to the needed specialty care is one of the most critical ingredients in quality health care. Timely access to a qualified specialist can often determine whether a patient lives or dies. For those living with chronic illnesses or with a physical or mental disability, access to specialty care can improve the quality of life, prevent deterioration, or cure or ameliorate the disease.

Nowhere is the contrast between the Republican plan and our proposal clearer than on the issue of access to needed specialty care. Our amendment, offered by Senators BINGAMAN, HARKIN, REED, and others, guarantees it. The Republican plan is a sham proposal that carries the label of access to specialty care but does nothing meaningful to help patients.

Our amendment has key protections that guarantee appropriate specialty care. Health plans are required to provide care by a qualified specialist or center of excellence when needed. If sufficient expertise does not exist inside the HMO network, it must allow patients to go to a specialist or a center of excellence outside the network, without any additional financial burden beyond what would be involved in seeing a network specialist.

For chronic or ongoing conditions, HMOs must allow standing referrals to a specialist or, where appropriate, allow the specialist to be a care coordinator—in effect, the primary care gatekeeper for treatment related to the condition.

These provisions are especially critical for anyone suffering from a chronic disease or disability and for disabled children with their complex needs. If there is a disagreement between a plan and a physician or patient about the need for specialty care or out-of-network care, the dispute will be resolved by a speedy independent review. It is guaranteed. It is written into the law.

The Republican plan includes none of these critical guarantees, not a single one. More than two-thirds of all patients are excluded even from the minimal protections it does provide. Access to qualified specialists is essential to quality care, particularly for those who need care the most: those with a disabling or life-threatening illness. If our proposal is adopted, every family can be confident that if serious illness strikes, their health plan will not deny them the care that is essential for recovery—no ifs, ands, or buts; the guarantee is there.

Once again, the issue is clear: Will the Senate protect the patients or will it protect the insurance industry profits? That is what is before the Senate in this amendment. That was basically the protections that were included in our legislation. This amendment will guarantee that any measure that comes out of this body will have those protections, and that is why this amendment is so important to be accepted.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. BINGAMAN addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, may I ask for time to ask for unanimous consent?

Mr. KENNEDY. Of course.

Mr. BINGAMAN. Mr. President, I referred in my earlier comments to a circumstance that was described to us this morning. Beth Gross talked about her 4-year-old named Matthew and the difficulties the family had in obtaining access to specialty care. I have been given a copy of a statement she made describing that in more detail. I ask unanimous consent that that statement be printed in the RECORD.

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

My name is Beth Gross, and I am here today on behalf of patients everywhere who are crying out for a real patients' bill of rights. We need protection, and can no longer afford to be at the mercy of health maintenance organizations.

While other interests say that the industry can regulate itself, my 4-year-old son can barely say anything at all because of an HMO policy. I am here today to tell you that my son was denied access to necessary, specialized medical treatment.

Matthew has a significant speech delay that has been directly linked to his repeated ear infections. For the first two years of his life, Matthew suffered 14 ear infections. In most cases, this is a normal childhood illness treatable with antibiotics. But the fluid in Matthew's ears remained behind the eardrum for a long period of time—causing repeated infection and delayed speech. To a young child like Matthew, when this fluid remains behind the inner ear, it distorts sound and sometimes impairs hearing completely.

The doctor who treated Matthew repeatedly used antibiotics instead of granting my request for a referral to an Ear, Nose, and Throat Specialist. As a nurse, I knew the risks of this chronic condition, and grew frustrated to know that a simple surgical procedure called an ear tube placement could immediately correct Matthew's problem. But I was left at the mercy of a doctor who kept treating Matthew with antibiotics—antibiotics that were never going to be able to correct the structural problems within his little ears.

I made the decision at that point to change my primary care physician, and called the

insurance company. When I explained our dilemma, I was outraged at their response. We could not get a referral for Matthew because it was their policy, to impose and I quote, ''monetary sanctions'' on the physician for giving a referral for something that he is able to treat.'' I felt shocked and helpless. I could not believe that I lived in a country that allowed an insurance company to be so ruthless with a child.

I fought for more than a year to get the referral Matthew needed. By that time, Matthew was 18-months-old and was still not speaking. Although we changed doctors, we could not change insurance companies. When he finally saw the Ear, Nose, and Throat Specialist, Matthew's test results were heartbreaking. His impairment left him only to hear distorted sounds of human speech, which is one of a child's most important tools for developing language.

Thankfully, Matthew finally received the ear tube surgery that he desperately needed. On the morning we brought him home from the hospital, you should have seen the joy and excitement in his face as he first heard birds chirping—a sound so many of us take for granted. Two and a half years have passed since our ordeal and Matthew has never had another ear infection. The ear tubes immediately corrected his hearing. He also had his adenoids removed, which were so large that they were blocking the natural structure of the inner ear that allows fluid to normally drain. These enlarged adenoids could only have been found by an Ear, Nose, and Throat Specialist.

If only Matthew had been treated earlier. Now our family must work to correct his speech problem. Our insurance company has changed since then, but it's been another fight with another HMO to cover speech therapy. They denied coverage for that service, until The National Patient Advocate Foundation stepped in and won that battle for Matthew.

I look back on our situation and wonder what our lives would be like today if there had been a law preventing that insurance company from financially penalizing our physician for giving a referral. Matthew would have had normal hearing during the critical developmental phase of his life. Instead, now Matthew is unable to make the correct sound for 90 percent of the alphabet. If Matthew received a timely specialist referral, my son wouldn't be self-conscious and hesitant to speak because he fears people not being above to understand him.

Matthew was caught in the crossfire of an insurance company being able to tell a doctor how to practice medicine. This is just plain wrong. Cost effective health care has cost my family, especially an innocent child, too much. I urge you to pass meaningful patients bill of rights for me and Matthew.

Thank you.

Mr. KENNEDY. Mr. President, I yield 4 minutes to my colleague, the Senator from Massachusetts.

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

Mr. KERRY. Mr. President, we have the best specialists, the best delivery system in the world. We have people who come here from all over the world to share in the remarkable expertise and capacities of our specialists in this country. Yet the fact is, under the Republican plan millions of our own citizens would be denied the right of access to specialists.

The stories of individuals are remarkable. I know every single one of us has received letters from anguished parents who run into the most extraordinary barriers of resistance from an HMO that is simply concerned with its bottom line and not concerned with the proper delivery of health to the individual they represent.

I will speak for just a few minutes today about one of the issues I believe cuts to the heart of this debate over managed care reform in the Senate today, and that is the broader question of what kind of access we are going to guarantee to specialists. Mr. President, in the United States, we are fortunate to have world-renowned health care facilities and some of the best doctors and researchers in the world. Each year thousands of people from around the world travel to this country because we have the best specialists in the world. But at the same time, every year, thousands of letters pour into my office from constituents in managed care plans who can't see the specialists their own doctors know have the expertise to meet their medical needs—because their HMOs won't permit it. Mr. President, there's something disturbing in the dichotomy we are facing: all the world knows our doctors are the best trained, our specialists the best educated and the most highly skilled—but our citizens aren't permitted to see them when they need them most. What can we say about that system which defies the limits of common sense and every notion of human compassion? I believe we should all be able to say that it demands reform—today.

When the American people say they support managed care reform, they are rejecting the one-size-fits all brand of health care practiced by many HMOs. Let me assure you, as well, that one of the most critical elements of any Patients' Bill of Rights must be access to quality speciality care—literally, the difference between life and death for thousands upon thousands of Americans each year.

Too many of the tragic cases that we hear about in the United States are the result of delay and denial of access to cardiologists, oncologists, surgeons, pediatric specialists and the doctors who have the specialized knowledge absolutely critical in so many cases today. I will never forget the story of Morgan smith—four years old, diagnosed with brain cancer, facing a life-threatening tumor. Imagine the horror of her parents, hearing that grim diagnosis. And you can understand her parents' reaction when pediatric oncologists at Hasbro Children's Hospital in Providence told them that Morgan needed to go to New England Regional Medical Center in Boston for a special chemotherapy treatment—her mother said ''I need to do whatever it's going to take to save my daughter's life, and I'm going to listen to our doctor.''

But can you imagine how Morgan's mother felt when she got a letter in the mail from her HMO denying payment for a specialist—demanding that she get a second opinion? Meanwhile, Mrs. Smith took Morgan to Boston for her treatments, unsure about how she would pay for it, but knowing that she couldn't afford to risk Morgan's health while she fought the insurance company. Despite a second opinion that Morgan needed the expertise of specialists in Boston, the HMO still refused to pay for the treatment. Mrs. Smith had to wage her own battle against the HMO by starting a letter-writing campaign, along with Morgan's doctors.

Fortunately, Morgan's story, unlike too many others, has a happy ending. Close to a month after Morgan had started her treatment, the insurance company finally agreed to cover the procedure that all the medical professionals agreed was necessary. But I would remind you that had Morgan's parents followed the HMO's mandate, their daughter may not have received the treatment that saved her life and it was at the very least, delayed. Morgan's parents have since changed insurance companies, but their health plan contract will be rewritten in August and the family is very nervous about possible changes that may affect Morgan's health care. Morgan will be six years old this November and she is attending kindergarten. We need to take the right steps today to guarantee that Morgan and children like her never face another HMO nightmare like the one that could have cost her and her family her life. We need to take the necessary steps to prevent the kind of bureaucratic nightmare that almost killed Sarah Pederson. Sarah Pederson's parents lives were changed overnight when their healthy, beautiful seven month old baby was diagnosed with an inoperable brain tumor—a condition which had to be monitored carefully by a specialist. But the Pedersons' HMO—in spite of the recommendation of their pediatrician—would not allow Sara to see a pediatric neuro-oncologist. A seven month old baby with a brain tumor, a brain tumor so complicated that the Pedersons' pediatrician knew only of a few pediatric neuro-oncologists capable of treating it, and the HMO said ''no''—they insisted that this child be sent to an adult neuro-oncologist. Why? No explanation was given other than ''this is our policy.'' And it goes on and on. The HMO refused to approve the chemotherapy regimen prescribed by their specialist—until it was approved by another one of their specialists. And what happened during that month of delay? The tumor grew. And in the end, what saved Sarah Pederson? Did the HMO relent and allow the doctors and the family to make decisions in the best interests of this child? No. The Pedersons only found relief when they left their HMO—and mortgaged their home to join a fee for service program. I challenge any one to look the Pedersons in the eye and tell them we don't need managed care reform to guarantee appropriate access to specialists.

Mr. President, I can tell you that—thanks to parents who didn't give up, who put their own financial security on the line, who fought and fought the red tape—Morgan Smith and Sarah Pederson survived. They survived in spite of their HMO's. Jack Jennings wasn't so lucky. Jack was from Andover, Massachusetts. He was diagnosed with mild emphysema, and later on with a pneumothorax, which can lead to a collapsed lung. His doctor believed a lung reduction procedure could not just improve his quality of life, but actually save his life—but this primary care doctor knew it would take a specialist to perform that operation. Jack was referred to see Dr. Sugarbaker, a top physician in Boston. The HMO rejected the referral. Jack's doctor wrote a lengthy appeal. The HMO rejected it. Months went by. Jack appealed again and again—literally taking a break from his oxygen machine to speak on the phone with the HMO claims adjuster. Finally, a letter arrived at the Jennings household, the referral for a specialist approved, a date for surgery set. But here's the tragedy: Jack Jennings had died before the letter reached his house, before the surgery was approved. And the letter from the HMO was right there in a pile of mail, surrounded by condolence cards. Mr. President, how can we say with a straight face that HMO's aren't running roughshod over patients in dire need of specialty care. How can we say that this isn't a gross abuse of fundamental patients' rights?

Our access to specialists amendment helps to ensure that patients will be able to secure the health care they need, no matter what the circumstance. All patients with special conditions absolutely must have access to providers who have the expertise to treat their problems.

Our amendment delivers on these common sense propositions: ensuring access to specialists by allowing patients in an HMO network of physicians to find specialty care outside that network at no extra cost if there is no qualified specialist available in the network and allowing patients who are seriously ill or require continued care to have their specialists coordinate their care without being required to ask permission again and again from a primary care provider. The Republican bill does not ensure access to speciality care; it lacks basic protections to ensure that patients can see doctors qualified to treat their condition. For example, if a child with cancer needed access to a pediatric oncologist, there is no guarantee in the Republican bill that she will have access to that specialist.

Not only that, but the Republican bill does not allow patients with diseases or disabilities requiring continuing care by a specialist to designate their specialist as their primary care doctor who can coordinate their care. Under the Republican bill, patients could be charged more for out-of-network specialty care—even if the plan is at fault for not having access to appropriate specialists. The Republican bill would not allow patients to appeal a denial of access to appropriate specialists. If the Republicans pass the legislation that they want to pass, children and adults with diseases such as cancer or severe arthritis will continue to face insurance company red tape when they go for routine visits to the oncologist or rheumatologist.

Mr. President, our opponents will say their bill includes access to specialty care but the fact is that their bill leaves out the key elements needed to ensure access to specialty care. Their bill may have the title Patients' Bill of Rights, but it sure doesn't have the substance. At a time when millions upon millions of Americans are feeling the squeeze from their HMO's, when millions of Americans are suffering needlessly because decisions are being made by bureaucrats rather than doctors, the style without the substance won't do a single thing to make health care better—it won't save Morgan Smith's family from another battle with an HMO when her family's energy should be dedicated to a fight against cancer, it won't do a single thing to prevent the all-too-real suffering that has become standard practice in the maze of red tape that is managed care health care in the United State today. Mr. President, we can do better than the Republican propsoal—we can actually guarantee access to a specialist. And that is a responsibility every one of us ought to work towards fulfilling.

The PRESIDING OFFICER. The Senator's 4 minutes have expired.

Mr. KERRY. Mr. President, it is clear that every American has the right to have a specialist, and we need to pass this amendment in appreciation of that fundamental need and right of our citizens.

The PRESIDING OFFICER. Who yields time?

Mr. JEFFORDS. Mr. President, I yield 5 minutes to the Senator from Pennsylvania.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, the issue of access to specialty care is very important. Many of us represent, as I do, hospitals that are very intensive tertiary care facilities with lots of specialists. Those of us who have had young children have had experience at children's hospitals and have dealt with specialists and recognized the need for that.

I can tell you as a father of four young children and a child who is due in September, I am not going to stand here and say we are not going to provide access to the kind of specialty care for children, or anybody else, that is needed. I am confident that the bill before us does exactly that. It does exactly that. It provides access to specialty care when it is necessary to save or help improve the life of a young child or anybody else.

As an example, if you have a baby who is born with a rare heart disease and the pediatrician recommends that a pediatric cardiologist treat the baby, the claim is made and it is denied initially, and it goes through the internal review process. Specialty care is covered under the contract. Remember, we are dealing with covered benefits, so obviously if it is not a covered benefit, that is a different issue. But if it is covered—and, of course, most HMOs cover some sort of specialty care—it is covered.

But in this case, say the network doesn't have a pediatric cardiologist. So you have, in a sense, what is laid out by the other side, the worst case scenario. The network doesn't have a specialist, and therefore they just won't give this specialist treatment because there isn't a pediatric cardiologist available to treat this. So a regular pediatrician would have to do so.

Well, that is not the case in our bill. Our bill says that this particular denial is eligible for review by an independent external reviewer. The dispute is about who should provide the specialty care. That is an element of medical judgment. Therefore, if it is an element of medical judgment, it is eligible for review. If it is an independent review and the reviewer says yes——

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

Mr. SANTORUM. If I can get through this first. It is eligible for a review. An independent reviewer, under our bill, will look at all of the facts in the case and determine whether, in fact, the pediatric cardiologist is necessary in medical judgment to, in fact, perform this procedure. They make an independent medical determination based on all of the information that is reviewed, including the recommendation of the doctor, the original pediatrician, including the recommendation by the internal reviewer. They look at all of the information, they get all of the relevant facts, and they put this together—as has been listed many times here—a laundry list of factors to consider, and they make an independent judgment as to whether a pediatric cardiologist is necessary. If it is necessary, the denial is overturned. The specialist outside of the network is selected to provide the care for this child within the HMO.

That is in our bill. That is covered under our bill. So all of this talk about we are not going to have this kind of access is not carefully reading this bill. I give a lot of credit to Senator FRIST and Senator JEFFORDS and those on the health committee. They have done an excellent job of looking through and making sure all of these kinds of situations where you have limitations—and in many cases you do have limitations, and the networks don't have a lot of specialists. But you can go outside the network if an independent reviewer determines that is what is medically necessary in that case.

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

Mr. SANTORUM. Yes.

Mr. BINGAMAN. As I understand the bill you are referring to, you say it provides this access. There is no requirement that access to the specialist be provided at the regular amount that is being paid. Whatever the HMO determines the additional cost should be to go to the outside specialist would be charged, is that correct? That is my understanding. I have read the bill fairly carefully, and that is a major difference between the amendment I have offered and the amendment that you are referring to.

The PRESIDING OFFICER. The time allotted to the Senator from Pennsylvania has expired.

Who yields time?

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I yield to the Senator from West Virginia.

PRIVILEGE OF THE FLOOR

Mr. ROCKEFELLER. Mr. President, I ask unanimous consent that Stephen Downs, a health care policy fellow, be given privileges of the floor during consideration of S. 1344.

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

Mr. ROCKEFELLER. Mr. President, yesterday, I talked to a 56-year-old woman I have known for a long time in West Virginia. She has a rare heart disease. She has been struggling with it. She has now discovered that the operation she is potentially going to need is not available for her in West Virginia. She is going to have to go to another State far south in order to get that operation. The problem is that her insurance company said they will not pay for her operation. They said she will either get her operation in West Virginia, where this kind of operation is not readily available because it is rather rare or she won't get it at all, or she has to pay for it herself. She is not a corporate giant. She runs a small business and has six people working for her.

This kind of thing should never happen. The Democratic bill would prevent that from happening. She would be able to go to that southern State where they do this kind of operation constantly and get that operation. That should happen in the United States of America.

Secondly, I talked with the physician of an 8-year-old girl 4 days ago. She has growth problems, seizure problems, and development problems, and she is under the care of a pediatric specialist in endocrinology and neurology at Western University. If you have a pediatric endocrinologist and somebody says you have to use an adult endocrinologist because that is in our plan, well, then people say, well, an endocrinologist is an endocrinologist. Not true. She will be denied care, and that is wrong.

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

Mr. ROCKEFELLER. Under the Democratic bill, she would get pediatric care, and she should.

Mr. JEFFORDS. Mr. President, I yield 1 minute to the Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I wanted to respond to the Senator from New Mexico. My time had run out. My understanding is that the provision in the bill says the network has to provide access to specialty care. We define in the report language clearly what access means as far as cost sharing is concerned:

> When the plan covers a benefit or service that is appropriately provided by a particular type of specialist not in the network, the benefit will be provided using the in-network cost-sharing schedule.

In other words, no additional costs. Only in cases where it is a preference to go outside the network for a specialist, other than somebody in the network, where it has not been referred by the plan or determined by a reviewer, is that additional cost borne. As long as an independent reviewer or the plan refers out of network, the cost sharing is the same.

The PRESIDING OFFICER. Who yields time?

Mr. JEFFORDS. I yield the remaining time to the Senator from Texas.

The PRESIDING OFFICER. The Senator from Texas is recognized for 9 minutes.

Mr. GRAMM. Mr. President, I wanted to come over today and try to end this debate by making a point this debate has cried out for all day.

What we have heard all day long is our Democrat colleagues stand up and attack HMOs. Every horror story they could imagine, every outrage that the human mind could conceive, they have talked about and laid at the doorstep of HMOs. I think someone watching this debate who just got off a turnip truck or who just emerged from a 10-year trip to outer space would believe that our Democrat colleagues hate HMOs and that they are the enemies of HMOs.

But let me remind those who may have just gotten off a turnip truck, or those who may have forgotten what has occurred in America in the last 20 years that you have been listening all day to the fathers and mothers of HMOs. They brought HMOs into Federal statutes. They exempted them from health planning.

They liked HMOs so much that in 1994 they sent this bill to the Congress.

For those who have forgotten it, this is the Clinton health care bill. The Clinton health care bill, which our colleagues who spoke today all supported and uniformly loved, forced every American to go into an HMO that was set up as a local health care cooperative. It was an HMO run by the Government with all the compassion of the IRS and with all of the efficiency of the post office.

They loved HMOs so much and they were so confident in them that they said: If you refuse to join your local health cooperative, HMO, Government-run health care system, we are going to fine you $5,000.

That was their position in 1994.

Now they have taken a poll. They have done a focus group. They do not love HMOs anymore. But in 1994 they loved them so much that they were going to fine every American $5,000 for refusing to join their Government-run HMO.

By the way, they banned suing the HMO when it was their HMO, when it was the Government HMO. They thought we ought not to do it.

Today they are worried about doctors providing care, and that for a doctor under an HMO, they can't do it. But when they were writing their health care bill, they fined a doctor $50,000 if he provided health care that their Government-run health care cooperative, HMO, did not allow.

So under this bill, when you had a health care collective run by the Government—one great big HMO, and if a doctor prescribed a medicine that they didn't allow, or prescribed a treatment, or provided a treatment that they didn't think was medically necessary, that is Dr. Clinton or Dr. Kennedy didn't think was necessary, a doctor could be fined $50,000 under this bill.

If your baby was really sick and they banned the treatment, and if I went to Dr. FRIST and I said, Dr. FRIST, I want my child to have this surgery, I know you can do it, I know that our Government collective HMO bans it, but I am willing to pay you for it, if Dr. FRIST had taken that payment, he would have gone to prison for 15 years under the Clinton health care bill.

These are the people who invented the HMO. They are the people who love HMOs. They are the people who wanted to put us under an HMO and fine us $5,000 for not giving it our money, and it put a doctor in prison for 15 years for violating their statute on what they thought was good medicine.

Today it has been a horror show about HMOs.

I want to conclude. I know people want to go home.

How do they fix this problem? They fix the problem with what they call a Patients' Bill of Rights.

There are two rights that they guarantee.

No. 1, you can look in the blue pages of the phonebook, and you can call up a Government bureaucrat, and you can complain. You can get an appointment. You can go see them next Tuesday at 8 o'clock. You can get a bureaucrat to join you in the examining room. That, to them, is a health care bill of rights.

The second right they guarantee is, you can call up an attorney. You can open up the Yellow Pages. Here is one that says, ''No fees unless we get you money.'' Anyway, whoever you find in here—criminal law, family law, personal injury specialist—you can pick any lawyer you want under their health care bill of rights, and you can call him, and you can sue.

But what you cannot do under their so-called bill of rights that you can do under our bill of rights is, under our bill of rights you can fire your HMO. You can set up a medical savings account and then you can look in the Yellow Pages under ''Physician.'' You can call any physician you want to call, and you can say to them, do you take a check? If they do, with the medical savings account that you can have under our bill with your employer, you can say ''no'' to your HMO. You don't call up the Government, because you don't like how they are treating you, or, go hire a lawyer. You fire your HMO and hire your doctor.

You can see what real freedom is. You can say to the HMO, you haven't done me right, you haven't treated my children right, and you are fired.

Our bill does that. Their bill does not do that.

I cannot end the day without pointing out two things.

One, all day long you have heard from people who invented HMOs and who love them so much that they wanted to put the whole country under HMOs in a mandated Government-run program. And they still do.

Second, their remedy for all of these concerns is, call the Government, or call a lawyer.

Our remedy is to first deal with the real concerns in HMOs with a review process that really works.

But we have one more freedom they don't have. Under our bill, you can fire your HMO. That is what I call real freedom. That is what we provide.

If you have listened all day to these horror stories, please remember, this is a monster that they helped create and that they loved so much, they wanted to mandate that everybody be in it.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, I yield myself 1 minute on the bill.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I am a good friend of the Senator from Texas. I will tell you, Mr. President, the Senator is as wrong in his explanation about the debate here on the floor of the Senate and as wrong about President Clinton's bill on health care as he was about President Clinton's proposal about economic recovery in 1993 when he predicted the end of the free market system, that inflation was going up through the roof, with unemployment lines around the Capitol of the United States. He predicted that deficits were going to grow and it was going to be the end of the American free enterprise system. He was wrong then, and he is wrong tonight.

Mr. President, I yield the last minute to the Senator from South Dakota,

The PRESIDING OFFICER. The Democratic leader.

Mr. DASCHLE. Mr. President, I will take a minute off the bill.

I do not know how you top that. I was simply going to say that if you believe anything the Senator from Texas just said, you are going to buy a turnip truck from him, too.

But I hope everybody can remember what this is all about. This is simply about whether or not patients have the right to a specialist, whether or not the HMO under any circumstances can tell a patient and his or her doctor that, no, you cannot go to a specialist, because in millions of cases around the country today, tomorrow, and for the past several years, that is exactly what has happened.

Do we have access to specialists or not? The Democrats are saying yes, we need access to the specialist. That is the essence of health care in America today. But people are being denied that access. We want to change that. This amendment will do it. It deserves our support.

I yield the floor.

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

The PRESIDING OFFICER. The Republican side controls 1 minute 30 seconds on the amendment.

Mr. GRAMM. Mr. President, I will take a very short amount of time.

If I am so wrong about the Clinton health care bill, I hope tomorrow to offer it as an amendment, and we will give everybody a chance to vote on it. We debated it for 2 years. It was like a great big overinflated balloon. When somebody pricked it with a little pin, all of the air ran out of it. We never got around to voting on it. We have it here. We can send it up tomorrow and give everybody a chance to vote on it.

If Senator KENNEDY thinks it is so right—I know he does in his heart because he is a very sincere person—then he can vote for the Clinton health care bill, and fine these people, and put doctors in prison for 15 years for providing ''unauthorized'' care. Then we will know where we all stand on these issues.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I yield the remainder of our time and ask for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. NICKLES. Mr. President, for the information of all Senators, this will be the last vote tonight. The Senate will go into morning business at 9:30 and be back on the bill at 10 o'clock tomorrow. We expect the first vote to be at approximately noon tomorrow.

The PRESIDING OFFICER (Mr. ALLARD). The question is on agreeing to amendment No. 1245.

On this question, the yeas and nays have been ordered and the clerk will call the roll.

The legislative clerk called the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

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

[Rollcall Vote No. 205 Leg.]

YEAS—47

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

NAYS—53

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

The amendment (No. 1245) was rejected.

Mr. ENZI. Mr. President, I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. ROTH. Mr. President, health care in America is the envy of the world. We have the finest doctors, nurses, and medical care personnel available anywhere. We have the best research facilities and the most advanced—state-of-the-art—technology. We are the world's leader in providing new and effective treatments and therapies. And it doesn't seem that a day goes by without news of some exciting breakthrough in medicine and health.

While this is the good news, there's no question that our health care delivery system also faces some serious challenges. No one argues that there isn't cause for concern when it comes to making high quality health care more affordable, and therefore more accessible, to millions of Americans who currently have no coverage, and for those who may even have coverage, but who are receiving substandard and even poor care.

For the last fifteen years, Congress has been concerned about the skyrocketing costs associated with health care. I remember the dire predictions we listened to in the 1980s and early 1990s. I recall the testimony of OMB Director Dick Darman in 1992, when he warned that given its current rate of increase, total public and private health spending was quickly taking over the Gross National Product. Unless something was done, he said, expenditures—which were less than six percent of GNP three decades earlier—would reach the unmaintainable level of 26 percent of GNP by the year 2030.

One of the innovative answers to curb this dangerous increase was the advent of managed care and the creation of Health Maintenance Organizations. Through this system, millions of Americans found access to health care that was affordable. Small businesses were better able to provide insurance for their employees. And competition between HMOs and other health care providers in the miraculous free market system worked to reduce the exploding costs of coverage. At the same time, it allowed those incentives to work that were continuing to promote new research and development, new therapies and technology, and the daily breakthroughs I mentioned earlier.

Was everything perfect? No. Questions and concerns—very relevant questions and concerns—soon surfaced regarding the quality of care delivered by some of the providers participating in the managed care system. But just as valid as these concerns was the fact that through managed care, millions of satisfied Americans were receiving high quality services that may have, otherwise, been unavailable to them. And because of the influence that managed care was having on the delivery of health care in America, free market principles were continuing to reward innovation and quality, while at the same time creating a new dimension of competition to help control costs.

With this background, we see more clearly the dynamics involved in the issue before us today. As we look to address the need of establishing a patients' bill of rights—and, again, the need is very real—we see clearly how the improvements we incorporate in such a bill of rights must protect Americans and improve the quality of the health care they are receiving while, at the same time, not undermine the strengths of the current system.

This is a delicate balance—one that was of primary importance to the task force that I served on with several of my colleagues. Together, we listened to dozens of experts and consumer representatives. We collected and reviewed reams of information. We reviewed countless areas that might be addressed and looked at countless possibilities for legislative action. There was no question that managed care could be improved. In fact, many providers from within managed care organizations agreed that there were improvements to be made, and it became clear by the evidence we reviewed that a bill of rights is warranted.

Our goal was simple: increase standards and the quality of health care delivered by providers, without excessively escalating costs that would make health care coverage less available to Americans who need it most. There is no question that any time costs go up, those who are most adversely affected are those who are least able to afford the increases. This not only includes the millions of American families that might not have access to health care without competitive managed care providers, but it also includes millions of Medicare beneficiaries who—to receive extra coverage and benefits—are participating in managed care programs.

If attempts to improve the system go to the extreme—opening up, and even encouraging, litigation, or increasing government intervention and regulation, or holding small businesses that provide health care coverage liable for the judgments made by physicians—costs are going to explode; countless individuals and families are going to suffer the adverse consequences.

On the other hand, if improvements focus on protecting the patient while strengthening the current system, then coverage can be expanded, quality can be assured, and even the most vulnerable will be protected. This, Mr. President, is our objective; it's what we intend to do with the Patients' Bill of Rights Act—a well-studied and common sense approach to protecting Americans, while at the same time improving our health care delivery system. The legislation we introduce today not only targets specific problems in the current system, but it will make health care more affordable, more accessible, and give consumers greater choice concerning their own care.

This is accomplished in several ways.

First, this legislation will guarantee patients a more thorough due process than they currently receive when they are denied a benefit by their health plan. This includes an external review by an independent medical expert to determine if a health plan has unfairly denied a benefit. In urgent cases, this review must be completed within 72 hours. This provision is so important because it will ensure that patients get the benefits they are entitled to, when they need those benefits most.

If, for some reason, the safety net of an independent external review process fails, our plan preserves an individual's right to sue his or her health plan in Federal court for all benefit denials. The individual can also sue in State court for malpractice claims.

Beyond this, our legislation increases the choices that are made available to patients by requiring health plans that contract with businesses of 51 or more employees to offer participants the opportunity to receive health care service from out-of-network providers. In this way, consumers will be able to choose providers that best suit their needs.

Outside of encouraging greater choice, our plan effectively increases access to health insurance by making coverage for self-employed Americans 100 percent tax deductible, starting next January. This is a provision that is long overdue. Self-employed individuals have unfairly been limited in the amount of money they can deduct from their taxes for health care coverage, while business and corporations have been able to deduct all the health care benefits they provided their employees. This provision will not only help restore equity, but it will benefit 25 million Americans who are in families headed by a self-insured individual—five million of whom are currently uninsured.

The legislation will require patients to be fully informed concerning their coverage, including cost-sharing requirements, supplemental benefits, out-of-area coverage, options for selecting primary health care providers, access to emergency care, and preventative services. In other words, no more surprises. And this legislation also gives patients the right to request and be given information concerning their plan's administrative details. For example, providers will be required to answer their customers' queries into the licensure and qualifications of the professionals who participate in the providers' plans. They will be required to provide relevant information concerning participating health care facilities and reimbursement methods between the plan and its participating professions, as well as the status of the plan with accrediting organizations. Likewise, consumers can request information about medications that are included in the plan and procedures to obtain medications that may not be a part of the program.

All of these provisions are fundamentally important to the rights that patients should have when dealing with their health care providers. But as you can see, Mr. President, they are constructed and included in this legislation in a way that the benefits are received without adversely influencing accessibility and affordability. In fact, as I have shown, accessibility and affordability will actually increase with this Patients' Bill of Rights Plus Act.

But the benefits of this plan do not stop there. The Patients' Bill of Rights Plus Act includes important prohibitions against gag rules that some health plans use to limit communication between doctors and patients. This legislation will prohibit health plans from restricting their doctors from sharing information and discussing treatment options with their patients.

This legislation will also patients to have direct access to obstetricians, gynecologists, and pediatricians for routine care without referrals.

And it includes important measure to protect sensitive patient information. It prohibits the use of genetic information to deny health care coverage or to set premium rates. And it enhances the role of the Agency for Health Care Quality Research to continue the important effort of improving the system for long-term.

These, too, are important, but perhaps the provisions in this legislation with which I am most pleased are those that will advance research, prevention and treatment for women with cancer and cardiovascular disease. These provisions will expand basic and clinical research, specifically for women, on the underlying causes and prevention of these diseases. Beyond this, the Patients' Bill of Rights Plus Act will fund

extended research related to osteoporosis and women's geriatric concerns. And it will support continued data collection through the National Center for Health Statistics and the National Program of Cancer Registries—two leading women's health data centers.

Mr. President, I don't think there's anyone who can argue with the important measures contained in this bill. It is, indeed, comprehensive. At the same time, it's balanced and constructive. It's the kind of effective leadership Americans expect from Congress—making access to health care easier, not harder, for individuals and small businesses.

It allows the incentives that make our health care system the envy of the world to continue, while it includes new incentives for providers to offer better quality, greater efficiency, and to be more responsive to their customers. While addressing the shortcomings of the current system, this legislation builds on what is good—what is working—in the current system. It expands the real rights of patients and provides for continued research and development in areas that are vitally important to America's changing demographics.

For these important reasons, I encourage all of my colleagues to join us in supporting this Patients' Bill of Rights Plus Act. It is not only comprehensive and very workable, it is constructive and necessary.

Mr. KOHL. Mr. President, I rise to express my strong support for S. 6, the Patients Bill of Rights. After 2 years of partisan struggles, I am pleased that we finally have the opportunity to consider this important bill, which could benefit all 161 million Americans in managed health care plans.

For many years, managed care has helped to rein in the rapidly growing costs of health care. That benefits all patients across the nation and helps to keep health care costs in check.

However, there is a real difference between making quality health care affordable and cutting corners on patient care. In Wisconsin, we are lucky that most health plans do a good job in keeping costs low and providing quality care. But too often across this nation, HMOs put too many obstacles between doctors and patients. In the name of saving a few bucks, too many patients must hurdle bureaucratic obstacles to get basic care. Even worse, too many patients are being denied essential treatment based on the bottom line rather than on what is best for them.

The Patients' Bill of Rights will ensure that patients come first—not HMO profits or health plan bureaucrats. It makes sure that doctors, in consultation with patients, are the ones who decide which treatments are medically necessary. It gives patients access to information about all available treatments and not just the cheapest. Whether to seek emergency care, pursue treatment by a specialist, or try an innovative new treatment—these are hard questions that should be answered by caring physicians and concerned families—not by a calculator. S. 6 puts these decisions back in human hands where they belong.

This legislation will also make sure that health plans are held accountable for the decisions they make. First, all health plans must have an external appeals process in place, so that patients who challenge HMO decisions may take their case to an independent panel of medical experts. And second, if a health plan's decision to deny or delay care results in death or injury to the patient, this bill ensures that the health plan can be held accountable for its actions.

Most importantly, this bill gives all of these protections to all Americans in managed health care plans, not just a few. All 161 million Americans in managed health plans deserve the same protections—no matter what State they live in.

I am shocked by the refusal of some of my colleagues to endorse this commonsense legislation. If you or a member of your family got sick, who would you trust to make decisions about their care? Who would you trust to decide what kind of specialist was necessary? Who would you trust to tell you about all available treatments and not just the cheapest? Wouldn't you insist on having access to the best possible medical care? Most of us would. Why should the 161 million Americans in managed health care deserve less than what we would insist upon?

The answer is, simply, that all Americans deserve access to the best quality health care available. As someone who comes from a business background, I understand the concerns of employers. Some of my colleagues on the other side have claimed that our bill will increase health care costs by as much as $72 billion, making it impossible for employers and families to afford coverage. But the Congressional Budget Office reported that the patient protections in our bill will only increase premiums by 4.8 percent over 5 years. This translates into only $2 per month for the average employee. An independent Coopers & Lybrand study found that our provision to hold health plans accountable—the provision the other side opposes the most—would only cost 3 to 13 cents per person per month. This is a small price to pay to make sure that health plans cover the health care services we all deserve.

I am willing to look at possible improvements to the bill. But there is no reason whatsoever to continue to allow health plans to skimp on quality in the name of saving profits. Patients have been in the waiting room long enough. It is time for the Senate to act and make sure they receive the health care they need, deserve, and pay for.

Mr. BURNS. Mr. President, I wish to talk about health care. I am very proud that this great country of ours provides the best quality of health care in the world. With this comes the question of how to manage the constantly growing costs associated with this and how to guarantee that as many Americans as possible can be provided affordable health care.

Currently, 43 million Americans are uninsured and many more live with the anxiety that they will lose their employer-sponsored health plans if premiums go up. The Congressional Budget Office estimates that Senator KENNEDY's bill, S. 6, will increase private health insurance premiums 6.1 percent above inflation. Data from the Barents Group, an economic consulting firm, reveal an increase of this magnitude will impose hundreds of dollars in hidden taxes on families, eliminate jobs, and cancel the health coverage of millions.

In Montana, farmers, ranchers, and small businesses pull the wagon and are the main source of income in our great state. You can only imagine what would happen if Senator KENNEDY's Patients' Bill of Rights bill passes. Hundreds of Montanans will lose their insurance for their families and quite possibly many could lose their jobs. With the current agriculture prices as low as they this would only make things much worse for Montanans.

The Republican Patients' Bill of Rights bill provides new rights to American patients. This bill will guarantee access to emergency room care, access to the doctor of your choice, access to ob-gyn care without prior authorization and access to a pediatrician without prior authorization. The Republican bill also improves continuity of care if a doctor leaves a health plan and improved access to medication. These are just a few of the things that our Patients' Bill of Rights bill guarantees patients.

I will not vote for a bill that squeezes patients into a one-size-fits-all health plan. We do not want a Washington-knows-best solution. As a former county commissioner I have always believed in local control.

The Republican bill provides tax-free medical savings accounts for patients and allows for 100 percent deductibility of health care costs for the self-employed. Medical savings accounts are similar to individual retirement accounts, except they are used to pay for health care needs instead of retirement. They permit individuals to set aside money, tax-free, to pay for medical expenses.

The Democrats want to pass a bill that would regulate the structure and operation of all health insurance products at the federal level; impose mandates on consumers, health insurers and employers; enable new lawsuits against employers and insurers for unlimited compensatory and punitive damages; and increase the number of uninsured Americans by an estimated 1.9 million.

In contrast the Republican bill guarantees to make health insurance more

affordable for the self-employed by letting them deduct 100 percent of their health premiums in 2000—three years ahead of schedule. The Congressional Budget Office estimates that the Democrats bill, S. 6, would increase health insurance premiums an average 6.1 percent which would force 1.8 million to 1.9 million Americans to lose their health coverage. This bill will also lower household wages an average of $207 annually, and would eliminate 194,000 jobs by 2003.

I am firmly behind a bill in the United States that will provide consumer protections and enhanced health care quality, while keeping insurance affordable and actually expanding access to insurance for millions of Americans.

Under the Republican bill, the patients have the right to talk freely and openly with their doctors about all treatment options and the right to see the doctor of their choice. Even more important, they have the right to a quick and cost-free appeals process if a health plan refuses to cover treatment.

The Republican bill does all these things, and also expands opportunity for millions of uninsured Americans to come into the health care system. We offer tax-free medical savings accounts to all, and extend tax equity to self-employed individuals.

Mr. President, the Republican Patients' Bill of Rights Plus makes sure all Americans have the access and protections they need and want. Americans deserve access to the best doctors and specialists available; reliable information about their doctors and their health plans, and affordable, quality care at every stage of life. This week, I will work to make sure Congress addresses these important issues with a plan that puts you, not a bureaucrat, in control of your health care.

I thank the chair.

MILITARY CONSTRUCTION APPROPRIATIONS ACT, 2000

The PRESIDING OFFICER. Under the order of June 15, 1999, the Senate having received from the House of Representatives the bill H.R. 2465, all after the enacting clause of H.R. 2465 is stricken, and the text of S. 1205, as amended, is inserted in lieu thereof.

Under the previous order, H.R. 2465 is read the third time, and passed, and the motion to reconsider is laid on the table.

The bill (H.R. 2465), as amended, was read the third time, and passed.

The PRESIDING OFFICER. Under the previous order, the Senate insists on its amendment and requests a conference with the House on the disagreeing votes of the two Houses on H.R. 2465, and the Chair is authorized to appoint conferees on the part of the Senate.

The Presiding Officer appointed Mr. BURNS, Mrs. HUTCHISON of Texas, Mr. CRAIG, Mr. KYL, Mr. STEVENS, Mrs. MURRAY, Mr. REID, Mr. INOUYE, and Mr. BYRD conferees on the part of the Senate.

MEASURE INDEFINITELY POSTPONED—S. 1205

The PRESIDING OFFICER. Under the previous order, passage of S. 1205 is vitiated, and the bill is indefinitely postponed.

MORNING BUSINESS

Mr. ENZI. Mr. President, I ask unanimous consent that the Senate now proceed to a period for morning business, with Senators permitted to speak for up to 10 minutes each.

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

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Tuesday, July 13, 1999, the Federal debt stood at $5,625,005,258,555.97 (Five trillion, six hundred twenty-five billion, five million, two hundred fifty-eight thousand, five hundred fifty-five dollars and ninety-seven cents).

One year ago, July 13, 1998, the Federal debt stood at $5,528,489,000,000 (Five trillion, five hundred twenty-eight billion, four hundred eighty-nine million).

Five years ago, July 13, 1994, the Federal debt stood at $4,624,337,000,000 (Four trillion, six hundred twenty-four billion, three hundred thirty-seven million).

Ten years ago, July 13, 1989, the Federal debt stood at $2,800,206,000,000 (Two trillion, eight hundred billion, two hundred six million).

Fifteen years ago, July 13, 1984, the Federal debt stood at $1,534,369,000,000 (One trillion, five hundred thirty-four billion, three hundred sixty-nine million) which reflects a debt increase of more than $4 trillion—$4,090,636,258,555.97 (Four trillion, ninety billion, six hundred thirty-six million, two hundred fifty-eight thousand, five hundred fifty-five dollars and ninety-seven cents) during the past 15 years.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Williams, 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.)

MESSAGES FROM THE HOUSE

At 12:30 p.m., a message from the House of Representatives, delivered by Mr. Hanrahan, 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. 916. An act to make technical amendments to section 10 of title 9, United States Code, and for other purposes.

H.R. 2465. An act making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2000, and for other purposes.

MEASURES REFERRED

The following bill, previously received from the House of Representative for the concurrence of the Senate, was read the first and second times and referred as indicated:

H.R. 1569. An act to prohibit the use of funds appropriated to the Department of Defense from being used for the development of ground elements of the United States Armed Forces in the Federal Republic of Yugoslavia unless that deployment is specifically authorized by law; to the Committee on Foreign Relations.

The following concurrent resolution, previously received from the House of Representatives for the concurrence of the Senate, was read and referred as indicated:

H. Con. Res. 88. Concurrent resolution urging the Congress and the President to increase funding for the Pell Grant Program and existing Campus-Based Aid Programs; to the Committee on Health, Education, Labor, and Pensions.

MEASURE PLACED ON THE CALENDAR

The following bill was read twice and placed on the calendar:

H.R. 1654. An act to authorize appropriations for the National Aeronautics and Space Administration for fiscal years 2000, 2001, and 2002, and for other purposes.

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–4191. A communication from the Director, Regulations Policy and Management, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Medical Devices; Performance Standard for Diagnostic X-ray Systems; Amendment'' (Docket No. 98N–0877), received July 13, 1999; to the Committee on Health, Education, Labor, and Pensions.

EC–4192. A communication from the Secretary of Commerce, transmitting, pursuant to the Anti-Bribery and Fair Competition Act of 1998, the annual report dated July 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4193. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans;

West Virginia: Approval of Revisions to Coal Preparation Plants and Coal Handling Operations'' (FRL # 6372–3), received July 7, 1999; to the Committee on Environment and Public Works.

EC–4194. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''National Emission Standards for Hazardous Air Pollutants: Halogenated Solvent Cleaning'' (FRL # 6376–5), received July 7, 1999; to the Committee on Environment and Public Works.

EC–4195. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans Tennessee: Approval of Revisions to the Tennessee SIP Regarding National Emission Standards for Hazardous Air Pollutants and Volatile Organic Compounds'' (FRL # 6378–4), received July 13, 1999; to the Committee on Environment and Public Works.

EC–4196. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of State Plans for Designated Facilities; New York'' (FRL # 6378–4), received July 13, 1999; to the Committee on Environment and Public Works.

EC–4197. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality State Implementation Plans; Louisiana; Approval of Clean Fuel Fleet Substitution Program Revision'' (FRL # 6378–3), received July 13, 1999; to the Committee on Environment and Public Works.

EC–4198. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Clean Air Act Direct Final Approval of Title V Prohibitory Rule as a State Implementation Plan Revision; Sacramento Metropolitan Air Quality Management District, California'' (FRL # 6378–5), received July 13, 1999; to the Committee on Environment and Public Works.

EC–4199. A communication from the Director, Office of Personnel Management, transmitting, pursuant to law, the report of a rule entitled ''Final Regulations on Lump-Sum Payments for Annual Leave'', received July 13, 1999; to the Committee on Governmental Affairs.

EC–4200. A communication from the Administrator, Small Business Administration, transmitting, pursuant to law, the report of the Office of Inspector General for the period October 1, 1998, through March 31, 1999; to the Committee on Governmental Affairs.

EC–4201. A communication from the Director, Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, a report entitled ''Amendments to Deferred Maintenance Reporting''; to the Committee on Governmental Affairs.

EC–4202. A communication from the Special Counsel, transmitting, pursuant to law, the annual report for fiscal year 1998; to the Committee on Governmental Affairs.

EC–4203. A communication from the Acting Assistant Attorney General, transmitting, pursuant to law, a report entitled ''Attacking Financial Institution Fraud: Fiscal Year 1996''; to the Committee on the Judiciary.

EC–4204. A communication from the Under Secretary of Defense, transmitting, pursuant to law, a report entitled ''Defense Manpower Requirements Report for Fiscal Year 2000''; to the Committee on Armed Services.

EC–4205. A communication from the Under Secretary for Export Administration, Department of Commerce, transmitting, pursuant to law, a report relative to export licenses for commercial communications satellites and related items for the period February 26, 1999 to May 21, 1999; to the Committee on Armed Services.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. MCCAIN, from the Committee on Commerce, Science, and Transportation, without amendment:

S. 1248. A bill to correct errors in the authorizations of certain programs administered by the National Highway Traffic Administration (Rept. No. 106–107).

By Mr. JEFFORDS, from the Committee on Health, Education, Labor, and Pensions, without amendment:

S. Res. 138. An original resolution authorizing expenditures by the Committee on Health, Education, Labor, and Pensions.

By Mr. SHELBY, from the Select Committee on Intelligence, without amendment:

S. Res. 139. An original resolution authorizing expenditures by the Select Committee on Intelligence.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. BURNS:

S. 1362. A bill to establish a commission to study the airline industry and to recommend policies to ensure consumer information and choice; to the Committee on Commerce, Science, and Transportation.

By Mr. DURBIN:

S. 1363. A bill for the relief of Valdas Adamkus, President of the Republic of Lithuania; to the Committee on Finance.

By Mr. BAYH (for himself, Mr. DOMENICI, Mrs. LINCOLN, Mr. LIEBERMAN, Ms. LANDRIEU, Mr. GRAHAM, Mr. LUGAR, Mr. VOINOVICH, Mr. ROBB, Mr. BREAUX, Mr. EDWARDS, and Mr. BINGAMAN):

S. 1364. A bill to amend title IV of the Social Security Act to increase public awareness regarding the benefits of lasting and stable marriages and community involvement in the promotion of marriage and fatherhood issues, to provide greater flexibility in the Welfare-to-Work grant program for long-term welfare recipients and low income custodial and noncustodial parents, and for other purposes; to the Committee on Finance.

By Mr. MURKOWSKI (by request):

S. 1365. A bill to amend the National Preservation Act of 1966 to extend the authorization for the Historic Preservation Fund and the Advisory Council on Historic Preservation, and for other purposes; to the Committee on Energy and Natural Resources.

S. 1366. A bill to authorize the Secretary of the Interior to construct and operate a visitor center for the Upper Delaware Scenic and Recreation River on land owned by the New York State, and for other purposes; to the Committee on Energy and Natural Resources.

S. 1367. A bill to amend the Act which established the Saint-Gaudens Historic Site, in the State of New Hampshire, by modifying the boundary and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. TORRICELLI (for himself, Mr. KERRY, and Mr. CLELAND):

S. 1368. A bill to amend the Forest and Rangeland Renewable Resources Planning Act of 1974 and related laws to strengthen the protection of native biodiversity and ban clearcutting on Federal land, and to designate certain Federal land as ancient forests, roadless areas, watershed protection areas, special areas, and Federal boundary areas where logging and other intrusive activities are prohibited; to the Committee on Energy and Natural Resources.

By Mr. JEFFORDS (for himself, Mr. LIEBERMAN, Mr. MOYNIHAN, Mr. SCHUMER, Mr. KERRY, Mr. LAUTENBERG, Mr. DODD, and Mr. KENNEDY):

S. 1369. A bill to enhance the benefits of the national electric system by encouraging and supporting State programs for renewable energy sources, universal electric service, affordable electric service, and energy conservation and efficiency, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SHELBY:

S. 1370. A bill to amend the Internal Revenue Code of 1986 to extend the time for payment of the estate tax on certain timber stands; to the Committee on Finance.

By Mr. GORTON:

S. 1371. A bill to issue a certificate of documentation with appropriate endorsement for employment in the coastwise trade for the vessel Ocean Pride; to the Committee on Commerce, Science, and Transportation.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. JEFFORDS:

S. Res. 138. An original resolution authorizing expenditures by the Committee on Health, Education, Labor, and Pensions; from the Committee on Health, Education, Labor, and Pensions; to the Committee on Rules and Administration.

By Mr. SHELBY:

S. Res. 139. An original resolution authorizing expenditures by the Select Committee on Intelligence; from the Select Committee on Intelligence; to the Committee on Rules and Administration.

By Mr. CAMPBELL:

S. Res. 140. A resolution congratulating the United States women's soccer team for winning the 1999 Women's World Cup, recognizing the important contribution of each individual team member to the United States and to the advancement of women's sports, and inviting the members of the United States women's soccer team to the United States Capitol to be honored and recognized by the Senate for their achievements; to the Committee on the Judiciary.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BURNS:

S. 1362. A bill to establish a commission to study the airline industry and to recommend policies to ensure consumer information and choice; to the Committee on Commerce, Science, and Transportation.

TRAVEL AGENT COMMISSIONS

Mr. BURNS. Mr. President, I rise today to introduce a bill that will establish a commission to study the future of the travel agent industry and determine the consumer impact of airline interaction with travel agents.

Since the Airline Deregulation Act of 1978 was enacted, major airlines have controlled pricing and distribution policies of our nation's domestic air transportation system. Over the past four years, the airlines have reduced airline commissions to travel agents in an competitive effort to reduce costs.

I am concerned the impact of today's business interaction between airlines and travel agents may be a driving force that will force many travel agents out of business. Combined with the competitive emergence of Internet services, these practices may be harming an industry that employs over 250,000 Americans.

This bill will explore these concerns through the establishment of a commission to objectively review the emerging trends in the airline ticket distribution system. Among airline consumers there is a growing concern that the airlines may be using their market power to unfairly limit how airline tickets are distributed.

Mr. President, if we lose our travel agents, we lose a competitive component to affordable air fare. Travel agents provide a much needed service and without, the consumer is the loser.

The current use of independent travel agencies as the predominate method to distribute tickets ensures an efficient and unbiased source of information for air travel. Before deregulation, travel agents handled only about 40 percent of the airline ticket distribution system. Since deregulation, the complexity of the ticket pricing system created the need for travel agents resulting in travel agents handling nearly 90 percent of transactions.

Therefore, the travel agent system has proven to be a key factor to the success of airline deregulation. I'm afraid, however, that the demise of the independent travel agent would be a factor of deregulation's failure if the major airlines succeed in dominating the ticket distribution system.

Travel agents and other independent distributors comprise a considerable portion of the small business sector in the United States. There are 33,000 travel agencies employing over 250,000 people. Women or minorities own over 50 percent of travel agencies.

The assault on travel agents has been fierce. Since 1995, commissions have been reduced by 30 percent, 14 percent for domestic travel alone in 1998. Since 1995, travel agent commissions have been reduced from an average of 10.8 percent to 6.9 percent in 1998. Travel agencies are failing in record numbers.

Mr. President, I think it is important to study this issue as well as the related issues of the current state of ticket distribution channels, the importance of an independent system on small, regional, start-up carriers, and the role of the Internet.

By Mr. DURBIN:

S. 1363. A bill for the relief of Valdas Adamkus, President of the Republic of Lithuania; to the Committee on Finance.

PRIVATE RELIEF LEGISLATION FOR HIS EXCELLENCY VALDAS ADAMKUS OF LITHUANIA

Mr. DURBIN. Mr. President, I am introducing legislation today on behalf of the current President of Lithuania, His Excellency Valdas Adamkus. President Adamkus is a Lithuanian native and a former U.S. citizen with more than a quarter century of distinguished service to our nation. His election last year to the Lithuanian presidency made necessary his renunciation of his U.S. citizenship. My legislation provides an exemption for President Adamkus from several consequences associated with his renunciation. More specifically, my bill exempts President Adamkus from any expatriate taxes, restores President Adamkus' Social Security benefits, ensures his right to his federal pension, and grants President Adamkus the right to travel freely throughout the United States.

Valdas Adamkus was born on November 3, 1928 in Kaunas, Lithuania. Before immigrating to the United States in 1949, he was involved with Lithuanian resistance efforts against both Nazi Germany and Soviet Russian invaders. Settling in Chicago, President Adamkus remained active in Lithuanian Emigre organizations and helped raise public awareness of Lithuania's occupation by the Soviet Union. Following the return of independence to the Baltics, President Adamkus served as a Coordinator for the United States Aid to the Baltic States, specializing in environmental issues and academic coordination.

President Adamkus is a graduate of the Illinois Institute of Technology, where he earned a B.S. in civil engineering before spending ten years as a consulting engineer. In 1970, President Adamkus joined the newly-created United States Environmental Protection Agency where he initially served as the Deputy Regional Administrator of the fifth region—which includes Illinois, Indiana, Michigan, Minnesota and Ohio. In 1981, President Adamkus was promoted to Regional Administrator for the fifth region, a position he held until his retirement in 1997.

In a distinguished EPA career which stretched 27 years, President Adamkus held a number of leadership positions, including Chairman of the Great Lakes Water Quality Board and Chairman of the United States group that worked with the Soviet Union on water pollution issues. In 1975, he was appointed Advisor to the UN World Health Organization and represented the EPA on environmental issues in the Soviet Union, Eastern Europe, Japan, and China.

In 1985, President Reagan personally presented President Adamkus with the Executive Presidential Rank Award—the highest honor for a civil servant. Other honors he earned include the EPA's highest award, the gold medal for exceptional service, and the EPA's first Fitzhugh Green Award in 1988 for outstanding contributions to environmental protection internationally.

To President Adamkus, the collapse of the Soviet Union in the late 1980s and subsequent liberation of the Baltics marked the successful culmination of his lifelong commitment to Lithuania's freedom. As Lithuania began the long and painful transition from a communist totalitarian system to a free-market economy, Mr. Adamkus emerged as an ideal candidate for the Lithuanian presidency, not only because of his past work for Lithuanian freedom, but also because of the experience he gained through his career as a U.S. civil servant.

Mr. Adamkus was elected President of the Republic of Lithuania on January 4 of last year and took office on February 25. Before assuming the Lithuanian presidency, Mr. Adamkus was required to renounce his U.S. citizenship. As I mentioned at the beginning of my statement, the bill I am offering today provides a limited exemption for President Adamkus from some of the negative consequences associated with renunciation. More specifically, my bill:

(1) Exempts President Adamkus from the expatriate tax. As an expatriate, President Adamkus is subject to sections 877 and 2107 of the Internal Revenue Code, provided it is determined that his renunciation had ''for one of its principal purposes the avoidance of taxes.'' My bill exempts President Adamkus from sections 877 and 2107 by stating that his renunciation shall not ''be treated as having as one of its purposes the avoidance of any Federal tax.''

(2) Restores President Adamkus' Social Security benefits and ensures his right to his federal pension. Title 42 Section 402(t) of the US code denies Social Security benefits to non-citizens residing outside the United States. While Section 433 of that title allows our President to enter agreements with foreign countries which allow non-resident non-citizens to receive pension benefits based on periods of coverage in the United States, the U.S. currently has no such agreement with Lithuania. As a result, President Adamkus is not entitled to the Social Security benefits he earned from 37 years of work in the United States. My bill restores these benefits. My bill also ensures that Mr. Adamkus retains the federal pension he earned as an employee of the EPA.

(3) Restores President Adamkus' right to travel in the United States. As a non-resident alien, Mr. Adamkus no longer has the right to travel freely in the U.S. My bill restores this privilege.

Mr. President, with this bill, I do not suggest that we trivialize the act of renouncing one's U.S. citizenship. Renunciation of U.S. citizenship is an act of

the highest gravity that should not be undertaken without fully considering its consequences. I believe it appropriate, however, that we provide President Adamkus with special treatment in light of his long and distinguished service to our nation, his lifelong commitment to freedom and democracy in Lithuania, and his reason for renunciation. Indeed, it is in the interest of the United States that developing countries—particularly the former Soviet Republics—succeed in establishing free-market democratic societies. Hence, even in renouncing his citizenship, President Adamkus continues to serve our nation admirably. I thank my colleagues for their consideration and urge them to join me in supporting this bill.

Mr. President, I ask unanimous consent that this bill be printed in the RECORD.

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

S. 1363

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That, notwithstanding any other provision of law, the renunciation of United States citizenship by Valdas Adamkus on February 25, 1998, in order to become the President of the Republic of Lithuania shall not—

(1) be treated under any Federal law as having as one of its purposes the avoidance of any Federal tax,

(2) result in the denial of any benefit under title II or XVIII of the Social Security Act, or under title 5, United States Code, or

(3) result in any restriction on the right of Valdas Adamkus to travel or be admitted to the United States.

By Mr. BAYH (for himself, Mr. DOMENICI, Mrs. LINCOLN, Mr. LIEBERMAN, Ms. LANDRIEU, Mr. GRAHAM, Mr. LUGAR, Mr. VOINOVICH, Mr. ROBB, Mr. BREAUX, Mr. EDWARDS, and Mr. BINGAMAN):

S. 1364. A bill to amend title IV of the Social Security Act to increase public awareness regarding the benefits of lasting and stable marriages and community involvement in the promotion of marriage and fatherhood issues, to provide greater flexibility in the Welfare-to-Work grant program for long-term welfare recipients and low income custodial and noncustodial parents, and for other purposes; to the Committee on Finance.

RESPONSIBLE FATHERHOOD ACT OF 1999

• MR. BAYH. Mr. President, I rise today with my good friend Senator DOMENICI to introduce the Responsible Fatherhood Act of 1999.

The irony in our nation's unprecedented economic prosperity is that many Americans still feel the country is on the wrong track—that there is a deterioration of values in our society. There seems to be a fraying of the social fabric and many indicators point to the increase in absentee fathers as the culprit.

America's moms are true heroes in the lives of their children. While most fathers are heroic in their own right, many are not involved enough—too many are completely absent. Fathers can teach kids about respect, honor, duty and the values that make our communities strong. But there has been a troubling decline in the involvement of fathers in the lives of their children over the last 40 years—a decline that should worry us all.

The number of kids living in households without fathers has tripled over the last forty years, from just over 5 million in 1960 to more than 17 million today. The United States leads the world in fatherless families and too many kids spend their lives without any contact with their fathers. The consequences of this dramatic decrease in the involvement of fathers in the lives of their children are severe. When fathers are absent from their lives, children are: five times more likely to live in poverty, twice as likely to commit crime, more likely to bring weapons and drugs into the classroom, twice as likely to drop out of school, twice as likely to be abused, more likely to commit suicide, over twice as likely to abuse alcohol or drugs, and more likely to become pregnant as teenagers.

Community efforts have sprung up around the country to stem the rising tide of fatherless families and encourage responsible parenting. Today I am introducing the Responsible Fatherhood Act of 1999 with Senators DOMENICI, LINCOLN, LIEBERMAN, LANDRIEU, GRAHAM, LUGAR, VOINOVICH, ROBB, BREAUX, EDWARDS, and BINGAMAN. This bill is a fiscally responsible approach that will provide support to states and communities to promote responsible fatherhood.

Specifically, our bill would do three things. First it would raise awareness about the importance of responsible fatherhood by authorizing a public awareness campaign, designed by states and communities, to help change attitudes, particularly among young men, about the responsibilities that go with fathering a child. Second, our legislation creates a block grant program expanding responsible fatherhood promotion programs at the state and local level. The grants would be supplemented by funds and involvement from state and local government, civic, charitable, non-profit and faith-based organizations. Finally, the bill changes existing federal law to encourage a stronger connection between fathers and their children through increased child support to families and more available training through the Welfare-to-Work program for low-income fathers.

Congress alone cannot solve this problem. However, I believe this bill represents an important first step toward reversing the rising tide of fatherlessness in this country. I urge my colleagues to support this important initiative.•

• Mr. DOMENICI. Mr. President, it is with great pleasure that I rise today with Senator BAYH to introduce the Responsible Fatherhood Act of 1999.

Even on its best day the government can never be a replacement for a loving two parent family. As the father of eight I cherish the moments I have spent and will spend with my children because they are my best friends.

But sadly, there is a growing trend among American children, they are growing up without the love and guidance of their fathers and in many cases these children are going years without seeing their fathers.

This trend has taken a terrible toll on not only our children and families, but our nation as a whole. For instance in my home state of New Mexico over 24 percent of families do not have fathers present in the home.

Nationally, the numbers are not any better; nearly 25 million children or 36 percent of all kids live without their biological father and since 1960 the number of children living without their father has jumped from 5 million to 17 million. Additionally, about 40 percent of these children have not seen their father in the last year.

I cannot think of two more important issues facing our nation than the dual goal of promoting marriage and responsible fatherhood. I believe you could describe the role parents play in the lives of their children in the following way: providing love, guidance, and discipline; while at the same time teaching about respect, honor, duty and the values that make our nation so great.

And while we all acknowledge the positive benefits of a two parent family these are more and more families where fathers simply are not present in the lives of their children. I would submit this is a tragedy because a child growing up without a father or a mother simply misses out on something very special.

I recently came across a quotation that I think is appropriate: ''it is a wise father that knows his own child.'' However, the exact opposite is now occurring with a growing trend towards absentee fathers.

The bill we are introducing today seeks to reverse this trend by providing states and communities with support for the dual goal of promoting marriage and responsible fatherhood.

Specifically, the bill: authorizes a public awareness campaign to promote responsible fatherhood and the formation and maintenance of married two parent families.

Additionally, our bill creates a responsible parenting block program to provide support for state and local governments, nonprofit, charitable and religious organizations' efforts to promote responsible fatherhood and the formation and maintenance of married two parent families at the state and local level.

The final component of the bill changes existing Federal law to encourage a stronger connection between fathers and children through increased child support to families and more available training through the Welfare-

to-Work program for low-income noncustodial fathers. There is one provision within this component I would like to specifically focus on and that is the State option to disregard child support collected for purposes of determining eligibility for, or amount of, TANF assistance.

While it is the intent of this section to allow States to disregard certain child support collected that amount is also limited only to cases where states have chosen to pass-through up to $75 of child support payments per month directly to the family and then only that $75 may be disregarded by states.

In closing, I want to encourage my colleagues to lend their support to this important issue and Senator BAYH, I very much look forward to working with you on this exciting piece of legislation.●

● Mr. LIEBERMAN. Mr. President, our society is suffering from the deterioration of the married, two-parent family. According to a recent report by the National Marriage Project at Rutgers, ''The State of Our Unions: The Social Health of Marriage in America,'' marriage rates are at a 40-year low and there are fewer social forces holding them together. As the number of marriages has declined, unwed births have dramatically grown. Unfortunately, the result is more and more children are being born into fragile families.

As the report states, ''Marriage is a fundamental social institution . . . It is the 'social glue' that reliably attaches fathers to children.'' Nearly 25 million children, more than 1 out of 3, live absent their biological father, and 17 million kids live without a father of any kind. Even more troubling, about 40 percent of the children living in fatherless households have not seen their fathers in at least a year, and 50 percent of children who do not live with their fathers have never stepped foot in their father's home.

This growing problem of father absence is taking a terrible toll on those children, who are being denied the love, guidance, discipline, emotional nourishment and financial support that fathers usually provide.

Parents act as a nurturing and stable foundation for children. They are a guiding force to which children readily open their arms. In a recent poll conducted by Nickelodeon and Time magazine, three-quarters of the children, ages six to 14, polled stated that they wished they could spend more time with their parents. In addition, kids consistently ranked parents at the very top of the list when asked to name the people they look up to.

More than friends or teachers, parents shape their children's value systems. As dads disappear, the American family is becoming significantly weaker, as are the values we depend on families to transmit. In turn, the risks to the health and well-being of children are becoming significantly higher. Social science research repeatedly shows that children growing up without fathers are far more likely to live in poverty, to fail in school, experience behavioral and emotional problems, develop drug and alcohol problems, commit suicide, and experience physical abuse and neglect.

We have seen the devastating results of this breakdown in our culture as the number of violent incidences among young males, in particular, rises. Statistics reveal that violent criminals are overwhelmingly males who grew up without fathers.

Concerned citizens and grass-roots groups are paying attention to the statistics, and they are actively seeking solutions neighborhood by neighborhood across the nation. A shining example of this united effort is the National Fatherhood Initiative (NFI) which was formed to help raise awareness of the problem of father absence and its consequences and to mobilize a national response to it. To date, the NFI has made tremendous progress, working in communities across the country to set up educational programs and promote responsible fatherhood.

There are limits to what we in government and here in Congress can do to change society's attitudes toward marriage and out-of-wedlock births, but we are not powerless. I am proud to sign on to the proposal introduced by my colleagues Senators EVAN BAYH and PETE DOMENICI, ''The Resppnsible Fatherhood Act of 1999,'' that will help strengthen fragile families and promote responsible fatherhood, as well as promote the formation and maintenance of married, two-parent families.

I would like to highlight a few key provisions that will significantly increase efforts at the state and local level to reconnect fathers and families, thereby ensuring a brighter, more secure future for our youth.

Unfortunately, few television shows and movies produced today highlight the value of marriage. Cohabitation and out-of-wedlock sex are handled so casually that young people see little incentive for marriage. This bipartisan legislation authorizes a challenge grant to encourage states and local communities to initiate media campaigns that promote responsible fatherhood and the importance of a married, two-parent family in a child's life. Rather than the typical barrage of negative images, young people need to see positive messages on fatherhood and marriage.

States, localities and community organizations are already helping lead the fight at the local level for responsible fatherhood. Their efforts must be bolstered, not hindered. This proposal authorizes a Responsible Parenting Block Grant to provide support for state and local government, nonprofit, charitable and religious organizations' efforts.

No one solution exists that will reconnect fathers and families, but a combined effort can make a difference. That is why a national clearinghouse would be established to facilitate the exchange of ideas and sharing of success stories. Such a clearinghouse also would produce and distribute resources to aid those leading the charge at the community level. The National Fatherhood Initiative has been highlighted as an exemplary group to house such a clearinghouse.

Although many fathers desire to make a financial contribution to their family, they are unable to because they lack the necessary skills to obtain jobs. In 1997, Congress passed Welfare to Work legislation to help the hardest-to-employ welfare recipients and low-income, non-custodial parents move into jobs. Unfortunately, many states have not been able to use their full funding because of restrictive federal guidelines. The Responsible Fatherhood Act will provide states and cities the flexibility they need to serve a broader group of low-income, noncustodial fathers, and provide services to increase the employment and parenting skills of eligible fathers.

Under the current system, fathers with children on welfare are discouraged from paying child support as payments are instead typically shifted to state agencies to offset welfare benefits. Research demonstrates that fathers are more connected with their children and more likely to pay child support when they believe their payment is going directly to their family, and not the government. Children on welfare are precisely the children who have been identified as group most in need of father involvement, and we should eliminate any barriers that prevent this critical bond from taking place. Therefore, this legislation would establish the federal government as a partner to states that want to exercise an option to pass-through up to $75 of child support payments per month directly to the family without impacting welfare eligibility.

Implementing new innovative fatherhood initiatives should not be a rigorous, burdensome process. States should have the flexibility to use child-support funds on programs that support and promote fatherhood instead of paying funds back to TANF. Getting fathers back to work and reconnected to their families will do more to move families off of welfare permanently.

The Responsible Fatherhood Act of 1999, I believe, marks a major turning point in the politics of the family as is evidenced by the solid bipartisan consensus coalescing behind this proposal. Promoting responsible fatherhood does not take away from the efforts of single mothers, but helps ensure that children receive the benefits provided by two caring parents. Addressing the critical role fathers play in the lives of their children is no longer a politically taboo topic. The research is convincing and, unfortunately, mounting every year—children need the support and involvement of both parents to lead happy, healthy, productive lives.

I thank Senators BAYH and DOMENICI for leading this effort. I am proud to join them as a cosponsor.●

By Mr. MURKOWSKI (by request):

S. 1365. A bill to amend the National Preservation Act of 1966 to extend the authorization for the Historic Preservation Fund and the Advisory Council on Historic Preservation, and for other purposes; to the Committee on Energy and Natural Resources.

AUTHORIZATION FOR THE HISTORIC PRESERVATION FUND AND THE ADVISORY COUNCIL ON HISTORIC PRESERVATION

Mr. MURKOWSKI. Mr. President, at the request of the administration, I rise today to introduce legislation to extend the authorization for the Historic Preservation Fund, and for other purposes.

I ask unanimous consent that the bill, a summary of the legislation, and the administration's letter of transmittal be printed in the RECORD for the information of my colleagues.

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

S. 1365

Be it enacted by the Senate and the House of Representatives of the United States in Congress assembled,

That the National Historic Preservation Act of 1966 (P.L. 89–665; 80 Stat. 915; 16 U.S.C. 470) is amended—

(1) in section 108 (16 U.S.C. 470h), by striking ''1997'' and inserting ''2005''; and

(2) in section 212(a) (16 U.S.C. 470t(a)), by striking ''2000'' in the last sentence and inserting ''2005''.

SUMMARY

This legislation amends the Historic Preservation Act of 1966 to extend the authorization of $150,000,000 per year for the Historic Preservation Fund through fiscal year 2005 and the authorization of $4,000,000 per year for the Advisory Council on Historic Preservation. The fund is currently authorized through fiscal year 1996, and the Council through fiscal year 2000.

U.S. DEPARTMENT OF THE INTERIOR,
OFFICE OF THE SECRETARY,
Washington, DC, April 9, 1999.

Hon. ALBERT GORE, JR.,
President of the Senate, Washington, DC.

DEAR MR. PRESIDENT: Enclosed is a draft of a bill ''to extend the authorization for the Historic Preservation Fund, and for other purposes. Also enclosed is a section-by-section analysis of the bill. We recommend that the bill be introduced, referred to the appropriate committee for consideration, and enacted.

The enclosed bill would amend the Historic Preservation Act of 1966 to extend the authorization of $150,000,000 for the Historic Preservation Fund through the year 2005. The fund is currently authorized at $150,000,000 per year through 1997. In addition, the enclosed bill would amend the 1966 Act to extend the current authorization of $4,000,000 for the Advisory Council on Historic Preservation through 2005. The Counsel's authorization expires at the end of fiscal year 2000.

The Historic Preservation Act of 1966 provides for the protection of significant historic properties across the country. It encourages and supports America's effort to preserve the tangible evidence of our past for the benefit and enjoyment of future generations. As part of the National Historic Preservation Act, Congress established the Historic Preservation Fund to carry out the provisions of the bill.

The purpose of this measure is to continue this successful program of protecting historic structures and sites. For over 30 years, since the passage of the National Historic Preservation Act, private citizens, industry, Federal, state, local and tribal governments have worked together to create a cost-effective, successful program. These unique partnerships have resulted in the preservation of historic places, which are the tangible embodiment of American history.

The Office of Management and Budget has advised that there is no objection to the enactment of the enclosed draft legislation from the standpoint of the Administration's program.

Sincerely,

STEPHEN C. SAUNDERS,
Acting Assistant Secretary for Fish and Wildlife and Parks.

By Mr. MURKOWSKI (by request):

S. 1366. A bill to authorize the Secretary of the Interior to construct and operate a visitor center for the Upper Delaware Scenic and Recreation River on land owned by the New York State, and for other purposes; to the Committee on Energy and Natural Resources.

UPPER DELAWARE SCENIC AND RECREATION RIVER LEGISLATION

Mr. MURKOWSKI. Mr. President, at the request of the administration, I rise today to introduce legislation to construct and operate a visitor center for the Upper Delaware Scenic and Recreational River on land owned by the State of New York, and for other purposes.

I ask unanimous consent that the bill, a section-by-section analysis of the legislation, and the administration letter of transmittal be printed in the RECORD for the information of my colleagues.

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

S. 1366

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 ''Upper Delaware Scenic and Recreational River Mongaup Visitor Center Act of 1999.''

SEC. 2. FINDINGS.

(1) the Secretary of the Interior approved a management plan for the Upper Delaware Scenic and Recreational River, as required by P.L. 95–625 (16 U.S.C. 1274 note), on September 29, 1987;

(2) the river management plan called for the development of a primary visitor contact facility located at the southern end of the river corridor;

(3) the river management plan determined that the visitor center would be built and operated by the National Park Service;

(4) the Act which designated the Upper Delaware Scenic and Recreational River and the approved river management plan limits the Secretary of the Interior's authority to acquire land within the boundary of the river corridor; and

(5) the State of New York authorized on June 21, 1993, a 99–year lease between the New York State Department of Environmental Conservation and the National Park Service for the construction and operation of a visitor center by the Federal government on state-owned land in the Town of Deerpark, Orange County, New York in the vicinity of Mongaup, the preferred site for the visitor center.

SEC. 3. AUTHORIZATION OF VISITOR CENTER FOR UPPER DELAWARE SCENIC AND RECREATIONAL RIVER.

For the purpose of constructing and operating a visitor center for the Upper Delaware Scenic and Recreational River and subject to the availability of appropriations, the Secretary of the Interior may—

(a) enter into a lease with the State of New York, for a term of 99 years, for State-owned land within the boundaries of the Upper Delaware Scenic and Recreational River located at an area known as Mongaup near the confluence of the Mongaup and Upper Delaware Rivers in the State of New York; and

(b) construct and operate a visitor center on land leased under paragraph (a).

SEC. 4. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary to carry out the purposes of this Act.

SECTION-BY-SECTION ANALYSIS—UPPER DELAWARE SCENIC AND RECREATIONAL RIVER

Section 1. SHORT TITLE.—Provides a short title for the Act—''Upper Delaware Scenic and Recreational River Mongaup Visitor Center Act of 1999.''

Section 2. FINDINGS.—Provides a discussion regarding the need for a visitor center at the Upper Delaware Scenic and Recreational River including references in the enabling legislation for the river and general management plan. Also cites the State of New York's granting of permission of construction and operation of the facility on state-owned land.

Section 3. AUTHORIZATION OF VISITOR CENTER.—Provides the Secretary of the Interior the authority to enter into a lease with the State of New York for a term of 99 years and authorizes the Secretary to construct and operate a visitor center on the leased property.

Section 4. AUTHORIZATION OF APPROPRIATIONS.—Authorizes funds that may be necessary to carry out the purposes of this Act.

DEPARTMENT OF THE INTERIOR,
OFFICE OF THE SECRETARY,
Washington, DC, April 30, 1999.

Hon. ALBERT GORE, Jr.,
President of the Senate, Washington, DC.

DEAR MR. PRESIDENT: Enclosed is a draft bill ''To authorize the Secretary of the Interior to construct and operate a visitor center for the Upper Delaware Scenic and Recreational River on land owned by the State of New York, and for other purposes.'' We recommend the bill be introduced, referred to the appropriate committee, and enacted.

The legislation would authorize the Secretary of the Interior to construct and operate a visitor center on state-owned land within the boundary of the Upper Delaware Scenic and Recreational River. The Act which established the Upper Delaware Scenic and Recreational River severely limited the Secretary's authority to acquire land. The approved general management plan for the river calls for the development of a visitor center and determined that the best location for such a center was at Mongaup near the confluence of the Mongaup and Delaware Rivers.

The preferred site is on property owned by the State of New York and administered by the New York Department of Environmental Conservation. The New York State Legislature authorized the Department of Environmental Conservation to enter into a lease with the National Park Service for the construction and operation of a visitor center on the preferred site.

This legislation is necessary because the Secretary of the Interior is not authorized to expend federal funds for the construction and operation of a facility on non-federal land. Passage of this legislation would provide the authority for the Secretary to enter into a lease with the State of New York and to subsequently develop a visitor center on the site thus implementing a significant element of the Upper Delaware Scenic and Recreational River's River Management Plan.

The Office of Management and Budget has advised that there is no objection to the enactment of the enclosed draft legislation from the standpoint of the Administration's program.

Sincerely,

DONALD J. BARRY,
Assistant Secretary for Fish and Wildlife and Parks.

By Mr. MURKOWSKI (by request):

S. 1367. A bill to amend the Act which established the Saint-Gaudens Historic Site, in the State of New Hampshire, by modifying the boundary and for other purposes.

SAINT-GAUDENS HISTORIC SITE LEGISLATION

Mr. MURKOWSKI. Mr. President, at the request of the administration, I rise today to introduce legislation to modify the boundaries of Saint-Gaudens National Historic Site, in the State of New Hampshire.

I ask unanimous consent that the bill, a section-by-section analysis of the legislation, and the administration's letter of transmittal be printed in the RECORD for the information of my colleagues.

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

S. 1367

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled,

The Act of August 31, 1964 (78 Stat. 749), which established Saint Gaudens National Historic Site is amended:

(1) in Section 3 by striking ''not to exceed sixty-four acres of lands and interests therein'' and inserting ''215 acres of lands and buildings, or interests therein'';

(2) in Section 6 by striking ''$2,677,000'' from the first sentence and inserting ''$10,632,000''; and

(3) in Section 6 by striking ''$80,000'' from the last sentence and inserting ''$2,000,000''.

SECTION-BY-SECTION ANALYSIS—SAINT-GAUDENS NATIONAL HISTORIC SITE

Amends the Act of August 31, 1964, which originally established the historic site.

Amendment (1).—Authorizes the Secretary to acquire additional lands, up to 215 acres, which will be added to the historic site.

Amendment (2).—Increases the authorized development ceiling for the site to $10,632,000, to allow for the implementation of the approved general management plan.

Amendment (3).—Increases the authorized land acquisition ceiling for the site to $2 million, to allow for the acquisition of the lands identified for expansion in the general management plan.

DEPARTMENT OF THE INTERIOR,
Washington, DC, April 30, 1999.

Hon. ALBERT GORE, Jr.,
President of the Senate,
Washington, DC.

DEAR MR. PRESIDENT: Enclosed is a draft bill ''to amend the Act, which established the Saint-Gaudens National Historic Site, in the State of New Hampshire, by modifying the boundary and for other purposes.'' We recommend the bill be introduced, referred to the appropriate committee, and enacted.

The purpose of the legislation is to authorize the Secretary to expand the boundary at the site in response to the recommendations of the general management plan completed in 1996. The legislation would also increase the land acquisition ceiling and the development ceiling for the site so as to allow the acquisition of lands identified for expansion in the general management plan and to address the site development program outlined in the plan.

The present boundary of Saint-Gaudens National Historic Site includes approximately 150 acres. The majority of this acreage is the historical zone of the historic site and therefore unavailable for the development of visitor service facilities, parking, administrative offices and facilities, or new exhibition space. The enlarged boundary would allow for the development of such facilities. The current natural areas that are part of the site would be protected with the addition of adjacent property and the viewshed from the historic area would also be protected.

The Office of Management and Budget has advised that there is no objection to the enactment of the enclosed draft legislation from the standpoint of the Administration's program.

Sincerely,

DONALD J. BARRY,
Assistant Secretary for Fish and Wildlife and Parks.

By Mr. TORRICELLI (for himself, Mr. KERRY, and Mr. CLELAND):

S. 1368. A bill to amend the Forest and Rangeland Renewable Resources Planning Act of 1974 and related laws to strengthen the protection of native biodiversity and ban clearcutting on Federal land, and to designate certain Federal land as ancient forests, roadless areas, watershed protection areas, special areas, and Federal boundary areas where logging and other intrusive activities are prohibited; to the Committee on Energy and Natural Resources.

THE ACT TO SAVE AMERICA'S FORESTS

● Mr. TORRICELLI. Mr. President, today, Senator KERRY and I are introducing the Act to Save America's Forests. When this country was founded over two hundred years ago, there were hundreds of millions of acres of virgin forest land across what is now the United States. Today, 95 percent of those original virgin forests have been cut down.

Our Federal forests are unique and precious public assets. Large, unbroken forest watersheds provide high-quality water supplies for drinking, agriculture, industry, as well as habitat for recreational and commercial fisheries and other wildlife. The large scale destruction of natural forests threatens other industries such as tourism and fishing with job loss. As a legacy for the enjoyment, knowledge, and well-being of future generations, provisions must be made for the protection and perpetuation of America's forests.

Clearcutting, even aged logging practices, and timber road construction have been the preferred management practices used on our Federal forests in recent years. These practices have caused widespread forest ecosystem fragmentation and degradation. The result is species extinction, soil erosion, flooding, declining water quality, diminishing commercial and sport fisheries, including salmon, and mudslides. Mudslides in Western forest regions during recent winter flooding have caused millions of dollars of environmental and property damage, and resulted in several deaths.

An environmentally sustainable alternative to these practices is selection management: the selection system involves the removal of trees of different ages either singly or in small groups in order to preserve the biodiversity of the forest.

Destructive forestry practices such as clearcutting on Federal lands was legalized by the passage of the National Forest Management Act of 1976. From 1984 to 1991, an average of 243,000 acres were clearcut annually on Federal lands. During the same time period an average of only 33,000 acres were harvested using the protective selection management practices. Proclearcutting interpretations of forestry laws have also been used by Federal managers to promote even age logging and road construction. In addition, the laws are not effective in preserving our forests because in many cases judges do not allow citizens standing in court to ensure that the Forest Service or other agencies follow the environmental protections of the law.

I am introducing this legislation to halt and reverse the effects of deforestation on Federal lands by ending the practice of clearcutting, while promoting environmentally compatible and economically sustainable selection management logging. It is important to note this legislation would only apply to Federal forests which are currently supplying less than 6 percent of America's timber consumption. According to a recent Congressional Research Service report we can reduce timber supply from the national forests and still meet our nation's timber needs. The vast majority of the 490 million acres of harvestable timber are privately owned and unaffected by the bill.

This legislation puts forward positive alternatives that will achieve two principal policies for our Federal forests. First, the Act would ban logging and road-building in remaining core areas of biodiversity throughout the Federal forest system including roadless areas, specially designated areas and 13 million acres of Northwest Ancient Forests. Second, in non-core areas it would abolish environmentally destructive forms of logging such as clearcutting and even aged logging.

The Act requires selection management logging practices to be used. Therefore, timber companies would only be allowed to log a certain percentage of the forests over specified periods of time. Further it takes extra

steps to protect watersheds and fisheries by prohibiting logging in buffer areas along streams, lakes, and wetlands. The Act would also call for an independent panel of scientists to develop a plan to restore and rejuvenate those forests and their ecosystems that are damaged from decades of these logging practices. And finally, the legislation would empower citizen involvement in insuring compliance with environmental protections of forest management laws by making certain that all citizens have standing to pursue actions in court.●

● Mr. KERRY. Mr. President, I want to speak for a few minutes today in support of the Act to Save America's Forests. Over the past 200 years, 95 percent of America's forests have been logged. The Act to Save America's Forests is an effort to save the remaining 5 percent of these original forests.

The legislation is based on our best science and recognizes that we can preserve our national forests for future generations and still harvest the renewable resource of timber. It is supported by over 600 scientists, who wrote to Congress that the act will ''give our nation's precious forest ecosystems the best chance for survival and recovery into the 21st century and beyond.''

The truth is, this bill represents a prudent approach. It has been criticized by those who want to ban all logging on national lands and by those who feel that our current forest policy is too restrictive. I am optimistic that it will bring opposing sides together around common progress.

The Act to Save America's Forests will protect some of the most treasured wild lands in America. Millions of Americans visit our national forests every year, generating more than $100 billion for local economies. In our forests, families hike, fish, boat, mountain climb, bird watch ad even dog sled. And, they act as watersheds and are home to rare species.

In Oregon, our national forests have trees over 1,000 years old. The Sequoia National Forest in California is home to the world's oldest trees. These are true natural—and national—treasures.

In New England, we have the Green Mountain and White Mountain National Forests. Only 100 miles from Boston, they are home to Mt. Washington, the Old Main of the Mountain and the Appalachian Trail. These are favorite spots for our citizens to backpack, ski, canoe, kayak and witness the fall foliage.

The remaining unbroken forests in the Green Mountain draw wildlife from great distances, such as migratory song birds from central and South America. The Lamb Brook, Glastenbury and Robert Frost Mountain forests, which are threatened with clearcut logging, are critical habitat for New England's black bear population, who needs these remote areas of solitude to breed and forage. The Act to Save America's Forests would permanently protect these forests and their biodiversity from logging or roadbuilding.

Today, there are 490 million acres of harvestable timberlands in the United States. Only approximately 20 percent of this harvestable timberland, some 98 million acres, are owned by the Federal Government and would be impacted by the Act to Save America's Forests. The remaining 80 percent of the harvestable timberland is on private land, and would not be regulated by the Act to Save America's Forests.

The major provisions of the Act to Save America's Forests will ban logging and road building of any kind in 13 million acres of ''core'' national forest. Core forests include ancient forest and biologically significant and roadless areas. Only environmentally compatible, sustainable logging would be permitted outside of the protected core forest areas. Clearcutting and even age logging would be banned on all federal lands. The Act will protect watersheds and fisheries by prohibiting logging within 300-foot buffer areas along streams and lakes. It directs the Federal agencies to protect and restore native biological diversity. Finally, it establishes a panel of scientists to provide guidance on Federal forest management.

I want to thank Senator TORRICELLI for introducing this legislation and Representative ANNA ESHOO for offering similar legislation in the House of Representatives. I strongly support this effort to balance our need to preserve and restore our national forests while allowing for the harvest of the renewable resource these forests provide.●

By Mr. JEFFORDS (for himself, Mr. LIEBERMAN, Mr. MOYNIHAN, Mr. SCHUMER, Mr. KERRY, Mr. LAUTENBERG, Mr. DODD, and Mr. KENNEDY):

S. 1369. A bill to enhance the benefits of the national electric system by encouraging and supporting State programs for renewable energy sources, universal electric service, affordable electric service, and energy conservation and efficiency, and for other purposes; to the Committee on Energy and Natural Resources.

CLEAN ENERGY ACT OF 1999

Mr. JEFFORDS. Mr. President, I rise today to introduce the Clean Energy Act of 1999, for myself and Senators LIEBERMAN, MOYNIHAN, SCHUMER, KERRY, LAUTENBERG, DODD, and KENNEDY.

Air pollution from dirty power plants threatens the health of lakes, forests, and people across our Nation. Today, we call for an end to code red air pollution alerts, smog filled afternoons and chemical induced haze. Today, we will introduce legislation to protect our environment from the damaging effects of air pollution and move our Nation closer to a sensible energy future.

Why should we live with smog, acid rain and code red summer afternoons when the technology is here to capture the sun and wind in our backyard? It is time for our Nation to transition from smokestacks, coal power and smog to a future with windmills, solar power and blue skies. Like the wall in Berlin, we hope to watch the dirty power plants dismantled brick, by brick, knowing that once again we can breath freely.

As the U.S. PIRG report indicates, air pollution produced from dirty power plants has skyrocketed. With recent wholesale deregulation, coal fired power plants increased their output almost 16%. This has got to end.

Electric utility deregulation has the potential to save consumers millions of dollars in energy costs. At the same time, deregulation can move us away from reliance on dirty fossil fuels. A study by the Union of Concerned Scientists showed that we can decrease electricity prices by 13% while still achieving great public and environmental benefits.

Electricity prices in the Northeast are double those in the Midwest. Under current law, old, dirty coal fired power plants in the Midwest are exempt from the same air quality standards that our plants meet. Their emissions settle into our streams, forests, eyes, and lungs. They get the benefit, we get the cost.

Not anymore. Our bill will level the playing field for clean Northeast utility companies. It will knock dirty upwind coal burners out of the competitive arena. It will give our utilities the ability to compete successfully in deregulated markets.

Our proposal will cap emissions from generation facilities, forcing old coal plants to meet tighter air quality standards or shut down. We attack pollutants that lead to smog, acid rain, mercury contamination and ground-level ozone.

Our bill will put in place a nationwide wires charge to create an electric benefit fund to develop renewable energy sources and promote energy efficiency and universal access. It will mandate that generation facilities purchase increasing percentages of renewable power each year. We begin at 2.5% in 2000 and increase to 20% renewables by 2020. Either buy renewables, or don't play in the market place.

Our legislation will make it cheaper and easier for consumers to install renewable energy sources in their homes, farms, and small businesses by simplifying the metering process. And finally, our bill has a comprehensive disclosure provision, giving consumers honest and verifiable information regarding their energy choices.

Our Nation's future depends on clean, reliable energy. We can end dirty air from tall utility smokestacks. We can capture the global market for renewable energy. We can stop acid rain from killing our forests and we can keep our summer days from being ozone days. We can increase our energy security. And we can do all this while saving consumers millions of dollars on their utility bills.

Mr. LIEBERMAN. Mr. President, I am pleased today to join with my distinguished colleague from Vermont to introduce the Clean Energy Act of 1999. This landmark legislation provides a comprehensive, long-term blueprint for fulfilling the promise of fishable rivers, swimable streams, and clean, breathable air as envisioned by the groundbreaking Clean Water and Clean Air Acts.

As Senator JEFFORDS has explained, the Clean Energy Act would reduce emissions of the full range of pollutants that damage human health and the global environment. The public health standards embodied in this bill are ambitious. But they reflect the significant strides Northeastern utilities have made in recent years to reduce pollution from electric power plants. They also reflect the reality that goals can, and must, be achieved regionally and nationally if we are to ensure clean air and clean water for every community.

As utilities invest in control technologies to help them meet existing and future clean air requirements, they face difficult choices. Some technologies control for one pollutant, while exacerbating emissions of another and often utilities make large capital investments without knowing what pollutant reductions may be required of them in the future. The Clean Energy Act will bring order to the equation by providing a comprehensive but flexible guide for controlling the full range of pollutants associated with electricity generation, including nitrogen oxides, sulphur dioxide, mercury, and carbon.

The Clean Energy Act will help reduce emissions of nitrogen oxides that lead to smog that makes it difficult for children, asthmatics, and the elderly to breathe. It will help reduce acid rain by reducing the amount of sulphur that our smokestacks pump into the air.

The bill will accelerate efforts to make the fish in rivers safe to eat by lowering the amount of mercury introduced into the food chain. And it will help reduce the U.S. contribution to the problem of climate change by recognizing carbon dioxide as a pollutant of the global atmosphere.

Last year, I introduced a bill designed to close a loophole in the Clean Air Act that exempts older power plants from rigorous environmental standards. We know that to ensure fairness in an era of increasing competitiveness, we must strengthen pollution controls so that dirty power plants don't gain an unfair share of the market while polluting at higher rates than cleaner, more efficient utilities. The Clean Energy Act builds on the effort begun last year, by requiring all plants, no matter what their vintage, to meet the same standards.

Electricity deregulation carries the promise of enormous benefits for the consumer—mainly in reduced electric bills—which I strongly support. But electricity deregulation can also cause adverse environmental and public health consequences if we don't do it right.

The principles behind the Clean Energy Act—comprehensive control of pollutants and equitable across-the-board standards, enhanced by emissions trading—provide a vision for how the electricity industry and our economy can grow even as we improve the quality of our air and water for generations to come.

● Mr. KERRY. Mr. President, I rise today to make a few remarks in support of the Clean Energy Act of 1999.

There is a strong consensus in Congress, and throughout the nation, that it is time to restructure our electric utility industry. The driving force behind this consensus is the potential to save working families and businesses billions of dollars in their electricity bills as competition replaces regulated markets and drives down costs.

The Clinton Administration has estimated that the nation may save as much as $20 billion through restructuring, and other estimates are even higher. Some twenty states, including Massachusetts, have already acted to bring competition to their state industry and capture these savings.

In addition to saving billions of dollars, electric utility restructuring also presents us with the opportunity to enhance environmental protections. The Clean Energy Act of 1999 advances environmental goals that I believe should be considered as part of the final electric utility restructuring proposal passed by the Senate—and that is why I am an original cosponsor.

I know that some in Congress have argued that we should not include environmental protections in a utility restructuring proposal. I think that would be a grave mistake, because some—by no means all—power plants are the source of too much pollution to be ignored.

In Massachusetts, for example, five power plants release more than 90 percent of the pollution from power plants in the state. If each of these plants met modern standards, it would reduce as much pollution as taking more than 750,000 cars off the road. And, while Massachusetts struggles with some of these dirty plants, many more can be found in the Midwest and other parts of the nation.

The consequences of this pollution are significant. In the Northeast we experience frequent and widespread violations of national health standards for ozone. Long-term exposure to ozone may increase the incidence of respiratory disease and premature aging of the lungs. Acid deposition, whose source may be plants far outside of the Northeast, degrades public health and damages aquatic and terrestrial ecosystems. Mercury, which is highly poisonous, accumulates in aquatic species. Finally, carbon dioxide pollution continues to accumulate in the atmosphere and increase the potential for destructive and irreversible climate change.

The Clean Energy Act of 1999 would put in place important public health and environmental policies. Most importantly, it would level the playing field by requiring old, heavily-polluting power plants that are now exempt from health and environmental standards, to clean up. This is important for New England, because while many of these plants are located in the Midwest, their pollution is carried through weather patterns to our air, forests, lakes, streams and lungs.

We should close this loophole. Many energy companies have achieved environmental improvements, and those achievements should not be minimized, but the fact remains that electricity generation from old, heavily-polluting power plants increased 15.8 percent from 1992 to 1998, nationwide.

I want to add that I have heard from the citizens of Massachusetts who live around old coal and oil plants that pollute far more than newer plants. They feel strongly that all plants should comply with environmental standards and employ the best environmental technology, and that no family should be forced to live in the shadows of a plant that may cause environmental harm.

In addition to having tougher standards and closing loopholes in current law, the Act would require the Environmental Protection Agency to review any plant that emits excessive pollution through pollution permit trading to determine whether it is causing adverse local environmental and health impacts. As a result, the bill allows for robust trading so that we can capture all of its economic and broader environmental benefits, but only when it does not harm local communities.

Finally, other provisions of the Act will benefit the environment and make the U.S. a leader in clean energy technologies. For example, it would require that a percentage of the Nation's power is generated by solar, wind and other renewable sources. For years we have given heavily-polluting plants a free ride. Now it is time to reverse course and create a market force to bolster our renewable energy technologies so that we will have a growing clean power industry as we start the 21st Century.

I thank Senator JEFFORDS for introducing the Clean Energy Act of 1999, and I am pleased to join Senators LIEBERMAN, MOYNIHAN, SCHUMER, KENNEDY, DODD, and LAUTENBERG as an original cosponsor. I hope this legislation will help shape the Senate debate over utility restructuring and ensure that provisions to protect the environment and the public health will be part of the final legislation.●

By Mr. SHELBY:

S. 1370. A bill to amend the Internal Revenue Code of 1986 to extend the time for payment of the estate tax on certain timber stands; to the Committee on Finance.

TIMBERLAND CONSERVATION AND TAX RELIEF ACT OF 1999

Mr. SHELBY. Mr. President, I recently introduced legislation that would amend our estate taxation laws to correct a highly unjust situation that regularly occurs throughout our country. The problem I am referring to is the difficult situation persons who inherit valuable timberland often find themselves. Because the timberland is usually the major estate asset, the estate frequently lacks the liquidity to pay the hefty tax burden. Therefore, many times persons are forced to harvest the timber or even worse, to sell portions of the land, just to be able to meet this large tax liability.

Besides essentially invalidating many testamentary gifts, such a tax policy creates numerous economic and ecological problems. As estate taxes are due nine months after a decedent's death, the current law strongly encourages persons to harvest the timber regardless of it's maturity, prevailing price or demand. Encouraging such behavior not only leads to economic waste, but also discourages responsible use of a valued natural resource. The decision of if and when to harvest timberlands should be made by the individual landowner after he has considered the current market, tree maturity and other relevant factors. It certainly should not be based on an uncompromising tax code that completely disregards these critical factors.

Mr. President, the decision to sell the land is in no way a viable alternative to premature harvesting. Selling portions of a contiguous tract leads to fragmentation of the land, which in turn can lead to legal disputes and other inefficiencies. Furthermore, wildlife and forestry conservation efforts by earlier landowners are often ignored by new owners who look to exploit the land in order to turn a quick profit. But most importantly, our tax code should never place someone in a position where they must sell a testamentary gift just to be able to pay the taxes on the transfer. Besides being inherently unfair, such a tax tramples upon the property rights of American landowners.

Mr. President, we must not allow the tax code to perpetuate these injustices. My bill, the Timberland Conservation and Tax Relief Act of 1999 eliminates these problems by removing mechanical and unthinking tax laws from the decision of when it appropriate to harvest American timberlands. It introduces a flexible deferred payment provision into the estate taxation scheme that will allow timberland owners to exercise their own good judgment in deciding what the most efficient use of their land would be. Furthermore, the Timberland Conservation and Tax Relief Act promotes the responsible use of our environment by no longer placing persons in a position where they must harvest immature or unneeded timber. For these reasons, I strongly urge my colleagues in the Senate to join me in support of this bill.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1370

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. EXTENSION OF TIME FOR PAYMENT OF ESTATE TAX ON CERTAIN TIMBER STANDS.

(a) IN GENERAL.—Subchapter B of chapter 62 of the Internal Revenue Code of 1986 (relating to extensions of time for payment) is amended by adding at the end the following:

"SEC. 6168. EXTENSION OF TIME FOR PAYMENT OF ESTATE TAX ON CERTAIN TIMBER STANDS.

''(a) IN GENERAL.—In the case of an interest in a qualified timber property which is included in determining the gross estate of a decedent who was (at the date of his death) a citizen or resident of the United States, the executor may elect to pay part or all of the tax imposed by section 2001 on or before the date which is the earliest of—

''(1) the date the property is no longer qualified timber property,

''(2) the date the individual who inherited the interest in the qualified timber property either transfers the interest or dies, or

''(3) the date which is 25 years after the date of death of the decedent.

''(b) LIMITATION.—The maximum amount of tax which may be paid under this subsection shall be an amount which bears the same ratio to the tax imposed by section 2001 (reduced by the credits against such tax) as—

''(1) the fair market value of the interest in the qualified timber property, bears to

''(2) the adjusted gross estate of the decedent.

''(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) QUALIFIED TIMBER PROPERTY.—The term 'qualified timber property' means trees and any real property on which such trees are growing which is—

''(A) located in the United States, and

''(B) used in timber operations (as defined in section 2032A(e)(13)(C)).

''(2) ADJUSTED GROSS ESTATE.—The term, 'adjusted gross estate' means the value of the gross estate reduced by the sum of the amounts allowable as a deduction under section 2053 or 2054. Such sum shall be determined on the basis of the facts and circumstances in existence on the date (including extensions) for filing the return of tax imposed by section 2001 (or, if earlier, the date on which such return is filed).

''(3) CERTAIN TRANSFERS AT DEATH OF HEIR DISREGARDED.—Subsection (a)(2) shall not apply to any transfer by reason of death so long as such transfer is to a member of the family (within the meaning of section 267(c)94)) of the transferor in such transfer.

''(d) ELECTION.—Any election under subsection (a) shall be made not later than the time prescribed by section 6075(a) for filing the return of tax imposed by section 2001 (including extensions thereof), and shall be made in such manner as the Secretary shall by regulations prescribe. If an election under subsection (a) is made, the provisions of this subtitle shall apply as though the Secretary were extending the time for payment of the tax.

''(e) TIME FOR PAYMENT OF INTEREST.—If the time for payment of any amount of tax has been extended under this section, interest payable under section 6601 on any unpaid portion of such amount shall be paid at the time of the payment of the tax.

''(f) SPECIAL RULE FOR CERTAIN DIRECT SKIPS.—To the extent that an interest in a qualified timber property is the subject of a direct skip (within the meaning of section 2612(c)) occurring at the same time as and as a result of the decedent's death, then for purposes of this section any tax imposed by section 2601 on the transfer of such interest shall be treated as if it were additional tax imposed by section 2001.

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to the application of this section.

''(h) CROSS REFERENCES.—

''(1) SECURITY.—For authority of the Secretary to require security in the case of an extension under this section, see section 6165.

''(2) LIEN.—For special lien (in lieu of bond) in the case of an extension under this section, see section 6324A.

''(3) PERIOD OF LIMITATION.—For extension of the period of limitation in the case of an extension under this section, see section 6503(d).

''(4) INTEREST.—For provisions relating to interest on tax payable under this section, see subsection (j) of section 6601.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 163(k) of the Internal Revenue Code of 1986 is amended by striking ''6166'' in the heading and the text and inserting ''6166 or 6168''.

(2) Section 2053(c)(1)(D) of such Code is amended—

(A) by striking ''6166'' and inserting ''6166 or 6168'', and

(B) by striking ''6166'' in the heading and inserting ''6166 OR 6168''.

(3) The following provisions of such Code are amended by striking ''or 6166'' each place it appears and inserting ''6166, or 6168'':

(A) Section 2056A(b)(10)(A).

(B) Section 2204(a).

(C) Section 2204(b).

(D) Section 6503(d).

(4) Section 2011(c)(2) of such Code is amended by striking ''or 6166'' and inserting '', 6166, or 6168'':

(5) The following provisions of such Code are amended by inserting ''or 6168'' after ''6166'' each place it appears:

(A) Section 2204(c).

(B) Section 6601(j) (except the second sentence of paragraph (1)).

(C) Section 7481(d).

(6) Section 6161(a)(2) of such Code is amended—

(A) in subparagraph (A), by striking ''or'' at the end,

(B) in subparagraph (B), by adding ''or'' at the end,

(C) in the matter following subparagraph (B)—

(i) by striking ''subparagraph (B)'' and inserting ''subparagraph (B) or (C)'', and

(ii) by inserting ''or payment'' after ''installment'', and

(D) by inserting after subparagraph (B) the following:

''(C) any part of the payment determined under section 6168,''.

(7) Section 6324A of such Code is amended—

(A) by adding at the end the following:

''(f) APPLICATION OF SECTION TO DEFERRED TAX UNDER SECTION 6168.—Rules similar to the rules of this section shall apply to the amount of tax and interest deferred under section 6168 (determined as of the date prescribed by section 6151(a) for payment of the tax imposed by chapter 11).'', and

(B) in the title, by striking ''**estate tax deferred under section 6166**'' and inserting ''**deferred estate tax**''.

(8) The table of sections for subchapter B of chapter 62 of such Code is amended by adding at the end the following:

''Sec. 6168. Extension of time for payment of estate tax on certain timber stands.''.

(9) The item relating to section 6324A in the table of sections for subchapter C of chapter 64 of such Code is amended by striking ''estate tax deferred under section 6166'' and inserting ''deferred estate tax''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to estates of decedents dying after the date of enactment of this Act.

ADDITIONAL COSPONSORS

S. 25

At the request of Ms. LANDRIEU, the names of the Senator from Arkansas (Mr. HUTCHINSON), the Senator from Kansas (Mr. ROBERTS), the Senator from Nebraska (Mr. KERREY), and the Senator from Colorado (Mr. CAMPBELL) were added as cosponsors of S. 25, a bill to provide Coastal Impact Assistance to State and local governments, to amend the Outer Continental Shelf Lands Act Amendments of 1978, the Land and Water Conservation Fund Act of 1965, the Urban Park and Recreation Recovery Act, and the Federal Aid in Wildlife Restoration Act (commonly referred to as the Pittman-Robertson Act) to establish a fund to meet the outdoor conservation and recreation needs of the American people, and for other purposes.

S. 85

At the request of Mr. BUNNING, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 85, a bill to amend the Internal Revenue Code of 1986 to reduce the tax on vaccines to 25 cents per dose.

S. 216

At the request of Mr. MOYNIHAN, the names of the Senator from Nebraska (Mr. KERREY) and the Senator from West Virginia (Mr. ROCKEFELLER) were added as cosponsors of S. 216, 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. 253

At the request of Mr. MURKOWSKI, the names of the Senator from Idaho (Mr. CRAIG) and the Senator from Montana (Mr. BURNS) were added as cosponsors of S. 253, a bill to provide for the reorganization of the Ninth Circuit Court of Appeals, and for other purposes.

S. 317

At the request of Mr. DORGAN, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 317, a bill to amend the Internal Revenue Code of 1986 to provide an exclusion for gain from the sale of farmland which is similar to the exclusion from gain on the sale of a principal residence.

S. 333

At the request of Mr. LEAHY, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 333, a bill to amend the Federal Agriculture Improvement and Reform Act of 1996 to improve the farmland protection program.

S. 472

At the request of Mr. GRASSLEY, the name of the Senator from South Carolina (Mr. THURMOND) was added as a cosponsor of S. 472, a bill to amend title XVIII of the Social Security Act to provide certain medicare beneficiaries with an exemption to the financial limitations imposed on physical, speech-language pathology, and occupational therapy services under part B of the medicare program, and for other purposes.

S. 486

At the request of Mr. ASHCROFT, the name of the Senator from Georgia (Mr. COVERDELL) was added as a cosponsor of S. 486, a bill to provide for the punishment of methoamphetamine laboratory operators, provide additional resources to combat methamphetamine production, trafficking, and abuse in the United States, and for other purposes.

S. 510

At the request of Mr. CAMPBELL, the name of the Senator from Alaska (Mr. MURKOWSKI) was added as a cosponsor of S. 510, a bill to preserve the sovereignty of the United States over public lands and acquired lands owned by the United States, and to preserve State sovereignty and private property rights in non-Federal lands surrounding those public lands and acquired lands.

S. 515

At the request of Mr. AKAKA, the names of the Senator from California (Mrs. BOXER) and the Senator from New Hampshire (Mr. GREGG) were added as cosponsors of S. 515, a bill to amend the Packers and Stockyards Act of 1921, to make it unlawful for any stockyard owner, market agency, or dealer to transfer or market nonambulatory livestock, and for other purposes.

S. 635

At the request of Mr. MACK, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 635, a bill to amend the Internal Revenue Code of 1986 to more accurately codify the depreciable life of printed wiring board and printed wiring assembly equipment.

S. 664

At the request of Mr. CHAFEE, the names of the Senator from Montana (Mr. BAUCUS) and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of S. 664, a bill to amend the Internal Revenue Code of 1986 to provide a credit against income tax to individuals who rehabilitate historic homes or who are the first purchasers of rehabilitated historic homes for use as a principal residence.

S. 676

At the request of Mr. CAMPBELL, the names of the Senator from Alabama (Mr. SHELBY) and the Senator from Illinois (Mr. FITZGERALD) were added as cosponsors of S. 676, a bill to locate and secure the return of Zachary Baumel, a citizen of the United States, and other Israeli soldiers missing in action.

S. 720

At the request of Mr. HELMS, the name of the Senator from Georgia (Mr. COVERDELL) was added as a cosponsor of S. 720, a bill to promote the development of a government in the Federal Republic of Yugoslavia (Serbia and Montenegro) based on democratic principles and the rule of law, and that respects internationally recognized human rights, to assist the victims of Serbian oppression, to apply measures against the Federal Republic of Yugoslavia, and for other purposes.

S. 820

At the request of Mr. CHAFEE, the name of the Senator from Montana (Mr. BAUCUS) was added as a cosponsor of S. 820, a bill to amend the Internal Revenue Code of 1986 to repeal the 4.3-cent motor fuel excise taxes on railroads and inland waterway transportation which remain in the general fund of the Treasury.

S. 926

At the request of Mr. DODD, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. 926, a bill to provide the people of Cuba with access to food and medicines from the United States, and for other purposes.

S. 935

At the request of Mr. LUGAR, the names of the Senator from Colorado (Mr. ALLARD), the Senator from South Dakota (Mr. DASCHLE), the Senator from New Mexico (Mr. DOMENICI), the Senator from Nebraska (Mr. KERREY), the Senator from Vermont (Mr. LEAHY), and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. 935, a bill to amend the National Agricultural Research, Extension, and Teaching Policy Act of 1977 to authorize research to promote the conversion of biomass into biobased industrial products, and for other purposes.

S. 980

At the request of Mr. BAUCUS, the name of the Senator from West Virginia (Mr. BYRD) was added as a cosponsor of S. 980, a bill to promote access to health care services in rural areas.

S. 1017

At the request of Mr. MACK, the name of the Senator from Utah (Mr. BENNETT) was added as a cosponsor of S. 1017, a bill to amend the Internal Revenue Code of 1986 to increase the State ceiling on the low-income housing credit.

S. 1020

At the request of Mr. GRASSLEY, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1020, a bill to amend chapter 1 of title 9, United States Code, to provide for greater fairness in the arbitration process relating to motor vehicle franchise contracts.

S. 1044

At the request of Mr. KENNEDY, the names of the Senator from Hawaii (Mr.

INOUYE) and the Senator from California (Mrs. BOXER) were added as cosponsors of S. 1044, a bill to require coverage for colorectal cancer screenings.

S. 1074

At the request of Mr. TORRICELLI, the name of the Senator from Georgia (Mr. CLELAND) was added as a cosponsor of S. 1074, a bill to amend the Social Security Act to waive the 24-month waiting period for medicare coverage of individuals with amyotrophic lateral sclerosis (ALS), and to provide medicare coverage of drugs and biologicals used for the treatment of ALS or for the alleviation of symptoms relating to ALS.

S. 1142

At the request of Ms. MIKULSKI, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 1142, a bill to protect the right of a member of a health maintenance organization to receive continuing care at a facility selected by that member, and for other purposes.

S. 1165

At the request of Mr. MACK, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 1165, a bill to amend the Internal Revenue Code of 1986 to repeal the limitation on the amount of receipts attributable to military property which may be treated as exempt foreign trade income.

S. 1215

At the request of Mr. DODD, the name of the Senator from West Virginia (Mr. BYRD) was added as a cosponsor of S. 1215, a bill to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to furnish headstones or markers for marked graves of, or to otherwise commemorate, certain individuals.

S. 1268

At the request of Mr. HARKIN, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 1268, a bill to amend the Public Health Service Act to provide support for the modernization and construction of biomedical and behavioral research facilities and laboratory instrumentation.

S. 1310

At the request of Ms. COLLINS, the name of the Senator from West Virginia (Mr. BYRD) was added as a cosponsor of S. 1310, a bill to amend title XVIII of the Social Security Act to modify the interim payment system for home health services, and for other purposes.

S. 1341

At the request of Mr. DORGAN, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 1341, a bill to amend the Internal Revenue Code of 1986 to expand the applicability of section 179 which permits the expensing of certain depreciable assets.

SENATE CONCURRENT RESOLUTION 9

At the request of Ms. SNOWE, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of Senate Concurrent Resolution 9, a concurrent resolution calling for a United States effort to end restrictions on the freedoms and human rights of the enclaved people in the occupied area of Cyprus.

SENATE CONCURRENT RESOLUTION 25

At the request of Mr. JEFFORDS, the name of the Senator from Arizona (Mr. MCCAIN) was added as a cosponsor of Senate Concurrent Resolution 25, a concurrent resolution urging the Congress and the President to fully fund the Federal Government's obligation under the Individuals with Disabilities Education Act.

SENATE CONCURRENT RESOLUTION 34

At the request of Mr. SPECTER, the names of the Senator from Wisconsin (Mr. FEINGOLD) and the Senator from West Virginia (Mr. BYRD) were added as cosponsors of Senate Concurrent Resolution 34, A concurrent resolution relating to the observence of ''In Memory'' Day.

SENATE RESOLUTION 118

At the request of Mr. REID, the names of the Senator from Georgia (Mr. CLELAND), the Senator from Utah (Mr. BENNETT), the Senator from Nebraska (Mr. HAGEL), the Senator from Florida (Mr. MACK), and the Senator from Ohio (Mr. DEWINE) were added as cosponsors of Senate Resolution 118, a resolution designating December 12, 1999, as ''National Children's Memorial Day.''

SENATE RESOLUTION 139—AUTHORIZING EXPENDITURES BY THE SELECT COMMITTEE ON INTELLIGENCE

Mr. SHELBY, from the Select Committee on Intelligence, reported the following original resolution; which was referred to the Committee on Rules and Administration:

S. RES. 139

Resolved, That, in carrying out its powers, duties, and functions under the Standing Rules of the Senate, in accordance with its jurisdiction under rule XXV of such rules, including holding hearings, reporting such hearings, and making investigations as authorized by paragraphs 1 and 8 of rule XXVI of the Standing Rules of the Senate, the Select Committee on Intelligence is authorized from October 1, 1999, through September 30, 2000, and October 1, 2000, through February 28, 2001, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable or non-reimbursable basis the services of personnel of any such department or agency.

SEC. 2. The expenses of the committee for the period October 1, 1999, through September 30, 2000, under this resolution shall not exceed $2,674,687, of which amount not to exceed $65,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended).

(b) For the period October 1, 2000 through February 28, 2001, expenses of the committee under this resolution shall not exceed $1,141,189, of which amount not to exceed $65,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 29, 2000 and February 28, 2001, respectively.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required (1) for the disbursement of salaries of employees paid at an annual rate, or (2) for the payment of telecommunications provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (3) for the payment of stationery supplies purchased through the Keeper of the Stationery, United States Senate, or (4) for payments to the Postmaster, United States Senate, or (5) for the payment of metered charges on copying equipment provided by the Office of the Sergeant at Arms and Doorkeeper, United States Senate, or (6) for the payment of Senate Recording and Photographic Services, or (7) for payment of franked and mass mail costs by the Sergeant at Arms and Doorkeeper, United States Senate.

SEC. 5. There are authorized such sums as may be necessary for agency contributions related to the compensation of employees of the committee, from October 1, 1999, through September 30, 2000, and October 1, 2000 through February 28, 2001, to be paid from the Appropriations account for ''Expenses of Inquiries and Investigations.''

SENATE RESOLUTION 140—CONGRATULATING THE UNITED STATES WOMEN'S SOCCER TEAM FOR WINNING THE 1999 WOMEN'S WORLD CUP, RECOGNIZING THE IMPORTANT CONTRIBUTION OF EACH INDIVIDUAL TEAM MEMBER TO THE UNITED STATES AND TO THE ADVANCEMENT OF WOMEN'S SPORTS, AND INVITING THE MEMBERS OF THE UNITED STATES WOMEN'S SOCCER TEAM TO THE UNITED STATES CAPITOL TO BE HONORED AND RECOGNIZED BY THE SENATE FOR THEIR ACHIEVEMENTS

Mr. CAMPBELL submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 140

Whereas each of the athletes on the United States women's soccer team has honored the Nation through her dedication to excellence;

Whereas the United States women's soccer team has raised the level of awareness and appreciation for women's sports throughout the United States;

Whereas the members of the United States women's soccer team have become positive role models for the young people of the United States aspiring to participate in national and international level sports; and

Whereas the United States women's soccer team has qualified for the 2000 summer Olympic games: Now, therefore, be it

Resolved,

SECTION 1. CONGRATULATION, RECOGNITION, AND INVITATION.

The Senate—

(1) congratulates the United States women's soccer team for winning the 1999 Women's World Cup;

(2) recognizes the important contribution of each individual team member to the United States and to the advancement of women's sports; and

(3) invites the members of the United States women's soccer team to the United States Capitol to be honored and recognized by the Senate for their achievements.

SEC. 2. TRANSMISSION OF ENROLLED RESOLUTION.

The Secretary of the Senate shall transmit an enrolled copy of this resolution to the United States women's soccer team.

Mr. CAMPBELL. Mr. President, today I submit a resolution in honor of the Women's World Cup Soccer Champions, the U.S. Women's Soccer Team.

From the first game of the Women's World Cup in New Jersey, which was played before a sold-out crowd, to the final game at the Rose Bowl filled with 90,185 screaming fans, setting the women's sports record for attendance, this U.S. Women's Soccer Team has inspired us all. The U.S. Women's Soccer Team had an outstanding run during the 1999 Women's World Cup which culminated in an amazing victory against the Chinese in the final game.

After 120 minutes of exciting soccer, the game came down to a shoot-out where the U.S. Women's Team prevailed 5 to 4 to become the champions. From Briana Scurry's game winning save to the nail-biting seconds before Brandi Chastain made the winning goal, they had us all sitting on the edge of our chairs.

As a former Olympic athlete, I know the dedication and determination that these women must have in order to achieve this tremendous accomplishment. I want to point out that every member of this team either has a college degree or is pursuing one. I can't think of better role models for today's youth than this World Cup Team.

I want to congratulate and recognize each and every member of this team and I ask unanimous consent that their names and the resolution be printed in the RECORD. I would also like to thank my good friend and former Olympian Donna de Varona, the Chairwoman of the Women's World Cup, for her hard work and dedication to ensure that women's soccer is finally given the recognition it deserves. I urge my colleagues to join in strong support of passage of this resolution.

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

U.S. WOMEN'S SOCCER TEAM

Michelle Akers, Brandi Chastain, Tracy Ducar, Lorrie Fair, Joy Fawcett, Danielle Fotopoulos, Julie Foudy, Mia Hamm, Kristine Lilly, Shannon MacMillan, Tiffeny Milbrett, Carla Overbeck, Cindy Parlow, Christie Pearce, Tiffany Roberts, Briana Scurry, Kate Sobrero, Tisha Venturini, Saskia Webber, Sara Whalen.

AMENDMENTS SUBMITTED

PATIENTS' BILL OF RIGHTS ACT OF 1999

SNOWE (AND OTHERS) AMENDMENT NO. 1241

Ms. SNOWE (for herself, Mr. ABRAHAM, Mr. FITZGERALD, Mr. CRAPO, Ms. COLLINS, Mr. JEFFORDS, Mr. MURKOWSKI, and Mr. DEWINE) proposed an amendment to amendment No. 1239 proposed by Mr. DODD to the bill (S. 1344) to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage; as follows:

Strike section 152 of the bill, and insert the following:

WOMEN'S HEALTH AND CANCER RIGHTS.

(a) SHORT TITLE.—This section may be cited as the ''Women's Health and Cancer Rights Act of 1999''.

(b) FINDINGS.—Congress finds that—

(1) the offering and operation of health plans affect commerce among the States;

(2) health care providers located in a State serve patients who reside in the State and patients who reside in other States; and

(3) in order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in 1 State as well as health plans operating among the several States.

(c) AMENDMENTS TO ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 301, is further amended by adding at the end the following:

''SEC. 715. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000;

whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d).''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.''.

(d) AMENDMENTS TO PHSA RELATING TO THE GROUP MARKET.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by section 201, is further amended by adding at the end the following new section:

"SEC. 2708. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000;

whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d).''.

(e) AMENDMENTS TO PHSA RELATING TO THE INDIVIDUAL MARKET.—Subpart 2 of part B of title XXVII of the Public Health Service Act, as amended by section 202, is further amended by adding at the end the following new section:

"SEC. 2754. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND SECONDARY CONSULTATIONS.

''The provisions of section 2708 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(f) AMENDMENTS TO THE IRC.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 401, is further amended—

(A) in the table of sections, by inserting after the item relating to section 9813 the following new item:

''Sec. 9814. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.''; and

(B) by inserting after section 9813 the following:

"SEC. 9814. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan and shall be transmitted—

''(1) in the next mailing made by the plan to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000;

whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES.—A group health plan may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan involved under subsection (d).''.

(2) CLERICAL AMENDMENT.—The table of contents for chapter 100 of such Code is

amended by inserting after the item relating to section 9813 the following new item:

''Sec. 9814. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.''.

KENNEDY (AND OTHERS) AMENDMENT NO. 1242

Mr. DASCHLE (for Mr. KENNEDY (for himself, Mr. REID, Mr. DURBIN, Mr. WELLSTONE, Mr. WYDEN, Mr. REED, Mrs. MURRAY, Mr. DASCHLE, Mr. CHAFEE, and Mrs. FEINSTEIN)) proposed an amendment to amendment No. 1239 to the bill, S. 1344, supra; as follows:

At the appropriate place, insert the following:

SEC. ___. APPLICATION TO ALL HEALTH PLANS.

(a) ERISA.—Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as added by section 101(a)(2) of this Act, is amended by adding at the end the following:

''SEC. 730A. APPLICATION OF PROVISIONS.

''(a) APPLICATION TO GROUP HEALTH PLANS.—The provisions of this subpart, and sections 714 and 503, shall apply to group health plans and health insurance issuers offering health insurance coverage in connection with a group health plan.

''(b) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a group health plan that provides benefits under 2 or more coverage options, the requirements of this subpart, other than section 722, shall apply separately with respect to each coverage option.

''(c) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of this Act with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) section 721 (relating to access to emergency care).

''(B) Section 722 (relating to choice of coverage options), but only insofar as the plan is meeting such requirement through an agreement with the issuer to offer the option to purchase point-of-service coverage under such section.

''(C) Section 723, 724 and 725 (relating to access to specialty care).

''(D) Section 726) (relating to continuity in case of termination of provider (or, issuer in connection with health insurance coverage) contract) but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(E) Section 727 (relating to patient-provider communications).

''(F) Section 728 (relating to prescription drugs).

''(G) Section 729 (relating to self-payment for certain services).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 714, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

''(3) GRIEVANCE AND INTERNAL APPEALS.—With respect to the grievance system and internal appeals process required to be established under section 503, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such system and process (and is not liable for the issuer's failure to provide for such system and process), if the issuer is obligated to provide for (and provides for) such system and process.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 503, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of section 727, the group health plan shall not be liable for such violation unless the plan caused such violation.

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(d) CONFORMING REGULATIONS.—The Secretary may issue regulations to coordinate the requirements on group health plans under this section with the requirements imposed under the other provisions of this title.''.

(b) APPLICATION TO GROUP MARKET UNDER PUBLIC HEALTH SERVICE ACT.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.), as amended by section 203(a)(1)(B), is further amended by adding at the end the following new section:

''SEC. 2708. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with the following patient protection requirements, and each health insurance issuer shall comply with such patient protection requirements with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection:

''(1) The requirements of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) The requirements of section 714 of the Employee Retirement Income Security Act of 1974.

''(3) The requirements of subsections (b) through (g) of section 503 of the Employee Retirement Income Security Act of 1974.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 104(b)(1) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(c) APPLICATION TO INDIVIDUAL MARKET UNDER PUBLIC HEALTH SERVICE ACT.—Subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-51 et seq.), as amended by section 203(b)(2), is further amended by adding at the end the following new section:

''SEC. 2754. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with the following patient protection requirements with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection:

''(1) The requirements of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) The requirements of section 714 of the Employee Retirement Income Security Act of 1974.

''(3) The requirements of section 503 of the Employee Retirement Income Security Act of 1974.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 104(b)(1) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such subtitle as if such section applied to such issuer and such issuer were a group health plan.

''(c) NONAPPLICATION OF CERTAIN PROVISION.—Section 2763(a) shall not apply to the provisions of this section.''.

(d) APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Standard relating to patients' bill of rights.''; and

(2) by inserting after section 9812 the following:

''SEC. 9813. STANDARD RELATING TO PATIENTS' BILL OF RIGHTS.

''A group health plan shall comply with the following requirements (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section:

''(1) The requirements of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) The requirements of section 714 of the Employee Retirement Income Security Act of 1974.

''(3) The requirements of section 503 of the Employee Retirement Income Security Act of 1974.''.

(e) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2708)'' after ''requirements of such subparts''.

(f) NO IMPACT ON SOCIAL SECURITY TRUST FUND.—

(1) IN GENERAL.—Nothing in the amendments made by this section shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(2) TRANSFERS.—

(A) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this section has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(B) TRANSFER OF FUNDS.—If, under subparagraph (A), the Secretary of the Treasury estimates that the enactment of this section has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such section.

(g) INFORMATION REQUIREMENTS.—

(1) INFORMATION FROM GROUP HEALTH PLANS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following:

''(7) INFORMATION FROM GROUP HEALTH PLANS.—

''(A) PROVISION OF INFORMATION BY GROUP HEALTH PLANS.—The administrator of a group health plan subject to the requirements of paragraph (1) shall provide to the Secretary such of the information elements described in subparagraph (C) as the Secretary specifies, and in such manner and at such times as the Secretary may specify (but not more frequently than 4 times per year), with respect to each individual covered under the plan who is entitled to any benefits under this title.

''(B) PROVISION OF INFORMATION BY EMPLOYERS AND EMPLOYEE ORGANIZATIONS.—An employer (or employee organization) that maintains or participates in a group health plan subject to the requirements of paragraph (1) shall provide to the administrator of the plan such of the information elements required to be provided under subparagraph (A), and in such manner and at such times as the Secretary may specify, at a frequency consistent with that required under subparagraph (A) with respect to each individual described in subparagraph (A) who is covered under the plan by reason of employment with that employer or membership in the organization.

''(C) INFORMATION ELEMENTS.—The information elements described in this subparagraph are the following:

''(i) ELEMENTS CONCERNING THE INDIVIDUAL.—

''(I) The individual's name.

''(II) The individual's date of birth.

''(III) The individual's sex.

''(IV) The individual's social security insurance number.

''(V) The number assigned by the Secretary to the individual for claims under this title.

''(VI) The family relationship of the individual to the person who has or had current or employment status with the employer.

''(ii) ELEMENTS CONCERNING THE FAMILY MEMBER WITH CURRENT OR FORMER EMPLOYMENT STATUS.—

''(I) The name of the person in the individual's family who has current or former employment status with the employer.

''(II) That person's social security insurance number.

''(III) The number or other identifier assigned by the plan to that person.

''(IV) The periods of coverage for that person under the plan.

''(V) The employment status of that person (current or former) during those periods of coverage.

''(VI) The classes (of that person's family members) covered under the plan.

''(iii) PLAN ELEMENTS.—

''(I) The items and services covered under the plan.

''(II) The name and address to which claims under the plan are to be sent.

''(iv) ELEMENTS CONCERNING THE EMPLOYER.—

''(I) The employer's name.

''(II) The employer's address.

''(III) The employer identification number of the employer.

''(D) USE OF IDENTIFIERS.—The administrator of a group health plan shall utilize a unique identifier for the plan in providing information under subparagraph (A) and in other transactions, as may be specified by the Secretary, related to the provisions of this subsection. The Secretary may provide to the administrator the unique identifier described in the preceding sentence.

''(E) PENALTY FOR NONCOMPLIANCE.—Any entity that knowingly and willfully fails to comply with a requirement imposed by the previous subparagraphs shall be subject to a civil money penalty not to exceed $1,000 for each incident of such failure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as those provisions apply to a penalty or proceeding under section 1128A(a).''

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect 180 days after the date of the enactment of this Act.

(h) MODIFICATION TO FOREIGN TAX CREDIT CARRYBACK AND CARRYOVER PERIODS.—

(1) IN GENERAL.—Section 904(c) of the Internal Revenue Code of 1986 (relating to limitation on credit) is amended—

(A) by striking ''in the second preceding taxable year,'', and

(B) by striking ''or fifth'' and inserting ''fifth, sixth, or seventh''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to credits arising in taxable years beginning after December 31, 2001.

(i) LIMITATIONS ON WELFARE BENEFIT FUNDS OF 10 OR MORE EMPLOYER PLANS.—

(1) BENEFITS TO WHICH EXCEPTION APPLIES.—Section 419A(f)(6)(A) of the Internal Revenue Code of 1986 (relating to exception for 10 or more employer plans) is amended to read as follows:

''(A) IN GENERAL.—This subpart shall not apply to a welfare benefit fund which is part of a 10 or more employer plan if the only benefits provided through the fund are 1 or more of the following:

''(i) Medical benefits.

''(ii) Disability benefits.

''(iii) Group term life insurance benefits which do not provide for any cash surrender value or other money that can be paid, assigned, borrowed, or pledged for collateral for a loan.

The preceding sentence shall not apply to any plan which maintains experience-rating arrangements with respect to individual employers.''

(2) LIMITATION ON USE OF AMOUNTS FOR OTHER PURPOSES.—Section 4976(b) of such Act (defining disqualified benefit) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR 10 OR MORE EMPLOYER PLANS EXEMPTED FROM PREFUNDING LIMITS.—For purposes of paragraph (1)(C), if—

''(A) subpart D of part I of subchapter D of chapter 1 does not apply by reason of section 419A(f)(6) to contributions to provide 1 or more welfare benefits through a welfare benefit fund under a 10 or more employer plan, and

''(B) any portion of the welfare benefit fund attributable to such contributions is used for a purpose other than that for which the contributions were made,

then such portion shall be treated as reverting to the benefit of the employers maintaining the fund.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

(j) MODIFICATION OF INSTALLMENT METHOD AND REPEAL OF INSTALLMENT METHOD FOR ACCRUAL METHOD TAXPAYERS.—

(1) REPEAL OF INSTALLMENT METHOD FOR ACCRUAL BASIS TAXPAYERS.—

(A) IN GENERAL.—Subsection (a) of section 453 of the Internal Revenue Code of 1986 (relating to installment method) is amended to read as follows:

''(a) USE OF INSTALLMENT METHOD.—

''(1) IN GENERAL.—Except as otherwise provided in this section, income from an installment sale shall be taken into account for purposes of this title under the installment method.

''(2) ACCRUAL METHOD TAXPAYER.—The installment method shall not apply to income from an installment sale if such income would be reported under an accrual method of accounting without regard to this section. The preceding sentence shall not apply to a disposition described in subparagraph (A) or (B) of subsection (l)(2).''

(B) CONFORMING AMENDMENTS.—Sections 453(d)(1), 453(i)(1), and 453(k) of such Act are each amended by striking ''(a)'' each place it appears and inserting ''(a)(1)''.

(2) MODIFICATION OF PLEDGE RULES.—Paragraph (4) of section 453A(d) of such Act (relating to pledges, etc., of installment obligations) is amended by adding at the end the following: ''A payment shall be treated as directly secured by an interest in an installment obligation to the extent an arrangement allows the taxpayer to satisfy all or a portion of the indebtedness with the installment obligation.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to sales or other dispositions occurring on or after the date of the enactment of this Act.

COLLINS (AND OTHERS) AMENDMENT NO. 1243

Ms. COLLINS (for herself, Mr. HUTCHINSON, Mr. JEFFORDS, Mr. FRIST, Mr. GRAMS, Mr. GRASSLEY, and Mr. ABRAHAM) proposed an amendment to amendment No. 1232 proposed by Mr. DASCHLE to the bill, S. 1344, supra; as follows:

In the language proposed to be stricken, at the appropriate place, insert the following:

SEC. ___. INCLUSION OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS IN CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125(f) of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by striking the last sentence and inserting the following: ''Such term includes any qualified long-term care insurance contract.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. ___. DEDUCTION FOR PREMIUMS FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 222 as section 223 and by inserting after section 221 the following:

''SEC. 222. PREMIUMS FOR LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a deduction an amount equal to 100 percent of the amount paid during the taxable year for any coverage for qualified long-term care services (as defined in section 7702B(c)) or any qualified long-term care insurance contract (as defined in section 7702B(b)) which constitutes medical care for the taxpayer, his spouse, and dependents.

''(b) LIMITATIONS.—

''(1) DEDUCTION NOT AVAILABLE TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), subsection (a) shall not apply to any taxpayer for any calendar month for which the taxpayer is eligible to participate in any plan which includes coverage for qualified long-term care services

(as so defined) or is a qualified long-term care insurance contract (as so defined) maintained by any employer (or former employer) of the taxpayer or of the spouse of the taxpayer.

''(B) CONTINUATION COVERAGE.—Coverage shall not be treated as subsidized for purposes of this paragraph if—

''(i) such coverage is continuation coverage (within the meaning of section 4980B(f)) required to be provided by the employer, and

''(ii) the taxpayer or the taxpayer's spouse is required to pay a premium for such coverage in an amount not less than 100 percent of the applicable premium (within the meaning of section 4980B(f)(4)) for the period of such coverage.

''(2) LIMITATION ON LONG-TERM CARE PREMIUMS.—In the case of a qualified long-term care insurance contract (as so defined), only eligible long-term care premiums (as defined in section 213(d)(10)) shall be taken into account under subsection (a)(2).

''(c) SPECIAL RULES.—For purposes of this section—

''(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).

''(2) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this section shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.''

(b) CONFORMING AMENDMENTS.—

(1) Subsection (a) of section 62 of the Internal Revenue Code of 1986 is amended by inserting after paragraph (17) the following:

''(18) LONG-TERM CARE INSURANCE COSTS OF CERTAIN INDIVIDUALS.—The deduction allowed by section 222.''

(2) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

''Sec. 222. Premiums for long-term care insurance.

''Sec. 223. Cross reference.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. ___. PATIENT RIGHT TO MEDICAL ADVICE AND CARE.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is amended—

(1) by redesignating subpart C as subpart D; and

(2) by inserting after subpart B the following:

''SEC. 723. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE

(1) GENERAL RIGHTS.—

(A) WAIVER OF PLAN REFERRAL REQUIREMENT.—If a group health plan described in paragraph (2) requires a referral to obtain coverage for speciality care, the plan shall waive the referral requirement in the case of a female participant or beneficiary who seeks coverage for obstetrical care or routine gynecological care (such as preventive gynecological care).

(B) RELATED ROUTINE CARE.—With respect to a participant or beneficiary described in subparagraph (A), a group health plan described in paragraph (2) may treat the ordering of other care that is related to obstetric or routine gynecologic care, by a physician who specializes in obstetrics and gynecology as the authorization of the primary care provider for such other care.

(2) APPLICATION OF SECTION.—A group health plan described in this paragraph is a group health plan (other than a fully insured group health plan), that—

(A) provides coverage for obstetric care (such as pregnancy-related services) or routine gynecologic care (such as preventive women's health examinations); and

(B) requires the designation by a participant or beneficiary of a participating primary care provider who is not a physician who specializes in obstetrics or gynecology.

(3) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of obstetric or gynecologic care described in paragraph (1);

(B) to preclude the plan from requiring that the physician who specializes in obstetrics or gynecology notify the designated primary care provider or the plan of treatment decisions;

(C) to preclude a group health plan from allowing health care professionals other than physicians to provide routine obstetric or routine gynecologic care; or

(D) to preclude a group health plan from permitting a physician who specializes in obstetrics and gynecology from being a primary care provider under the plan.

(4) APPLICATION OF PROVISIONS.—

(A) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the provisions of this subsection shall only apply to group health plans (other than fully insured group health plans).

(B) FULLY INSURED GROUP HEALTH PLAN.—In this subsection, the term ''fully insured group health plan'' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.

''SEC. 725. TIMELY ACCESS TO SPECIALISTS.

''(a) TIMELY ACCESS.—

''(1) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall ensure that participants and beneficiaries have timely, in accordance with the medical exigencies of the case, access to primary and speciality health care professionals who are appropriate to the condition of the participant or beneficiary, when such care is covered under the plan. Such access may be provided through contractual arrangements with specialized providers outside of the network of the plan.

''(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

''(A) to require the coverage under a group health plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants or beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan; or

''(B) to override any State licensure or scope-of-practice law.

''(b) TREATMENT PLANS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to prohibit a group health plan (other than a fully insured group health plan) from requiring that speciality care be provided pursuant to a treatment plan so long as the treatment plan is—

''(A) developed by the specialist, in consultation with the case manager or primary care provider, and the participant or beneficiary;

''(B) approved by the plan in a timely manner in accordance with the medical exigencies of the case; and

''(C) in accordance with the applicable quality assurance and utilization review standards of the plan.

''(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan from requiring the specialist to provide the case manager or primary care provider with regular updates on the specialty care provided, as well as all other necessary medical information.

''(c) REFERRALS.—Nothing in this section shall be construed to prohibit a plan from requiring an authorization by the case manager or primary care provider of the participant or beneficiary in order to obtain coverage for speciality services so long as such authorization is for an adequate number of referrals.

''(d) SPECIALITY CARE DEFINED.—For purposes of this subsection, the term 'speciality care' means, with respect to a condition, care and treatment provided by a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise (including age-appropriate expertise) through appropriate training and experience.

SEC. . PATIENT ACCESS TO EMERGENCY MEDICAL CARE.

(a) COVERAGE OF EMERGENCY CARE.—

(1) IN GENERAL.—To the extent that the group health plan (other than a fully insured group health plan) provides coverage for benefits consisting of emergency medical care (as defined in subsection (c)) or emergency ambulance services, except for items or services specifically excluded—

(A) the plan shall provide coverage for benefits, without requiring preauthorization, for emergency medical screening examinations or emergency ambulance services, to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations or emergency ambulance services to be necessary to determine whether emergency medical care (as so defined) is necessary; and

(B) the plan shall provide coverage for benefits, without requiring preauthorization, for additional emergency medical care to stabilize an emergency medical condition following an emergency medical screening examination (if determined necessary under subparagraph (A)), pursuant to the definition of stabilize under section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(2) REIMBURSEMENT FOR CARE TO MAINTAIN MEDICAL STABILITY.—

(A) IN GENERAL.—In the case of services provided to a participant or beneficiary by a nonparticipating provider in order to maintain the medical stability of the participant or beneficiary, the group health plan involved shall provide for reimbursement with respect to such services if—

(i) coverage for services of the type furnished is available under the group health plan;

(ii) the services were provided for care related to an emergency medical condition and in an emergency department in order to maintain the medical stability of the participant or beneficiary; and

(iii) the nonparticipating provider contacted the plan regarding approval for such services.

(B) FAILURE TO RESPOND.—If a group health plan fails to respond within 1 hours of being contacted in accordance with subparagraph (A)(iii), then the plan shall be liable for the cost of services provided by the nonparticipating provider in order to maintain the stability of the participant or beneficiary.

(C) LIMITATION.—The liability of a group health plan to provide reimbursement under subparagraph (A) shall terminate when the

plan has contacted the nonparticipating provider to arrange for discharge or transfer.

(D) LIABILITY OF PARTICIPANT.—A participant or beneficiary shall not be liable for the costs of services to which subparagraph (A) in an amount that exceeds the amount of liability that would be incurred if the services were provided by a participating health care provider with prior authorization by the plan.

(b) IN-NETWORK UNIFORM COSTS-SHARING AND OUT-OF-NETWORK CARE.—

(1) IN-NETWORK UNIFORM COST-SHARING.—Nothing in this section shall be construed as preventing a group health plan (other than a fully insured group health plan) from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to coverage for benefits described in subsection (a), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in subsection (c)) provided to such similarly situated participants and beneficiaries under the plan, and such cost-sharing is disclosed in accordance with section 714.

(2) OUT-OF-NETWORK CARE.—If a group health plan (other than a fully insured group health plan) provides any benefits with respect to emergency medical care (as defined in subsection (c)), the plan shall cover emergency medical care under the plan in a manner so that, if such care is provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider.

(c) DEFINITION OF EMERGENCY MEDICAL CARE.—In this section:

(1) IN GENERAL.—The term ''emergency medical care'' means, with respect to a participant or beneficiary under a group health plan (other than a fully insured group health plan), covered inpatient and outpatient services that—

(A) are furnished by any provider, including a nonparticipating provider, that is qualified to furnish such services; and

(B) are needed to evaluate or stabilize (as such term is defined in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd)(e)(3)) an emergency medical condition (as defined in paragraph (2)).

(2) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(A) placing the health of the participant or beneficiary (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(d) APPLICATION OF PROVISIONS.—

(1) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the provisions of this section shall only apply to group health plans (other than fully insured group health plans).

(2) FULLY INSURED GROUP HEALTH PLAN.—In this section, the term ''fully insured group health plan'' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.

AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION AND RELATED AGENCIES APPROPRIATIONS ACT, 2000

CONRAD AMENDMENT NO. 1244

(Ordered to lie on the table.)

Mr. CONRAD submitted an amendment intended to be proposed by him to the bill (S. 1233) making appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies programs for the fiscal year ending September 30, 2000, and for other purposes; as follows:

On page 76, between lines 6 and 7, insert the following:

TITLE ____—RURAL ECONOMY EMERGENCY STABILIZATION

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Rural Economy Emergency Stabilization Act of 1999''.

SEC. ___02. MARKET LOSS ASSISTANCE.

(a) IN GENERAL.—Except as provided in subsections (d) and (e), the Secretary of Agriculture (referred to in this title as the ''Secretary'') shall use not more than $5,600,000,000 of funds of the Commodity Credit Corporation to provide assistance to owners and producers on a farm that are eligible for payments for fiscal year 1999 under a production flexibility contract for the farm under the Agricultural Market Transition Act (7 U.S.C. 7201 et seq.) to partially compensate the owners and producers for the loss of markets for the 1999 crop of a commodity.

(b) AMOUNT.—Except as provided in subsections (d) and (e), the amount of assistance made available to owners and producers on a farm under this section shall be proportionate to the amount of the contract payment received by the owners and producers for fiscal year 1999 under a production flexibility contract for the farm under the Agricultural Market Transition Act.

(c) TIME FOR PAYMENT.—The assistance made available under this section for an eligible owner or producer shall be provided as soon as practicable after the date of enactment of this Act.

(d) DAIRY PRODUCERS.—

(1) IN GENERAL.—Of the total amount made available under subsection (a), $200,000,000 shall be available to provide assistance to dairy producers in a manner determined by the Secretary.

(2) FEDERAL MILK MARKETING ORDERS.—Payments made under this subsection shall not affect any decision with respect to rulemaking activities under section 143 of the Agricultural Market Transition Act (7 U.S.C. 7253).

(e) PEANUTS.—

(1) IN GENERAL.—Of the total amount made available under subsection (a), the Secretary shall use not to exceed $45,000,000 to provide payments to producers of quota peanuts or additional peanuts to partially compensate the producers for the loss of markets for the 1998 crop of peanuts.

(2) AMOUNT.—The amount of a payment made to producers on a farm of quota peanuts or additional peanuts under paragraph (1) shall be equal to the product obtained by multiplying—

(A) the quantity of quota peanuts or additional peanuts produced or considered produced by the producers under section 155 of the Agricultural Market Transition Act (7 U.S.C. 7271); by

(B) an amount equal to 5 percent of the loan rate established for quota peanuts or additional peanuts, respectively, under section 155 of that Act.

SEC. ___03. CROP INSURANCE PREMIUM REFUNDS.

The Secretary, acting through the Federal Crop Insurance Corporation, shall use not more than $400,000,000 of funds of the Commodity Credit Corporation to provide premium refunds or other assistance to purchasers of crop insurance for their 2000 or preceding insured crops.

SEC. ___04. CROP LOSS ASSISTANCE.

(a) IN GENERAL.—In addition to amounts that have been made available before the date of enactment of this Act to carry out section 1102 of the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 1999 (7 U.S.C. 1421 note; Public Law 105–277) under other law, the Secretary shall use not more than $360,000,000 of funds of the Commodity Credit Corporation to provide crop loss assistance in accordance with that section in a manner that, to the maximum extent practicable—

(1) fully compensates agricultural producers for crop losses in accordance with that section (including regulations promulgated to carry out that section); and

(2) provides equitable treatment under that section for agricultural producers described in subsections (b) and (c) of that section.

(b) CITRUS CROP LOSSES.—Notwithstanding any other provision of law (including regulations), for the purposes of section 1102 of that Act, a loss of a citrus crop caused by a disaster in 1998 shall be considered to be a loss of the 1998 crop of the citrus crop, without regard to the time of harvest.

(c) COMPENSATION FOR DENIAL OF CROP LOSS ASSISTANCE BASED ON TAXPAYER IDENTIFICATION NUMBERS.—The Secretary shall use not more than $70,000,000 of funds of the Commodity Credit Corporation to make payments to producers on a farm that were denied crop loss assistance under section 1102 of the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 1999 (7 U.S.C. 1421 note; Public Law 105–277), as the result of a change in the taxpayer identification numbers of the producers if the Secretary determines that the change was not made to create an advantage for the producers in the crop insurance program through lower premiums or higher actual production histories.

SEC. ___05. EMERGENCY LIVESTOCK FEED ASSISTANCE.

For an additional amount to provide emergency livestock feed assistance in accordance with section 1103 of the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 1999 (7 U.S.C. 1421 note; Public Law 105–277), there is appropriated, out of any money in the Treasury not otherwise appropriated, $295,000,000.

SEC. ___06. FUNDS FOR STRENGTHENING MARKETS, INCOME, AND SUPPLY (SECTION 32).

For an additional amount for the fund maintained for funds made available under section 32 of the Act of August 24, 1935 (7 U.S.C. 612c), there is appropriated, out of any money in the Treasury not otherwise appropriated, $355,000,000.

SEC. ___07. DISASTER RESERVE.

(a) IN GENERAL.—For the disaster reserve established under section 813 of the Agricultural Act of 1970 (7 U.S.C. 1427a), there is appropriated, out of any money in the Treasury not otherwise appropriated, $500,000,000.

(b) CROP AND LIVESTOCK INDEMNITY PAYMENTS.—The Secretary shall use the amount made available under this section to establish a program to provide crop or livestock indemnity payments to agricultural producers for the purpose of remedying losses caused by damaging weather or related condition resulting from a natural or major disaster or emergency over a prolonged period.

SEC. ___08. FLOODED LAND RESERVE PROGRAM.

For an additional amount to carry out a flooded land reserve program, there is appropriated, out of any money in the Treasury not otherwise appropriated, $300,000,000.

SEC. ___09. FARM SERVICE AGENCY.

For an additional amount for the Farm Service Agency, to be used at the discretion of the Secretary, for salaries and expenses of the Farm Service Agency, there is appropriated, out of any money in the Treasury not otherwise appropriated, $50,000,000.

SEC. ___10. OILSEED PURCHASES AND DONATIONS.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall use not less than $750,000,000 of funds of the Commodity Credit Corporation for the purchase and distribution of oilseeds, vegetable oil, and oilseed meal under applicable food aid authorities, including—

(1) section 416(b) of the Agricultural Act of 1949 (7 U.S.C. 1431(b));

(2) the Food for Progress Act of 1985 (7 U.S.C. 1736o); and

(3) the Agricultural Trade Development and Assistance Act of 1954 (7 U.S.C. 1691 et seq.).

(b) LEAST DEVELOPED COUNTRIES.—Not less than 75 percent of the commodities distributed pursuant to this section shall be made available to least developed countries, as determined by the Secretary.

(c) LOCAL CURRENCIES.—To the maximum extent practicable, local currencies generated from the sale of commodities under this section shall be used for development purposes that foster United States agricultural exports.

SEC. ___11. UPLAND COTTON PRICE COMPETITIVENESS.

(a) IN GENERAL.—Section 136(a) of the Agricultural Market Transition Act (7 U.S.C. 7236(a)) is amended—

(1) in paragraph (1), by inserting ''(in the case of each of the 1999–2000 and 2000–2001 marketing years for upland cotton, at the option of the recipient)'' after ''or cash payments'';

(2) by inserting ''(or, in the case of each of the 1999–2000 and 2000–2001 marketing years for upland cotton, 1.25 cents per pound)'' after ''3 cents per pound'' each place it appears;

(3) in paragraph (3), by striking subparagraph (A) and inserting the following:

''(A) REDEMPTION, MARKETING, OR EXCHANGE.—

''(i) IN GENERAL.—The Secretary shall establish procedures for redeeming marketing certificates for cash or marketing or exchange of the certificates for—

''(I) except as provided in subclause (II), agricultural commodities owned by the Commodity Credit Corporation in such manner, and at such price levels, as the Secretary determines will best effectuate the purposes of cotton user marketing certificates; or

''(II) in the case of each of the 1999–2000 and 2000–2001 marketing years for upland cotton, agricultural commodities owned by the Commodity Credit Corporation or pledged to the Commodity Credit Corporation as collateral for a loan in such manner, and at such price levels, as the Secretary determines will best effectuate the purposes of cotton user marketing certificates, including enhancing the competitiveness and marketability of United States cotton.

''(ii) PRICE RESTRICTIONS.—Any price restrictions that would otherwise apply to the disposition of agricultural commodities by the Commodity Credit Corporation shall not apply to the redemption of certificates under this subparagraph.''; and

(4) in paragraph (4), by inserting before the period at the end the following: '', except that this paragraph shall not apply to each of fiscal years 2000 and 2001''.

(b) ENSURING THE AVAILABILITY OF UPLAND COTTON.—Section 136(b) of the Agricultural Market Transition Act (7 U.S.C. 7236(b)) is amended—

(1) in paragraph (1), by striking ''The'' and inserting ''Except as provided in paragraph (7), the''; and

(2) by adding at the end the following:

''(7) 1999–2000 AND 2000–2001 MARKETING YEARS.—

''(A) IN GENERAL.—In the case of each of the 1999–2000 and 2000–2001 marketing years for upland cotton, the President shall carry out an import quota program as provided in this paragraph.

''(B) PROGRAM REQUIREMENTS.—Except as provided in subparagraph (C), whenever the Secretary determines and announces that for any consecutive 4-week period, the Friday through Thursday average price quotation for the lowest-priced United States growth, as quoted for Middling (M) 1$\frac{3}{32}$-inch cotton, delivered C.I.F. Northern Europe, adjusted for the value of any certificate issued under subsection (a), exceeds the Northern Europe price by more than 1.25 cents per pound, there shall immediately be in effect a special import quota.

''(C) TIGHT DOMESTIC SUPPLY.—During any month for which the Secretary estimates the season-ending United States upland cotton stocks-to-use ratio, as determined under subparagraph (D), to be below 16 percent, the Secretary, in making the determination under subparagraph (B), shall not adjust the Friday through Thursday average price quotation for the lowest-priced United States growth, as quoted for Middling (M) 1$\frac{3}{32}$-inch cotton, delivered C.I.F. Northern Europe, for the value of any certificates issued under subsection (a).

''(D) SEASON-ENDING UNITED STATES STOCKS-TO-USE RATIO.—For the purposes of making estimates under subparagraph (C), the Secretary shall, on a monthly basis, estimate and report the season-ending United States upland cotton stocks-to-use ratio, excluding projected raw cotton imports but including the quantity of raw cotton that has been imported into the United States during the marketing year.

''(E) LIMITATION.—The quantity of cotton entered into the United States during any marketing year described in subparagraph (A) under the special import quota established under this paragraph may not exceed the equivalent of 5 weeks' consumption of upland cotton by domestic mills at the seasonally adjusted average rate of the 3 months immediately preceding the first special import quota established in any marketing year.''.

(c) REMOVAL OF SUSPENSION OF MARKETING CERTIFICATE AUTHORITY.—Section 171(b)(1)(G) of the Agricultural Market Transition Act (7 U.S.C. 7301(b)(1)(G)) is amended by inserting before the period at the end the following: '', except that this subparagraph shall not apply to each of the 1999–2000 and 2000–2001 marketing years for upland cotton''.

(d) REDEMPTION OF MARKETING CERTIFICATES.—Section 115 of the Agricultural Act of 1949 (7 U.S.C. 1445k) is amended—

(1) in subsection (a)—

(A) by striking ''rice (other than negotiable marketing certificates for upland cotton or rice)'' and inserting ''rice, including the issuance of negotiable marketing certificates for upland cotton or rice'';

(B) in paragraph (1), by striking ''and'' at the end;

(C) in paragraph (2), by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following:

''(3) redeem negotiable marketing certificates for cash under such terms and conditions as are established by the Secretary.''; and

(2) in the second sentence of subsection (c), by striking ''export enhancement program or the marketing promotion program established under the Agricultural Trade Act of 1978'' and inserting ''market access program or the export enhancement program established under sections 203 and 301 of the Agricultural Trade Act of 1978 (7 U.S.C. 5623, 5651)''.

SEC. ___12. EMERGENCY CONSERVATION PROGRAM.

For an additional amount to carry out the emergency conservation program authorized under sections 401, 402, and 404 of the Agricultural Credit Act of 1978 (16 U.S.C. 2201, 2202, 2204) to provide cost-sharing assistance to eligible persons—

(1) to control weeds and establish cover crops in counties in which at least 20 percent of available cropland is prevented from being planted to an agricultural commodity as the result of damaging weather or related condition; and

(2) to reestablish permanent vegetative cover on acreage on which such cover is absent as the result of prolonged flooding;

as determined by the Secretary, there is appropriated, out of any money in the Treasury not otherwise appropriated, $30,000,000.

SEC. ___13. EMERGENCY REQUIREMENT.

(a) IN GENERAL.—The entire amount necessary to carry out this title and the amendments made by this title shall be available only to the extent that an official budget request for the entire amount, that includes designation of the entire amount of the request as an emergency requirement as defined in the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900 et seq.) is transmitted by the President to Congress.

(b) DESIGNATION.—The entire amount is designated by Congress as an emergency requirement pursuant to section 251(b)(2)(A) of that Act (2 U.S.C. 901(b)(2)(A)).

SEC. ___14. AVAILABILITY.

The amount necessary to carry out this title and the amendments made by this title shall be available for fiscal years 1999 and 2000.

PATIENTS' BILL OF RIGHTS ACT OF 1999

BINGAMAN (AND OTHERS) AMENDMENT NO. 1245

Mr. KENNEDY (for Mr. BINGAMAN (for himself, Mr. HARKIN, Mr. DODD, Mrs. MURRAY, Mr. REID, Mr. EDWARDS, Mrs. BOXER, Mr. DURBIN, Mr. GRAHAM, Mr. KENNEDY, Mr. DASCHLE, Mr. FEINGOLD, Mr. ROCKEFELLER, Mrs. FEINSTEIN, Mr. REED, and Mr. KERRY)) proposed an amendment to amendment No. 1243 proposed by Ms. COLLINS to the bill, S. 1344, supra; as follows:

At the appropriate place, insert the following:

SEC. ___. ACCESS TO SPECIALTY CARE.

(a) SPECIALTY CARE FOR COVERED SERVICES.—

(1) IN GENERAL.—If—

(A) an individual is a participant or beneficiary under a group health plan or an enrollee under group health insurance coverage offered by a health insurance issuer,

(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, and

(C) benefits for such treatment are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

(2) SPECIALIST DEFINED.—For purposes of this subsection, the term ''specialist'' means, with respect to a condition, a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

(3) CARE UNDER REFERRAL.—A group health plan, or health insurance issuer in connection with group health insurance coverage, may require that the care provided to an individual pursuant to such referral under paragraph (1) be—

(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) 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 individual's condition and that is a participating provider with respect to such treatment.

(5) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

(b) SPECIALISTS AS CARE COORDINATORS.—

(1) IN GENERAL.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary or enrollee and who has an ongoing special condition (as defined in paragraph (3)) may receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care. If such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(2) TREATMENT AS CARE COORDINATOR.—Such specialist shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan (referred to in subsection (a)(3)(A)).

(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ''special condition'' means a condition or disease that—

(A) is life-threatening, degenerative, or disabling, and

(B) requires specialized medical care over a prolonged period of time.

(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

(c) STANDING REFERRALS.—

(1) IN GENERAL.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or 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 make such a referral to such a specialist.

(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

(d) APPLICATION OF SECTION.—This section shall supersede the provisions of section 104.

(e) REVIEW.—Failure to meet the requirements of this section shall constitute an appealable decision under section 132(a)(2).

(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any provision of this subchapter, the group health plan shall not be liable for such violation unless the plan caused such violation.

(g) NONAPPLICATION OF CERTAIN PROVISION.—Only for purposes of applying the requirements of this section under section 714 of the Employee Retirement Income Security Act of 1974 (as added by section 301 of this Act), sections 2707 and 2753 of the Public Health Service Act (as added by sections 201 and 202 of this Act), and section 9813 of the Internal Revenue Code of 1986 (as added by section 401 of this Act)—

(1) section 2721(b)(2) of the Public Health Service Act and section 9831(a)(1) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section; and

(2) with respect to limited scope dental benefits, subparagraph (A) of section 733(c)(2) of the Employee Retirement Income Security Act of 1974, subparagraph (A) of section 2791(c)(2) of the Public Health Service Act, and subparagraph (A) of section 9832(c)(2) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section.

(h) NO IMPACT ON SOCIAL SECURITY TRUST FUND.—

(1) IN GENERAL.—Nothing in this section shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(2) TRANSFERS.—

(A) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this section has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(B) TRANSFER OF FUNDS.—If, under subparagraph (A), the Secretary of the Treasury estimates that the enactment of this section has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such section.

(i) LIMITATION ON ACTIONS.—

(1) IN GENERAL.—Except as provided for in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 of the Employee Retirement Income Security Act of 1974 by a participant or beneficiary seeking relief based on the application of any provision in this section.

(2) PERMISSIBLE ACTIONS.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 of the Employee Retirement Income Security Act of 1974 by a participant or beneficiary seeking relief based on the application of this section to the individual circumstances of that participant or beneficiary; except that—

(A) such an action may not be brought or maintained as a class action; and

(B) in such an action relief may only provide for the provision of (or payment for) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.

(j) EFFECTIVE DATE.—The provisions of this section shall apply to group health plans for plan years beginning after, and to health insurance issuers for coverage offered or sold after, October 1, 2000.

(k) INFORMATION REQUIREMENTS.—

(1) INFORMATION FROM GROUP HEALTH PLANS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following:

''(7) INFORMATION FROM GROUP HEALTH PLANS.—

''(A) PROVISION OF INFORMATION BY GROUP HEALTH PLANS.—The administrator of a group health plan subject to the requirements of paragraph (1) shall provide to the Secretary such of the information elements described in subparagraph (C) as the Secretary specifies, and in such manner and at such times as the Secretary may specify (but not more frequently than 4 times per year), with respect to each individual covered under the plan who is entitled to any benefits under this title.

''(B) PROVISION OF INFORMATION BY EMPLOYERS AND EMPLOYEE ORGANIZATIONS.—An employer (or employee organization) that maintains or participates in a group health plan subject to the requirements of paragraph (1) shall provide to the administrator of the plan such of the information elements required to be provided under subparagraph (A), and in such manner and at such times as the Secretary may specify, at a frequency consistent with that required under subparagraph (A) with respect to each individual described in subparagraph (A) who is covered under the plan by reason of employment with that employer or membership in the organization.

''(C) INFORMATION ELEMENTS.—The information elements described in this subparagraph are the following:

''(i) ELEMENTS CONCERNING THE INDIVIDUAL.—

''(I) The individual's name.

''(II) The individual's date of birth.

''(III) The individual's sex.

''(IV) The individual's social security insurance number.

''(V) The number assigned by the Secretary to the individual for claims under this title.

''(VI) The family relationship of the individual to the person who has or had current or employment status with the employer.

''(ii) ELEMENTS CONCERNING THE FAMILY MEMBER WITH CURRENT OR FORMER EMPLOYMENT STATUS.—

''(I) The name of the person in the individual's family who has current or former employment status with the employer.

''(II) That person's social security insurance number.

''(III) The number or other identifier assigned by the plan to that person.

''(IV) The periods of coverage for that person under the plan.

''(V) The employment status of that person (current or former) during those periods of coverage.

''(VI) The classes (of that person's family members) covered under the plan.

''(iii) PLAN ELEMENTS.—

''(I) The items and services covered under the plan.

''(II) The name and address to which claims under the plan are to be sent.

''(iv) ELEMENTS CONCERNING THE EMPLOYER.—

''(I) The employer's name.

''(II) The employer's address.

''(III) The employer identification number of the employer.

''(D) USE OF IDENTIFIERS.—The administrator of a group health plan shall utilize a unique identifier for the plan in providing information under subparagraph (A) and in other transactions, as may be specified by the Secretary, related to the provisions of this subsection. The Secretary may provide to the administrator the unique identifier described in the preceding sentence.

''(E) PENALTY FOR NONCOMPLIANCE.—Any entity that knowingly and willfully fails to comply with a requirement imposed by the previous subparagraphs shall be subject to a civil money penalty not to exceed $1,000 for each incident of such failure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as those provisions apply to a penalty or proceeding under section 1128A(a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect 180 days after the date of the enactment of this Act.

(l) MODIFICATION TO FOREIGN TAX CREDIT CARRYBACK AND CARRYOVER PERIODS.—

(1) IN GENERAL.—Section 904(c) of the Internal Revenue Code of 1986 (relating to limitation on credit) is amended—

(A) by striking ''in the second preceding taxable year,'', and

(B) by striking ''or fifth'' and inserting ''fifth, sixth, or seventh''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to credits arising in taxable years beginning after December 31, 2001.

MCCAIN AMENDMENTS NOS. 1246–1249

(Ordered to lie on the table.)

Mr. MCCAIN submitted four amendments intended to be proposed by him to the bill, S. 1344, supra; as follows:

AMENDMENT NO. 1246

At the appropriate place, insert the following:

SEC. ___. PERMISSIBILITY OF CIVIL ACTIONS.

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following subsection:

''(e) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS.—

''(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

''(A) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action under State law to recover damages resulting from personal injury or for wrongful death against any person—

''(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan; or

''(ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

''(B) REQUIREMENTS.—A participant or beneficiary may only commence a civil action under subparagraph (A) if the participant or beneficiary has participated in and completed an external appeal with respect to the decision involved.

''(C) DAMAGES.—In a civil action permitted under subparagraph (B), the participant or beneficiary may only seek compensatory damages.

''(D) LIMITATION ON DAMAGES.—A group health plan shall not be liable for any noneconomic damages in the case of a cause of action brought under subparagraph (A) in excess of $250,000.

''(2) EXCEPTION FOR EMPLOYERS AND MEDICAL PROVIDERS.—

''(A) EMPLOYERS.—

''(i) IN GENERAL.—Subject to clause (ii), paragraph (1) does not authorize—

''(I) any cause of action against an employer maintaining the group health plan or against an employee of such an employer acting within the scope of employment, or

''(II) a right of recovery or indemnity by a person against an employer (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1).

''(ii) SPECIAL RULE.—Clause (i) shall not preclude any cause of action described in paragraph (1) against an employer (or against an employee of such an employer acting within the scope of employment) if—

''(I) such action is based on the employer's (or employee's) exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(II) the exercise by such employer (or employee of such authority) resulted in personal injury or wrongful death.

''(B) MEDICAL PROVIDERS.—Paragraph (1) does not authorize any cause of action against a health care provider for failure to provide a health care item or service where such provider acted in good faith in relying upon a determination by the group health plan involved to deny such item or service and such denial results in injury or death.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting a cause of action under State law for the failure to provide an item or service which is specifically excluded under the group health plan involved.

''(4) DEFINITION.—In this subsection, the term 'medical provider' means a physician or other health care professional providing health care services.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts and omissions occurring on or after the date of the enactment of this Act from which a cause of action arises.

AMENDMENT NO. 1247

At the appropriate place, insert the following:

SEC. ___. COVERAGE OF MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

(a) GROUP HEALTH PLANS.—

(1) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

(A) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.), as amended by section 201, is further amended by adding at the end the following:

''SEC. 2708. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 713(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.''.

(B) CONFORMING AMENDMENT.—Section 2723(c) of the Public Health Service Act (42 U.S.C. 300gg–23(c)) is amended by striking ''section 2704'' and inserting ''sections 2704 and 2708''.

(2) ERISA AMENDMENTS.—

(A) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 301, is further amended by adding at the end the following:

''SEC. 715. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease,

or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.''.

(B) CONFORMING AMENDMENTS.—

(i) Section 731(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191(c)) is amended by striking ''section 711'' and inserting ''sections 711 and 715''.

(ii) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 715''.

(iii) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''.

(3) INTERNAL REVENUE CODE AMENDMENTS.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 401, is further amended—

(A) in the table of sections, by inserting after the item relating to section 9813 the following new item:

''Sec. 9814. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''; and

(B) by inserting after section 9812 the following:

''SEC. 9814. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.''.

(b) INDIVIDUAL HEALTH INSURANCE.—

(1) IN GENERAL.—Part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-41 et seq.), as amended by section 202, is further amended by inserting after section 2753 the following new section:

''SEC. 2754. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 713(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.''.

(2) CONFORMING AMENDMENT.—Section 2762(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–62(b)(2)) is amended by striking ''section 2751'' and inserting ''sections 2751 and 2754''.

(c) EFFECTIVE DATES.—

(1) GROUP MARKET.—The amendments made by subsection (a) shall apply with respect to group health plans for plan years beginning on or after January 1, 2000.

(2) INDIVIDUAL MARKET.—The amendment made by subsection (b) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

(d) COORDINATED REGULATIONS.—Section 104(1) of Health Insurance Portability and Accountability Act of 1996 is amended by striking ''this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, and chapter 100 of the Internal Revenue Code of 1986''.

● Mr. McCAIN. Mr. President, I am offering an amendment which would help one of our most vulnerable populations, our children, by addressing the growing problem of HMOs denying insurance coverage of reconstructive surgery for kids suffering from physical defects and deformities. This amendment would require medical plans to cover the medical procedures to reconstruct a child's appearance if they are born with abnormal structures of the body, including a cleft lip or palate.

Today, approximately seven percent of American children are born with pediatric deformities and congenital defects such as cleft lip, cleft palate, missing external limbs, such as ears, and other facial deformities. Unfortunately, it has become commonplace for insurance companies to label these medical procedures as cosmetic surgery and deny coverage to help these children eradicate or reduce deformities and acquire a normal appearance.

In fact, a recent survey of the American Society of Plastic and Reconstructive Surgeons indicated that over half of the plastic surgeons questioned have had a pediatric patient in the last two years who has been denied, or experienced tremendous difficulty in obtaining, insurance coverage for there surgical procedures.

I find it disgraceful that many insurance companies claim that reconstructive procedures are not medically necessary and are therefor cosmetic. These companies claim that medical services restoring some semblance of a normal appearance are superfluous and performed merely for vanity or cosmetic purposes. Many of my colleagues may be wondering how such a ludicrous and cruel practice can occur when it seems obvious that these procedures are clearly reconstructive and not cosmetic in nature. While an insurance plan may attempt to claim that helping a child born without ears or with a cleft so severe it extends to her hairline is superfluous surgery, I adamantly disagree and am committed to stopping the abhorrent practice.

The medical and developmental complications which arise from many of these conditions are tremendous. Speech impediments, hearing difficulties and dental problems are a few of

the physical side effects which may result from a child's physical deformity. In addition, the effect a child's deformities may have on their personal development, confidence, self-esteem and their future aspirations and achievements are often very far reaching.

A healthy self image is vitally important to develop self esteem and confidence. How a person sees themselves, and how others see them, determines how the person feels about himself and defines whether he has the strength to resist unfortunate obstacles, including the taunting of peer and disengagement from school activities. As parents, we want our children to be armed with a healthy sense of self esteem and confidence. The best way to guarantee that happens is to help them develop a strong and health self image. While this is critical, we must be pragmatic and recognize that we live in a society which places a high value on physical beauty and often unfairly uses it as a measurement of a person's worth, ability or potential in society. While this is wrong and we must work together to instill self-worth in our children, it is unrealistic to not recognize the importance which is place on physical appearances in our world and the unfair obstacles which children born with deformities face if they are not provided access medical services which help them attain a normal physical appearance.

Some of my colleagues may know that my daughter Bridget, whom Cindy and I adopted from Mother Theresa's orphanage in Bangladesh, was born with a severe cleft. We are fortunate to have had the means and opportunities to provide the expert medical care necessary to help Bridget physically and emotionally. However, we, too, encountered numerous obstacles and denials by our insurance providers who did not believe that Bridget's medical treatment was necessary. Fortunately, Cindy and I were able to provide Bridget access to the reconstructive services she needs, despite denials by our health plan. Unfortunately, most hard working American families are not so fortunate. This is not right and it is why I am offering this important amendment to assist all American children.

I want to stress that this is not a new mandate which could cause health care premiums to escalate. What I am proposing simply prohibits plans from frivolously ruling that substantial, medically needed reconstructive surgery for children to obtain a relatively normal appearance is cosmetic, or denying reconstructive coverage which American families have purchases. I urge each of my colleagues to work with me on behalf of our children and ensure that they are afforded an opportunity to realize their full potential.●

AMENDMENT NO. 1248

At the appropriate place, insert the following:

SEC. ___. COVERAGE OF MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

(a) GROUP HEALTH PLANS.—

(1) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

(A) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.), as amended by section 203(a), is further amended by adding at the end the following:

"SEC. 2708. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 713(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.''.

(B) CONFORMING AMENDMENT.—Section 2723(c) of the Public Health Service Act (42 U.S.C. 300gg–23(c)) is amended by striking ''section 2704'' and inserting ''sections 2704 and 2708''.

(2) ERISA AMENDMENTS.—

(A) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 111 and 202(a), is further amended by adding at the end the following:

"SEC. 716. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.''.

(B) CONFORMING AMENDMENTS.—

(i) Section 731(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191(c)) is amended by striking ''section 711'' and inserting ''sections 711 and 716''.

(ii) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 716''.

(iii) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) is amended by inserting after the item relating to section 715 the following new item:

''Sec. 716. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''.

(3) INTERNAL REVENUE CODE AMENDMENTS.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 204, is further amended—

(A) in the table of sections, by inserting after the item relating to section 9814 the following new item:

''Sec. 9815. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''; and

(B) by inserting after section 9814 the following:

"SEC. 9815. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment

which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.''.

(b) INDIVIDUAL HEALTH INSURANCE.—

(1) IN GENERAL.—Part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-41 et seq.), as amended by section 203(b), is further amended by inserting after section 2753 the following new section:

''SEC. 2754. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 713(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.''.

(2) CONFORMING AMENDMENT.—Section 2762(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–62(b)(2)) is amended by striking ''section 2751'' and inserting ''sections 2751 and 2754''.

(c) EFFECTIVE DATES.—

(1) GROUP MARKET.—The amendments made by subsection (a) shall apply with respect to group health plans for plan years beginning on or after January 1, 2000.

(2) INDIVIDUAL MARKET.—The amendment made by subsection (b) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

(d) COORDINATED REGULATIONS.—Section 104(1) of Health Insurance Portability and Accountability Act of 1996 is amended by striking ''this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, and chapter 100 of the Internal Revenue Code of 1986''.

AMENDMENT NO. 1249

Strike section 302 of the bill and insert the following:

SEC. 302. PERMISSIBILITY OF CIVIL ACTIONS.

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following subsection:

''(e) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS.—

''(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

''(A) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action under State law to recover damages resulting from personal injury or for wrongful death against any person—

''(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan; or

''(ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

''(B) REQUIREMENTS.—A participant or beneficiary may only commence a civil action under subparagraph (A) if the participant or beneficiary has participated in and completed an external appeal with respect to the decision involved.

''(C) DAMAGES.—In a civil action permitted under subparagraph (B), the participant or beneficiary may only seek compensatory damages.

''(D) LIMITATION ON DAMAGES.—A group health plan shall not be liable for any noneconomic damages in the case of a cause of action brought under subparagraph (A) in excess of $250,000.

''(2) EXCEPTION FOR EMPLOYERS AND MEDICAL PROVIDERS.—

''(A) EMPLOYERS.—

''(i) IN GENERAL.—Subject to clause (ii), paragraph (1) does not authorize—

''(I) any cause of action against an employer maintaining the group health plan or against an employee of such an employer acting within the scope of employment, or

''(II) a right of recovery or indemnity by a person against an employer (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1).

''(ii) SPECIAL RULE.—Clause (i) shall not preclude any cause of action described in paragraph (1) against an employer (or against an employee of such an employer acting within the scope of employment) if—

''(I) such action is based on the employer's (or employee's) exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(II) the exercise by such employer (or employee of such authority) resulted in personal injury or wrongful death.

''(B) MEDICAL PROVIDERS.—Paragraph (1) does not authorize any cause of action against a health care provider for failure to provide a health care item or service where such provider acted in good faith in relying upon a determination by the group health plan involved to deny such item or service and such denial results in injury or death.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting a cause of action under State law for the failure to provide an item or service which is specifically excluded under the group health plan involved.

''(4) DEFINITION.—In this subsection, the term 'medical provider' means a physician or other health care professional providing health care services.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts and omissions occurring on or after the date of the enactment of this Act from which a cause of action arises.

NOTICE OF HEARING

SUBCOMMITTEE ON WATER AND POWER

Mr. SMITH of Oregon. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on Water and Power.

The hearing will take place on Wednesday, July 28, 1999 at 2:30 p.m. in room SD–366 of the Dirksen Senate Office Building in Washington, DC.

The purpose of this hearing is to receive testimony on S. 624, To authorize construction of the Fort Peck Reservation Rural Water System in the State of Montana, and for other purposes; S. 1211, to amend the Colorado River Basin Salinity Control Act to authorize additional measures to carry out the control of salinity upstream of Imperial Dam in a cost-effective manner; S. 1275, to authorize the Secretary of the Interior to produce and sell products and to sell publications relating to the Hoover Dam, and to deposit revenues generated from the sales in to the Colorado River Dam fund; and S. 1236, to extend the deadline under the Federal Power Act for commencement of the construction of the Arrowrock Dam Hydroelectric Project in the State of Idaho.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Subcommittee on Water and Power, Committee on Energy and Natural Resources, United States Senate, 364 Dirksen Senate Office Building, Washington, DC, 20510–6150.

For further information, please call Kristin Phillips, Staff Assistant or Colleen Deegan, Counsel, at (202) 224–8115.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. JEFFORDS. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be granted permission to meet

during the session of the Senate on Wednesday, July 14, for purposes of conducting a joint committee hearing with the Committee on Indian Affairs, which is scheduled to begin at 9:30 a.m. The purpose of this oversight hearing is to receive testimony on the Report of the General Accounting Office (GAO) on the Interior Department's Planned Trust Fund.

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

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Mr. JEFFORDS. Mr. President, I ask unanimous consent that the full Committee on Environment and Public Works be granted permission to conduct a hearing on conformity under the Clean Air Act on Wednesday, July 14, 9:30 a.m., Hearing Room (SD–406).

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

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. JEFFORDS. Mr. President, I ask unanimous consent that the Governmental Affairs Committee be permitted to meet on Wednesday, July 14, 1999 at 3:00 p.m. for a hearing on S. 1214, the Federalism Accountability Act.

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

COMMITTEE ON INDIAN AFFAIRS

Mr. JEFFORDS. Mr. President, I ask unanimous consent that the Senate Committee on Indian Affairs and the Senate Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Wednesday, July 14, 1999 at 9:30 a.m. to conduct a joint oversight hearing on the Report of the General Accounting Office (GAO) on the Interior Department's Planned Trust Fund Reform. The hearing will be held in room 216 of the Hart Senate Office Building.

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

COMMITTEE ON THE JUDICIARY

Mr. JEFFORDS. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet for a hearing re Broadband: Competition and Consumer Choice in High-Speed Internet Services and Technologies, during the session of the Senate on Wednesday, July 14, 1999, at 10:00 a.m., in SD226.

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

SELECT COMMITTEE ON INTELLIGENCE

Mr. JEFFORDS. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Wednesday, July 14, 1999 at 2:00 p.m. to hold a closed hearing on intelligence matters.

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

SUBCOMMITTEE ON CHILDREN AND FAMILIES

Mr. JEFFORDS. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions, Subcommittee on Children and Families, be authorized to meet for a hearing on FMLA Oversight during the session of the Senate on Wednesday, July 14, 1999, at 9:30 a.m.

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

SUBCOMMITTEE ON INTERNATIONAL TRADE

Mr. JEFFORDS. Mr. President, the Finance Committee Subcommittee on International Trade requests unanimous consent to conduct a hearing on Wednesday, July 14, 1999 beginning at 3:00 p.m. in room 215 Dirksen.

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

ADDITIONAL STATEMENTS

TRIBUTE TO EVERETT McKENNEY, LEGION OF HONOR AWARD RECIPIENT

● Ms. SNOWE. Mr. President, I rise to congratulate a courageous World War I veteran from my home state of Maine who on Friday will be awarded the most prestigious honor that France bestows, the National Order of the Legion of Honor.

Everett McKenney who has lived in Augusta and Waterville will receive this distinguished honor for the tremendous sacrifices he made to safeguard freedom and democracy while serving in France during the first World War.

In 1998, the French Government announced Project 1918–1998. The purpose of Project 1918–1998 is to honor the 80th anniversary of the armistice of World War I, and as part of this undertaking, France announced that it would award the Legion of Honor designation to surviving American veterans who, like Mr. McKenney, served in France between 1914 and 1918. This step is taken in recognition of the decisive support Americans gave to French soldiers as they fought to defend French soil.

Up to 1,000 American veterans who served in France during World War I may still be alive today, and there is a search underway to locate as many of these men and women as possible.

Private Everett McKenney, who is 104 and a longtime resident of Waterville and Augusta, has two daughters, five grandchildren, four great grandchildren, and one great, great grandchild. He was the youngest of four children and was born in Freedom, Maine in 1895. He enlisted in July 1918 at 23, in Waterville. He was stationed in Fort Devens, Massachusetts and received special training in New Jersey. He was assigned to the 41st Rainbow Division and later was assigned to the 101st Field Artillery unit. In New Jersey, he was notified to pack his gear and prepare for an overseas assignment. During a 12-day Atlantic crossing, a flu epidemic broke out and many of his comrades were buried at sea. This would be the first of many trials he would face.

I have nothing but the utmost respect for those who have served with courage, honor and distinction when their country—and the world—needed them so desperately. Indeed, I am truly honored to represent these men and women as Maine's senior Senator.

On November 11, 1918, almost 81 years ago, at the eleventh hour, the Armistice was signed in France that silenced the guns and ended the carnage of World War I. From the War for Independence, to World War I, through the Persian Gulf War and the Balkans more than two hundred years later, Americans like Everett have answered the call to duty—not for the glory or conquest or empire, but to ensure that the flame of liberty burns ever brightly.

The debt of gratitude owed to our veterans can never be fully repaid. What we can and must do for those who, like Mr. McKenney, answered the call to duty is keep alive the values of freedom and democracy they have defended, and honor them as the guardians of those ideals.

Elmer Runyon once wrote that: ''We will remain the home of the free only as long as we are also the home of the brave.'' Today, America and the world is basking in the shine of freedom because of yesterday's and today's service men and women—who offer nobly to sacrifice in war so that others may live in peace. These are America's true heroes.

This occasion reminds us that winning freedom is not the same as keeping it. The cost of safeguarding freedom is high. It requires vigilance and sacrifice. Time and again when freedom has been threatened, men like Everett McKenney emerged as heroes. America's veterans have served our country and the world ably in times of need, and know well the personal sacrifices which the defense of freedom demands. It is a true honor to congratulate Mr. McKenney on a well-deserved recognition.●

RAE LIU

● Mr. MOYNIHAN. Mr. President, today I rise to thank Rae Liu, a brilliant young intern from Columbia University where she is a National Merit Scholar and a debater. Rae came to my office this May. When an opening appeared on my personal staff in June, Rae was our unanimous choice to fill it until we could hire someone permanently. At 18, she took on the task of being a full-fledged member of my staff.

From the outset, Rae displayed judgment, maturity, initiative, and a work ethic way beyond her years. She worked tirelessly overhauling and drafting legislation, attending policy reviews, and meeting with constituents. She quickly made herself indispensable to my foreign policy, intelligence, and defense legislative assistant, and distinguished herself with her quick mind, sharp wit and devastating competence. It is rare to see so much ability and professionalism in one so young.

Rae is exactly the sort of young person we need to attract to public service. This is not going to be easy as we compete with the best law and business schools for talented young Americans who can earn much more than taking the Queen's shilling. We must try, however, for if we do not, we risk losing a new generation of bright ideas and insights. This would be not only tragic but shortsighted.

I wish this young lady from Texas godspeed in her studies and thank her again for her contributions.●

TRIBUTE TO DOCTOR EUGENE OLIVERI

● Mr. ABRAHAM. Mr. President, I rise today to honor the newly elected President of the American Osteopathic Association, Dr. Eugene Oliveri.

Dr. Oliveri is a prominent leader in the practice of osteopathic medicine. Throughout his career, he has maintained the strongest of commitments to the highest level of medical standards. From his early days as an undergraduate at Brooklyn College in new York, Dr. Oliveri has distinguished himself for his extensive knowledge and tireless support of osteopathy. Dedicated to helping others, Dr. Oliveri took two years off from his personal studies to work in the U.S. Army Medical Corps. Perhaps most importantly, Dr. Oliveri has raised three wonderful children: Gregory, Lisa, and Michelle.

Dr. Oliveri serves on numerous professional boards, and is currently practicing at Botsford General Hospital in Farmington Hills, Michigan, as the senior member of the Department of Internal Medicine. He also serves as a director of a fellowship program and chairman of a section of Gastroenterology at Botsford Hospital. Most recently, he has also served as a Vice-Chairman for the American Osteopathic Association. Dr. Oliveri's experience and renowned leadership capabilities make him well suited for this exciting new challenge.

Mr. President, it gives me great pleasure to congratulate Dr. Oliveri on this tremendous honor. I am confident that the American Osteopathic Association will be well served during his tenure as President.●

TRIBUTE TO JOHN McLAUGHLIN

● Mr. SMITH of New Hampshire. Mr. President, I rise today to honor John McLaughlin, Chairman of McLaughlin Transportation Systems, Inc. for being named the 1999 Greater Nashua Chamber of Commerce Citizen of the Year.

The Citizen of the Year Award is an effort to recognize a local individual for their contributions to the betterment of life in the Greater Nashua Area. The award recipient has sustained a lifelong commitment to the best interests of Nashua and the state of New Hampshire. John has definitely exceeded these requirements.

A longtime resident of Nashua, New Hampshire, John started with his father's business as a teenager sweeping floors. After graduating from high school and serving in the armed forces, he went to work for the company upon his father's death in 1949. From the company's initial size of 3–4 trucks and a hand full of employees, McLaughlin Transportation has grown into a company that includes approximately 120 trucks, five facilities, and approximately 150 employees. The company's core focus is the moving and storing business, however, they have now expanded to include a limousine service and fuel-oil delivery business.

Although he has been extremely successful in business, John is equally recognized for his community stewardship. He has been involved with the Nashua Chamber for over 50 years, served for two decades as the Nashua fire commissioner and served four terms as the District 13 State Senator. In addition, he has held many leadership positions within the community, including the Nashua Parks and Recreation Commission, Rivier College Advisory Board, N.H. Council on Aging, and many more.

As a former small business owner, I admire John for his hard work, determination and dedication to the community. He is a role model for us all and I commend him for his efforts. It is an honor to represent him in the United States Senate.●

A TRIBUTE TO FRED GYLFE, LEGION OF HONOR AWARD RECIPIENT

● Ms. SNOWE. Mr. President, I rise today to pay tribute a veteran from Maine who this week will have bestowed upon him high honors from the French Government for the sacrifices he made during World War I.

Fred Gylfe will receive the most prestigious honor that France bestows, the award of the National Order of the Legion of Honor, in gratitude for the valor he displayed serving in France during the First World War.

Last year, the French Government announced Project 1918–1998, which honors the 80th anniversary of the armistice of World War I. As part of this undertaking, France is awarding the Legion of Honor Award to surviving American veterans who served in France between 1914 and 1918—in recognition for the crucial support American veterans lent to French soldiers fighting to defend French soil.

It is estimated that as many as 1,000 American veterans who served in France during World War I may still be living, and there is a search underway to locate as many of these men and women as possible.

Fred Gylfe was born in Worcester, Massachusetts on August 14, 1897. His parents emigrated from Sweden, and he was their first child born in the U.S. He entered the U.S. National Guard in 1916 and departed for France on May 16, 1918. He fought in Ypres/Lys and Saint Quentin Tunnel in the French province of Somme. He was a Sergeant in Headquarters Company for the 108th Infantry 27th division of the New York National Guard. He is the father of two children, and three grandchildren.

I have nothing but the utmost respect for those who have served with courage, honor and distinction, answering the call to duty when their country—and the world no less—needed them so desperately. Indeed, it is no small challenge to put into words the enormous pride I feel for the opportunity to represent men like Fred Gylfe as Maine's senior Senator.

On November 11, 1918, almost 81 years ago, at the eleventh hour, the Armistice was signed in France that silenced the guns and ended the carnage of World War I. From the War for Independence, to World War I, through the Persian Gulf War and the Balkans more than two hundred years later, Americans have answered the call to duty—not for the glory of conquest or empire, but to ensure that the flame of liberty burns ever brightly.

The debt of gratitude owed to our veterans can never be fully repaid. What we can and must do for the men and women who, like Mr. Gylfe, answered the call to duty is keep alive the values of freedom and democracy they have defended, and honor them as the guardians of those ideals.

This occasion reminds us that winning freedom is not the same as keeping it. The cost of safeguarding freedom is high. It requires vigilance and sacrifice. Time and gain when freedom has been threatened, men like Fred Gylfe emerged as heroes, America's veterans have served our country and the world ably in times of need, and know well the personal sacrifices which the defense of freedom demands. It is a true honor to congratulate this Maine hero today on such as well-deserved recognition.●

EXECUTIVE SESSION

NOMINATION OF ROBERT A. KATZMANN, OF NEW YORK

Mr. ENZI. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider Executive Calendar No. 160 on today's Executive Calendar. I further ask unanimous consent that the nomination be confirmed, the motion to reconsider be laid upon the table, any statements relating to the nomination be printed in the RECORD, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

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

The nomination was considered and confirmed, as follows:

DEPARTMENT OF JUSTICE

Robert A. Katzmann, of New York, to be United States Circuit Judge for the Second Circuit.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. LEAHY. Will my friend yield for a moment at this point?

The PRESIDING OFFICER. Does the Senator from Wyoming wish to yield to the Senator from Vermont?

Mr. ENZI. Certainly.

Mr. LEAHY. I thank my friend from Wyoming.

Mr. President, I know there are going to be more statements made afterward. We have just confirmed Robert Katzmann, of New York, to be United States Circuit Judge for the Second Circuit. This is to replace the very distinguished and former chief justice of the Second Circuit, Jon Newman, who has retired, or has taken senior status. I cannot say he is retired. I know how hard Judge Newman continues to work. I get reports from his former law clerk, Bruce Cohen, who is the chief counsel for the Democrats on the Judiciary Committee.

I note Judge Katzmann now for two reasons. First, of course, Vermont is in that circuit. But far more important, this is a man who was brought here at the strong urging and behest of the senior Senator from New York, my dear friend and one of the most distinguished Members of this body, Senator DANIEL PATRICK MOYNIHAN, really the intellectual giant of the Senate.

I first met now Judge Katzmann when Senator MOYNIHAN brought him to my office, and I was immediately impressed with him. This is the first circuit court judge to be confirmed this year.

Historians can determine what helped the most: the brilliance of persuasion of the distinguished Senator from New York or the brilliance of Judge Katzmann. I say that it was a symbiotic relationship that made the confirmation possible. I applaud my dear friend from across that great and beautiful Lake Champlain, my dear friend from New York, but I also commend Robert Katzmann. I thank my dear friend from Wyoming for allowing me to say this.

Mr. MOYNIHAN. Will the Senator from Wyoming yield for a very brief remark?

Mr. ENZI. Certainly.

Mr. MOYNIHAN. Mr. President, first, I thank my friend and distinguished ranking member on the Judiciary Committee for his remarks about Judge Katzmann, as I believe he now is. I am very much indebted to Senator HATCH, the chairman of the committee. I thank the acting majority leader, the Senator from Wyoming.

On a brief personal note, this is a very special moment for the Senator from New York. Judge Katzmann was a graduate student of mine. I was a member of the orals examining committee when he received his Ph.D. He has been a remarkable student, a professor of law at Georgetown University at this point, and an author of important articles and books on the relationship between the Congress and the judiciary, a subject little attended and important. It attracted the attention of Senator HATCH and Senator LEAHY.

I thank the Senator for his indulgence. I thank the Senate for its great good judgment in this important confirmation which I do believe history will one day record.

Mr. ENZI. Mr. President, I thank our colleagues for their kind words about our new judge. I will mention, any other statements relating to the nomination will be printed in the RECORD. I am certain that since he has had such distinguished tutoring, there will be more comments. I am pleased to know that.

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will now return to legislative session.

ORDERS FOR THURSDAY, JULY 15, 1999

Mr. ENZI. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until the hour of 9:30 a.m. on Thursday, July 15. I further ask unanimous consent that on Thursday, immediately following the prayer, the Journal of proceedings be approved to date, the morning hour be deemed to have expired, the time for the two leaders be reserved for their use later in the day, and the Senate stand in a period for morning business until 10 a.m., with Senators allowed to speak for up to 5 minutes each, with the following exceptions: Senator SPECTER, 15 minutes, and Senator BYRD, 15 minutes.

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

Mr. ENZI. Further, I ask unanimous consent that Senator NICKLES, or his designee, be recognized at 10 a.m. to offer an amendment.

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

PROGRAM

Mr. ENZI. Mr. President, for the information of all Senators, the Senate will convene at 9:30 a.m. and be in a period for morning business until 10 a.m. Following morning business, the Senate will immediately resume consideration of S. 1344, the Patients' Bill of Rights legislation. Senator NICKLES, or his designee, will then be recognized to offer a second-degree amendment to the Collins amendment No. 1243. By previous consent, this legislation will be completed on Thursday. Therefore, Senators can expect additional amendments and votes throughout tomorrow's session of the Senate.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. ENZI. Mr. President, if there is no further business to come before the Senate, I now ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 8:19 p.m., adjourned until Thursday, July 15, 1999, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate July 14, 1999:

THE JUDICIARY

JAMES J. BRADY, OF LOUISIANA, TO BE UNITED STATES DISTRICT JUDGE FOR THE MIDDLE DISTRICT OF LOUISIANA VICE JOHN V. PARKER, RETIRED.

CHARLES A. PANNELL, JR., OF GEORGIA, TO BE UNITED STATES DISTRICT JUDGE FOR THE NORTHERN DISTRICT OF GEORGIA VICE FRANK M. HULL, ELEVATED.

FLORENCE-MARIE COOPER, OF CALIFORNIA, TO BE UNITED STATES DISTRICT JUDGE FOR THE CENTRAL DISTRICT OF CALIFORNIA VICE LINDA H. MCLAUGHLIN, DECEASED.

DEPARTMENT OF STATE

TIBOR P. NAGY, JR., OF TEXAS, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA.

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT AS CHIEF OF NAVAL PERSONNEL, UNITED STATES NAVY, AND APPOINTMENT TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTIONS 601 AND 5141:

To be vice admiral

REAR ADM. NORBERT R. RYAN, JR., 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be vice admiral

VICE ADM. ROBERT J. NATTER, 0000

IN THE MARINE CORPS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES MARINE CORPS UNDER TITLE 10, U.S.C., SECTION 624:

To be major

JAMES R. JUDKINS, 0000

IN THE NAVY

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVAL RESERVE UNDER TITLE 10, U.S.C., SECTION 12203:

To be Captain

DEAN D. HAGER, 0000
DAVID F. SANDERS, 0000

WITHDRAWAL

Executive message transmitted by the President to the Senate on July 14, 1999, withdrawing from further Senate consideration the following nomination:

DEPARTMENT OF VETERANS AFFAIRS

KENNETH W. KIZER, OF CALIFORNIA, TO BE UNDER SECRETARY FOR HEALTH OF THE DEPARTMENT OF VETERANS AFFAIRS FOR A TERM OF FOUR YEARS, WHICH WAS SENT TO THE SENATE ON JANUARY 6, 1999.

CONFIRMATION

Executive nomination confirmed by the Senate July 14, 1999:

DEPARTMENT OF JUSTICE

Robert A. Katzmann, of New York, to be United States Circuit Judge for the Second Circuit.