

order to review whether that particular pharmaceutical drug or other therapy is useful or not. That is not paid for by the insurance companies. So they only have to pay for the routine health needs—the costs that they would pay for even in the absence of a clinical trial. The regime, the testing group or organization or pharmaceutical company that is having that clinical trial, pays for the rest.

But what we are seeing is virtually the beginning of the collapse of clinical research taking place. I will just make a final point on this issue. The group that has had the greatest amount of clinical research done on them in this country has been children. The greatest progress that has been made in the battle for cancer has been—where?—with children.

Most of the clinical researchers who have reviewed this whole question of our efforts on cancer would make the case that one of the principal reasons that we have made the greatest progress in the war on cancer in children, in extending their lives and improving their human condition, is because of these clinical trials.

We want to continue to encourage participation in clinical trials. They offer hope for the future. If the doctor says this is what is necessary for the life and the health of a woman who has cancer, that this is the one way she may be able to save her life, and there is a clinical trial available, we want to be able to say she ought to be able to go there. The opposition says: Let's study it. I say: Let's vote on it.

I yield the floor.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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 President, I ask unanimous consent that the order for the quorum call be rescinded.

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

EXTENSION OF MORNING BUSINESS

Mr. NICKLES. Mr. President, I ask unanimous consent to extend morning business until 3 o'clock, with the time equally divided.

The PRESIDING OFFICER. Is there objection?

Mrs. BOXER. Reserving the right to object. I have a question and I shall not object. Can our friend tell us if there is any progress being made on getting the Patients' Bill of Rights to the floor so the good Senator from California, Senator FEINSTEIN, can offer an amendment to assure that doctors make the decisions when people are sick and not a bureaucrat? Is there any chance we might have that on the floor this afternoon?

Mr. NICKLES. Mr. President, I am happy to respond. Our colleagues from California may want to join our bill; we have doctors make the decisions. To answer the Senator's question, we are negotiating in good faith. We are getting closer, I believe, to coming to an agreement that would have consideration of the Patients' Bill of Rights be the pending business when we return from the Fourth of July break. Hopefully, we will have that resolved in the not-too-distant future.

Mrs. BOXER. I thank the Senator.

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

Mrs. FEINSTEIN addressed the Chair.

The PRESIDING OFFICER. The Senator from California, Mrs. FEINSTEIN, is recognized.

PATIENTS' BILL OF RIGHTS

Mrs. FEINSTEIN. Mr. President, I am on the floor because I anticipated that at 2 o'clock we would be returning to the agriculture appropriations bill. I indicated this morning that I would be proposing an amendment to that bill that has to do with giving the physician the right to provide medically necessary services in a setting which that physician believes is best for the patient. I now see that this has been postponed an hour, so I would like to speak to the amendment now and then introduce it at 3 o'clock. I hope there will be no objection to that.

Let me begin by saying, once again, what this amendment does. Essentially, the amendment says that a group health plan or a health insurance issuer, in connection with health insurance coverage, may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or the setting in which particular services are delivered if the services are medically necessary or appropriate for treatment or diagnosis, to the extent that such treatment or diagnosis is otherwise a covered benefit.

I read that specific language because it is important to understand that because most people buying a health insurance plan believe that their doctor is, in fact, going to be prescribing the treatment that is best for them, not the treatment that is the least cost effective, not the treatment that might run a risk to the patient but be good for somebody else, but the treatment or the procedure, in an appropriate setting, that is right for that patient. What is right for a patient who is 18 years old may not be right for a patient who is 75 years old, and so on. I will read from the legislation the definition of "medical necessity" or "appropriateness":

The term "medical necessity" or "appropriate" means, "with respect to a service or a benefit, a service or benefit which is consistent with generally accepted principles of professional medical practice."

That is something that everyone expects, that everyone is accustomed to in this Nation, and I believe that is the way medicine should, in fact, be practiced. I am very pleased to say the language of this amendment, from the larger Patients' Bill of Rights (S. 6) is supported by some 200 organizations all across the United States, including the American Academy of Emergency Medicine; the American Academy of Neurology; American Academy of Pediatrics; American Association of University Women; American Cancer Society; American College of Physicians; American Heart Association; American Lung Association, and the American Medical Association, which is the largest association of practicing physicians in the country.

Then there is the American Psychological Association; the American Public Health Association; the American Society of Clinical Oncology; virtually every breast cancer organization; the Consumer Federation of America; the Epilepsy Foundation; the Leukemia Society; the National Alliance of Breast Cancer Organizations; the National Association of Children's Hospitals; the National Association of People with AIDS; the National Council of Senior Citizens; the National Black Women's Health Project; the National Breast Cancer Coalition; the Older Women's League; the Paralyzed Veterans of America—on and on and on.

This is a widely accepted amendment that virtually has the support of every professional and patient organization that deals with health care anywhere in the United States.

Let me read a statement from the American College of Surgeons, certainly the most prestigious body for surgeons, and one to which my husband, Bert Feinstein, belonged:

We believe very strongly that any health care system or plan that removes the surgeon and patient from the medical decision-making process only undermines the quality of that patient's care and his or her health and well-being.

Similarly, the American Medical Association has said, "Medical decisions should be made by patients and their physicians, rather than by insurers or legislators."

I have worked on this now for 3 years. In the last Congress, I introduced legislation to allow doctors to decide when to discharge a woman from the hospital after a mastectomy. I did this with Senator D'Amato in the last Congress and with Senator SNOWE in this Congress. And I introduced a bill that would allow doctors to decide when to discharge a person from the hospital after any procedure or treatment, with Senators D'Amato and SNOWE.

Why do we need these bills? Senator MIKULSKI from Maryland this morning made a very impassioned case about mastectomies. And we learned in 1997 that women were being pushed out of the hospital on the same day after a mastectomy.

I was amazed to hear from a woman named Nancy Couchot of Newark, CA, who wrote me in 1997 that she had a modified radical mastectomy at 11:30 in the morning and was released from the hospital by 4:30 that afternoon. She could not walk to the bathroom without help. She said in her letter:

Any woman, under these circumstances, should be able to opt for overnight stay to receive professional help and strong pain relief.

Victoria Berck of Los Angeles wrote that she went in at 7:30 a.m. and was released at 2:30 p.m. with drains attached to her body. She said, "No civilized country in the world has a mastectomy as an outpatient procedure."

It was a very large health care network in California that was doing these "drive-through" mastectomies on the same day.

I believe "drive-through" mastectomies have been largely stopped, but patients had to rise up, and patients had to say you can't do this to me. You can't push me out a few hours after an anesthetic with drains in my body, having had a radical mastectomy and not being able to take care of myself.

What if the woman is 75 instead of 25? It makes no sense.

We also learned that insurance plans were insisting one-night hospital stays if you had a child.

We learned that babies—infants—were going home with jaundice, and they had to come back to the hospital for treatment once, twice, or three times. There was a lot of "tsk-tsking." What a terrible procedure. How could they do this? Now it has changed because Congress acted, requiring a minimum of two days for childbirth, for a normal delivery. What if you need 5 days for care, or 6 days for care?

The point is that it should be a decision made by the physician. It should not be countermanded by someone unqualified to make that decision.

A California neurologist told us about a 7-year-old girl with an ear infection who went to the doctor with a high fever which developed into pneumonia, and she was hospitalized. The HMO insisted that she be sent home after 2 days. She ended up returning to the hospital three times, sicker each time to the point where she developed meningitis. The doctor said that if she had stayed in the hospital for 5 to 7 days the first time that she could have been given antibiotics, been monitored, and would not have gotten meningitis.

What is the problem?

Let me read the definition of medical necessity in an insurance contract provided to me by the American Medical Association. This is from the Aetna/U.S. Healthcare standard Texas contract. I quote: "Health care services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards and which

are likely to result in demonstrable medical benefit," and here is the point, "and which are the least costly of alternative supplies or levels of service."

It is not "and/or." It is "and which are the least costly."

So if you belong to that plan and there is a drug that is the least costly, perhaps not as effective or perhaps not good for you with your present condition, or because of your age, that is the drug you are forced to take because the insurance plan says so, despite what the doctor says. If there is a diagnostic process that may be less effective than an MRI, that MRI is very often prohibited for you.

What is happening out there? What is the problem?

The problem is that doctors are finding insurance plans overriding their decisions, dictating their decisions, second-guessing their decisions about what is medically necessary.

We aim in this amendment to give that basic right of medical practice back to the physician.

In fact, today doctors all across this Nation will tell you that they spend hours hassling with insurance company accountants and adjusters to justify medical necessity decisions—why a person needs another day in a hospital, why a person needs an MRI, why a patient needs a blood test, why a patient should get this drug instead of that drug.

Seventy percent of doctors across this great Nation say they are forced to exaggerate a patient's symptoms to make sure HMOs don't discharge patients from hospitals prematurely.

Is this the kind of medical care that we want to see HMOs press us toward where a doctor has to lie, fabricate, or exaggerate the condition of the patient to be sure that patient gets what is medically appropriate for that particular patient? I truly think not.

Every patient is different. Every patient brings to a situation his or her own unique history and biology. Doctors should be able to use their best professional judgment in each individual case based upon the needs or condition of the patient.

Pneumonia in a 30-year-old patient is different from pneumonia in a 70-year-old patient. Doctors know the difference, and most of us do, too.

A Maryland nurse said: I spend my days watching the care in my unit be directed by faceless people from insurance companies on the other end of the phone. My hospital employs a full-time nurse whose entire job is to talk to insurance reviewers.

I myself in 1989 had to have a hysterectomy. I was extraordinarily anemic. As I was in the hospital for a blood transfusion, the phone rang. I picked up the phone. It was my insurance company. What they said to me is: Why are you still in the hospital? You are supposed to be out of there by now.

My only response was: I am here because I am currently having a blood transfusion.

A patient shouldn't have to go through this. It happened to me. You can be sure it is happening all across this country.

Doctor Robert Weinman told the San Jose Mercury News that a doctor prescribed a brain wave test for a convulsing epileptic child. The HMO board—consisting of one accountant, the chief financial officer, and one doctor—refused coverage, depriving the doctor of the necessary diagnostic information.

On June 14, just a couple of weeks ago, a California nurse practitioner told my staff that insurance plans will allow people with ulcers to take Prilosec for only 4 to 6 weeks, even though the gastroenterologists say that it is needed for a longer period. Plans say patients can take Tagamet, which is cheaper but not as effective for this particular condition.

This is what this amendment seeks to avoid.

The doctor should be able to prescribe based on medical necessity what is appropriate to each patient—a hallmark of good medical care.

A California doctor told us about a patient who needed a total hip replacement because her hip had failed. The doctor said that patient should remain in the hospital for 7 days. The plan would only authorize 5 days.

Let me quote once again from a Los Angeles physician.

Many doctors are demoralized. They feel like they have taken a beating in recent years. . . physicians train years to learn how to practice medicine. They work long hours practicing their field. Under this health care system, that training and hard work often seem irrelevant. A bureaucrat dictates how doctors are allowed to treat parties. . . When I tell someone he is fit to leave the hospital after an operation, I am often given an accusing stare. Sometimes my patients even say: "Is that what you really think or are you caving in to HMO pressure to cut corners on care?"

Medicine shouldn't have to be practiced this way in the United States of America.

Over 80 percent of the people of my State are in some form of managed care. California has been a laboratory for managed care. Californians are speaking out on the issue. Over one half of Californians say that major changes are needed in our health care system. Californians say they have to wait for care longer, they are rushed through appointments, they have to navigate impersonal systems when they are trying to get care.

A survey of 900 doctors in California found that 7 out of 10 were dissatisfied with managed care organizations. Insurance companies have invaded the examining room, the emergency room, and the hospital room. The "care" is rapidly going out of health care. Getting good health care should not be a battle.

I think everyone in this body understands HMOs can be effective good, they can reduce costs in a medically acceptable way. And that is the key—in a medically acceptable way, without adversely impacting the patient. The way to do this is not to countermand the physician, not to tell the physician what drug he or she can or cannot give a patient based on the cost, not to tell a physician he has to conduct a radical mastectomy at 7:30 in the morning, removing sometimes both of a woman's breasts and lymph nodes, and push her out on the street with drains in her chest and pain coursing through her body. That isn't good health care for anyone.

This is a simple amendment. It is supported by virtually over 200 health organizations.

Some might say why not wait until we work out an agreement so a Patients' Bill of Rights—whether it be Democrat or Republican—can come to the floor. I have waited for 3 years for an opportunity to move this kind of legislation. We cannot wait any longer. Senator D'AMATO and I, 3 years ago, held a press conference urging this kind of legislation. Senator SNOWE and I, in this Congress, have introduced similar legislation.

The beauty of this amendment, that I want to bring before the Senate for a vote, is that it states very simply that health insurance coverage may not arbitrarily interfere or alter the decision of the treating physician regarding the manner or setting—hospital, emergency room, outpatient clinic, whatever it is—in which particular services are delivered, if the services are medically necessary or appropriate for treatment or diagnosis.

Every single patient in managed care anywhere in the United States of America will be better off the sooner this amendment becomes law.

I believe to wait is wrong. I believe to wait will cost lives. I believe to wait will increase morbidity. I believe to wait is unfair to the physicians who are trained, able, and ready to carry out their profession.

I am hopeful I will have an opportunity, in 25 minutes when the agricultural appropriations bill is on the floor, to offer this amendment which is broadly and widely supported all across the United States. Once and for all, the physician and the patient will together make the medical decisions—not a green eyeshade somewhere in a remote HMO office.

I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island. The Chair notes the Senator has 2 minutes 2 seconds.

Mr. REED. I ask unanimous consent to speak for 10 minutes as if in morning business.

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

Mr. REED. Mr. President, I take this opportunity to talk about the Patients' Bill of Rights in one particular area. That is the area of appeals, both internal appeals and external appeals.

Both versions of this legislation, both the Republican proposal and the Democratic proposal, purport to have provisions for appeals of denial of service to consumers of health care in HMOs. Looking closely at the proposals, we find that the Republican process is significantly deficient.

We will hear discussions about these various proposals, but I will highlight a couple of the areas which suggest the deficiencies that are inherent in the Republican proposal versus the Democratic proposal.

First, under the Republican plan, an internal review—one that is being conducted by the HMO itself—that reviewer is restricted from looking at all the evidence in a case.

For example, if a patient thought they were not receiving appropriate care, they might go to another physician outside of their network and ask for an opinion. That type of information cannot be used by the internal reviewer to make a judgment about the decision rendered by the HMO. This narrowly restricted access to information prejudices the review process against the patient. It also leads to something I think is evident today and would be even more pronounced in the future, a growing cynicism that the managed care companies simply want to protect the bottom line, not the health of the patient.

I strongly suggest the internal review process in the Republican legislation is deficient since it will not allow, essentially, a de novo review of the case by the reviewing authority.

The second weakness with respect to the Republican proposal is with regard to external reviews. External reviews are reviews which are conducted by an outside party. Under the Republican plan, a review could only be conducted if there is a claim that some type of medical necessity has been violated, or the proposed treatment is experimental—again, two very narrow grounds.

A patient cannot have an external review if the claim is about contractual rights. In the world of HMOs, it is so easy for the HMO to claim: This is not really an issue of medical necessity. It is not an issue even of innovative treatment. This treatment is just not covered under your plan.

These contracts are pages and pages of small print. When the average consumer or family tries to figure out what the contract says, they are no match for the reviewing authorities and spokespeople for the HMOs.

As a result, there is a very real possibility an aggrieved party will never get an external review. They will be buried in a barrage of verbiage indicating "it

is not covered in the contract" or it "doesn't meet our definition of medical necessity." I refer to the text provided by my colleague from California where part of the definition of "medical necessity" included the low-cost alternative in the provision of services.

All of this, in my view, is an invitation to endless argumentation about legalisms at a time when people need a prompt response to a health care crisis in their family.

There is another deficiency with respect to the external review provisions. Under the Republican proposal, the HMO actually picks the reviewing authority. Now that just does not sound fair. If it does not sound fair to us, it will certainly not sound fair to the families of America.

Mrs. BOXER. Will the Senator yield on that point?

Mr. REED. Certainly.

Mrs. BOXER. Because the Senator has made a point that is rather stunning to me. In other words, he is saying that in the Republican proposal which purports to be a Patients' Bill of Rights, if a patient believes he or she has not received the appropriate treatment and there is an internal review—and let's pass over that—and then there is an external review; in other words, people are coming in from the outside to take a look at whether or not you should have had a different treatment for your cancer, let's say, the Senator is saying to me that under the Republican proposal, the very organization that denied you a certain kind of treatment gets to pick the people who are going to decide if that HMO was wrong? So if they pick their friends, naturally, what chance does the patient have? I say to my friend, this seems like a kangaroo court if I have ever heard of one. Does he not agree?

Mr. REED. I agree completely. The Senator is absolutely right. Both the perception of an unfair, unbalanced procedure, and I would also argue the reality, ultimately, will be such that you are not going to get a fair evaluation of your claim.

I cannot conceive of a company—and the HMOs are famous now for their concern for the bottom line—that would go out of its way to retain people who are sensitive to the needs of patients versus the needs of the company and its bottom line. They will pick reviewing authorities who will invariably decide that this expensive procedure, or this inexpensive procedure, is not needed by a patient.

What you are doing also is creating a degree of cynicism about the whole process of appeals. As a result, rather than making a sound, objective, external evaluation of the merits of the case with all the evidence and telling the patient, no, this is not necessary for you, or, yes, it is, a huge legal, bureaucratic labyrinth is created, at the end

of which you find yourself facing somebody who basically works for the HMO.

Mrs. BOXER. I wonder, in comparing these two bills, if my friend has made an analysis of the way the Democratic bill treats the appeals process? And can he tell us the difference here?

Mr. REED. The Democratic legislation tries to create, and I think succeeds in creating, a situation where there is an external review where a party who is not beholden to the HMO, an individual reviewing authority outside of the company will review external appeals. It would be truly independent and there would not be a conflict of interest, and that, I believe, is the appropriate way to proceed.

By creating an independent external review procedure, it will, No. 1, strengthen the confidence of consumers that they are getting a fair shake and, No. 2, it will lead to better judgments about the type of health care that should be necessary.

Mr. KENNEDY. Will the Senator yield?

Mr. REED. I am happy to yield to the Senator from Massachusetts.

Mr. KENNEDY. If I understand the Republican proposal, if you had a child, for example, with cancer, and you had a pediatrician, but what you needed was an oncologist for that child, one who is a specialist in pediatrics, and the HMO denied you that, and you believed this was enormously important for the treatment for the child, under the Republican proposal you have no right to appeal that particular decision. I understand that the right to an independent appeal applies only to certain decisions, and a denial of access to a specialist is not one of them. I believe I am correct.

We heard our wonderful friend, Dr. FRIST, yesterday talk about how any child who had cancer would be guaranteed a specialist and everybody said: Doesn't that do the trick? No.

We know you need not just a pediatrician, but as the Senator from Rhode Island knows—as one who has been a leader in the Senate on children's issues regarding access, and has introduced special legislation on this—that child needs a pediatric oncologist. That kind of specialist is absolutely crucial, if that child is to have a fighting chance; but denial of access to that particular specialist would not be eligible for appeal under the majority's program.

The PRESIDING OFFICER. The time of the Senator from Rhode Island has expired.

Mr. KENNEDY. Mr. President, I ask for 6 more minutes evenly divided.

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

Mr. KENNEDY. I was just asking whether the Senator's understanding is the same understanding as mine? If the Senator would just reflect on the significance of that, I would appreciate it.

How important, really, is specialty care access, I ask the Senator, as an expert on this issue for the treatment of a child?

Mr. REED. The Senator is exactly correct. The way the appeals process is drafted in the Republican legislation, a child who has a serious cancer might be offered the services of an oncologist for adults. In the view of the plan, that would be adequate, sufficient for the purposes of the medical necessity. As a result, the parents of the child, who want access to a pediatric oncologist, may not even get the chance to even protest internally, externally, or in any way.

That is wrong. Frankly, I have been trying to learn as much as I can about pediatric specialties. I, like so many people, once thought an oncologist is an oncologist is an oncologist like a rose is a rose is a rose. It turns out pediatric oncology is a very specialized part of medicine.

I was talking to a specialist recently who pointed out the case of a young child who was discovered with a particular type of cancer and was treated by an adult's oncologist using what is standard procedure for an adult. In fact, using the adult procedure produced additional problems for the child and only further complicated the situation. As a result, the child has to have an additional regime of chemotherapy. All of this could have been avoided, of course, had that child seen a pediatric oncologist immediately.

The provisions in this legislation do not give a fair chance to appeal a denial of access to a specialist like the case I have just outlined. They do not give Americans, but particularly children, a fair chance to get good health care. That is what we want to do and should do.

Mr. KENNEDY. Will the Senator yield just for another moment? It is now approaching 3 o'clock. To the best of my recollection, the good Senator from California, Senator FEINSTEIN, has been here since 10 o'clock this morning, prepared to go ahead and introduce her amendment and has still not been able to do it. There has been an extension of the time limits, evidently because of some negotiations about which all of us are hopeful. But I think we probably could have disposed of the amendment of the Senator and probably the proposal of the Senator from Rhode Island also. I do not know whether the Senator would agree with me or not.

Mr. REED. I do agree. I have been listening to Senator FEINSTEIN's very eloquent and thoughtful comments about the need for access to specialists and the need to have a physician make a decision about your health care and not an accountant.

The PRESIDING OFFICER. The time of the Senator from Rhode Island has expired.

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

The PRESIDING OFFICER. The Chair, acting in his capacity as a Senator from New Hampshire, notes the absence of a quorum. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

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

The PRESIDING OFFICER. The Chair, in his capacity as a Senator from the State of New Hampshire, objects. The clerk will continue to call the roll.

The legislative clerk continued with the call of the roll.

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

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

EXTENSION OF MORNING BUSINESS

Mr. NICKLES. Mr. President, for the information of all colleagues, we are still in the process of negotiating a time agreement on proceeding. We are not quite there. We are getting closer.

Mr. President, I ask unanimous consent that morning business be extended for 30 minutes to be equally divided.

The PRESIDING OFFICER. Is there objection?

Mrs. FEINSTEIN. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from California.

Mrs. FEINSTEIN. Mr. President, I say to the distinguished whip, I have been here for a long time hoping to offer an amendment to the agriculture appropriations bill.

Can you give me any time when that bill might be coming to the floor?

Mr. NICKLES. I will be happy to respond.

It is our intention that the ag bill will not be the vehicle for the Patients' Bill of Rights or any amendments related to it. The unanimous consent request we are proposing or negotiating would bring up the Patients' Bill of Rights when we return from the Fourth of July break, with the bill to be brought up on, I believe, July 11, to be completed by July 15. So no amendments relating to the Patients' Bill of Rights will be offered on the ag appropriations bill.

Mrs. FEINSTEIN. In exchange for a definitive date of bringing up the Patients' Bill of Rights?

Mr. NICKLES. Correct. Absolutely.

Mrs. FEINSTEIN. We would have minority rights to amend that bill?

Mr. NICKLES. That is correct.

Mrs. FEINSTEIN. I thank the Senator.

The PRESIDING OFFICER. Is there objection the request of the Senator from Oklahoma?