

But when the global economic crisis boomeranged on American steelworkers, the message from the administration and the Senate was: You get stuck with the bill.

The crisis is not over. The May import numbers prove it. The question for all of you who oppose the Rockefeller bill, the question for this administration, a Democratic administration that is supposed to care about working people is: What do you propose to do now?

Let me just repeat this one more time. I was thinking to myself, I wonder why the administration hasn't released figures, since they were making the case that the crisis was over. Surely they will release the May figures. They must have had them a few days ago. Two days ago, one of the major arguments used for opposing our legislation was "the crisis is over." Now we find out 2 days later, overall steel imports are up 30 percent from April to May, and imports of blooms and billets and slabs, which compete against our taconite on the Iron Range, are up 122 percent. We didn't get those figures from the administration 2 days ago. I think I know why.

I say to the President, I say to the administration, and I say to Senators who voted against an opportunity to even debate this legislation: The crisis is not over. The statistics prove it. My question is: What do you propose to do now? What do you propose to do now?

Mr. President—not the President that is presiding on the floor of the Senate, but Mr. President of the United States of America—what do you propose to do now? Your administration told us 2 days ago this crisis was over. Now we have the figures: 30 percent increase in imports of steel, 122 percent in imports of blooms, billets, and slabs. It is going to be an economic convulsion for the Iron Range of Minnesota. It is going to be an economic convulsion for steelworkers, illegally dumped steel. We will compete against anybody. But if you are going to make the argument that we should not do anything about illegally dumped steel, that we can't provide any protection for our workers, that we can't have an administration and a Government that negotiates a fair and a tough trade policy that provides protection to our workers, then what in the world are we here for?

I speak with a little bit of—not bitterness but outrage. I heard what was being said just two days ago. Now the numbers have come out. Now we know we have this crisis. Now we know we have this surge of imports. It is illegally dumped steel.

My question for the President of the United States of America is: What are you going to do? You defeated our legislation. What are you going to do now?

I am not going to give up on this. I hope the steelworkers and their fami-

lies won't give up on this. My suggestion is that we need to have a meeting with the President and the administration because I have to still believe that they are concerned and they will be willing to take some action. We need to talk about what kind of action we will take soon, because if we don't, there are going to be a lot of broken dreams, a lot of broken lives, and a lot of broken families all across our country, including in Northeast Minnesota, the iron range of Minnesota. I can't turn my gaze away from that. I can't quit fighting because of the vote a couple days ago.

I yield the floor.

Mrs. FEINSTEIN addressed the Chair.

The PRESIDING OFFICER. The Senator from California is recognized.

PATIENTS' BILL OF RIGHTS

Mrs. FEINSTEIN. Mr. President, I don't want to be redundant, but I would like to continue the statement I began to make earlier this morning. Let me quickly put it in perspective.

The statement further explains an amendment that I have at the desk, which essentially says that a group health plan or an insurance issuer may not arbitrarily interfere with, or alter, the decision of the treating physician with respect to the manner or the setting in which particular services are delivered if those services are medically necessary or appropriate.

It then goes on to define "medically necessary" as "that which is consistent with generally accepted principles of professional medical practice." The amendment, of course, means that the doctor can determine what is a medically necessary length for a hospital stay, and the doctor can determine the kind of treatment or drug the patient can be best treated with.

I know some people wonder why am I so vociferous about physicians making medical decisions. California has the largest number of individuals in managed care. We have around 20 million people in managed care plans in California.

I have heard of many different cases. Let me just give you one other case—I just talked about the person with the brain illness. I can also give you the case of the Central Valley man, 27 years old who had a heart transplant and was forced out of the hospital after 4 days because his HMO would not pay for more days. That constituent of mine died. That is the reason I feel so strongly.

Additionally, I know—and the Washington Post this morning documents—that doctors are increasingly frustrated, demoralized, and hamstrung by insurance plans' definitions of medical necessity. An American Medical Association survey reported in the March 2,

1999, Washington Post, quoted an AMA spokeswoman who said that some managed care companies have begun to define explicitly what treatments are "medically necessary," and they have chosen to define them in terms of lowest cost.

She says:

Doctors used to make that decision solely on the basis of what was best for the patient.

She stressed that doctors are unhappy that managed care organizations are "controlling or influencing medical treatment before the treatment is provided." She said, "Denials and delays in providing care directly harm the health and well-being of the patients."

A fall 1998 report found that "patients and physicians can expect to see more barriers to prescriptions being filled as written," according to the Scott-Levin consultant firm, because HMOs are requiring more "prior authorizations" by the plans before doctors can prescribe them.

Then, as I spoke of a little earlier, there is the issue of financial incentives, another form of interference in medical necessity decisions. In November, the New England Journal of Medicine pointed out:

Many managed care organizations include financial incentives for primary care physicians that are indexed to various measures of performance. Incentives that depend on limiting referrals or on greater productivity applies selective pressure to physicians in ways that are believed to compromise care.

That is what we are trying to stop.

Incentives that depend on the quality of care and patients' satisfaction are associated with greater job satisfaction among physicians.

Let me describe how Charles Krauthammer put it in writing in the January 9, 1998 Washington Post under the headline, "Driving the Best Doctors Away":

The second cause of [doctors leaving the profession] is the loss of independence. More than money, this is what is driving these senior doctors crazy: some 24-year-old functionary who knows as much about medicine as he does about cartography demanding to know why Mr. Jones, a diabetic in renal failure, has not been discharged from the hospital yet. Dictated to by medically ignorant administrators, questioned about every prescription and procedure, reduced in status from physician to "provider," these doctors want out.

Mr. President, that is a sorry commentary, and it is the truth.

One of my deepest interests is cancer. I co-chair the Senate Cancer Coalition with the distinguished Senator from Florida, Senator Connie Mack. Let me quote from a report of the President's Cancer Panel:

Under the evolving managed care system, participating physicians are increasingly being asked to do more with less—to see a greater volume of patients and provide significantly more documentation of care with less assistance or staff. In addition, managed care has dictated a major shift to primary care gatekeepers who are under pressure to limit referrals to specialists and care provided in tertiary care facilities, and may be

financially rewarded for their success in doing so.

Nancy Ledbetter, an oncology nurse and clinical research nurse coordinator for Kaiser Permanente said, “. . . necessary care is being withheld in order to contain costs.” This is from the June 16, 1999 Journal of the National Cancer Institute.

A breast cancer surgeon wrote me:

Severe limitations are being placed upon surgeons in giving these women [with breast cancer] total care . . . Patients feel that their care is reduced to the mechanics of surgery alone, ignoring the whole patient's medical, emotional, and psychological needs.

Surely, one of the oldest axioms of medicine, and the way my father used to practice medicine, is that you can't just treat the wound, you have to treat the whole patient as an individual, as a human being.

In my State, again, over 80 percent of people who have insurance are in managed care. Forty percent of California's Medicare beneficiaries are in managed care. Some say Californians have been pioneers for managed care. Some even say Californians have been the Nation's “guinea pigs.”

The complaints don't abate: delaying diagnoses and treatments as tumors grow; trying the cheapest therapies first, instead of the most effective; refusing needed hospital admissions; refusing to refer patients to specialists who can accurately diagnose conditions and provide effective treatments; we hear complaints about shoving patients out of the hospitals prematurely, against doctor's wishes. We hear complaints about misclassifying medically necessary treatments as “cosmetic.”

We hear about plans demanding that doctors justify their care and second-guessing doctors' medical judgments.

We have had heard about doctors exaggerating the patient's condition to be able to give them a certain drug, or keep them in a hospital beyond a certain length of time, to get plans to pay for care.

I hope this amendment can restore some balance to the system by empowering patients and the medical profession to provide the kind of quality medical care that people not only pay for but that they deserve.

That is why I feel so strongly about this amendment.

Again, I harken back to the day when I had the first example in 1997 of a woman in a major managed care plan undergoing an outpatient radical mastectomy—7:30 in the morning, surgery; 4:30, out on the street with drains hanging from her chest, and unable to know where she was going.

That is not good medicine.

I can only end my comments on this amendment by saying that the amendment is sincerely presented.

The amendment is the heart of a Patients' Bill of Rights.

The amendment should not increase premium costs.

The amendment is what the American people expect.

And the amendment simply says that an insurance company cannot arbitrarily interfere with the doctor's decision with respect to treatment or hospitalization.

I don't think that is too much to ask this body to legislate and to state unequivocally, and I think every single person in my State, as well as every State, will be much better off once this is accomplished.

Let me end by saying that I believe that Senator DASCHLE is willing to work out an agreement which allows a number of amendments to come to the floor and be debated, provided that these amendments can be voted up or down.

I suspect that what we are going to really end up with is a bipartisan Patients' Bill of Rights. I suspect that if we can get this unanimous consent agreement, we will find that there will be many on the other side of the aisle who will vote for this amendment, and there will be some of us who will vote for some of the amendments on the other side as well.

It seems to me that when you have a situation whereby the physicians in America have reached the point where they have decided to unionize and collectively bargain that this should be a very loud call that all is not well with the practice of medicine in the United States of America.

It should be a very loud call for a unanimous consent agreement which will allow us, on the floor of the Senate, to work out a series of amendments which can provide the kind of quality care that the people of the United States are entitled to, and that certainly 20 million Californians in managed care are.

I thank the Chair.

I yield the floor.

PLEDGE OF ALLEGIANCE RESOLUTION

Mr. FEINGOLD. Mr President, I want to express my support for the resolution, which was adopted by the Senate yesterday, to begin a new tradition in this distinguished body: to begin our days by saying the Pledge of Allegiance each morning in this Chamber. There were about ten of my colleagues on the floor this morning to inaugurate this new tradition, and I only wish there could have been more to join us.

We will pay tribute to our flag, the greatest symbol of our freedom, in the Chamber where we are sworn to uphold the very freedoms the flag symbolizes. There can be no more fitting tribute to our Constitution than the free and unfettered expression of patriotism that the Pledge of Allegiance represents.

Today in the Senate, we honor the flag. In contrast to this voluntary cele-

bration of our flag, the other chamber today may vote on an amendment to our Constitution that asks us to turn away from the freedoms we cherish in order to protect our flag, in effect to compel reverence for the flag. This amendment, in a misdirected attempt to protect a cherished symbol, instead tears at the very fabric of our freedom.

In the past, I have walked in the Appleton, WI, parade on Flag Day. I am told that it is the largest Flag Day parade in our country—it is certainly one of the best. As I saw the faces of those people, those Americans, as they waved the flag, filled with pride in our great nation, I knew then not only that patriotism shouldn't be legislated, but that it doesn't need to be. It is in this Chamber and in the hearts and minds of millions of Americans across this country. Again, I celebrate the effort to pay tribute to the flag, and the freedom it represents, in this Chamber each day. I only hope when and if the amendment that threatens that freedom is considered on this floor, we will remember the Pledge of Allegiance, and remain true to the liberty it speaks of, and that all of us hold so dear.

CUBA

Mr. SPECTER. Mr. President, during the Memorial Day recess, I spent two days in Havana, Cuba, from June 1 to 3. I met with numerous Cuban officials, including a marathon six-and-a-half hour session with President Fidel Castro, with Cuban human rights dissidents, with religious leaders, with several foreign ambassadors and with our U.S. team. I am convinced there are a number of steps we can take, pursuant to our existing U.S. policy, to create closer people-to-people relations with Cuba. Sharing medical research, especially on immunizations, would be appropriate, between the National Institutes of Health and the Cuban Ministry of Health. Former Gen. Barry McCaffrey, head of U.S. drug policy, had suggested to me that we should work closer with the Cuban government on drug interdiction, and I think he is right.

Relations between our two countries, only 90 miles apart, are almost non-existent. We have an embargo and a boycott. We have no exchange of ambassadors, and the limited coordination between our governments does not extend beyond very limited cooperation on drug interdiction.

I believe it is worthwhile to share with my colleagues some of my findings and impressions from my trip. The issue of the embargo is complex, and I am not yet ready to advocate a position. But there are other issues, such as the benefits of increasing contact and cooperation, which merit comment at this time.

Upon arrival in Havana about 2 pm June 1, we were met by Jorge Lexcano