

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 assistant legislative clerk read as follows:

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

Pending:

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

Daschle (for Kennedy) amendment No. 1233 (to Amendment No. 1232), to ensure that the protections provided for in the Patients' Bill of Rights apply to all patients with private health insurance.

Nickles (for Santorum) amendment No. 1234 (to Amendment No. 1233), to do no harm to Americans' health care coverage, and expand health care coverage in America.

Graham amendment No. 1235 (to amendment No. 1233), to provide for coverage of emergency medical care.

Mr. FRIST addressed the Chair.

The PRESIDING OFFICER. The Senator from Tennessee.

AMENDMENT NO. 1235

Mr. FRIST. Mr. President, I understand we are currently on the Graham amendment. Could you tell us how much time remains on either side?

The PRESIDING OFFICER. There are 33 minutes 8 seconds for the majority; and 7 minutes 59 seconds for the minority.

Mr. FRIST. Thank you.

Mr. President, today we will be talking about a number of issues that have to do with the Patients' Bill of Rights. Yesterday, the discussions began on what I regard as a very significant, important piece of legislation that is called the Patients' Bill of Rights. The debates that we will be having on the floor address really two underlying bills that were introduced formally yesterday: One is the Kennedy bill from the Democratic side, and the other is the Republican leadership bill. Both bills set out to accomplish what I think we all absolutely must keep in mind as we go through this process, and that is to make sure that we are focusing on the patients in improving the quality and the access of care for those patients and at the same time help this pendulum swing back to where patients and doctors are empowered once again; not to have this be so much in favor of managed care that, when it comes down to an individual patient versus managed care on certain issues, managed care enters into this realm of practicing medicine.

Again, I think if we keep coming back to focusing on the individual pa-

tient, we are going to end up with a very good bill.

We left off last night with the discussion of the Graham amendment which focuses on emergency services. In the Republican bill, basically there are a list of patient protections which include a prohibition of gag clauses, access to medical specialists, access to an emergency room, which is the real thrust of the Graham amendment, continuity of care—a range of issues that we call patient protections.

A second very important part of our bill focuses on quality and how we can improve quality for all Americans. I am very excited about that aspect of the bill. We will be discussing that later this week. That is our responsibility as the Federal Government, to invest in figuring out what good quality of care actually is. It is similar to investing in the National Institutes of Health: The research behind determining where the quality is, and spreading that information around the country so that excellent quality can be practiced and people can have access to that.

A third component of the Republican bill which I think is, again, very important that we will keep coming back to, is the access issue, the problem of 43 million people in this country who are uninsured. Some people say: No, that is a separate issue; we can put it off for another day.

But when you look at patient protections, you look at quality and you look at access. It is almost like a triangle. If you push patient protections too far you end up hurting access. If you push issues beyond what is necessary, to get that balance between coordinated care and managed care and fee for service and individual physicians' and patients' rights, if you get too far out of kilter, all of a sudden premiums go sky-high.

When premiums go sky-high in the private sector, employers, small employers start dropping that insurance. It becomes too expensive for an individual to go out and purchase a policy, and therefore instead of having 43 million uninsured, you will have 44 million, 45 million, or 46 million, all of which is totally unacceptable. As trustees to the American people, we simply cannot let that happen. Therefore, you will hear this quality and access and patient protection discussion go on over the course of the week.

Last night and today over the next 45 minutes or so we will be focusing on this patient access to emergency medical care. Let me just say that I have had the opportunity to work in emergency rooms in Massachusetts for years, in California on and off for about a year and a half, in Tennessee for about 6 years, and almost a year in Southampton, England.

Whether it is a laceration, whether it is a sore throat, whether it is chest

pain, whether it is cardiogenic shock from a heart attack, access to emergency room care is critically important to all Americans.

We have certain Federal legislation which guarantees that access, but it is clear there are certain barriers that are felt today by individuals that their managed care plan is not going to allow them to go to a certain emergency room or, once they go, those services are not covered. That is the gist of what we have in the Republican bill—a very strong provision for patient access to emergency medical care.

This Republican provision, as reported out of the Health, Education, Labor, and Pension Committee where this was debated several months ago, requires group health plans, covered by the scope of our bill, to pay, without any prior authorization, for an emergency medical screening exam and stabilization of whatever that problem is—whether it is cardiogenic shock, whether it is a laceration or a broken bone or falling down the steps or a broken hip—to pay for that screening and that stabilization process with no questions asked—no authorization, no preauthorization, whether you are in the network or outside of the network.

The prudent layperson standard is very important for people to understand. The prudent layperson standard is at the heart of the Republican bill. We use the words "prudent layperson." By prudent layperson, we define it as an individual who has an average knowledge of health and medicine. The example I have used before is, if you have a feeling in your chest, and you do not know if it is a heart attack or indigestion, and you go to the emergency room, a prudent layperson, an average person, would go to the emergency room in the event that that was a heart attack, and therefore is the standard that is at the heart of the Republican bill. Now, there are two issues that need to be addressed. We talked about them a little bit yesterday. One is what happens with the poststabilization period. You are at home. You have this feeling in your chest. You go to the emergency room. Under our bill, you are screened; you are examined. Initial treatment stabilization of that condition is given.

Then the question is, What happens with poststabilization? This is where I have great concern in terms of what my colleague from Florida has proposed and what is in the underlying Kennedy bill. That is, once you get in the door, you can't open that door so widely that any condition is taken care of out of network. Why? Because it blows open the whole idea of having coordinated care, having a more managed approach to the delivery of health care.

This is a huge door you could get into. Then, once you get into that hospital door, you might say: Well, I have