The Senate met at 9:15 a.m. and was called to order by the Honorable HERB KOHL, a Senator from the State of Wisconsin.

PRAYER

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

Thank You, dear Father, for infusing Your nature in the Senators You have called to lead our beloved Nation. You have reproduced in them Your concern and caring for the health and healing of all of our people. Thank You for Your compassion expressed in the legislation for patient protection in America.

The Senators may differ on aspects of the implementation of this concern but are one in seeking unity on what is best for citizens across our land. Be with the Senators today as all aspects of this crucial legislation are focused and voted upon. Thank You for the managers on both sides of the aisle who have worked so long and tirelessly to review all possibilities for the best potential for all Americans.

Now as the Senators seek to complete debate and take conclusive votes, may they sense the unity of a common concern for a crucial cause of caring for our people. Place Your hand upon their shoulders and remind them that You are the magnetic center who draws them to unity for the welfare of our Nation. You are the healing power of the world who uses the medical professions to heal. Help the Senators to complete legislation that will assure the best care for the most people.

You, dear God, are our Lord and Saviour. Amen.

PLEDGE OF ALLEGIANCE

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

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER, the clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable HERB KOHL, a Senator from the State of Wisconsin, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. KOHL thereupon assumed the chair as Acting President pro tempore.

RESERVATION OF LEADER TIME

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

BIPARTISAN PATIENT PROTECTION ACT

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will now resume consideration of S. 1052, which the clerk will report. The legislative clerk read as follows: A bill (S. 1052) to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

Pending:

Thompson amendment No. 819, to require the exhaustion of administrative remedies before a claimant goes to court.

Collins amendment No. 826, to modify provisions relating to preemption and State flexibility.

Breaux amendment No. 830, to modify provisions relating to the standard with respect to the continued applicability of State law.

Mr. ROBERTS. Mr. President, here is the issue: The ability of States to determine what is best for themselves. That is the issue. Sure, the issue is the Patients’ Bill of Rights. But if Kansas or Nebraska or Maine or Massachusetts or Louisiana or Connecticut—as I look at Members in the Chamber—have an effective patient protection system that is working, why impose new Federal regulations that will force them to overhaul the system they have in place?

The Collins-Nelson-Roberts, and others, amendment would simply give the State of Kansas and other States the flexibility to provide patient protection required under this bill in a way that best fits each State. For example, last year in Kansas we implemented a new law that assists patients who get into a dispute with their insurance company over the refusal to pay for medical procedures. It is a long process, but the independent reviewer will make a decision and reply within 30 business days after an appeal procedure.

We are going to complete the legislation, plus the supplemental appropriations bill before we go home. He said he would work Saturday, Sunday, Monday, and Tuesday and Wednesday, the 4th—take that off—and come back after that to complete our work. We are cooperating and doing our very best to meet the requests of Senators BYRD and STEVENS. Their last unanimous consent request has been cleared on this side as far as the filing of amendments. We applaud the four managers who have been working on this bill. We look forward to continuing to work today.

AMENDMENT NO. 826

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be 30 minutes for debate to be equally divided between the Senator from Maine, Ms. COLLINS, and the Senator from Louisiana, Mr. BREAUX, prior to a vote on or in relation to the Collins amendment No. 826.

Who yields time? The Senator from Maine.

Ms. COLLINS. Mr. President, I ask unanimous consent that the Senator from Virginia, Mr. ALLEN, be added as a cosponsor of the Collins-Nelson amendment.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Ms. COLLINS. I yield 6 minutes to the Senator from Kansas, Mr. ROBERTS.

The ACTING PRESIDENT pro tempore. The Senator from Kansas is recognized.

Mr. ROBERTS. Mr. President, here is the issue: The ability of States to determine what is best for themselves. That is the issue. Sure, the issue is the Patients’ Bill of Rights. But if Kansas or Nebraska or Maine or Massachusetts or Louisiana or Connecticut—as I look at Members in the Chamber—have an effective patient protection system that is working, why impose new Federal regulations that will force them to overhaul the system they have in place?

The Collins-Nelson-Roberts, and others, amendment would simply give the State of Kansas and other States the flexibility to provide patient protection required under this bill in a way that best fits each State. For example, last year in Kansas we implemented a new law that assists patients who get into a dispute with their insurance company over the refusal to pay for medical procedures. It is a long process, but the independent reviewer will make a decision and reply within 30 business days after an appeal procedure.
According to Kathleen Sebelius, our very good Kansas State Department of Insurance Commissioner, they have 22 cases that have been filed with the Kansas Insurance Department. Simply put, our State commissioner, Kathleen Sebelius, and the Kansas State Department of Insurance are doing a good job looking out for the best interests of Kansans covered by HMOs. So the question is, Why does the Federal Government need to tell our State we have to completely scrap what we are doing and put into place a Federal layer of new Washington-knows-best requirements? How good is this really for Kansans, or your States' families? In fact, Kansas has a large number of patient protections that have been in place for years, and the list is impressive. The list includes a comprehensive bill of rights, the internal and external appeals I have already described, consumer grievance procedures, emergency room services, OB/GYN access, prompt payment, continuity of care, a ban on gag clauses and financial incentives, screening and breast reconstruction, prostate cancer screening, maternity stay, drug and alcohol abuse treatment, standing referral, and the list goes on and on and on.

Under the bill we are debating today, many of these effective consumer protections Kansas has in place will have to be thrown out and we will have to start all over. Our Kansas State Insurance Commissioner, Kathleen Sebelius, also serves as the president of the National Association of Insurance Commissioners. Kathleen Sebelius, in a letter written clearly lays out the devastating effects the Washington one-size-fits-all plan will have on State insurance markets, and she warns—listen to this, colleagues—that this is going to be administered by an outfit called the Center for Medicare and Medicaid Services. It used to be called HCFA. If you really want to turn over your State regulations to HCFA, that is another issue that we can talk about for at least an hour or two. The commissioner stated in her letter:

*I think she nailed it right on the head. I am an original cosponsor of the Collins-Nelson amendment because it gives the States the maximum ability of what they are already doing well. If these standards are not met, only then would the Federal Government come in and impose its standards, and the State would then be required to meet a higher standard in order to be made eligible for the Patient Quality Enhancement Grant Program. Other amendments will have a stick; this is a carrot. I prefer a carrot; other Senators may prefer a stick.*

Let me just say, in summation, can any other Member of this body honestly tell me what is in this bill is better than what the State of Kansas already has in terms of patient protection? Do you know better than our commissioner, Kathleen Sebelius, or Governor Graham of Kansas State Legislature? The answer is no.

My colleagues, support this amendment and give States a chance to apply the standards they have currently in place, that are working. The external and internal appeals process is working. Don't make us reinvent the Federal wheel.

*I thank the Chair and my colleagues. The ACTING PRESIDENT pro tempore. Who yields time?* Mr. BREAUX. I yield myself 5 minutes.

Mr. President, I rise in strong support of the so-called Breaux-Jeffords compromise amendment. We are dealing with a question of how are we going to allow the States to continue to operate their own patient protection bills that many of them have already instituted. My own State of Louisiana has passed over 35 different patients' bills of rights guarantees, and they are working fairly well. I think my colleague, Senator JEFFORDS, wants to continue to allow those States to have their State plans in effect when they are substantially complying to what we are trying to do here on a national level.

As Senator KENNEDY said last night, if you had the Collins amendment, there would be no guarantee that States would have a Patients' Bill of Rights. They would not have to do anything if they so chose. A State could say they are not interested in guaranteeing patients within their borders any rights at all, period. We don't think it is the right thing to do. We are not doing it. The only thing that they would suffer, if they decided to take that approach under the Collins-Nelson amendment, is that they would lose grant money that is being authorized under this legislation.

We think that is an unfortunate in the sense that we are talking about a national program to guarantee patients the rights they should have under this legislation. I think there is strong agreement nationwide that there is a need to have some kind of a national guarantee that covers all Americans, not just some Americans, not just a few Americans, not just a handful of Americans, but all Americans, in dealing with their health insurance program.

Our compromise amendment does accomplish that goal, and it does it in a way that gives the maximum ability of the States to do what they think is necessary in crafting their Patients' Bill of Rights. The language that we have put forth says that State plans would not be superseded. They will continue to operate the way they do today, if they substantially comply with the patient protection requirements that we are instituting on a national level for all Americans.

That doesn't mean their plan has to be exactly the same as the Federal requirements. It has to substantially comply. That is a legal term used in Congress on many other occasions. On the SCHIP program for providing insurance to children, which we have enthusiastically supported, the requirement is that a State can run their own program if it substantially complies with the Federal requirements for all Americans that were instituted by this Congress.

On the Medicare Program, folks here in Washington understand how to apply that terminology. It is working. My State of Louisiana runs its own plan. I am very confident that any State of Louisiana that continue to run the plan we have in place right now under the Breaux amendment because it clearly would, in my opinion, substantially comply with what we are talking about here.

I have a definition of what "substantially comply" means by saying a State law would have the same or similar features as the patient protection requirements and would have a similar level of standards. That is not standard at all. It does not have to be exactly. It just has to have the same or similar features. They can design those rights on States that will be tailored to the needs of that particular State, and the only requirement is that it have the same or similar features. That is not too strong a guideline to the States or a requirement on behalf of the States. I think it can work. Most of the States, if not every single State, that have adopted a Patients' Bill of Rights will find their plans in their respective States will stay intact and will still be the State Patients' Bill of Rights under this legislation.

If a State decides for some reason they do not care, they are not going to do anything, there should be the ability for us to make sure all Americans are guaranteed the rights we are talking about today; that they are enforceable; there is an opportunity to go to court to enforce them; and that there is an appeals process when they are being abused.
This is what the Breaux-Jeffords amendment will allow. That is why it is a realistic compromise compared to the one from my good friends, Senator NELSON and Senator COLLINS, with whom I have worked on many occasions and will continue to do so in areas such as health. They are trying to do the right thing. Their amendment will allow some States to do nothing. Potentially thousands of Americans will not have any coverage whatsoever if that is the decision of the State.

We are writing legislation for all Americans, and I suggest the Breaux-Jeffords bill is a proper compromise that can bring this about.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator’s time has expired.

The Senator from Maine is recognized.

Ms. COLLINS. Mr. President, how much time is remaining on our side?

The ACTING PRESIDENT pro tempore. Nine minutes.

Ms. COLLINS. I yield 5 minutes to the Senator from Nebraska.

The ACTING PRESIDENT pro tempore. The Senator from Nebraska is recognized for 5 minutes.

Mr. WILSON of Nebraska. I thank Senator Collins for her strong support for this amendment, and I commend my colleague, Senator BREAUXT from Louisiana, for his strong support and consistent efforts to find a compromise.

Certainly, the effort is an improvement over where we had been. One area I want to point out I disagree with my friend from Louisiana is his suggestion that maybe the States will not do anything. If you take a look at the charts, you will see that the States have the opportunity to opt out so we will have continuing experimentation under the Jefferson principle that the States are the laboratories of democracy. I am not against all pre-emptions, but I do have a question about one. It is allowing the States to do their own thing. It makes sense under the circumstances with the progress that the States have made.

The charts will show the States have been active. They have worked very hard and they have been continuing to do so. Delaware just last week enacted additional patient protection laws. What we need to do is make sure we continue to permit the States to experiment.

I am also worried that with the application of these standards to the States, we will not have further experimentation, we will not have further development of patient protections. I hate to think we are at a point where the status quo will be sufficient for today as well as for tomorrow. I worry this effort in having a floor will result in it becoming a ceiling.

If you look at the charts, you will see to one degree or another, whether it is emergency room care or whether it is the external appeals or the internal appeals, that nearly every State is doing it. Many States have decided not to do anything under every set of circumstances. I do not think they ought to be penalized where they have made a conscious decision that that is not going to work within their State. We ought not to have, in my judgment, a one-size-fits-all approach. We have not found, if you will, the Holy Grail as it relates to what patient protection truly looks like. If we continue to experiment, we will find that they will be innovative and they will come up with new methods of providing even better patient protections. After all, this is coming from the grassroots; this is coming from the bottom up.

I think we are making a mistake trying to drive it from the top down which will stifle and create the opportunity for stagnation rather than experimentation. I hope that will not be the case, but I do not see it really any other way.

The National Association of Insurance Commissioners, the president of the National Association of Insurance Commissioners, the National Council of State Legislators all agree with this approach.

The ACTING PRESIDENT pro tempore. The Senator’s time has expired.

Who yields time?

Mr. BREAUXT. I yield 5 minutes to Senator JEFFORDS.

The ACTING PRESIDENT pro tempore. The Senator from Vermont is recognized for 5 minutes.

Mr. JEFFORDS. Mr. President, I commend the Senator from Maine for keeping this issue alive. It is critically important that we defer as much as we can to the States because they are already set up for it. Why not let them do it?

On the other hand, this is a Federal Patients’ Bill of Rights. That means equal rights to everyone in this country, so I do not like that concept for uniformity as well as to make sure we get a firm and even enforcement of this bill.

A lot has been said about HIPAA and using HIPAA as an example of bad policy, and it was totally different. HIPAA dealt with portability of insurance in the case of people being laid off work.

They said, if you do not do it, HCFA will come in and do it, and five States said let HCFA do it, and it made a mess of it. This is different. We are talking about the enforcement of rights, an even enforcement across the country. Yet we do recognize it is important for the States to do it themselves. Many, if not most of them, are already doing a legislative enforcement to require the appropriate and fair enforcement of the rights of individuals on health care.

This is an important difference. HIPAA was a mess, but this has nothing to do with that. This is quite different from HIPAA.

We all support the Patients’ Bill of Rights. The question is who ought to enforce it. We say, yes, let the States that want to do it do it. On the other hand, we need to make sure it is done fairly and uniformly across this country. We do give the authority to the Secretary to review it, and we also say he should lean over backwards to make sure the States do it if at all possible. It is not a HIPAA-type situation; we ought to defer it.

It is important that we also recognize that the compromise requires States to have protections that are “substantially compliant with” Federal protection and defines this standard as having the “same or similar provisions and the same or similar effect.” The Secretary must approve the State’s certification of compliance in a manner that is in deference to existing State laws. If he does not act on the State application within 90 days, it is automatically approved. States that have their certification disapproved may challenge that disapproval in court.
The amendment developed by Senator Breaux and myself requires States to adopt new authority to implement strong patient protections while guarantees a basic level of protection for all Americans in all health plans. Requiring the States to be in substantial compliance with the Federal law—not exact compliance but substantial compliance—provides States with the flexibility they need to implement strong patient protections while ensuring that all patients receive the Federal floor of protections. Under this amendment, States can keep their own laws as long as their basic intent is similar to the Federal standard and will have a similar effect.

The Secretary is required to be deferential to the States—give them every break you can but make sure that the bill of rights will be enforced. Give them every possible opportunity to do it themselves rather than having to go to court. However, this requirement does not infringe upon the Secretary’s authority to determine whether current State laws will provide the basic level of protection promised to all Americans in the health plans under the Patients’ Bill of Rights.

So HIPAA is just a totally different situation. It is a mess; we agree with that; but it is totally different. Do not get confused on the HIPAA example.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. Who yields time?

The Senator from Maine.

Ms. Collins. How much time is remaining on my side?

The ACTING PRESIDENT pro tempore. Three minutes forty-seven seconds.

Ms. Collins. Mr. President, I yield 2½ minutes to the Senator from Ohio, Mr. Voinovich.

The ACTING PRESIDENT pro tempore. The Senator from Ohio is recognized.

Mr. Voinovich. Mr. President, I thank my friends from Maine and Nebraska for offering this important amendment. I believe the Collins-Nelson amendment will allow the Senate to move forward and pass a strong Federal patient protection bill without suffocating the patient protections States have adopted over the last several years.

I wholeheartedly agree that the Senate should take action to protect those Americans not covered under state plans. While the States were in front protecting the majority of those insured individuals through state regulation, the federal government has dragged its feet.

However, a federal patient’s bill of rights should not preempt the patient protections that have already been passed by the States. There are more than 117 million Americans who are covered under fully insured plans, government plans and individuals policies, which are all regulated under state law.

My colleagues supporting the McCain-Kennedy legislation believe that the federal mandates in the bill should apply not only to ERISA plans, but also to those 117 million Americans in state regulated health plans. Apparently, they think that the States, which have already acted and are already protecting millions of Americans, are competent enough to do the job. Instead, they think that the federal government will do a much better job.

My colleagues on the other side of this debate want the public to believe that all Americans need to be covered under a federal patient protections bill or else the quality of their health care will be jeopardized. The fact of the matter is that the majority of Americans are already covered under very good, very comprehensive state health care laws.

As a former Governor of Ohio, I was on the front lines in the fight to give working men and women in Ohio real health care choices. As governor, I signed into law five legislative measures and pushed through several administrative improvements to protect families who rely on state-regulated plans for their health care coverage.

The majority of states, including Ohio, have moved aggressively—certainly more quickly than the federal government—to reduce health care inflation, expand access for the working poor, enhance consumer protections and bring greater accountability to the system.

If the states had waited for the federal government to provide the plate to provide patient protections, 117 million Americans would not have the patient protections they currently enjoy.

The simple truth is that the states have been out in front of the federal government in providing sound protections for its citizens. The following facts prove this point:

42 states already have enacted a comprehensive Patient’s Bill of Rights;
50 states have mandated strong patient information rights;
50 states already have an internal appeals process and 41 states have included an external appeals process;
49 states already enforce consumer protections regarding gag clauses on doctor-patient communications;
47 states already have regulations regarding prompt payment; and
44 states already enforce consumer protections for access to emergency care services.

The states are already getting the job done for the majority of insured Americans. But if we do not pass this amendment, we will be turning over to the Health Care Finance Administration (HCFA) the enforcement of state sponsored protection plans that are not substantially equivalent with the federal bill.

The fact is, HCFA already has its hands full. Administering and regulating Medicare and Medicaid has already overburdened this federal agency. Think about it. HCFA already has under its purview over 70 million Americans through these federal programs. Now, my colleagues want to place the health care of an additional 130 million Americans on HCFA’s shoulders.

The simple fact is that HCFA cannot handle the burden.

Those individuals on the front lines of protecting the 117 million Americans with state regulated insurance know what will happen if the federal government is given the responsibility to oversee these state regulated health insurance plans.

In fact, the National Conference of State Legislatures has made clear its concerns about the McCain-Kennedy bill as, “. . . federal legislation that will largely preempt important state laws and replace them with federal laws that . . . the federal government is ill-prepared to monitor and enforce.”

Additionally, the National Association of Insurance Commissioners has made clear its concerns about the McCain-Kennedy bill if the federal government unilaterally imposes an “one-size-fits-all” standard on the states, it “could be devastating to state insurance markets.”

The amendment that Senators Collins and Nelson have offered will give true deference to state laws and the traditional authority that states have had to regulate insurance.

By “grandfathering” all state patient protection laws, Senators Collins and Nelson recognize that the vast majority of states have enacted comprehensive patient protection laws, as Ohio has done.

The amendment also encourages states, through Patient Quality Enhancement Grants, to review their current patient protection and, if the state legislature and governor so desire, take action to mirror federal patient protections.

I want to relay to my colleagues that I truly believe that this will be the most important federalism vote that the Senate takes this year.

In conclusion, it has been the traditional role of States to regulate the needs of our States. However, both the McCain-Kennedy bill as written and the Breaux amendment seek to preempt what the States have accomplished in protecting patients. The underlying bill as written would step over the 10th amendment which says: the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

The bottom line is that the States have been involved in protecting patients a lot longer than the Federal
Government, and they are doing a good job with the protections they have put in place. They debated them in their State legislatures. Their insurance departments are doing a good job of enforcing those laws. The Breaux amendment and the underlying bill gets the States out of their role. We will have a dual system of enforcement—State insurance commissioners and HCFA. And I can tell you, anyone who knows anything about HCFA in terms of the responsibilities they have, knows they have a hard-enough time doing their job now. We should not get them involved in a system that is already working on the State level.

I beg my colleagues not to go along with federalizing this issue. Let’s take care of the Federal people who have been exempted over the years because we haven’t done the job we are supposed to do, and let the States continue to do the job they have been doing.

I thank the Chair.

The ACTING PRESIDENT pro tempore.

Mr. BREAUX. I yield 2 1/2 minutes to my good friend, the Senator from Connecticut.

The ACTING PRESIDENT pro tempore. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, I thank my colleague from Louisiana. I commend him and the Senator from Vermont for their compromise proposal we will be voting on shortly. I reluctantly oppose my friend from Maine, my fellow New Englander. I have joined with her on so many issues and have such great respect for her.

There is a title to this bill. It is not titled casually; it is called the Patients’ Bill of Rights. Obviously we are all most familiar with our Constitution and the Bill of Rights we embrace and cherish so richly as American citizens. But if we are going to have a bill of rights when it comes to basic fundamental health care, as has been pointed out by the Senator from Louisiana and the Senator from Massachusetts and others, then there ought to be a floor that applies across the country to all 50 States. That is what we are really advocating.

If the Collins amendment is adopted, then what you are developing is a trapdoor in that basic floor that exists. Let me make the case just by pointing to one particular provision of this bill. That is the access to emergency room care, Mr. President.

I have this chart to make the point. In the States that are in red in this chart, they have laws that are weaker than the underlying bill when it comes to access to emergency rooms. We are not talking about some grandiose new plan. We are talking about a fundamental right that you can have access to the closest emergency room. In 27 States, they have a much weaker provision than is in this law. We are saying when it comes to a Patients’ Bill of Rights, specialty care to clinical trials, specialists, emergency rooms, this is the floor across the country. If you want to pass laws at the State level that are substantially in compliance with that, we welcome that. If you want to do something more than we are doing here, we welcome that. But if you are going to say that we are going to allow weaker laws to exist in the access to a gynecologist, to a pediatrician, to a clinical trial, to a specialist, or to an emergency room, then we don’t think that is right.

If you are for the Collins amendment, in many ways you are going against this bill. I understand that. I appreciate the fact that people do not want to pass Patients’ Bill of Rights and just leave it up to each State to decide. But if you believe, as a majority of us do, and an overwhelming majority of the American public, that there ought to be a Patients’ Bill of Rights, a basic floor that provides the basic standards, then you must vote to adopt the Breaux-Jeffords compromise amendment and retain the integrity of this bill.

The ACTING PRESIDENT pro tempore. The Senator’s time has expired. Who yields time?

Mr. KENNEDY. I imagine the Senator would like to close the debate, would she not?

I believe I have 2 1/2 minutes.

Mr. President, the issue is very simple and very basic and very fundamental. It is whether all Americans are going to be covered as included in this legislation. We do not believe it should depend upon where you live. We believe it should depend necessarily on where you work. If a child needs a specialist to treat cancer, he or she ought to be entitled to see the specialist and receive the treatment. If a woman needs to be enrolled in a clinical trial that could be lifesaving, she ought to be entitled to participate. If a breadwinner who is crippled with arthritis needs a specialty kind of drug from a formula, he or she ought to be able to obtain it.

Now, our bill guarantees these kinds of protections, but with the Collins amendment it is a roll of the dice. President Bush believes that all Americans should be covered. Every Republican bill that was introduced and considered in the House of Representatives said all Americans are covered. She covers about 40 percent of them; 60 percent of Americans are left out. We believe if you are interested in assuring that all Americans be covered, you ought to support the Breaux-Jeffords amendment. That will be doing the right thing.

The ACTING PRESIDENT pro tempore. The Senator from Maine is recognized.

Ms. COLLINS. Mr. President, one of the myths in this debate is that unless the Federal Government preempts State insurance laws, millions of Americans will be unprotected in their disputes with HMOs. That is simply untrue. Ironically, my friend from Connecticut makes the point on emergency room care. Forty-four States have enacted legislation guaranteeing access to the nearest emergency room. But they have crafted their laws in different ways depending on the needs of those States. Why should the Federal Government second-guess those laws, substitute its judgment for the judgment of State legislators and Governors’ offices all over this country? It does not make sense. The proposal of the Senator from Louisiana would be both burdensome to States and ineffective for consumers.

Does anyone really believe that a consumer with a problem with his or her insurance policy is better off calling the HCFA office in Baltimore than dealing with their own State bureau of insurance?

The States have more than 50 years of experience in regulating insurance. They have acted without any prod or mandate from Washington to enact good, strong patient protection laws. Let’s honor their work. Let’s build upon the good works of the States rather than preempting, second-guessing, and superseding their laws.

The ACTING PRESIDENT pro tempore. Who yields time?

Ms. COLLINS. Is there any time remaining?

The ACTING PRESIDENT pro tempore. The Senator from Maine has 24 seconds.

Mr. BREAUX. I yield back the remainder of my time if the other side is ready to yield back.

I ask for the yeas and nays on the amendment.

The ACTING PRESIDENT pro tempore. All time is yielded back. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. REID. Mr. President, I move to table the Collins amendment and ask for the yeas and nays.

The ACTING PRESIDENT pro tempore. Is there a sufficient second? There is a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Delaware (Mr. BIDEN) is necessarily absent.

Mr. NICKLES. I announce that the Senator from New Mexico (Mr. DOMENICI) and the Senator from Alabama (Mr. SHELBY) are necessarily absent.

Mr. REED. PREVING OFFICER (Mr. REED). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 53, nays 44, as follows:
June 28, 2001

[Roll Call Vote No. 202 Leg.]

YEAS—83

Akaka 
Baucus 
Bayh 
Bingaman 
Boxer 
Breaux 
Byrd 
Cantwell 
Carnahan 
Carper 
Chafee 
Cleland 
Clinton 
Conrad 
Corinne 
Daschle 
Dayton 
DeWine 

Dodd 
Durbin 
Erlenmeyer 
Edwards 
Feinstein 
Fitzgerald 
Feinstein 
Graham 
Harkin 
Holmes 
Insorey 
Jeffords 
Johnson 
Kennedy 
Kyl 
Lott 
Landrieu

Levin 
Lincoln 
McCain 
Mikulski 
Miller 
Murray 
Nelson (FL) 
Reed 
Reid 
Stabenow 
Torricelli 
Wellstone

McConnell

RANGE—44

Allard 
Allen 
Bennett 
Bond 
Brownback 
Burns 
Campbell 
Cooper 
Cranston 
Cranston 
Craig

Graham 
Grasso 
Gregg 
Hatch 
Hatch 
Helm 
Helm 
Inhofe 
Jackson 
Jackson

Nickles 
Robert

RANGE—3

Biden 
Domenici 

NAY—36

Allard 
Allen 
Bennett 
Bond 
Brownback 
Bunning 
Burns 
Campbell 
Collins 
Craig 
Cra公交 
Domenici 

Lott

McConnell 
Murkowski 
Nickles 
Roberts 
Sessions 
Shelby 
Smith (NI)

Wellstone

Mr. President, I understand the need to compromise, and I think we are moving forward in a very positive way. I do want to point out for the record that what we are now saying is that a State need only be "substantially compliant" with Federal protections as opposed to "substantially equivalent to." My big worry is that if you look at this amendment, we are also saying we need to give deference to the State's interpretation of its own law and its compliance with Federal protections.

I say two things to colleagues. No. 1, I think, in the best of all worlds, consumers would also have a right to appeal if they believe the State is in error.

To be fair, we want to give deference to what States are doing, as long as we have strong consumer protections for everyone regardless of where they live. I also believe if we are going to do that, we have to make sure not only that the States are given their proper due but also consumers.

This amendment weakens the bill somewhat in that it says only "the State which has strong consumer protection." It is a good compromise in terms of where we are. I wanted to speak out of where we are. I wanted to speak out and express my concerns.

I do not believe this amendment takes us in a strong consumer direction. It is a good compromise in terms of where we are. I wanted to speak out and express my concerns.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 830.

The amendment No. 830 was agreed to.

The PRESIDING OFFICER. Under the previous order, there will now be 2 minutes for debate equally divided prior to a vote on or in relation to the Breaux amendment No. 830.

Who yields time?

Mr. BREAUX. Mr. President, I do not mind using the time allocated for remarks, but in light of the previous vote, after the remarks could we just vitiate the rollcall vote and have a voice vote on this amendment? I ask unanimous consent that that be in order.

The PRESIDING OFFICER. The yeas and nays have not been ordered on the Breaux amendment No. 830.

Mr. BREAUX. That would be my suggestion. We have the time allocated for comments on it, and then have a voice vote on it afterward.

Mr. KENNEDY. Mr. President, I think we will have the Senator from Minnesota speaking for 2 minutes, and then I think we will voice vote the Breaux-Jeffords amendment.

The PRESIDING OFFICER. Who yields time?

Mr. BREAUX. I yield 2 minutes to the Senator from Minnesota.

Mr. WELLS. I thank my colleague for his graciousness.

Mr. President, I understand the need to compromise, and I think we are...
AWARD.—The term ‘award’ means the sum of—

(1) any monetary consideration provided to a participant or beneficiary (or the estate of such participant or beneficiary) by a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with a group health plan, or an agent of the plan, issuer, or plan sponsor in connection with a cause of action brought under this subsection, including any monetary consideration provided for in any—

(aa) final court decision;

(bb) court order;

(cc) settlement agreement;

(dd) arbitration procedure; or

(ee) alternative dispute resolution procedure (including mediation); plus

(2) any—

(A) attorney’s fees awarded under subsection (g)(1) with respect to the participant or beneficiary (or estate); less

(bb) any reimbursement for any expenses incurred in connection with direct or indirect representation or other legal work performed in connection with a cause of action under this subsection, after subtracting the amount of any attorneys’ fees from the total amount of such award.

(B) EXCEPTION.—This paragraph shall not apply where the amount awarded as a result of a cause of action brought by a participant or beneficiary (or estate) under this subsection is less than $100,000.

(C) DEFINITIONS.—In this paragraph—

(i) ATTORNEYS’ FEES.—The term ‘attorneys’ fees’ means any compensation for the direct or indirect representation or other legal work performed in connection with a cause of action brought under this subsection. Such term shall not include reimbursements for any expenses incurred in connection with such representation or work.

(ii) AWARD.—The term ‘award’ means the sum of—

(I) any reimbursement for any expenses incurred in connection with direct or indirect representation or other legal work performed in connection with a cause of action under this subsection.

Mr. BOND. Mr. President, several days ago in debate in this Chamber, I talked about how employees of small businesses might lose their health care coverage if the provisions of McCain-Kennedy went into effect unamended. The junior Senator from North Carolina indicated that I was interested only in protecting the businesses. Unfortunately, he misconstrued my arguments because we are concerned about patients. We hope the employees of small businesses will continue to get the benefit of health insurance coverage by their employers.

I spoke about employees, however, because if this bill is not significantly amended, there are not going to be patients covered by this bill; they are going to be thrown out of health care coverage. We are concerned about patients.

It is not only small businesses that should be worried about this bill, but employees of small businesses should also be worried about this bill.

This amendment I offer today provides additional protection to patients. It provides protection to patients from trial lawyers, so we will find out whether my colleagues are more interested in taking care of patients or ensuring that the rights to sue by trial lawyers are unabated.

There are a lot of words in the McCain-Kennedy bill, but there are also some heavy-duty new lawsuits that are authorized by this bill.

The Federal claim of action really begins on page 140. It starts off:

IN GENERAL.—In any case in which

(A) a person is a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with the plan, or agent of the plan, issuer, or plan sponsor—

(i) any monetary consideration provided to a participant or beneficiary (or the estate of such participant or beneficiary) by a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with a group health plan, or an agent of the plan, issuer, or plan sponsor in connection with a cause of action brought under this subsection, including any monetary consideration provided for in any—

(aa) final court decision;

(bb) court order;

(cc) settlement agreement;

(dd) arbitration procedure; or

(ee) alternative dispute resolution procedure (including mediation); less

(ii) any reimbursement for any expenses incurred in connection with direct or indirect representation or other legal work performed in connection with a cause of action under this subsection.

Preemption does not apply, “non-preemption of certain causes.” It begins on page 157.

Except as provided in this subsection, nothing in this title . . . shall be construed to supersede or otherwise alter . . .

It goes on page after page. There are exceptions for wrongful death, exceptions for willful disregard of safety of persons . . .

The amendment effectively prohibits obscene contingency fees where large judgments are won and the plaintiff’s attorney takes 30 or 40 percent after judgments are won and the plaintiff’s attorney.

Some may say lawyers will not take the cases. We do not want to take the cases. When we talk about setting a patient minimum, we need to be cautious. Just as it doesn’t help to have a right to sue your HMO when your employer drops health care coverage, as would happen under this bill if it is not amended, it doesn’t help to have a recovery minimum except if it means no attorney will take your case. This amendment includes two strong protections to make sure access to attorneys is not threatened.
First, before the patient minimum is applied, the amendment allows the attorney to be reimbursed for expenses incurred during the case. Only after expenses are deducted from the award will a patient minimum apply. In practice, this means an attorney can never lose money on a lawsuit that results in an award.

I am not sure any State has taken the exact approach this amendment establishes. The Patient Protection Act of 2005 has 14 States have established caps on attorney fees. The strictest cap is in New York where lawyers are limited to 10 percent of awards over $1.25 million. That is the equivalent of a 90-percent patient minimum. California has the most well-known cap on attorney fees. In California, lawyers are limited to 15 percent of any award in excess of $600,000. When you add Florida and Indiana, which also have a 15-percent cap for the highest level awards, 4 of the 14 States that established caps on awards of attorney fees essentially require that plaintiffs get at least 85 percent of an award.

Have these caps served as a barrier for plaintiffs? Have they denied access to the courts? From the data we have, we conclude they definitely have not. The State with the toughest cap, New York, produces almost twice as many malpractice awards per capita and California’s rate of large awards per capita and California’s rate is about the average. Indiana, with a 15-percent cap, falls below the national average.

It is hard to argue that the caps threaten access to the courts through attorneys. The Patient Protection Act has existed for at least a decade. By not changing the law, the State legislature seems to have come to the same conclusion.

What do we take 85 percent? When you take out expenses and exempt lower level awards, patients should get the overwhelming amount of an award. For a patient who has been harmed, it is perfectly reasonable to ask that at least the State legislatures think about the award. By choosing 85 percent as the highest minimum amount to which a patient is entitled, this amendment simply reconciles Federal law with laws that seem to be working in four of the largest States in this country.

We know of the horror stories. We have heard too many horror stories. I point out an August 16, 2000, article in the Los Angeles times about Rodney King, who was brutally beaten by Los Angeles police. He is taking a beating from his lawyers, he says. They made more money on his case than he has. By his reckoning, they cheated him out of more than $1 million. In a nutshell, the man whose 1991 videotaped beating made him an international symbol of police brutality and civil rights and took a $44,000 verdict in the case, a $19,800 contingency fee, and collected $378,000 in fees awarded by the trial court; the client received $310.

I have other examples. But one of my favorites is the Lawyers Weekly report that a growing number of lawyers are putting arbitration clauses in the fine print, shielding them from being sued by another trial lawyer if the clients say they botched a case. The lawyers themselves who are making the money off the large judgments prefer their disputes go to private arbitration because arbitration is faster, cheaper, decisions are made by other lawyers rather than juries, and there is no public record. So how they have recognized that there are certain instances in which it does not make sense to allow unfettered access to the courts for people with a claim.

If a patient is harmed and wins an award through a lawsuit, it is perfectly reasonable to expect the patient will receive at least 85 percent of the money. Almost 180 pages of the bill protect patients from HMOs and insurance companies. I simply propose we add a few pages to the bill to protect patients from trial lawyers.

I see the Senator from North Dakota is on the floor. I ask after the other side finishes speaking that my colleague from Iowa be recognized for 10 minutes.

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

The Senator from North Dakota is recognized.

Mr. DORGAN. Mr. President, this amendment is one more in a series of amendments we are trying to try to derail the Patients’ Bill of Rights, or the Patient Protection Act.

There is no evidence of unfairness in the attorney fee portion of the bill that we brought to the floor of the Senate. No one has alleged that; no one has disagreed with us. This is the first moment in which there is an amendment offered and we have been working on this legislation for five years. It is interesting that the amendments are always designed to try to take the ground out from under patients, to diminish the opportunity for the patients to address the enormous problems they face in confronting a managed care organization that does not want to give the care promised the patients.

This amendment ultimately prevents injured patients from finding the adequate legal protection they need in order to confront a managed care organization. Congress has passed over 300 laws allowing attorney fees, and the laws are described for every Senator to see in a Congressional Research Service report No. 94-870-8. I commend any one to that CRS report which describes these laws.

I have not found any Federal law on attorney’s fees that is as restrictive as is proposed in this amendment. I repeat, there isn’t any Federal law on attorney’s fees that is as restrictive as that proposed this morning on the Patient Protection Act.

Why, when we have this issue of managed care organizations not providing the care required for patients and we have the opportunity in this legislation to hold the managed care organization accountable, why is it that those who don’t like this Patient Protection Act try to carve the ground out from under patients once again with a restrictive proposal that almost certainly would diminish the opportunity of a patient to acquire access to an attorney to make that HMO accountable?

I find it also interesting that the concern behind this Bond amendment is apparently excessive attorney fees. There are striking excesses with respect to managed care organizations. Let me mention just a couple.

What about excessive salaries, excessive stock options? I don’t hear anyone coming to the floor of the Senate complaining about $50 million in compensation that the CEO of a managed care organization receives. I don’t hear anybody saying that is an excessive salary for an individual to receive. How is it these CEO’s get to be rewarded in amounts a large as $50 million? By pinching on access to care that ought to be delivered to patients.

The opponents of our patients protection bill are not here on the floor saying that $50 million paid to the president of a managed care organization is excessive. We just hear them come out here to say we are worried about an excessive fee received by an attorney who is representing a patient trying to hold an HMO accountable.

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

Mr. DORGAN. I will be happy to yield, of course.
This amendment, if it were genuine, if it were really concerned about fees, would not just address attorney’s fees. They would address the compensation paid to those who run these organizations, which make $50 million, $10 million, or $250 million in stock options. Is that excessive? We don’t hear anyone on the floor of the Senate talking about that. Why? Because this is not about fees. It is about with whom do you stand. It is about people who really do not want this legislation to pass. They have been dragging their feet now, day after day after day, bringing out amendments to try to defeat the Patients Protection Act. In every case, in every circumstance, they have failed. This amendment is the latest attempt to do that. The amendment limits attorney’s fees to what patients would try to hold a managed care organization accountable. It limits attorney’s fees, as I understand it, to an amount below all other attorney’s fees that are now written in Federal law. We have had it in a number of places in Federal law. I have referenced the CRS report. All Senators can look at it. This amendment proposes we limit attorney fees below all those other areas mandated by federal law. Why? Because here we are talking about patients. We are trying to advocate on behalf of patients. Why would anyone want to take away the patients’ rights when they are confronting big organizations?

One of the interesting things is I hear all this talk about a patient who would hire an attorney to make a managed care organization accountable. I hear no discussion about the legion of attorneys who are hired by managed care organizations to deal with patients. Do you think the big insurance companies and big managed care organizations do not have a battalion of lawyers they pay? Of course they do. Maybe you want to limit their opportunity to use lawyers? I don’t think so. I don’t propose that.

Then why would you want to limit the opportunity of patients to use attorneys to make an HMO accountable? This just makes no sense on its face. It is one more step, one more attempt to try to defeat this bill. We have had it day after day after day, amendment after amendment. I hope my colleagues will understand the last thing we ought to do is weaken the ability of the American people, who as medical patients expect certain care but did not get it, to be able to hire an attorney and make that managed care organization accountable.

I would say one more thing. I would like those who offered this amendment, who are indeed concerned about “fees,” to be concerned about all fees. If they are concerned about lawyer’s fees, good for you. Then be also concerned about $50 million, and $250 million in compensation paid to a CEO who runs a managed care organization. Be concerned about those fees as well. You would not be consistent, bring both amendments to the floor and let’s debate both amendments.

I reserve the remainder of my time and yield the floor.

The PRESIDING OFFICER (Mrs. CARNAN). Under the previous order, the Senator from Iowa is recognized for 10 minutes.

Mr. GRASSLEY. Madam President, I suggest the absence of a quorum and I ask unanimous consent to have the time run equally on this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

The Senator from Iowa.

Mr. GRASSLEY. Madam President, I support the Bond amendment and want to speak specifically to that point. It also deals with the point I have made in other speeches—that this is a very good bill. But during the process of considering giving patients a bill of rights against insurance companies, I think we always have to keep our eye focused upon the fact that we want to give treatment for patients and not torture for lawyers.

This amendment takes a very good approach in fixing the Kennedy-McCain bill’s provisions dealing with the liability parts of the bill, which, in my view, amount to nothing less than a trial lawyer’s pot of gold.

I have always believed that medical malpractice liability laws should provide adequate compensation for those who are truly injured while reducing frivolous lawsuits.

I firmly believe that it is a principle of any case, including patients against insurance companies, that people who are harmed ought to be made economically whole. But there has to be a balance between frivolous lawsuits and making sure that people can be made whole if harmed.

I think the Kennedy-McCain bill fails to strike that very carefully needed balance and instead creates a lottery for trial lawyers, which not only inflates the cost of health insurance for all of us but also leads to more and more hard working Americans losing health coverage.

We shouldn’t do anything in this bill that will cause people to lose their
health insurance. We already have 42 million uninsured Americans. The best opportunity for affordable health insurance is represented by employer-related health insurance programs. Don’t forget that we have over 50 million insured Americans under the self-insured plans that employers offer. The case is that most of these self-insured plans come from small business more so than large corporations. We should not be putting these employers and their employees in a situation where an employer, because of the threat of suit under this bill and losing a generation and a lifetime of savings in that family business, will not want to take a chance of losing his investment which has been built up through a family working together and investing everything they could regardless because of a threatened lawsuit. If that is a threat, then you can understand why the employer might just eliminate their self-insurance and in the process throw the employees into a situation of having no health insurance, resulting increases in the number of 42 million people in this country who now do not have such insurance.

Here is how I believe this will inflate costs, and thus cause employers and employees to not have health insurance coverage. Except for the $5 million cap that is in this bill on punitive damages in Federal courts, the Kennedy-McCain bill sets absolutely no limits on what damages trial lawyers can collect.

When it comes to patients and those harmed because of lawsuits, it ought to be an axiom of all of our public policy that the people harmed, not lawyers, should get most of the money from a lawsuit.

Of course, the Bond amendment then makes this more true than under the existing practice. You have to consider that trial lawyers generally collect 40 percent of their clients’ recoveries. In fact, in many cases, you can have the lawyer’s fees plus other court costs work out to where the person harmed is getting less than 50 percent of what the jury might award.

Trial lawyers generally collect 40 percent of their clients’ recoveries. Incentives for bringing cases regardless of merit are then extremely high. It is a perverse incentive to go to court and to go to trial. But the real jewel in the trial lawyer’s crown is this bill’s provision that allows the same suits for the same claims brought by the same trial lawyers, whether they proceed in State or Federal courts.

Even though this debate is supposed to be about patients, the Kennedy-McCain liability scheme isn’t about patients at all. It is about trial lawyers. In fact, as you can see, I call this the “trial lawyers lottery ticket.” I want to show where five out of six opportunites for monetary awards are virtually jackpots for lawyers.

Take a closer look. You do not call it the trial lawyer’s lottery ticket and see what the lawyer gets. Let’s start with medical costs.

Peel off the lottery ticket top, both for State court and Federal courts, you will see “bingo”—no limit on what trial lawyers can collect in both State and Federal court. That is a jackpot that ought to make any lawyer happy.

But why quit when you are ahead? Let’s take a look at what is in store on pain and suffering. Peel that lottery ticket, and you can see what you get on pain and suffering. It is another jackpot—unlimited damages in State and Federal courts.

The sky is the limit. That is where the trial lawyers are really winning big.

Now, for the trial lawyer’s favorite damages, punitive damages, they stand to reap tens of millions of dollars.

Let’s see what this ticket offers the trial lawyers. So we pull off the punitive damages square. You can see unlimited damages in State court, and up to a $5 million cap in damages as far as the Federal courts are concerned.

This is another big win. Talk about good luck: unlimited punitive damages in State courts, and in the Federal courts almost unlimited—a $5 million cap. If you ask me, that is hardly any limit at all.

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

Mr. GRASSLEY. No, I will not. I only have 10 minutes. And we lost some other time on this question of waiting for the leader.

Mrs. BOXER. On my time. I would ask a question on my time.

Mr. GRASSLEY. Finally, if I could, let’s not forget about class action lawsuits which multimillion-dollar damages are the name of the game. So here again we peel off the lottery ticket. You can have class action lawsuits in State courts. You can have class action lawsuits in Federal court.

So bingo again. Kennedy-McCain has no limits on class action lawsuits. It even creates new grounds for bringing class action cases.

As you can see, everybody wins—every lawyer, that is—with the trial lawyers’ lottery ticket.

What we get back to then is that we are more concerned about treatment for trial lawyers, not treatment for patients. It seems ironic that the very individuals this bill claims to protect are the ones who lose. Despite what its sponsors say, the bill before us exposes employers to the constant threat of litigation, even for simple administrative tasks and clerical errors.

What is the ultimate result? What everybody says they do not want to ever happen. People lose coverage. When this sort of perverse incentive is out there to threaten small business, particularly those that are self-insured—because they do not want to put in jeopardy their lifetime of work but that is happening in part of the community, so they can have good workers and pay their workers well—and, most importantly, workers want good fringe benefits; and the No. 1 fringe benefit they want is health insurance—it puts it in jeopardy employer-based coverage. Then the ranks of the uninsured go up tremendously.

I yield myself more time.

Mrs. BOXER. Reserving the right to object, I would ask for 1 minute as well upon the conclusion of the Senator’s remarks.

Mr. GRASSLEY. I object to that. There is plenty of time on that side for the Senator to take her time. I am taking time off our side.

Madam President, how much time do I have left?

The PRESIDING OFFICER. There are 3½ minutes left for the sponsor.

Mr. GRASSLEY. I would like to take 1 minute of that 3½ minutes.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. So the ranks of the uninsured are going to go up. There are 42 million uninsured now. Do we want to increase that? No, nobody wants to increase that, but that is going to be the end result when these self-insured plans are dropped. Then, of course, the employees become the biggest losers in this lottery.

So I urge my colleagues to reject this lottery and to support the Bond amendment, which creates much needed patient minimums and ensures that patients, not lawyers, get fair compensation for their losses.

I reserve the remainder of the time and yield the floor.

The PRESIDING OFFICER. Who yields time?

The majority leader.

Mr. DASCHLE. Madam President, I will use my leader time and not take any time off the agreed-upon time allocated for the amendment.

Madam President, I would just say on the amendment, there is nothing in there that would limit the lawyers’ fees for the insurance industry. Those are unlimited. While they limit the legal fees for lawyers defending patients, there is nothing to limit the legal fees for lawyers defending HMOs and insurance companies. I find that quite ironic.

SUPPLEMENTAL APPROPRIATIONS

Madam President, I want to propose a unanimous consent request. I will not do that at this time because I have been talking with the distinguished Republican leader. But I want to propound a request, as I had indicated I would, to lock in the debate for the supplemental.

There are a number of amendments that have been suggested. I know the unanimous consent agreement has been
cleared on our side now for I think 3 days. We have been unable to get consent from our Republican colleagues for the last 3 days.

Now I am told they may object to even going to the supplemental, at least initially. If that happens, of course, I will be forced to file a motion to proceed. But I think it is important.

There was a story in the Washington Times dated June 26, and I think for the RECORD it would be helpful if I just read it because I think it does capture the urgency with which we address the supplemental. So I will take just a moment to read it:

The U.S. military would be forced to curtail or cancel training exercises, facility repairs and equipment maintenance if Senate Majority Leader Tom Daschle holds up a pending emergency budget until late July, according to Pentagon projections.

The Pentagon provided a list of hardships at the request of Senate Minority Leader Trent Lott. It used the list yesterday to criticize Mr. Daschle for threatening to delay action on a $6.5 billion supplemental budget bill until the Senate completes work on a controversial patients' bill of rights. That delay would push approval of the fiscal 2001 defense legislation until late July or beyond.

"If we don't get this bill completed by mid-July, we're going to have canceling of base-property maintenance, [and] holding some of our deployed units where they are overseas until the end of the fiscal year [Sept. 30]," said Mr. Lott. "So we're really pushing the envelope when it comes to the needs of our military personnel in health as well as in training hours."

Picking his first confrontation with Democrats since they took control of the Senate, Mr. Lott also accused Mr. Daschle of sacrificing the nation's urgent energy needs in order to push through the health care bill.

"If we don't get this bill completed by . . . mid-July, we're going to have canceling of base-property maintenance, [and] holding some of our deployed units where they are overseas until the end of the fiscal year," said Mr. Lott. "So we're really pushing the envelope when it comes to the needs of our military personnel in health as well as in training hours."

Picking his first confrontation with Democrats since they took control of the Senate, Mr. Lott also accused Mr. Daschle of sacrificing the nation's urgent energy needs in order to push through the health care bill.

"We need to get this defense and other important supplemental done here, because it is critical for nonessential operations like pilot training, steering hours, fleet exercises," Mr. Lott said. "I'm very worried that by not acting on the defense supplemental appropriations bill we're asking for more delay and even more problems with our defense needs."

Mr. Daschle has been threatening to cancel the Senate's vacation to compel Republicans to finish work on the health care bill. Republicans and Democrats have been sniping politely about legislative priorities ever since the power shift in the Senate. Republican lawmakers have been pressing for passage of President Bush's energy plan, but Mr. Daschle has expressed more interest in the health-care legislation, as well as increasing the minimum wage and passing a hate crimes bill.

Mr. Lott said yesterday that Democratic leaders do not intend to address the energy issue by the end of July.

Congress is in recess for the entire month of August, meaning the Senate would not take up the administration's energy plan until September at the earliest.

House and Senate Republicans met with White House representatives yesterday and agreed to call attention to Democrats' inaction on an energy plan over the recess next week. The meeting took place in the office of House Majority Whip Tom DeLay, Texas Republican.

Mr. DASCHLE. Madam President, Senator STEVENS and Senator BYRD came to me a couple of weeks ago and asked for a special exemption from the understanding we have been working under here in the Senate that no official action can take place on any legislation until we have broken the impasse on the organizing resolution and assigned each committee its full complement of members. I, of course, agreed on the basis of urgency, to allow the Appropriations Committee to work its will and to finish this supplemental, which is what it did. I applaud both of them for taking the action they did.

The House, of course, has now acted. Now it is up to us. A couple of days ago the President called me and said: Above all, I hope that you will pass the supplemental before you leave. I gave whether to guarantee votes on Supreme Court nominees. Daschle spokeswoman Molly Rowley said Mr. Daschle wants to complete the patients' bill of rights, the spending bill and the reorganization before the Senate adjourns for the Fourth of July recess.

"We think all three of these things can be done this week before we leave," she said.

Sen. Robert C. Byrd, West Virginia Demo- crat and chairman of the Appropriations Committee that approved the spending bill last week, said yesterday he was "not in a position to comment" on Mr. Daschle's intentions.

"The leader has to balance a lot of things," Mr. Byrd said. "I'm sure he'll get to the [spending bill] when he thinks he can."
Mr. DASCHLE. The Senator is correct. As I understand it, this bill was not subject to amendment in the Senate. I think it is important that we dispose of this issue quickly so that we can get back to the debate on the amendment that Senator LOTT recommended, that there be a separate vote on the amendment. That was my purpose when I moved referral of the bill to the Appropriations Committee and the distinguished Republican leader are on the floor.

I ask unanimous consent that the majority leader, following consultation with the Republican leader, may proceed to the consideration of Calendar No. 76, S. 1077, the supplemental appropriation bill that we are considering here in this Senate before we leave.

I ask unanimous consent that the Appropriations Committee and the distinguished Republican leader are on the floor.

I ask unanimous consent that the majority leader, following consultation with the Republican leader, may proceed to the consideration of Calendar No. 76, S. 1077, the supplemental appropriation bill that we are considering here in this Senate before we leave.

I see both the ranking member of the Appropriations Committee and the distinguished Republican leader are on the floor.

I ask unanimous consent that the Appropriations Committee and the distinguished Republican leader are on the floor.

I wish to have two letters dealing with the Patients Protection Act for some long while. We have gone through most of the major amendments. We started debating this issue 5 years ago. It has now been on the floor for some while. We have done most of the major amendments. If we could complete the Patient’s Bill of Rights later today we could move on to other business. I am a member of the Appropriations Committee. When we passed the supplemental bill, it was passed almost with no amendments in the House of Representatives; that bill is very important—we did it with very little debate in the full Appropriations Committee. The organizing resolution can be completed, I understand, with perhaps one vote.

It is the case, isn’t it, that all of this could be done perhaps this evening if we had cooperation? Is that not the case?
right now to consider this very important supplemental appropriations resolution. I would like that to be considered.

Failing that, I think we are not going to object to agreeing to this unanimous consent request, but there are 35 amendments now—34 or 35. Some of them clearly are important to Senators involved on both sides of the aisle. Senator Bond has a couple of them. Senator Boxer has one I think she probably feels very strongly about. Senators Cleland, Roberts, and others have amendments with regard to the B-1 bomber. Senator Conrad, I haven't talked to him, but he has one on Turtle Mountain Indians. As you look down the list, some of them are not just relevant, some of them are amendments about which Senators are going to care greatly and I do not look to you as if you are talking about an extended period of time at this point to complete action on this legislation. I regret that.

If we could get an agreement to go to it now—I see Senator McCain; I know he has an amendment he feels very strongly about—if we could do that now, maybe we could get some time agreements and move to completion.

I see the distinguished Senator from Alaska, the senior member of the Appropriations Committee on the Republican side, who wants to speak. I am glad to yield under my reservation, Madam President.

Mr. Stevens. Madam President, I am here to urge that the Senate take the bill up now. I think if we took it up now, working with the people who have those amendments, we ought to be able to finish it today. I think if we finish today, the House will stay, and we could complete this before the recess.

If we wait until Monday after the House goes home, it will be very difficult to get them back, even from the point of view of getting travel arrangements for the House to come back on Monday or Tuesday.

I cannot speak for the chairman, but I can say that we both have sought for the last 2 weeks to try to have this bill become law in time to meet the needs of the armed services. Very clearly, they have been demonstrated now. There is no question that if we do not get this bill passed, there is going to be an impact on the armed services. I will commit myself to both leaders to work with all Members to see what we can work out, to constrict the time and finish it tonight, if we can take it up now.

That might put pressure on the other bill, too.

I urge that the organization resolution get resolved. I personally say to both leaders, my Kenai Peninsula is on fire. That is where I want to go fishing next week, too. So there is a disaster and the urgent call of the pink salmon to respond to.

I pledge myself to work even harder than Senator Reid does to find some way to constrict this time so we can vote on this and get it to the House and bring it back so we can all vote on the bill. I will deal with the leaders to let us have the rems for a few hours and see what we can do. I think we can finish this bill tonight.

Mr. Lottt. Madam President, under my reservation, I will propose as an alternative unanimous consent agreement that the same proposal the majority leader has made, except that in the first paragraph under consultation with the Republican leader, I would add: ‘‘may proceed immediately to the consideration of Calendar No. 76, S. 1077.’’ I make that in the form of a unanimous consent request.

The PRESIDING OFFICER. Is there objection?

Mr. Daschle. Madam President, I reserve the right to object. I have offered this to our Republican colleagues now for several days. I have said, give me a definitive list that will allow us to finish our work on the Patients’ Bill of Rights. We will proceed immediately to the supplemental and then return to the Patients’ Bill of Rights with the understanding that we will complete work on that as well.

Unfortunately, our Republican colleagues have been unable to do that. My offer still stands. Give me a definitive list that we can complete before we leave, and I will go immediately to the supplemental. I have offered it privately to Senator Lottt. I have offered it to our other colleagues. That offer still stands. Until we get that assurance, I will object.

Mr. Lottt. Under my reservation, I have one inquiry. I thought we had a definitive list. It may be big, but I thought we had a list of amendments still pending out there.

Mr. Daschle. I have not seen it.

Mr. Lottt. We will work on that.

The PRESIDING OFFICER. Is there objection to the original request?

Mr. Reid. While the two leaders are here, if I may chime in, first of all, Senator Daschle has read the important parts of this supplemental. If it is as important as has been read into the RECORD, it would seem to me the House should hang around a little while longer.

I say to the Republican leader and our majority leader, I haven’t seen a list of amendments. Everybody knows we have just a few important amendments to finish the Patients’ Bill of Rights. If we are given a list of amendments that is large in number, I don’t think that is in keeping with what I think should be the general agreement to finish the legislation. If we are given a list of 10, 20, 30, 50 amendments, I suggest to the majority leader, that is not the consensus of the Senate. We have a few amendments left to go.

Mr. Lottt. If Senator Daschle will yield to respond briefly, I thought you had been given a list. I am going to make sure you have it and then we can evaluate that and work on it.

Mr. Daschle. Madam President, I offer unanimous consent that the Senate complete its work on the Patient Protection Act by 6 o’clock tonight, and we have final passage by 6 o’clock tonight. If we can agree to that right now, I will move to the supplemental at 12 o’clock this afternoon.

Mr. Lottt. Madam President, I object to that. Obviously, I have to consult with the managers of the legislation on our side about the amendment list, which is very long, and I have it now, and about what is possible in terms of completing it. I don’t think it is possible at all to set an arbitrary time, in view of the very serious amendments that are pending on the Patients’ Bill of Rights. So I object to that request.

Mr. Lottt. Madam President, I object to that. Obviously, I have to consult with the managers of the legislation on our side about the amendment list, which is very long, and I have it now, and about what is possible in terms of completing it. I don’t think it is possible at all to set an arbitrary time, in view of the very serious amendments that are pending on the Patients’ Bill of Rights. So I object to that request.

Mr. Stevens. Reserving the right to object, Madam President, I am constrained to say with due respect to the Republican leader and the majority leader and the majority whip, I find it very difficult to deal with the concept putting ahead of this supplemental the completion of two very controversial items. We know the House is going home, and having spent 8 years here on the floor as leader, I can tell you I have never seen the time when any Senate could dominate the House. We have a bipartisan agreement to go home. They have told me they will stay if we get this bill done and over there today.

I do believe that the interest of national defense should come ahead of concepts that we are dealing with here in terms of whether it is the Patients’ Bill of Rights or organization of the Senate. We know we have told they cannot train in July and August unless we get this bill done this week. It is not something on which we have been dilatory. We have been trying for a long time.

I have great respect for the leader and the assistant leader, but I cannot stay silent and have a concept that because the leader has stated these things must be done, they must be done before the supplemental is brought up. That is unacceptable to the Senate. I think it is unacceptable to the Senate. I hope it is.

I say with great humility now that the needs of our people in the armed services must come ahead of concepts of scheduling or prerogatives here on the floor. These needs are very real. We have twice held hearings now where the chiefs have told us what is going to happen if this bill is not signed by the President before the Fourth of July.

Even the concept of taking up and passing it now and letting it wait for the House to come back is unacceptable to me because, again, we all travel and we know you can’t let the House go home and expect they will come back...
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here on July 3 just before the Fourth of July. You can’t travel in this country that easy during that period.

So I yield the floor to the Senate, let us proceed with this bill. We should put aside all other desires. There is no timeframe on the Patients’ Bill of Rights that matters to this country. It is a bill that must be passed, and I am going to vote for it. But it does not have the urgency of this supplemental.

This supplemental deals with more than that. It now deals with matters that are emergencies coming out of the disasters that have happened in this country this spring.

I hope the leader will accept my comment that I mean no offense to him. I have served under several leaders, and I admire both Senator DASCHLE and Senator REID for what they are doing. But this is an unusual request in terms of a request that has come on a bipartisan basis to put this bill aside for a few hours and pass a bill as important to the military of this country as is this supplemental.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. DASCHLE. Madam President, I remind my dear friend and colleague, the Senator from Nevada, in 1999, we took up the Patients’ Bill of Rights under a unanimous consent request and passed it in 4 days, with 17 amendments. Now we are told we can’t do it in 2 weeks. While we may differ on whether the supplemental is more or less important than the Patients’ Bill of Rights, I would hope we could all agree that completing action before we leave on a supplemental dealing with the safety of our troops is a top priority. The Pentagon places an extraordinary price on this legislation—so much so that the Commander in Chief called it that it be done this week. Certainly we can agree it is more important than fishing or any other kinds of vacation we could be taking next week. While there may be some differences on other issues, I would think there would be unanimity that getting the supplemental done is more important than taking a vacation.

So that is what the issue is. We are not going to take a vacation until we have completed action on the supplemental. We are not going to leave until this is done. This is something that not only has been requested by the Pentagon but by the Commander in Chief as well; I would hope if the President makes additional calls, he will call the House and say: Don’t leave until we get this done. You have heard the Pentagon. Don’t leave until this is done. Vacations are secondary to work. We have to get it done.

I yield the floor.

Mr. STEVENS. Reserving the right to object, that is a little bit of a cheap shot. I am not talking about a vacation. I am willing to stay here as long as any other Senator. I am talking about the realities of the House. Leader, I am not going to forget that was a cheap shot, and for the time being, I object to the request.

The PRESIDING OFFICER. Objection is heard.

The PRESIDING OFFICER. Who yields time on the amendment? The Senator from Missouri.

Mr. BOND. Madam President, I reserve the remainder of my time. I believe there is more time on the other side. I want to give the other side their remaining 19 minutes, but I believe we only have 2 minutes. I reserve those 2 minutes for the end of the debate, and I do have a couple of minutes after they have had an opportunity to present their points.

Mr. REID. Madam President, the Senate wishes to be recognized. I will not take long.

Many years ago, before I came to Congress, I practiced law. I was a lawyer. I was a trial lawyer. I am very proud of that fact.

With that brief background, I received a call last night from a lifetime friend. I have not talked with him in a while, but we went to high school together. We played ball together. We were inseparable friends. He did not have my phone number. I had moved. He called my office and said it was urgent.

He called because his son was in trouble. Why? Because they had hired a cheap lawyer. His son was in trouble, and they hired a cheap lawyer who was not a lawyer. The young man is now in jail.

My friend from Missouri is a lawyer, a fine lawyer, I am sure. I refer to the pending amendment as the ‘‘cheap lawyers amendment.’’ You cannot find decent lawyers to take a case for 15 percent. Almost 50 percent of the cases in our Federal court system take 4 years to litigate, with files stacked as high as my desk. People work to prepare those papers representing people who are injured, hurt, and need an attorney. That is why we have contingent fees. It is hard to find lawyers to take even a good contingent fee case because they have to consume so much time and effort.

Of course, there are some people who are paid too much. I am sure, because they put in the time and it is a contingent fee. I sold my home in Virginia within the past year. The woman who sold my home was a good realtor. I tried to pay her what I could. I signed a contract with her. She made a ton of money on my home. She worked about a week. I don’t know, but she probably took a lot of time off during that week.

My home sold in a week. She made a lot of money for the few hours she spent on my home, but that is the way America works.

If we have people who need help, we need to have the full panoply of lawyers available so they can get a good lawyer.

My friend from Iowa had a chart and pleaded off medical bills: These people are going to get their medical bills. Well, isn’t that too bad. If someone does something wrong, should they not pay your medical bills? Do you need to have a lottery, as he says, a lottery to get your medical bills paid? I hope not.

We have heard mentioned several times, if we are concerned about attorney’s fees, how much are these attorneys for these big HMOs making to prevent people from getting medical care? I hope the leader will accept my comment that I mean no offense to him. I have served under several leaders, and I admire both Senator DASCHLE and Senator REID for what they are doing. But this is an unusual request in terms of a request that has come on a bipartisan basis to put this bill aside for a few hours and pass a bill as important to the military of this country as is this supplemental.

We talk about these cases in the abstract, but the fact is that attorneys, whom everyone wants to hate, are necessary; they help. I am proud of the fact I was a lawyer. I have four sons. Eight of them are lawyers, and I am proud of the fact that they followed in the footsteps of their father. My daughter is a schoolteacher. She married a lawyer. I am very happy for that.

We do not have to be shameful, concerned, or embarrassed about some lawyers getting paid a contingent fee. That is how people who are injured and hurt are allowed to take those cases.

Fifteen percent will discourage representation by good lawyers. My friends on the other side of the aisle talk about the sanctity of contracts. Why do we want to step in and tell States what lawyers can be paid based on a contract they get?

This amendment is only to protect HMOs from all the amendments from the other side, to try to derail this legislation. This amendment is a frivolous amendment. It has nothing to do with the merits of this legislation.

Mr. DASCHLE. Madam President, will the Senator from Nevada yield?

Mr. REID. I will be happy to yield to my friend from North Dakota.

Mr. DORGAN. Mr. President, the Senator from Nevada and I had a brief discussion previously about this issue. He is correct that this amendment attempts to limit the ability of patients to hold HMOs accountable.

The discussion by those on the other side who have offered this amendment talks about lawyers in a pejorative way on behalf of patients. Does the Senator know of any attempts by those who have offered this amendment to limit HMOs, managed care organizations, from using attorneys, or is this just saying we will limit patients from using an attorney to go after a managed care organization that did not provide the care they promised, but we will not limit managed care organizations from using attorneys to do whatever they want to do?
Mr. REID. Madam President, I answer as follows: Of course, there is nothing in the way of amendment to limit what attorneys for these wealthy, big, sometimes brutal HMOs are paid. But remember, I say to my friend, that people who are seeking help from a lawyer are looking for a lawyer who will do it not on an hourly basis but who will do it on what is called a contingent-fee basis. They have no money to hire one of the big HMO lawyers, so they look around and find somebody who will take their case on a contingent-fee basis.

I say to my friend, a 15-percent contingent fee will not get a good lawyer. It will be like my dear friend who called me last night. In effect, the client will not wind up in jail but will end up with no compensation.

Mr. DORGAN. I ask my friend from Nevada to yield further for a question.

Mr. REID. I will be happy to yield to my friend for a question.

Mr. DORGAN. Is it not the case that this entire process, this debate on the Patient Protection Act, is an attempt to balance things a bit; that patients do not have the ability to confront a big managed care organization?

The Senator from Nevada knows the story we have talked about coming from his State: Christopher Roe, a circumstance where a 16-year-old boy was fighting cancer at the same time he was fighting his managed care organization for treatment and care he needed. That is not a fair fight, asking a young boy to fight an insurance company and fight for his life at the same time. That young boy lost his life on his 16th birthday.

The question is, do those patients and their families have the right to get an attorney to hold the managed care organization accountable to deliver the care they promised? Do they have that right?

We have an amendment pending that says: No, we are going to limit the rights of the patients, we are going to limit the rights of citizens, but we are not interested in limiting the rights of the managed care organizations because we want to stand for them rather than standing for patients, and that is the issue.

Mr. REID. In answer to my friend, I have a CRS report that talks about attorneys' fees by Federal courts and Federal agencies. It is big. I know of no other Federal attorney fee statute that affects a State system.

This amendment is wrong. I appreciate very much my friend from North Dakota, but he is not a lawyer, standing up and speaking for the injured people and the potentially injured people of America.

Mr. KENNEDY. Madam President, I ask for 3 minutes.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, I rise in opposition to the amendment that has been offered. We have seen the efforts of the HMOs to undermine this legislation in different ways over the last few days. I am unable to bring this matter up for consideration by the Senate and get full consideration of the bill when we wanted to. This happened even during the last term when a majority of the Members would have supported a good, tough, effective Patients' Bill of Rights. We have seen over the past days constant efforts to undermine this legislation.

We see another effort to try to appeal to the Members about the excessive- ness of decisions made in the courts to reimburse individuals in terms of wrongdoing by other industries.

The fact is, as we are reminded by our colleagues, we have spent 3 days talking about the sanctity of the contract between the patient. We have had amendment after amendment saying, look, this is enormously important. We do not want to permit any changes in that contract. We want to stick with that contract. We want to respect it.

Now, with the Senator's amendment we are saying basically that we are going to ride roughshod over contracts that are decided, permitted, and authorized by law in the States between attorneys and their clients.

I have listened a great deal to talk about how Washington doesn't know best; how we don't want just one solution to solve all of our problems. We had that debate early this morning and last night. We now have one solution: to override States in terms of what decision the States make for compensation going to court.

The fact is, how many working families, and how many mid-income families are able to go out and hire lawyers? For the time it will take to get some kind of recovery after they have been wronged, how many are going to be able to do that and follow this through the State courts? How many will be able to do it after they have been hurt, after their child has been disabled, after a wife or husband has been killed? How many? Very few. The fact is, they are not going to be able to be compensated unless they are able to convince a jury they are right, that there has been wrongdoing.

Does that bother people in the Senate? Evidently it does. There are only a very few Americans who can afford the high-priced lawyers to go into court and pursue this. This amendment undermines it for the rest of the people. It undermines it for working families, undermines it for middle-income families. That is the record. That is what has been done.

It doesn't surprise me. We have seen the powerful financial interests overturn ergonomic regulations which were there to protect working families. Then we have the undermining of funding for the enforcement for protecting our air. There has been undermining of funding for protecting OSHA, effectively cutting back on the protection of workers. We are undermining regulations to protect workers, undermining the enforcement mechanism to protect consumers, and now they want to take this right away from individuals who will be harmed because of HMOs.

It is a common pattern. It is all targeted by the major financial special interests versus the consumer. That is what this is about. They don't like to hear about it. They keep offering amendments that are couched in other language about all the people that will be unemployed. However, it is the power of the HMOs against the little guy.

This amendment says the little guy will not be able to defend their interest in court. That is what this is about.

Make no mistake. They can't deal with us in giving protections to the consumers. They are going to take them away by denying them the rights to confront them. That is what this is about.

Expect that after we have this percentage, it will go a little higher, and then try to go even higher. Every time it does, it is an insult to middle-income and working families and individuals who will be harmed. Make no mistake, it is another assault on the fundamental protections of this act. That is what this amendment is about. I hope it will be defeated.

The PRESIDING OFFICER. Who yields time?

Mr. BOND. How much time remains?

The PRESIDING OFFICER. The Senator from Missouri has 3 minutes.

Mr. BOND. I want to respond. Does the other side desire more time?

Mr. KENNEDY. I don't. It is so. It depends on what the Senator says. We don't intend to at this time.

Mr. BOND. How much time remains on the other side?

The PRESIDING OFFICER. Five and a half minutes.

Mr. BOND. I yield myself the remaining time. I think some of the things that have been said deserve to be answered.

Our efforts are not to undermine a bill, but to deal with very bad provisions in the bill which skipped the committee, did not go through committee markup. We are marking up a bill now which we should have marked up in committee. It has come to the floor and we are a committee of the whole.

There are things that are in there that are very bad for patients, employees, particularly of small business. Why are we inserting the Federal Government into restricting attorney's fees? The States in this Nation have limited attorney's fees because they recognize the abuses of the trial lawyers. Under this bill, we are inserting
the Federal Government into areas that the States have already acted on, and I do not want to act on them and provide limbic on the amount that trial attorneys can take so the injured party can recover.

We have heard about the powers of special interests. Let me state who the special interests are that have a big stake in this, the four top trial lawyer PACs: Trial Lawyers Association of America; Williams & Bailey; Ness, Motley; and Angelos Law Offices, have given over $8 million, more money than all the HMOs together have given in political contributions.

If you want to talk about special interests, there are special interests on the other side, as well.

We believe the measures we brought forth are good for employees, for people who do not only want to be able to appeal the decision of an HMO, but they want to have health coverage.

Somebody suggests there have not been problems with fee structures. They are not in this bill. We know from the State experiences that there can be a tremendous amount of wasted money.

I urge my colleagues to support this measure.

I yield to my distinguished colleague from Tennessee.

Mr. FRIST. Madam President, I rise in support of the Bond amendment. This is a Patients’ Bill of Rights and we should focus on the patient. We are talking about a patient who has been harmed or injured, gone through an appeals process and through the court. If there is a multimillion-dollar suit, it should be to help the patient, not to fund the pockets of the trial lawyers.

This is not a Bill of Rights, not a trial attorney bill of goods.

Mr. KENNEDY. Madam President, every time you pay the HMO lawyers, that comes out of patient protections. So the point raised is, if you put a limitation on the trial lawyers because they are going to get the benefits, why not put a limitation on the attorneys for the HMOs so it doesn’t come out of patient protections?

But they won’t do it. They won’t do it.

I yield the remainder of our time.

Mr. REID. All time is yielded back?

Mr. REID. What is the matter before the Senate now?

The clerk will call the roll.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. 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. WARNER. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Objection is heard.

The clerk will continue the call of the roll.

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

The PRESIDING OFFICER. Without objection it is so ordered.

Mr. WARNER. Madam President, in consultation with the managers of the bill, it has been indicated to me this will be an appropriate time for this amendment to be raised. I send it to the desk in order that it be given immediate consideration. However, we have to set aside, as I understand it, the standing order with regard to the Snowe amendment, I first ask unanimous consent that it be set aside.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Madam President, reserving the right to object—and I will not object—we have been in consultation for the last hour or so. Senator Snowe of Maine is in the process of having her amendment drafted. She is a half hour away from being able to present something in writing that we can give to the Senator from New Hampshire. I have no objection.

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

The clerk will report.

The legislative clerk read as follows:

The Senator from Virginia [Mr. WARNER] proposes an amendment numbered 85.

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

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

The amendment is as follows:

(Purpose: To limit the amount of attorneys’ fees in a cause of action brought under this Act)

On page 154, between lines 2 and 3, insert the following:

"(11) LIMITATION ON AWARD OF ATTORNEYS’ FEES.—

"(A) IN GENERAL.—Subject to paragraph (C), with respect to a participant or beneficiary (or the estate of such participant or beneficiary) who brings a cause of action under this subsection and prevails in that action, the amount of attorneys’ fees that a court may award to such participant, beneficiary, or estate under subsection (g)(1) (not including the reimbursement of actual out-of-pocket expenses of an attorney as approved by the court in such action) may not exceed the sum of the amounts described in subparagraph (B).

"(B) AMOUNTS DESCRIBED.—For purposes of subparagraph (A), the amounts described in this subparagraph are as follows:

"(i) With respect to a recovery in a cause of action described in subparagraph (A) that does not exceed $100,000, the amount of attorneys’ fees awarded may not exceed an amount equal to 1/5 of the amount of the recovery.

"(ii) With respect to a recovery in such a cause of action that exceeds $100,000 but does not exceed $500,000, the amount of attorneys’ fees awarded may not exceed an amount equal to 25 percent of such excess recovery above $100,000.

"(iii) With respect to a recovery in such a cause of action that exceeds $500,000, the amount of the attorneys’ fees awarded may not exceed an amount equal to 15 percent of such excess recovery above $500,000.

"(C) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of an award of attorneys’ fees required under subparagraph (A) as equity and the interests of justice may require.

The amendment as follows:

On page 123, line 20, insert the following:

"(ii) With respect to a recovery in such a cause of action that exceeds $100,000 but does not exceed $500,000, the amount of attorneys’ fees awarded may not exceed an amount equal to 25 percent of such excess recovery above $100,000.

"(iii) With respect to a recovery in such a cause of action that exceeds $500,000, the amount of the attorneys’ fees awarded may not exceed an amount equal to 15 percent of such excess recovery above $500,000.

"(C) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of an award of attorneys’ fees required under subparagraph (A) as equity and the interests of justice may require.

On page 170, between lines 21 and 22, insert the following:

"(B) AMOUNTS DESCRIBED.—For purposes of subparagraph (A), the amounts described in this subparagraph are as follows:

"(i) With respect to a recovery in a cause of action described in subparagraph (A) that does not exceed $100,000, the amount of attorneys’ fees awarded may not exceed an amount equal to 1/5 of the amount of the recovery.

"(ii) With respect to a recovery in such a cause of action that exceeds $100,000 but does not exceed $500,000, the amount of attorneys’ fees awarded may not exceed an amount equal to 25 percent of such excess recovery above $100,000.

"(iii) With respect to a recovery in such a cause of action that exceeds $500,000, the amount of the attorneys’ fees awarded may not exceed an amount equal to 15 percent of such excess recovery above $500,000.

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"(iii) With respect to a recovery in such a cause of action that exceeds $500,000, the amount of the attorneys’ fees awarded may not exceed an amount equal to 15 percent of such excess recovery above $500,000.

"(C) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of an award of attorneys’ fees required under subparagraph (A) as equity and the interests of justice may require.

On page 170, between lines 21 and 22, insert the following:

"(B) AMOUNTS DESCRIBED.—For purposes of subparagraph (A), the amounts described in this subparagraph are as follows:

"(i) With respect to a recovery in a cause of action described in subparagraph (A) that does not exceed $100,000, the amount of attorneys’ fees awarded may not exceed an amount equal to 1/5 of the amount of the recovery.

"(ii) With respect to a recovery in such a cause of action that exceeds $100,000 but does not exceed $500,000, the amount of attorneys’ fees awarded may not exceed an amount equal to 25 percent of such excess recovery above $100,000.

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"(i) With respect to a recovery in a cause of action described in subparagraph (A) that does not exceed $100,000, the amount of attorneys’ fees awarded may not exceed an amount equal to 1/5 of the amount of the recovery.

"(ii) With respect to a recovery in such a cause of action that exceeds $100,000 but does not exceed $500,000, the amount of attorneys’ fees awarded may not exceed an amount equal to 25 percent of such excess recovery above $100,000.

"(iii) With respect to a recovery in such a cause of action that exceeds $500,000, the amount of the attorneys’ fees awarded may not exceed an amount equal to 15 percent of such excess recovery above $500,000.

"(C) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of an award of attorneys’ fees required under subparagraph (A) as equity and the interests of justice may require.

The amendment as follows:
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Mr. WARNER. Madam President, I will do something unusual. I am actually going to read the amendment myself such that colleagues and those observing floor operations from their offices can have a clear understanding of exactly what is in the amendment.

Futhermore, I do not desire to consume a great deal of time in the debate because we have just had a very thorough debate on the generic subject of attorney fees. Therefore, the Senate has pretty well framed in their minds the parameters in which they will or will not accept an amendment that has the effect of, in my judgment, preserving a reasonable amount of attorney's fees and at the same time allowing such awards as those attorneys obtain for their clients to be given; again, with the thought that it is a Patients' Bill of Rights and they have a right to get a reasonable amount of such recovery as is obtained from them.

I shall read from the amendment—it is very short—and say a few words, and then rest my case.

On page 154, insert the following: Limitation on award of attorney's fees—

(A) In general.—Subject to subparagraph (C), with respect to a participant or beneficiary (or the estate of such participant or beneficiary) who brings a cause of action under this subsection and prevails in that action, the amount of attorneys' fees that a court may award to such participant, beneficiary, or estate under subsection (g)(1) (not including the reimbursement of actual out-of-pocket expenses of an attorney as approved by the court in such action)—

In other words, that would be awarded by the court without any restriction except to the court itself—may not exceed the sum of the amounts described in paragraph (B).

The sums I am about to recite, we carefully researched all types of actions similar to this to get a scale of attorney fees which I felt was clearly reasonable.

(B) Amounts Described.—For purposes of subparagraph (A), the amounts described in this subparagraph are as follows:

(i) With respect to a recovery in a cause of action described in subparagraph (A) that does not exceed $100,000, the amount of the attorneys' fees awarded may not exceed an amount equal to 15 percent of such excess recovery if it is not accepted. I ask my friend from Virginia, who believes he has talked enough on this, to my dear friend from Virginia, is on the right track.

(ii) With respect to recovery in such a cause of action that exceeds $500,000, the amount of the attorneys' fees awarded may not exceed an amount equal to 15 percent of such excess recovery if it is not accepted. That is going to do what everybody wants but I think it would be something that we could all support and then get this issue off the table and get to the very important issues such as resolution of exhaustion of appeals that Senators Thompson and Edwards are working on, liability issues. Senator Frist has some important amendments, again, on liability issues, which we are narrowing down.

Hopefully, we can move forward. I thank the Senator from Virginia for his input.

Mr. WARNER. Madam President, if I might reply to my friend and colleague, there was no intention of the Senator from Virginia to repeat what is an historically important case on tobacco. I studied that case very carefully. There were, I think, three votes. My recollection is it was $4,000 per hour, at which time the Senate finally accepted. I would not participate in such a process. I struck the one-third for the lower amounts of the recovery and basically scaled it to 25 and the other percentage as the rate of recovery increase. I would be happy to work with colleagues.

It goes to the question of just how much will be eventually given to the recipients who need these funds.

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

Mr. REID. The Senator from Nevada.

Mr. REID. The Senator from Arizona and the Senator from Virginia are on the right track.

This amendment, with all due respect to my dear friend from Virginia, is really—we have another 15-percent limitation in here above a certain amount. I think that the most expeditious thing to do would be to set this aside, for the time being, and get some of the lawyers and nonlawyers to sit down and see if they can work out something acceptable to the managers. I am sure if it were acceptable to the managers, we could accept this.

I ask my friend from Virginia, who believes he has talked enough on this, that we withdraw this amendment, for the time being, in anticipation of working something out that is clear and workable.
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Mr. Mccain. If the Senator will yield, I say to my colleague from Virginia, and the outcome of this amendment is not to the Senator's satisfaction, then I hope we can enter into negotiations that on a reasonable level—again, I just plucked 33 1/3 percent because it is in there in one category, across the board, simple, two lines, and perhaps do move on.

I know the Senator from Virginia, as well as the rest of us, doesn't want to be hung up on a series of votes that are iterations over the same issue. It seems that we can sit down and come to some reasonable agreement, which the other side of the aisle would strongly resist applying to State court, and this side would resist it on Federal court. It is something to have a substantial majority vote for. I hope the Senator agrees to enter into those negotiations.

Mr. Warner. Madam President, I ask for the yeas and nays before I take the action.

The PRESIDING OFFICER. Is there a sufficient second?

The PRESIDING OFFICER. Without objection, the amendment is set aside.

Mr. Warner. I am agreeable. I ask unanimous consent that this amendment be set aside.

Mr. Warner. I ask unanimous consent that the amendment be set aside.

The PRESIDING OFFICER. Without objection, the amendment is set aside.

Mr. Warner. I suggest to the manager and my friend from Virginia, why don't we set this aside for a few minutes to see if we can work something out to get the matter resolved. I think as the Senator from Arizona indicated—

Ms. Snowe. Madam President, if the Senator really wants a vote on this, we will be happy to give it to him right now. I don't think it is the right thing to do. I suggest to the manager and my friend from Virginia, why don't we set this aside for a few minutes to see if we can work something out to get the matter resolved. I think as the Senator from Arizona indicated—

Ms. Snowe. Madam President, I ask unanimous consent that this amendment be set aside.

The PRESIDING OFFICER. The clerk will call the roll.

Mr. Warner. I am agreeable. I ask unanimous consent that this amendment be set aside.

The PRESIDING OFFICER. The clerk will call the roll.

Mr. Warner. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. The Senator from Maine.

Ms. Snowe. Madam President, 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. Snowe), for herself, Mrs. Lincoln, Mr. DeWine, Mr. Nelson of Nebraska, Mr. Specter, and Mr. Mccain, proposes an amendment numbered 834.

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

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

Ms. Snowe. Madam President, I rise today to endorse along with my colleagues Senator DeWine, Senator Lincoln, and Senator Nelson, who worked so hard, so diligently in crafting this compromise. Senator Mccain and Senator Specter are co-authors of this amendment.

The amendment we are offering today is designed to bridge the gap that exists between the supporters of the McCain-Edwards-Kennedy approach to employer liability in the Breaux-Frist-Jeffords cases.

I commend Senators Mccain, Edwards, and Kennedy for their willingness as well as their patience to work with us on resolving the many issues that are associated with employer liability.

Everyone involved has had the same goal essentially, and that is to protect employers from liability when they are not participating in making decisions concerning the health care of employee beneficiaries.

The discussion has really focused on how best to achieve that goal. This is an incredibly complex liability issue that has far-reaching consequences, and everyone who has been part of this discussion and this effort to reach this consensus recognizes that fact and has worked in good faith to arrive at a solution that we can live with and, more importantly, employers can live with and not denying care that patients rightly deserve.

This is an issue that is significant on a number of different levels. First of all, to what extent will employers that voluntarily offer health insurance be exposed to liability. To what extent will employers be involved in the decisionmaking process in terms of the provisions of health care for their employee beneficiaries, and perhaps more important, will patients have legal recourse should they have a grievance concerning the care they receive through their health care plan.

The goal we all share in designing and crafting this amendment to the McCain-Kennedy-Edwards legislation is how best we protect patients for their medical care without creating an expansive bureaucracy adding to the cost of providing that health care and generally creating an incentive to drive away employers from providing health care to their employees which, as I said earlier, they do so on a voluntary basis. We should be commending employers for providing these benefits, not penalizing them.

We should also take great care to write a provision under which employees remain insured through their employees while also protecting the employees' rights under their health insurance plans. What we do not want to do is create unintended consequences for employers by leaving legal questions open that can leave employers exposed to liability over matters in which they have no control and over matters in which they have not participated and having the resulting decision.

That is all the more significant when we realize there are more than 43 million Americans who remain without any insurance, and of those who have insurance, employers voluntarily provide health coverage to more than 172 million Americans. Obviously, what we do today is significant, and it will matter.

We cannot afford to have employers suddenly opting out of providing insurance to their employees because we do not want to create the unintended consequence that adds to the rolls of the uninsured in America. I think that is something on which we all can agree, and that is a very real risk. In fact, there was a recent poll taken of businesses in America, and it said that 57 percent of small businesses said they would drop coverage rather than risk a lawsuit.

As one businessman in my State wrote to me recently:

We're not an HMO or an insurance company. We are an employer. We cannot afford the time, expense, and aggravation of litigation. And, please, make no mistake, that is what this is about.

So we approach the issue of reconciling the differences between the two approaches by addressing the question: What language will deliver us to that mutual goal? We assess what was really the best qualities of the McCain-Edwards-Kennedy legislation, as well as the Breaux-Frist-Jeffords issues.

Ultimately, the solution we came to was a melding of the two approaches. The result was to provide employers with varying levels of liability protection depending on their involvement in the decisionmaking process but regardless, patients will have the legal recourse they deserve, no matter what.

There are many other issues that need to be resolved in this legislation. I realize this represents one facet, the liability question, that has been raised by others with respect to this legislation, and this is not intended to address all of those questions, but clearly it does address a most important issue when it comes to subjecting employers to litigation and liability.

Let me take a moment to explain the differences between the McCain-Edwards-Kennedy legislation and the Breaux-Frist-Jeffords approach and the approach we are taking in the amendment we have offered to S. 1052 and
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how our amendment affects the underlying legislation and addresses the concerns that have been raised about the net legal impact on employers.

Essentially, there are several categories we are attempting to address today when it comes to employer-sponsored health care insurance.

First, there are employers that contract with an insurance company that, in turn, pays beneficiary claims and administers the plans and the benefits.

Second, there are employers that fund a plan but leave the actual administration of the plan to an outside entity, generally an insurance company.

Third, there are those who both self-insure and self-administer, in essence creating their own insurance company within their existing businesses.

The McCain-Edwards-Kennedy legislation as written allows a suit against any employer if it directly participates in a decision that harms or results in the death of a patient. Direct participation is defined as the actual making of a medical decision or the actual exercise of control in making such a decision or in the conduct constituting the failure.

The bill then goes on to offer specific circumstances that do not constitute direct participation, including any participation by the employer or other plan sponsor in the selection of the group health plan or health insurance coverage for the third party administrator or other agent, or any engagement by the employer or other plan sponsor in any cost-benefit analysis undertaken with the selection of or continued maintenance of the plan or coverage involved.

While the bill language does not provide an exhaustive list of exceptions, it does allow an employer to offer into evidence in their defense that they did not directly participate in decisions affecting the beneficiaries of the health care plan.

That suggests while employer protections would be provided under the legislation, an employer would still have to go to court to make its defense. As with any such legal language, direct participation obviously can be open to legal interpretation, and that precisely is the circumstance which we are seeking to avoid and prevent.

Under the Breaux-Frist-Jeffords legislation that was introduced, the language provides for a designated decisionmaker, or DDM, which in most cases would be the insurance company an employer contracted with to be the party responsible for medical decisions and, therefore, the party could be subject to liability. In other words, the employer would designate the DDM as the responsible party to shield itself from that liability. If an employer chose not to designate a DDM, they would have no protection from that liability.

An argument that has been made against the Breaux-Frist-Jeffords language is if the DDM is a person designated within a company that self-insures, for example, they could under the current law escape liability by claiming that ultimate decision came from the employer; that they, as a DDM, did not make a final decision on a particular beneficiary’s case. In an effort to improve the Breaux-Frist-Jeffords language, that when a contract is signed with the employer, the DDM cannot mount any such defense, that somehow they defer the liability, defer the suggestions that the employer somehow participated in making the decision.

In an effort to improve the employer liability provisions, we encompassed key provisions of both models in the legislation while addressing their inherent weaknesses so we can attain our shared goals.

First, our amendment allows employers that turn their health care coverage to outside insurance companies, that their insurance company will automatically be their designated decisionmaker unless they specifically choose not to have a DDM. This is built directly on the Breaux-Frist-Jeffords model in which the decisionmaking authority shifts to the DDM, which will in most cases be the insurance company. Under this approach, an employer would not have to take the extra steps to secure a designated decisionmaker and would not be required to go to court to file papers or to make defenses against any actions they may have taken. In other words, they would not have to do anything different than what they are doing today with a contract with an insurance company.

When they sign up with an insurance carrier that will provide benefits to their employees and administer the benefits, they are signing up with, essentially, a designated decisionmaker, and they are signing up as well for a safe harbor from liability in both medical as well as contractual decisions.

Where we depart from the existing Breaux-Frist language is we clarify since the DDM, which is also the insurance company, has assumed full responsibility at the time the employer and the insurance company signed a contract, the designated decisionmaker would be prevented from turning around and assigning the employer for some failure that resulted in a lawsuit from a beneficiary. In other words, the dedicated decisionmaker can’t transfer liability to the employer because of something the employer does or failed to do.

The legislation we have introduced today to modify the McCain-Edwards-Kennedy legislation delineates specifically that self-insured but contract out the administration of their health care plan, we leave in place the general McCain-Edwards model in the underlying bill that protects employers insofar as they do not directly participate in the medical decisionmaking process.

Again, as I outlined earlier, direct participation is defined as the actual making of a medical decision, the actual exercise of control in making such a decision or in the conduct constituting the failure. These are two of the changes we have made in the amendment we are presenting today from the underlying McCain-Edwards legislation.

Under our amendment, we eliminate one element of the bill that would have potentially led to the filing of lawsuits on a variety of grounds unrelated to specific medical decisions impacting individual beneficiaries. The language is, in layman’s terms, broad and unspecific and potentially exposes a defendant to a wide array of nonlegal actions. If additional grounds for lawsuit should be added to the legislation, we should delineate and specify them and not have broad language that essentially leads to a legal potpourri.

Striking this language does not affect the ability of the patient to seek remedy in court for medical decisions made in their particular circumstance. But it does prevent a whole new arena of lawsuits from being created that would heighten an employers’ exposure to liability.

In addition, our amendment also modifies the underlying legislation to ensure that self-insured, self-administered plans do not have the ability to assign liability to a dedicated decisionmaker. As a result, they may opt to simply stop offering insurance for employees altogether rather than risk a substantial judgment on a contractual matter. That is, as a result, again, we simply cannot afford if we are going to ensure that people have the kind of health insurance plans in America in which they will continue to be insured, and that employers are the ones providing predominantly the health insurance in America today.

To describe our amendment in another way, we essentially are saying as an employer that is not self-insured, you can hand over all your decision-making process to the party to a written contract to a dedicated decisionmaker which will, in all likelihood, be your insurance company when you sign your contract with your insurance company. There is
nothing more you need to do to protect your business from liability for the decisions that are made by the designated decisionmaker. For the self-insured and for those who do not self-insure as an employer, you would still have the protections afforded under the underlying legislation if you don’t directly participate in those decisions. In other words, employers who contract out their health insurance have a clear choice under our amendment, although once again I stress that under this amendment patients will still have the legal recourse regarding questions over appropriate medical care and medical decisions related to the beneficiary’s plan, no matter which option the employer chooses.

The bottom line is we seek to protect employers from liability in cases where they are not making the medical decisions that result in death while still protecting parents rights, which after all is the goal of this legislation.

Finally, let me assure my colleagues, under this amendment, dedicated decisionmakers are going to have to demonstrate that they are financially capable of fulfilling their responsibilities as the party liable in causes of action. They could not be shell entities or sham individuals or organizations without the ability to actually pay the event of lawsuits.

The criteria the Secretary of Health and Human Services will require relating to the financial obligations of such an entity for liability should also include an insurance policy or other arrangements secured and maintained by the dedicated decisionmaker to effectively insure the DDM against losses arising from professional liability claims, including those arising from self-insurance decisions. A DDM would have to show evidence of minimum capital and surplus levels that are maintained by an entity to cover any losses as a result of liability arising from its service as a designated decisionmaker. It would have to show that they themselves have coverage adequate to cover potential losses resulting from liability claims or evidence of minimum capital and surplus levels to cover any losses.

Once again, I think we have designed an amendment that represents a workable approach, that addresses some of the more serious and significant concerns that had arisen in the various pieces of legislation that had been introduced here in the Senate and with the underlying legislation we are seeking to amend today.

We try to meld the best of both approaches, to balance the concerns of businesses that do seek to voluntarily provide this most important, critical benefit to their employees. That is an incentive we want to maintain and re-inforce in every possible way. But we also understand there are going to be those circumstances in which the employee has received inappropriate care that has resulted in significant harm, injury, or even death, and that they would have to seek legal redress for that inappropriate care or denial of care. That is the kind of consideration we want to ensure in this legislation, without creating the unintended consequences or the disincentive for employers to say we just simply cannot afford to provide this health insurance for our employees anymore because we are going to be subject to litigation, to endless losses, and we do not want to put ourselves in the position of that kind of exposure.

I think this approach has been examined on both sides of the political aisle. More important, I think it has been embraced by this bipartisan group in the Senate, my colleague Senator DeWine, based on the Frist-McCain, Senator Lincoln whom I see on the floor, and Senator Nelson. They have worked very diligently on behalf of this amendment to assure that we address all facets, all potential implications and ramifications associated with this approach, so hopefully address it in a way that will ultimately yield the best effect for both the employer as well as the employees.

I yield the floor. I will be glad to yield time to my colleague.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. DEWINE. Madam President, I thank my colleagues, Senator Snowe and Senator Lincoln, whom I see on the floor, and Senator Nelson, who have worked long and hard on this amendment.

The issue in front of us today is how do we help shield businessmen and businesswomen from liability at the same time providing access to the courts for people to sue HMOs. Everyone I think agrees, one of the things we worry about as we deal with this legislation is that we will do something that would cause businesses in this country to decide not to insure employees. That would be a very bad unintended consequence, so we have to be very careful as we write this legislation.

The amendment in front of us today is really a compromise. It is a compromise on the Frist-McCain bills. It is a compromise on the issue of employer liability, how we best protect the employers while at the same time ensuring people their right in court. I think we have really blended these bills. I think we have the best of both worlds. The situation and the language are clarified and made simpler.

We started this debate with some basic principles on which everyone agreed. In both bills we agreed we wanted to try to protect businesses. But at the same time we wanted to allow suits in limited circumstances against HMOs. The President agreed to that principle, and the two underlying bills do as well. This amendment, I believe, achieves that. This amendment effectively takes out 1 percant of business and provides them great protection. When you compare our amendment versus the underlying bill, it helps and improves the situation for the other 9 percent. We will talk about that in a moment.

My colleague from Maine has talked about this concept of the designated decisionmaker. What do we mean by that? What we mean is let’s just make it simple and let’s make it plain; let’s have the employer say who is going to make those decisions and therefore who will be sued. In essence, what we are saying is once that decision is made, that employer is no longer going to be subject to suits; the designated decisionmaker will be.

How will this work in the real world? Let’s say we have a small hardware and Greene Corporation, which say they employ 12 people, and let’s say what they do is they provide some health insurance and they do that by going out in the market, finding the best deal they can, and buying this group coverage for their 12 employees. Under this amendment, once they contracted with that insurance carrier, they would have automatically made that designated decisionmaker decision. They would have designated that automatically, that group as being the designated decisionmaker. They would not have to do nothing. They cannot make a mistake. It takes no affirmative action on their part. That is going to improve the language we have in front of us.

The other way of doing it, the way the underlying bill did it, was to talk about direct participation. Frankly, I think the language in the bill was pretty good. But I think it needs to be improved. By having the designated decisionmaker, it is a lot more clear. What we say is this is how it is set up. As a business, they have the employer say who is going to make this decision. The employer is responsible for that. As we all know, anybody can sue anybody. We cannot prevent suits, but we certainly can discourage them, and we certainly can provide when suits are filed against a business, the business has the ability to get out of that lawsuit very quickly. So by using the concept of the designated decisionmaker, as a practical matter, if a suit were brought against a businessperson, if a lawyer were foolish enough to file that suit, the business would simply have to go into court and file a copy of that designated decisionmaker decision and would be dismissed from the case. As a practical matter, this language significantly improves the underlying bill and will make a big difference.

Our amendment does build on the two bills in front of us, the two bills we have been talking about and have been considering, the Frist-Breaux bill and the underlying bill we have in front of us today, the McCain-Kennedy bill.
I believe our amendment would protect business owners from needless lawsuits as well as protect patients who rely on them. That is why we have put forward a plan that would stop companies from buying health care plans for their medical needs. I believe this amendment brings together the best of all worlds by providing certainty, much-needed certainty to employers, employees, and, yes, to health care providers. This is what American businesses desperately need in any patient protection bill.

Based on the designated decision-maker concept in the Frist-Breaux-Jefords bill, our amendment would automatically, as I have indicated, remove liability from small business owners and shift it to health care providers or other designated entities. In addition, our amendment stipulates this designated decisionmaker must follow strict actuarial guidelines and be capable of assuming financial responsibility for the liability coverage. This means the designated decisionmaker could not be a hollow shell, unable to come up with the money, the assets, to defend against potential lawsuits and financial damages and be able to satisfy those losses. Our language ensures that the designated decisionmaker cannot be a straw man, cannot be a sham that has no ability to pay a patient in the event a lawsuit is filed and that damages are in fact awarded.

In creating the designated decisionmaker process, it makes it easier for employers that provide health insurance coverage to be protected.

I say that is a major step forward for businesses, and especially for patients. I say that because the fear of being sued often becomes so great that employers simply stop offering health care coverage. We don’t want that to happen under this bill. We simply can’t let that happen. The reality is in this country that already there are more than 42 million Americans, including 10 million children, who have no health care coverage. The last thing we want to do is add to this number.

Our amendment greatly diminishes the likelihood that employers will stop offering health care coverage. Again, we believe it is the best of both worlds as it allows patients the ability to sue the designated decisionmaker if they are denied medical benefits to which they are entitled by their health plans. But at the same time it protects employers from unnecessary and costly lawsuits.

Under our amendment, employees would have the comfort of certainty and the comfort of knowing that the designated decisionmaker is ultimately responsible for health care decisions and, therefore, that individual or that entity bears the liability for a lawsuit. In another effort to keep employees insured, our amendment also adds language to the underlying McCain-Kennedy bill to limit the liability of businesses to self-insure and self-administer their health care plans. The fact is that these employers are assuming additional liability by obtaining and by administering health care coverage to employees. To that extent, I believe we must take their unique circumstances into consideration. This amendment does that.

Ultimately, our objective is to encourage employers to offer and to continue to offer their employees health care coverage. We don’t want to discourage them out of fear that they will be sued.

The reality is that these self-insured and self-administered plans are doing some very good things for their employees. We want them to continue to do these good things. Our amendment will help them keep their employees, to keep their plans, to keep their employees insured. That is what the Patients’ Bill of Rights should be all about.

Further, our amendment improves the original Frist language by making very clear exactly who is liable. The amendment eliminates ambiguity because it would not allow the designated decisionmaker to be broken into sub-decisionmakers. One, and only one, entity would be the sole bearer of liability. We think that is an improvement.

Finally, our language would strike vague and ambiguous language in the underlying McCain-Kennedy bill that is of great concern to employers. This language is a catch-all section of the bill that could open employers to a flood of lawsuits simply because of the imprecise nature of the language.

Let me read the exact language currently in the McCain-Kennedy bill in regard to the cause of action relating to provisions of health benefits. There is the problem:

Or otherwise fails to exercise ordinary care in the performance of the duty under the terms and conditions of the plan with respect to the participant or beneficiary.

We believe this language is simply too vague. We eliminate it in regard to businesses and their potential liability.

This language that I just quoted creates an explicit cause of action. This means employers could be the subject of lawsuits if it chose to do something that currently has no way to anticipate. The language is broad. It is too broad as currently drafted. Our amendment would completely remove this section.

Finally, I think we must recognize what this amendment does, but also we need to be very clear about what it does not do. Does this amendment solve every problem with this bill? The answer is that it does not. It does what we have said it does. It deals with the catastrophic liability problem in regard to businesses, but it does not solve all the problems.

I think it is important for us to have truth-in-labeling with this amendment. It is a good amendment. It is a probusiness amendment. It is an amendment that will encourage businesses men and women to do what we want them to do, which is good public policy, to insure their employees. It will give them important protections. It will give them more assurances.

This is why we drafted this amendment. It is a significant improvement over the underlying bill that is in front of us.

But it does not solve all the problems. It only deals with a portion of the pie. It does not deal with the caps issue. It does not deal with where the lawsuits should be brought and the issue of whether they should be brought exclusively in the Federal court or in the State court. It does not deal with the class action issue, about which I am very concerned. And I know my friend from Tennessee has been working on this issue as well. It does not deal with the class action issue. I intend to have an amendment later today or tomorrow in regard to the class action issue.

We want to say what it does. It helps businesses do the right thing. It encourages people to continue to insure their employees. But there are many things it does not do.

I would be much more happy to yield to my colleague.

Mr. GREGG, Madam President, I appreciate the Senator’s effort. I haven’t had a chance to digest all of it. I understand the intent and the thrust as described by the Senator from Ohio, which I think is appropriate and good.

As I look at the first section, I am wondering. It appears to me that under the definition section it draws union plans in, and they are being given a special status which is really higher than a self-employed plan is given. I am wondering why union plans are suddenly being raised to a special status under the amendment.

Mr. DeWINE. I would be more than happy to answer the question.

In the original language that we have been negotiating for the last few days, we could not figure out any way to really help the roughly 6 percent of businesses that self-insure and self-administer.

My colleague Senator LINCOLN has brought to our attention and businesses have brought to our attention the fact that this amendment as originally written really did not help those 6 percent. Why? Why originally didn’t it help? The basic problem is they do not have medical decisions. They are really effectively operating as their own HMO.

We thought about how to protect them and give them some help while at the same time preserving their employees’ rights to sue just as everybody else has. We came up with a compromise. My colleague Senator LINCOLN may want to get involved in this and explain it a little bit. But basically it
says for those self-insured, self-administered plans, we carve out a special exemption for them because of the special status they are in—and exempted from lawsuits brought in the Federal court on the nonmedical decisions based on the contract decisions. That is a break they are getting. We think it can be justified by what they do because we want to encourage them to continue to do what they do.

Why is the other group that you have mentioned included? They are included because they operate basically the same way the self-insured, self-administered businesses do. They basically take the risk. They basically make the medical decisions.

I appreciate the question, but I would disagree with my colleague the way he has categorized it. This is no special break to go out and get their health care, and then they come back and get their approval. And that exemption makes sense, but that exemption is not consistent with what unions do. So don't come here and represent to this Senate that it is because it is not. You have raised the unions to a brand new level of independent liability protection. So please do not make that representation.

Mr. DeWINE. I will reclaim my time. I thank my colleague for his comments.

The intention of the language is to treat people equally. If a union does in fact make the medical decisions and if they are operating in the same way that the Wal-Marts of the world are, they ought to be treated the same way. If they are operating in the same way, then they should not be treated the same.

Ms. SNOWE. Will the Senator yield?

Mr. DeWINE. Yes.

The PRESIDING OFFICER. The Senator from Maine.

Ms. SNOWE. The Senator from Ohio is exactly correct. We are treating all employers the same. In this instance, in this particular category, it is those employers who do not have a designated decisionmaker. That is the intent of this particular provision: To treat them equally so they are not subjected to liability when it comes to contractual matters, whereas other employers are not who contract with insurance companies and have a designated decisionmaker model. That is what the intent is of this legislation. It is to treat them equally and to draw that bright line.

We could say, let's not address the self-insured and self-administered programs. I do not think that is fair either because, obviously, they have a different kind of program, and we want to encourage that. We commend them for the kind of benefits they are providing their employees. They happen to be large employers, and they want to design their own internal program. But we don't want to subject them to litigation to which other employers are not going to be subjected. So that is the reason for the intent of this particular provision that happens to include union plans that are designed similarly.

Mr. FRIST. Will the Senator yield?

Mr. DeWINE. I am more than happy to yield to the Senator from Tennessee.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. This is an important point, and therefore I think the colloquy is important so we can address it.

We have just seen the language for the first time a few minutes ago. The way I understand it, we have about 170 million people out there we are talking about in an employer-sponsored plan. There are about 6 million people who are in what are called self-insured, self-administered plans. Over the last 2 to 3 years, as we have tried to figure out how to treat these 6 million people in a fair way, we have struggled because it is hard. We have produced the designated-decision-maker model—which I am a great believer in: and I believe most people in this body, if they step back and look at it, are great believers in—but what you have in your bill is you have carved out those 6 million people who addressed the issue directly, but in addition to that, you carve out the unions.

The argument that was made is that the unions are self-insured, self-administered plans like the other 6 million; that these are union plans, and therefore they should be treated the same as self-insured, self-administered. I think the Senator from New Hampshire and I would argue that the unions should not be carved out as well because—while a few may be self-insured and self-administered—the majority of union plans are not self-insured and self-administered. Therefore, why are you giving this privileged position to the unions that are not self-insured and self-administered like the 6 million whom you targeted initially? That is the question I think the Senator from New Hampshire and I wish to ask you, because we like very much more the designated-decision-maker model.

I guess the question is, Are you contending that the union plans that you carved out are self-insured and self-administered plans?

Mr. DeWINE. If I could reclaim my time to answer the question.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. DeWINE. I can tell you what the intent was. And, as you know, we have been drafting the language, and it has been going on and on. I can only tell you what the intent was.

I am more than happy to take a minute and look at that language again with your comments in mind.

The intent was to treat people who operated one way equally. In regard to unions, the intent was we would cover union plans that were the same as the Wal-Marts of the world which are self-insured and self-administered. That was the intent. It was not the intent to go one inch beyond that or to cover one group or one plan beyond that.

I will bluntly say, if the language in here is not consistent with that intent, then I think the language need to be drawn board and look at the language. That was the intent of the four or five of us who were working on this issue. That was the specific intent, and that was the instruction that was given to staff. If the lawyers did not come back with that language, and I did not catch it when I read it, I apologize, and we will look at that. But it is going to take us a few minutes to get the language out.

My understanding of what my colleague has said is that if a union does in fact operate a plan, and they are in fact self-insured and self-administered, he believes they should be treated the same way; anybody who runs a plan with those two qualifications should be treated the same way. Is my understanding correct?

Mr. FRIST. We have to be very careful.

Mr. DeWINE. If those are the facts, then I agree.
Mr. PRIEST. I believe we should go back and look at the way the bill is written.

Mr. DEWINE. Let me suggest we take a look at that as we continue this debate. We have a little time to debate. Let us look at the language.

I again want to reiterate something, though. And I do not want any of my colleagues who are watching this back in their office or who are in this Chamber to misunderstand this. This is a limited carve-out. It is not a huge carve-out.

Basically, what this carve-out says is, because of the unique situation of the self-insured, self-administered plans, we are going to exempt them from lawsuits, based on contract, in Federal court—they are not going to be exempt from other lawsuits and in State courts, and based on medical decisions. So it is a limited carve-out. I do not want anybody who is watching this debate to think this is some huge carve-out. It is a carve-out on a limited basis. Our intent was to treat people equally who were in that unique circumstance.

I know my colleague from Tennessee has been wrestling with this for a couple years: How do you deal with these folks who have this unique problem?

I find—my colleague from New Hampshire, this may not be perfect, but we think it improves the status quo. That is sort of what we are about today: Trying to improve the status quo.

Mr. GREGG. Will the Senator yield?

Mr. DEWINE. No, I will not yield yet.

We have had criticism of this amendment from people who say it does not solve all the problems. I came to this Chamber and said, no, it does not solve all the problems, but we are trying. And we are trying with this amendment. If we can improve the amendment, and if we can get the language more precise that does it, I will be more than happy to do it.

Yes, I yield to my colleague.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. I think the language, as presently drafted, is in your definitional section of the amendment where you find "(ii) (II)." It says: a group health plan that is maintained by one or more employers or employee organizations described in this section.

That essentially encompasses all union plans. Very few union plans do not use a third-party administrator, very few. So I think you want to tighten up that definition to make it clear that you are applying it to the self-insured, self-funded, self-administered plans, and then you would be picking up the same people that you are picking up under the Wal-Mart exception.

Mr. DEWINE. Reclaiming my time, that was our intent. If that is not reflected in the language, we will change the language.

I yield to my colleague from Maine.

Ms. SOWNE. The Senator from Ohio is making exactly the correct point. This particular provision was intended for those insurers, self-insured and self-administered plans, that obviously do not have a designated decisionmaker. I should further emphasize, all employers are treated equally when it comes to the idea that they participate in medical decisions on behalf of their employees. They are all treated the same. This particular area of the legislation is with respect to contractual decisions. We are attempting to craft out for self-administered, self-insured plans, and that includes union health plans that conform to that particular organization, that they would not be subjected to litigation that other employers would not be subjected to because they had designated decisionmakers.

We know self-insured, self-administered plans do not have designated decisionmakers. So we did not want to expose them to that kind of litigation in this particular section that delineates the causes of action. We were trying to treat all of the employers equally.

Mr. DEWINE. Madam President, I reclaim my time.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. DEWINE. Madam President, we have stated our intent. I think we ought to get about our business and come up with the language to do that, some possible language that we could use. It is always dangerous to try to draft language on the fly on the Senate floor.

I will at least throw this out for possible discussion. We could add "to the extent the Taft-Hartley Plan Act and self-insured, self-administered plans," something to that effect of basically qualifying so that you would get down to whatever the number is—I don’t know what the number is—that are self-insured and self-administered. We certainly could do that. There is no reason that cannot be done.

Mr. GREGG. Is the Senator suggesting that additional definition? Is the Senator suggesting that definition, that expansion of the definition, that expanded language be placed on the definition section?

Mr. DEWINE. We could do it that way. If the Senator has a suggestion of how better to do it, I would be more than happy to take the suggestion.

Mr. GREGG. That may well resolve the problem.

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

Mr. DEWINE. I yield to my colleague from Louisiana.

Ms. SNOWE. The Senator from Ohio, I think the discussion has been very helpful. Two points are important to have on the record. A self-insured and self-administered plan by this amendment would not relieve themselves of being subject to litigation for decisions made based on medical necessity under the Patients’ Bill of Rights bill we are adopting.

Mr. DEWINE. The Senator is absolutely correct. We believe the language does reflect that, but that is clearly his intent.

Mr. BREAUX. If the Senator would further yield, the point made by the Senator from New Hampshire is absolutely correct in the sense that on page 3 of the Senator’s amendment, line 18, when he talked about that group health plan—basically the Taft-Hartley group health plans, as I understand it—you didn’t have that limitation of those that would also be self-insured and self-administered. I think if you added that to that definition, you would correct the problem. I think it would be in keeping with what the Senator wants to do and certainly something I could support.

Mr. DEWINE. I appreciate my colleague’s comments. I think they are well taken. We will get about the business of dealing with that. The point is very well taken.

I yield the floor.

The PRESIDING OFFICER. Who yields time? The Senator from Tennessee.

Mr. PRIEST. Madam President, I yield myself approximately 15 minutes on the opposition time for the time being.

The PRESIDING OFFICER. The Senator from Maine has 7 minutes remaining in her time on the proponent’s side. Mr. PRIEST, Madam President, is this 4 hours evenly divided?

The PRESIDING OFFICER. There are four 1-hour segments. The Senator from Tennessee controls 1 hour of the 4-hour time. The Senator from Maine controls 1 hour. She has 7 minutes remaining on her hour. The Senator from New Hampshire controls 1 hour, and the Senator from Massachusetts controls 1 hour.

Mr. PRIEST. Madam President, I ask unanimous consent that for the first hour, it be equally divided so we can continue the debate for those in opposition.

Mr. REID. Madam President, I am sorry. What was that request?

Mr. PRIEST. For the first hour of the debate, which we are about, I guess, 20 or 30 minutes into, the opposition has not had the opportunity to speak. I was saying for the first hour, in which about 25 minutes has been used, if we can have 30 minutes on either side.

The PRESIDING OFFICER. The debate has already consumed 53 minutes of the proponent’s control and 25 minutes of the opposition’s control by the Senator from Maine.

Mr. REID. The Senator from Tennessee has an hour. He can use it any way he wants.

Mr. PRIEST. Madam President, I understand I have an hour on my side. I will use time off our side at this juncture. I yield myself such time as necessary.
The PRESIDING OFFICER. The Senator from Tennessee. 

Mr. PORTMAN. Mr. President, first of all, let me put perspective on this because we have had the amendment introduced, and there are basically three points I want to make. 

No. 1, I applaud the Senator from Ohio, Senator Jeffords from Maine, because they have, for the first time in the debate, addressed this issue of suing employers—this issue of who is responsible, who gets sued, if there is harm or injury or cause of action. As one can tell from their earlier discussion, there has been a lot of debate in struggling with how best to address who you sue and when you sue them and what entity. There is not very much certainty out there. Do you sue the plan? Do you sue the employer? Do you sue the beneficiary? Do you sue the physician or the hospital when there has been harm or injury? 

In the McCain-Edwards-Kennedy bill, there are exclusions for the physician and the hospital. However, the argument we have over the last 4 or 5 days has made it clear that you can sue the employers if they directly participate. And what has now been brought to the floor in a very positive way, I believe, is this concept of giving certainty to all that through a model that is called the designated-decision-maker. 

Really all that means is that since somebody is going to be sued—and the way it is designed now, you don't know who it is; that doesn't give anybody certainty—the easiest thing to do is for an employer to walk away. It might be me that is sued. It might be the entity that is administering my plan. It might be an agent of that plan. That is so confusing and puts so much risk out there. That is who you sue. The Frist-Breaux-Jeffords bill. The amendment on the floor is very similar to what is in the Frist-Breaux-Jeffords bill that you give certainty; you have to name an entity to be the designated-decision-maker. That is who you sue. The Frist-Breaux-Jeffords bill based that on what already passed the Senate about a year and a half ago. A designated-decision-maker amendment passed this body. That amendment came from the conversation that is going on in Washington between Democrats and Republicans sitting around a table addressing how to come up with a system that best addresses this problem of having employers being sued out here when you really want to go after HMOs. 

How do you delink employers versus HMOs? Basically, you make one entity responsible. It could be the employer, if they meet certain financial criteria; it could be the HMO; or the HMO might be the designated-decision-maker. That is decided in advance. 

The history of the designated-decision-maker model is interesting as well. It is in the Frist-Breaux-Jeffords bill. The amendment on the floor is very similar to what is in the Frist-Breaux-Jeffords bill in that you give certainty; you have to name an entity to be the designated-decision-maker. That is who you sue. The Frist-Breaux-Jeffords bill based that on what already passed the Senate about a year and a half ago. A designated-decision-maker amendment passed this body. That amendment came from the conversation that is going on in Washington between Democrats and Republicans sitting around a table addressing how to come up with a system that best addresses this problem of having employers being sued out here when you really want to go after HMOs. How do you delink employers versus HMOs? 

First point—I will come back to this—that is very positive in the underlying amendment is this broad cause of action which is being struck from the underlying bill. That is where the underlying bill, when you go to the Federal level in the underlying bill, there is a cause of action called "duty under the plan." Unfortunately, if you leave that cause of action in there, it swells in all sorts of things, whether it is the HIPAA regulations or the COBRA regulations, and all of a sudden for those sort of indications, you don't have just compensation, but you are exposed to these unlimited lawsuits out there. So it is very positive, in the amendment that has been put on the floor by the Senators from Maine and Ohio, to take that cause of action out of the bill. 

The third point is that the Senator from Ohio made the point that this is not the answer to liability. Liability involves exhaustion of appeals. And we have an amendment pending on the floor addressing whether there should be caps; and that entire debate, once you go to courts, whether it is noneconomic damages or punitive damages, involves whether you go to Federal court or State court and then this whole idea of who do you sue. Can the employer be sued? And that last point is what the designated decisionmaker selectively looks at, that sliver of the pie of liability. 

So far in the debate, over the last 4 or 5 days, we have not addressed Federal versus State jurisdiction, whether or not there are caps, full and complete exhaustion, or should there be class action suits. The Senator from Ohio made that point. It is critically important to address. If you read the press on this, this decision-maker model will take care of the liability. But it does not answer the questions on the part of myself and many others. 

The way that process works is there is a lawsuit, you are going to go up going to Federal court. If there is a lawsuit in advance, prospectively—not after the fact—a designated-decision-maker has been identified. If there is a lawsuit, there is no question of whether you sue the employer or the HMO or the agent of the plan or the hospital or the doctor. Indeed, you sue one person. That is the designated-decision-maker. That is decided in advance. 

The Snowe-Dwine amendment takes that concept. Again, I think it is the right way. I think most people would agree that is the most appropriate way to address this issue of employer liability. But what they have done is given a choice, from direct participation, of the decision-maker model. To me—and I will have to be honest—that leads to some sort of uncertainty because instead of having real certainty in the employer's mind and employee's mind, the beneficiary of the plan, that there is one person, and you know in advance a year before, 6 months before, that they have the responsibility, somebody has paid for it. Instead of having that certainty, you introduce more choice. Again, are they directly participating? Are they in the decision-maker model? The debate we just heard—are they a self-insured, self-administered plan which is carved out of the Federal cause of action, or are they a union plan? We just heard that debate. Some are self-insured. Some are not. Why carve unions out there? We will look at that particular language. All of that uncertainty is avoided with the designated-decision-maker model. 

Now, that second point that I have already mentioned, which is very positive in this bill—probably more positive, I believe, in the amendment introduced by the Senators from Maine and Ohio, is the part of their amendment which deletes the provision in the underlying McCain-Edwards-Kennedy bill that would allow lawsuits against employers and insurers for unspecified failures—and I quote from the bill—in the "performance of the duty under the terms and conditions of the plan." That is the language which is going to be deleted. That is important because if you don't take that out of the underlying bill, employers will still be highly vulnerable to lawsuits based on alleged failures in the whole realm of administrative duties. That could be under HIPAA, the Health Insurance
Portability and Accountability Act, which we passed in this body several years ago, and COBRA, whereby em-
ployees who are allowed to delegate ad-
ministrative duties, under those laws, to anyone else, by law. You can’t. So the liability for those administrative duties, because you can’t delegate, would fall on the employer, thus allowing there have to be sued. So that is very positive, I think. It was addressed directly in the amendment, and I com-
mand them for that.

Third is that we need to understand throughout this debate, as we hope-
fully can refine this amendment and pass it if we can resolve some of the specific issues in the language. We need to be crystal clear again that addressing the designated-decision-maker ad-
dresses the employer aspect of liability but does not address the many other factors of liability, which I think we have a responsibility to address on this floor, since this bill never went through committee and, in truth, we are marking up and writing this bill for the first time on this floor. We need to talk about Federal versus State courts, class action suits, whether or not there should be caps in a noneconomic dam-
age or should there be punitive dam-
ages. All of those other issues have not yet been addressed. Now I am quite pleased we are addressing the des-
ignated-decision-maker aspect of em-
ployers being sued.

Several quick examples. There need to be clear and effective limits, I be-
lieve, on class action lawsuits. There need to be firm requirements that we fully exhaust internal and external re-
views before initiating any lawsuits. There are a lot of broad exceptions. We talked about some of them as the Thompson amendment was on the floor. We addressed it. This bill needs to have complete exhaustion as we go through.

Second, if an independent external medical reviewer, who is a doctor, which is in the Frist-Breaux-Jeffords plan, as well as in the McCain-Ed-
wards-Kennedy plan, upholds the plan’s denial, then the plan should not be sub-
ject to liability. We need to discuss that on the floor. In the underlying McCain-Edward-Kennedy bill, a pa-
tient, even though that independent medical reviewer, a physi-
cian with age-appropriate expertise, has decided that the plan made the right decision in internal and external appeals and the physician says every-
thing was right going through. I be-
lieve the Frist-Breaux-Jeffords bill says, no, you can sue for care, injunc-
tive relief, but not for extraordinary rewards. That has to be addressed.

Also, the underlying McCain-Ed-
wards-Kennedy bill would allow the independent reviewer to “modify”—I believe that is the word used—the plan’s denial. And this is just as a physi-
cian. What it means is that in a paper review you never see the patient. You read records and hope they are com-
plete, and the reviewer is going to have to interpret that, to thousands of these, maybe hundreds, maybe 10. I don’t know. I was with a doctor a few minutes ago who has done thousands of these reviews.

The point is that you never see the patient. You never get the subtleties of clinical diagnosis, which all of us know is science, but there is also art to it. You are asking somebody to look at this paper and review it and say, yes, it was right or, no, it was wrong.

With the information written on that paper, you are allowed to come in and modify the treatment of that patient. I can say as a physician the fact that based on that paper review, a reviewer could require that the plan cover treat-
ment that I, current treating physi-
cian nor the plan ever contemplated or ever recommended, this reviewer who maybe over the telephone is reading it, is going to be able to modify it bothers me.

It bothers me because it becomes binding, and we all know it becomes binding. When it becomes binding and you have not had that direct experien-
tial observation, to me it is not right. It needs to be corrected.

I will give another example: The em-
ployer in the plan would be subject to simultaneous litigation in Federal and State court. Again, speaking to the under-
lying bill, we have to address that because we all know when we have law-
suits which result in—for example, a $120 million damage award such as there was 2 years ago. A $120 million award is a large award. Some will say it is too much; some will say it is too little. But a $120 million damage award results in total premiums being paid for about 55,000 enrollees for about 7 years.

I do not want to correlate the two, but $120 million is a lot of money, and, at least in my mind, I come back to the uninsured and the number of enrollees who could go out and buy insurance.

We need to be careful about encour-
aging shopping between the Federal courts and State courts, and once you get to the State courts, from State to State. Maybe tomorrow, Saturday, Sunday, or Monday we will come back to that. I talk about it. Clearly, if you are an attorney, for a single event, you have multiple causes of action, you can question that, but in addition to that, you have multiple venues: the Federal court, the State court, or from State to State to State. That is our inter-
pretation. That is our attorneys’ in-
terpretation. It has to be fixed.

In closing, I support the designated-
decision-maker model. The Senators from Maine and Ohio are to be con-
gratulated for getting this Chamber addressing in a sophisticated, appro-
appropriate way how to clarify the un-
certainty about suing employers versus suing HMOs.

I support the model. It is in the un-
derlying Frist-Breaux-Jeffords bill. We are looking at the language, as we hope to make some issue of mine and why they are specifically carved out. That needs to be addressed. We hope to have factual information. We will read the language, and I look forward to work-
ing aggressively with the authors of this amendment so we can all rally around it.

Mr. DeWINE. Will the Senator yield?

Mr. FRIST. Yes.

Mr. DeWINE. If I can respond to the Senator’s comments about why we crafted the bill, it was to give the em-
ployer a choice as to whether or not they would go under the designated de-
cisionmaker or under the language of the other bill, which is direct partici-
pation.

Frankly, I do not think this is a huge deal. The reality is that the vast majority of businesses will go under des-
ignated decisionmaker, and, in fact, we provide in the bill that it is automatic. That will just happen unless they make a conscious decision to say: We do not want to do the designated decision-
aker; we want to go under the direct participation language.

We are in an unknown area, and I do not think anyone knows how this is going to play out entirely in the real world and what decisions they are going to make. Some people come up with some scenarios under which they would not want to designate someone as a designated decisionmaker. The vast majority are. We wanted to pro-
vide this as a fallback position, more options.

I do not think it is going to make it more ambiguous or less definite be-
cause we provide automatically it is going to be designated decisionmaker unless they make an action and say: No, we do not want designated deci-
sionmaker; we want to go with our model because for some reason it works that way. We can look at the language and talk about it.

In explanation to our colleague from Tennessee, that is what our thinking was. We do not know where the world is going with this new language, and we wanted to give as many options to businesses as we could. That is why we did it.

Mr. DeWINE. Mr. President, I claim my time.

The PRESIDING OFFICER. The Sen-
ator from Tennessee.

Mr. FRIST. I guess this decision of cer-
tainty—I usually like choice coming through, and it appeals to me. I am a 50-person convenience store operator and have three or four convenience stores in the area, and I have people barely scraping by, working minimum wages, that I recognize giving people some insurance goes a long way. Some people say it does not matter; you still have your care. If you have insurance, you end up getting better care in the
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The PRESIDING OFFICER. The Senator from Tennessee has consumed about 22 minutes.

Mr. FRIST. How much has the other side used since we have been on the amendment?

The PRESIDING OFFICER. The other side has used 53 minutes.

Mr. FRIST. They have used 53 minutes, and we have used 22 minutes.

Mr. KENNEDY. How much have we used?

The PRESIDING OFFICER. The Senator from Massachusetts has used none.

Mr. FRIST. I was speaking in opposition to the amendment.

Mr. KENNEDY. I think the presenters ought to be entitled to whatever time they have remaining. I am a strong believer in that. I would like to inquire for purposes of clarification.

The PRESIDING OFFICER. The Senator from Tennessee still has the floor.

Mr. FRIST. Thank you, Mr. President. A matter of clarification. In speaking in opposition to the amendment, pursuant to Senator Gregg, we have used how much time?

The PRESIDING OFFICER. Twenty-three minutes.

Mr. FRIST. Twenty-three minutes since we have been on the amendment. Clarification: The proponents have used how much?

The PRESIDING OFFICER. Fifty-three minutes.

Mr. FRIST. I will be happy to yield the floor in a moment. Clarification on the designated-decision-maker model: We would not necessarily assume the insurance company is the designated-decision-maker. You would have to designate that, and that is part of our Frist-Breaux legislation, just to clarify that.

Ms. SNOWE. Will the Senator yield to the PRESIDING OFFICER? Who yields time?

Ms. SNOWE. Will the Senator yield on that point?

Mr. FRIST. I will be happy to.

Ms. SNOWE. It is important to emphasize in this amendment as we have drafted it includes a provision that starts out with automatic designation: That a health insurance issuer shall be deemed to be a designated-decision-maker for purposes of subparagraph (A) with respect to participants and beneficiaries of an employer or plan sponsor. That is important to emphasize, and it automatically occurs so we remove the ambiguity, extra steps, cost, and so on, with respect to that particular requirement.

Mr. KENNEDY. I yield such time as he desires to the Senator from Nebraska and then the Senator from Arkansas, two lead sponsors.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. NELSON of Nebraska. Mr. President, I thank the Senator from Massachusetts for the opportunity to speak to this amendment. There has been a lot of confusion recently around the issue as to what most people's heads are swimming about what a DDM is and what the purpose of this amendment truly is.

The purpose of this amendment is to make sure, whether you are a plan sponsor or an employer, if you are self-insured and self-administered, that you are treated the same. You have to treat one and all the same. That is what this is about. I believe there is some language being worked on that probably will be offered shortly to make it clear that is exactly what is intended by this amendment. It does not specifically carve out one group or another. It carves out all groups where there are plan sponsors or employers who are self-insured and self-administered. All other employers are in a position to have a DDM, designated-decision-makers, or they have an insurer which is a designated-decision-maker.

The whole purpose of this legislation is to be able to provide additional rights and opportunities for insurance. This does it. What it also does is make sure that employers are not entrapped in unnecessary litigation and that if they don't make decisions about health care and make decisions about claims, they are not involved in litigation.

Specifically, this amendment narrows it down to not being brought into Federal courts but also makes clear that it does not absolve employers or plan sponsors from any kind of litigation that may come through State courts.

While it may be difficult to follow the roadmap, there is one thing that needs to be clarified and that is, it does not treat any one group in any special way. It treats all plan sponsors and all employers who self-insure and self-administer, the same way. If they choose to get a third party administrator, which becomes a designee, they are in the same position as a self-insurer, they will be absolved from liability from litigation unless they somehow participated in the claim-making process, which they would not do if they had a designated decision-maker. This is intended to make sure we balance the interests of the right of the individuals, the right of the patients to sue, with the opportunity for employers not to be entangled in litigation where they should not be entangled. It also means that, in balancing these interests, there will be fewer cases of uninsureds, and there will be fewer employers deciding to get out of the business of providing health insurance to their employees.

We have heard from employer after employer about their concern—as a voluntary provider of these benefits, now suddenly they can be sued. This makes it clear they will not be sued and it also makes it clear that those who are plan sponsors will not also be sued unless they participate in making decisions about health care claims. That is what this is all about.

The purpose of this amendment is to make sure, whether you are a plan sponsor or an employer, if you are self-insured and self-administered, that you are treated the same. You have to treat one and all the same. That is what this is about. I believe there is some language being worked on that probably will be offered shortly to make it clear that is exactly what is intended by this amendment. It does not specifically carve out one group or another. It carves out all groups where there are plan sponsors or employers who are self-insured and self-administered. All other employers are in a position to have a DDM, designated-decision-makers, or they have an insurer which is a designated-decision-maker.

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We have heard from employer after employer about their concern—as a voluntary provider of these benefits, now suddenly they can be sued. This makes it clear they will not be sued and it also makes it clear that those who are plan sponsors will not also be sued unless they participate in making decisions about health care claims. That is what this is all about.
I applaud the work of my colleagues. I have enjoyed working with them. I appreciate everyone’s patience and understanding in the process. We hope to be very inclusive, to bring others in to make sure this language is exactly what it is: it is giving the protection and the comfort level to the employers of this Nation that are doing an excellent job in providing health care to their employees.

I also ask unanimous consent that Senator Baucus be added as a cosponsor to this amendment, and I yield.

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

The Senator from Massachusetts.

Mr. Kennedy. I yield the Senator from Michigan 5 minutes.

Ms. Stabenow. Mr. President, I rise first of all to ask unanimous consent to add my name as a cosponsor to this amendment.

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

Ms. Stabenow. Mr. President, I thank my colleagues on both sides of the aisle for their hard work and the innovative language that is put together in this amendment. For those of us who are sponsors of the Patients’ Bill of Rights, we have said since the beginning this was in no way intended to allow lawsuits to be brought against employers, this was about making sure those who make medical decisions were held accountable for those medical decisions.

As we said so many times on the floor, it is really about closing a loophole in the law as well. We have indicated over and over again, when you have only two groups of people in this country who are not held accountable for their behavior and their decisions, one being foreign diplomats, the other being HMOs, it doesn’t make any sense. We knew this was a loophole that was created by the outgrowth of HMOs and development of new ways of managing health care, and basically the Patients’ Bill of Rights is meant to clarify that and make sure those who are making medical decisions are held accountable for the outcomes of those medical decisions, just as are doctors and nurses and other medical professionals.

What I think is important about this amendment is it very clearly states to each and every employer, large and small, that in fact we will make sure if they are not making medical decisions—and in the vast majority of times an employer is not making a medical decision—the intent of the Patients’ Bill of Rights is not to create a liability for the employer. We have employers, many in Michigan—hundreds of thousands of them—who are responsible employers, providing insurance for their employees. We want to encourage and support and rally them for doing that and make nothing get in the way of that continuing.

I again thank my colleagues from both sides of the aisle who have put in
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The PRESIDING OFFICER. Who yields time?

The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I yield myself 3 minutes.

Both the Snowe amendment and the Frist amendment attempt to protect lawyers using the designated decisionmaker language. However, the fact that they use similar names can't mask the dramatic differences between these two amendments. Senator SNOWE's amendment helps employers without hurting patients.

There are two important differences between the designated decisionmaker language in the Snowe amendment and the Frist amendment. Senator SNOWE's amendment ensures that the person an employer designates as responsible and will be liable for all damages caused by any wrongful benefit determinations the patient gets under our bill. This is exactly what employers want and deserve, a clear way under the law to protect themselves.

The Snowe amendment allows employers to name an HMO or health insurer or plan administrator as their designated decisionmaker and not have to worry anymore about being sued. That is what President Bush wants, and that is what we want. If employers give up all control over medical decisions in individual cases such as this, Senator SNOWE's language helps guarantee employers will not be sued, period.

Senator FRIST's designated decisionmaker language is much weaker. Under his proposal, the only entity that can be sued is the designated decisionmaker. While the designated decisionmaker is supposed to have exclusive authority to make benefit determinations, a court or jury remains free to find in fact another person or company influenced the decision that caused the harm. People who are not designated decisionmakers may in fact influence decisions and share liability. But the Frist language leaves victims no way to hold these outsiders accountable. That is because, unlike the amendment of Senator SNOWE, the Frist amendment never deems the designated decisionmaker liable for the acts or omissions of other parties that affect benefit determinations. This is the most critical difference between the two proposals.

The other important difference is that under Senator SNOWE's amendment, only employers can name designated decision-makers; HMOs cannot. After all, the entire point of having designated decisionmakers is to ensure employers have a clear, easy way to avoid all possibility of being sued, not to protect HMOs.

Of course, the effect of allowing HMOs to have a designated decisionmaker is to enable them to escape liability for part or all of their actions. Under the Frist-Breaux amendment, if a judge finds an HMO harmed a patient and that person working for the HMO was not a designated decisionmaker, the HMO escapes liability.

I think the amendment is sound. I think it has been a matter of discussion and debate. I think those of us who were involved in the development of the initial legislation sought to achieve what this amendment does enormously fairly. It also treats the various Taft-Hartley aspects equally with the other parts, so we have equality for one and equality for the other.

Another important feature of Senator SNOWE's amendment is that it protects employers and Taft-Hartley plans which self-insure and self-administer claims. The Frist alternative contained in S.889 fails to address this issue. The Taft-Hartley plans have a long history of providing quality health care for their members. In their unique structure, employee advocates comprise half the membership of the board. The record shows that this has been an excellent protection even for beneficiaries who have extraordinary health care needs. In structuring this legislation, we wanted to be certain that we didn't impose any inappropriate burdens on these plans.

I commend the Senators. They spent a great deal of time on this amendment. One would think it would be easy in the drafting of it, but I know they have been challenged with it. I commend them for really advancing this whole issue in a very positive, constructive way, a way which really reflects what this President has enunciated and a way which we had hoped to include in our legislation. There was a significant point about it. Legitimate issues were raised. I think this is one of the important contributions in helping move this process. I commend all those on both sides who were very much involved in its development.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, I yield 5 minutes.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Mr. President, I think this amendment is a wonderful example of what can be done when we work together to solve problems. The beneficiaries of the work that has been done by Senators SNOWE, NELSON, DEWINE, and LINCOLN are not just the Members of the Senate but the people of this country, the families who need quality health care, and the employers that need to be protected from unnecessary lawsuits and unnecessary litigation.

First, I thank Senator SNOWE for her leadership. She has taken the lead on this issue from the beginning. Her work has been absolutely crucial. My friend, Mr. DeWine, the Senator from Ohio, has also lent tremendous leadership and expertise to the work on this effort.

I also thank my colleague seated near me, Senator NELSON from Nebraska, who not only brings great expertise to this issue but also as Governor and as insurance commissioner of the State of Nebraska, he has been dogged in his determination to ensure that the small employers, particularly, and employers generally, of America are protected in this legislation.

This effort could not have been achieved without his leadership and without his dogged involvement in this issue. He has been involved in so many of the issues with respect to this legislation. He and I have worked together. He and I and Senator MCCAIN have worked together. He has been involved in this patients' rights protection act from the very beginning. We thank him for all of his work and important contribution.

Also, the Senator from Arkansas, who has expressed a concern about employers from the very first moment, and I have talked about this issue. She cares deeply about patients and deeply about doctors making medical decisions, having a very well-trained physician in her own family, that being her husband. She has firsthand experience with that. But in addition to that, she has shown great concern for small employers and, as has Senator NELSON, has made it very clear to Senator MCCAIN and myself and Senator KENNEDY that the only way she could support this legislation is if we did what was necessary to protect employers. She has been absolutely crucial in achieving that goal.

Without the work of Senators LINCOLN, NELSON, SNOWE, and DeWine, the employers of this country would be in a different place than they are today. I think they will be after this amendment is voted on.

They have achieved two very important purposes:

No. 1, they have insured that there are real and meaningful protections for employers through the designated decisionmaker model which we have already talked about, which essentially
means the small employers that we have talked about are 100-percent protected. They cannot have liability under the original draft of this amendment, which is crucial. It is a goal and a principle that we have all shared from the beginning but, again, couldn’t have been done without their work. They have also managed to do it in a creative and innovative way that, while protecting employers, does not leave the patients and the families high and dry, which is exactly what needed to be done.

Honestly, it is a very difficult task, but they have worked doggedly on this issue. All of them managed to reach a bipartisan agreement.

The most important thing from the perspective of the overall legislation is that this is another in a series of obstacles language; working together on it. We know it is important.

The Senator from Tennessee and I, as we speak, are attempting to finalize an agreement on the exhaustion of appeal. Both of us believe, as do most Members of this body, that it is a sensible thing to do. We have talked about the exhaustion of appeal. The Senator from Tennessee and I are finalizing an agreement on the issue. The Senator from Indiana, were crucial in reaching a compromise going to the issue of independence of medical panels to make sure that those panels are, in fact, independent.

We have reached a resolution of that issue. On the issue of medical necessity, the Presiding Officer from Delaware, along with my friend, the Senator from Indiana, were crucial in being able to reach a resolution that shows proper respect for the sanctity of the contract and the specific language of the contract but some flexibility, where necessary, for the independent review panel with respect to patients, keeping in mind the interest of patients on the one hand, which I know you care about deeply, and the importance of the contract in keeping costs under control.

Without your work and Senator Bayh’s work, that would not have been achieved. The Senator from Tennessee and I, as we speak, are attempting to finalize an agreement on the exhaustion of appeal. Both of us believe, as do most Members of this body, that it is a sensible thing to have a patient go through the internal and external appeal before any case goes to court. We have tightened up that language; working together on it. We know it is important.

The Senator from Tennessee, Mr. Thompson, and I are resolving this issue of the exhaustion of appeal. All of us believe that the appeals process is crucial to getting patients the care they need.

If this bill works the way Senator McCain and Senator Kennedy and I believe it should, the ultimate goal will be achieved if there were never a lawsuit filed. It’s what would happen is the appeals process would have worked and the patients would have received the care they needed. That is what this is about.

We want patients to use this appeals process. The Senator from Tennessee and I am finalizing an agreement on the exhaustion of appeal. I also want to thank our colleagues on this specific amendment because that is another crucial obstacle. Scope, independence of the panel, protecting employers, medical necessity, and exhaustion of appeals are crucial issues in this legislation about which we have been able to reach consensus.

As I said earlier, the important result is not what is happening within this Chamber but that the families of this country will have more control over their health care, and we will actually have a more realistic possibility of getting the legislation they so desperately need passed.

I thank all of my colleagues for all of their hard work on them, this could not have been achieved.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Mr. President, let me begin by saying that this amendment is moving in the right direction. I believe, with some of the changes which we have discussed with the Senator from Ohio and the Senator from Maine, that we can make real progress on improving it. Unfortunately, the amendment came late. It is complicated. The issues involved are considerable. But before getting into the specifics of the amendment and how it may or may not play out in a positive way relative to producing a quality bill, let me make the point that this amendment addresses an important but not a broad part of the issue.

This amendment doesn’t, for example, address some very real and significant issues in the area of liability. It doesn’t address the issues of the 56 million people who are in self-insured plans.

It does not, therefore, solve the overall liability question, which if you were to rate the five issues that I think the Senator from North Carolina has appropriately highlighted, although I am not sure he mentioned liability—he probably wasn’t thinking in those terms, but he certainly hit the floor if you put liability on the table—liability is probably the key issue for a lot of people in this Chamber.

Issues such as forum shopping, class action, damages, punitive versus compensatory damages, are major issues that we still have to address. I think we recognize that there is still a fair amount of distance to go in the liability area.

But this amendment takes up the designated decisionmaker language. It takes a portion of the Frist-Jeffords-Breaux bill in this area and tries to basically graft that on to what is the McCain-Kennedy bill—a good and appropriate attempt, although I must admit that with just a quick reading of it I think there is going to be some real confusion on the part of employers between what they can do as a designated decisionmaker and direct participation. I had hoped that the language would have a firewall in there. But as a practical matter, at least the movement is in the right direction to give some insulation for designated decision makers and people who use designated decision makers.

As to the issue of union liability, there has been a lot of talk around here about making businesses liable. And they are liable. Small businesses and large businesses are all liable—and making HMOs liable.

If you are a union employee and have a union plan, and your union tells you you can’t get some sort of treatment that you need and should get, unfortunately, the unions have the ability to sue that union, any more than you or I could sue our company, and the company had sponsored that union plan. But under the original Frist-Jeffords-Gregg draft, you would not have been able to sue that union plan, any more than if you had been employed by a company, and the company had sponsored your plan, and you would be able to sue the company under this bill. The HMOs don’t address the issues of the 56 million people who are in self-insured plans, which are in the same basic position as those plans which are self-funded and self-administered, will be the ones which are taken out of the liability picture. That is reasonable. That is the way it should be. We look forward to that modification.

Another issue that this bill raised, which has not been really talked about at all, is the fact that it basically has Federal usurpation of what has been a very traditional State responsibility of determining the viability of the insurance agency, whether the insurance agency has adequate financial strength to cover the projected losses which may occur. This has been something on which States have spent a huge amount of time. It is a real specialty. It is an art form to look at these insurance companies and determine whether or not they have the depth and the ability to cover the costs if they get hit with a whole series of claims. I would hate to see the Federal Government step into this area where the States have been responsible and suddenly take it over. But under this amendment, as originally drafted, that would be the case: the Federal Government would now basically take all that responsibility away from the States.

We discussed this with the Senator from Maine and the Senator from Ohio and their staffs to try to straighten this out. They recognized the issue.

I think the Frist model in this area is the right model. It essentially says: Where the States have responsibility, where they are the insurer, then they...
will have the ability—and retain the ability—to evaluate the insurer. But where it is a new Federal cause of action, or a major Federal event, then the Federal Government will come in and do the evaluation. That seems to be a reasonable bifurcation of responsibility and will be an improvement if it is accepted.

I understand language is being developed which hopefully will be accepted. That is all very positive, in my opinion.

As I mentioned, this amendment, if we can get these issues worked out and there are one or two other small ones—becomes a much more positive event for moving the bill in the right direction. The question becomes: What do we have left to do in that we have taken up a lot of amendments? Unfortunately, we still have a lot of amendments to go. Most of them are in the liability area. Some of them are in tangential areas. But I do expect we will have amendments, as we move into the evening, which will address such issues as the small employer who decides to cash out their employees and what type of protection they get. Senator Enzi happens to have that amendment.

There will be amendments dealing with class action suits. I think Senator DeWine actually has an amendment in that area. There will be amendments dealing with coverage and liability. I have an amendment on punitive damages which essentially says if an employer lives by the terms of the external review, they should not be subject to punitive damages. There are a variety in that area. There will be amendments on forum shopping. I think Senator Specter has an amendment in that area that he may bring forward.

So there are still a fair number of issues, especially involving the liability questions, which have to be resolved, after we get past the language which the Senator from Maine and the Senator from Ohio have brought forward, which, as I mentioned, I think with some adjustment—which is major to the amendment, but which would be positive; and it appears to be acceptable to the sponsors—hopefully, will move the process in a better direction. At this time I will yield to the Senator from Wyoming for such time as he may need from my time.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. REID. If the Senator from Wyoming will yield for a brief inquiry of the Republican manager, it is my understanding that because of some people being at the White House and a conference that is going to be held by the minority at 3 o'clock, the minority does not wish to vote until 3:45 or 4 o'clock.

Mr. GREGG. I believe there is still approximately an hour and a half left on the amendment. I would hope that once we reach an agreement, and we have the language from Senator Snowe and Senator DeWine relative to the issue of coverage for union plans and liability,恼我们 have the responsibility for reviewing the adequacy of liability, and there is one other issue—once we have that language, I personally would think we could start yielding back time and go to a vote. I think it would be hard to get to a vote before 4 o'clock because of other commitments. It would be my hope we could vote at around 4 o'clock on this amendment.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, this bill is really a strange one for me to be working on at all. Wyoming has one HMO. It is owned by some doctors. So far as I know, there are not any complaints on it. But there are some basic problems here that people in Wyoming are asking about.

Because of Wyoming’s makeup, I usually talk about small companies, because under the Federal definition of 500 employees or less, we do not have a single company headquartered in Wyoming that would be considered “big business.” But on this amendment I have to talk about big business.

I have been hearing from the accountants of a number of these companies. They are a little bit concerned about what is going to happen to their health care. They work for these companies. They can see what the costs are going to be on their companies. I have to say that this amendment before us now does not address the problem. I would like to think that it did.

I would like to be able to pass this. I would like to not have to talk about a big company. There are the Caterpillars and Motorolras and the Pitts and the Packards. There are about a dozen of these big companies in the United States. Again, none of them is headquartered in Wyoming. I am pretty sure that none of them operates in Wyoming. I have still been concerned about them because there are 6 million people who get their insurance that way.

I would suspect that almost everybody in this Chamber, with the exception of my friend from Wyoming, has a QAO or these big companies in their State. Six million people are getting their insurance from these companies. What we are talking about is having a designated decisionmaker. It does sound like baseball season, doesn’t it?

Let me tell you how this insurance works. Right now they work in house. They are able to keep their administrative expenses down to 5 percent. Now they are faced with the possibility of having liability. These are the companies, for example, the Cadillac Insurance in this Nation.

I am not aware of complaints of these companies on their insurance. The insurance these people have is far better than the plan we have in the Senate. But they are self-funded, and they are self-administered. Where they make their big savings is in self-administration.

Now we are talking about having a designated decisionmaker. That means they are going to shift the administration to somebody else, which might still be done at 5 percent, but there is this new liability factor that goes with it. The guy that is over here, who is the designated decisionmaker, is going to have to charge them for their potential liability in the decisions that he makes incorrectly. He will not do that for 5 percent. He will need a lot more because what he is selling is liability insurance. So it is going to drive up the costs.

I have asked some of these companies what those costs would be. They have said that, quite frankly, what they will have to do is get group plans for their employees that have less benefits, to fit in the same cost level that they have got now, because the little bit of a liability factor drives up the price astronomically. So in this particular provision that is before us, we are not taking care of the self-insured and the self-administered.

I do have a proposal that I may offer after this one is finished, one that will provide some mechanism for them to continue to do that, and for those employees who they have, who are more concerned about their ability to sue than they are about the current benefits that they have, would have a choice. In exchange for that choice, this company would not have to hire a designated liability holder because that is what a designated decisionmaker would be.

For most of the firms that have the Cadillacs of the industry, most of them will have to change to a designated decisionmaker. That additional cost will be considerably more than the 5 percent they are currently paying to handle administration, that 5 percent that they do partly because they have employee committees that get involved in the decisions. And those employee committees are not going to want to be sued, so they are going to need some relief. I am here in the uncomfortable position of speaking up for the companies that are in your States, not mine, to protect the kind of health insurance that they have at the present time and not drive up the cost, forcing them to go to a lower benefit plan with a designated decisionmaker.

This is not the solution. I hope you will pay attention to the solution when that amendment comes forward.

Mr. DeWine. Will the Senator yield for a moment?

Mr. ENZI. I will yield on the time of the Senator from Ohio. I was just given pretty limited time.

The PRESIDING OFFICER (Mrs. Lincoln). Who yields time? The Senator from Wyoming still has the floor.
Mr. ENZI. Mr. President, I yield the floor and reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time? The Senator from Maine has approximately 7 minutes remaining.

Ms. SNOWE. Madam President, we are awaiting modifications to the underlying amendment. Unless there are any other speakers on the floor, I suggest the absence of a quorum.

The PRESIDING OFFICER. Is there objection?

Mr. REID. I object. We have to move this thing along.

The PRESIDING OFFICER. Objection is recognized.

Ms. SNOWE. I yield the floor.

The PRESIDING OFFICER. The Chair notes, if no one yields time, time is charged equally to all sides of the debate.

The PRESIDING OFFICER (Mr. DAYTON). The Senator from New York is recognized.

(The remarks of Mrs. CLINTON pertaining to the introduction of S. Res. 117 are located in today’s Record under “Submission of Concurrent and Senate Resolutions.”)

The PRESIDING OFFICER. The Senator from Nevada.

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

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

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

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

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

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

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

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

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

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

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

The amendment is temporarily set aside, and the Senator from Wyoming is recognized.

AMENDMENT NO. 840

Mr. ENZI. Mr. President, I call up amendment No. 840.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows: The Senator from Wyoming [Mr. ENZI] proposes an amendment numbered 840.

Mr. ENZI. Mr. President, I ask unanimous consent reading of the amendment be dispensed with.

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

The amendment is as follows: (Purpose: To provide immunity to certain self-insured group health plans that provide health insurance options.

On page 372, between lines 15 and 16, insert the following: SECT. 304. IMMUNITY FROM LIABILITY FOR PROVISION OF INSURANCE OPTIONS.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 302, is further amended by adding at the end the following:

“(d) IMMUNITY FROM LIABILITY FOR PROVISION OF INSURANCE OPTIONS.—

“(1) IN GENERAL.—No liability shall arise under subsection (n) with respect to a participant or beneficiary against a group health plan described in paragraph (4) if such plan offers the participant or beneficiary the coverage described in paragraph (2).”

“(2) COVERAGE OPTION.—The coverage option described in this paragraph is one under which the group health plan, at the time of enrollment for or promotion of such plan, provides the participant or beneficiary with the option to—

“(A) enroll for coverage under a fully insured health plan; or

“(B) receive an individual benefit payment, in an amount equal to the amount that
would be contributed on behalf of the participant, be determined by the plan sponsor for enrollment in the group health plan (as determined by the plan actuary, including factors relating to participant or beneficiary’s age and health status), for use by the participant in obtaining health insurance coverage in the individual market.

(3) TIME OF OFFERING OF OPTION.—The coverage option described in paragraph (2) shall be offered to a participant or beneficiary—

(4) GROUP HEALTH PLAN DESCRIBED.—A group health plan described in this paragraph is a group health plan that is self-insured and self-administered prior to the general effective date described in section 401(a)(1) of the Bipartisan Patient Protection Act.

(b) AMENDMENTS TO INTERNAL REVENUE CODE.—

(1) EXCLUSION FROM INCOME.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following:

(2) NONDISCRIMINATION RULES.—Section 105(h) of such Code (relating to self-insured medical expense reimbursement plans) is amended by adding at the end the following:

(3) TREATMENT OF CERTAIN COVERAGE OPTIONS.—Section 502(o)(2) of the Employee Retirement Income Security Act of 1974, as amended by section 3 of the Patient Protection and Affordable Care Act of 2010, is amended by inserting , or (B) during any special enrollment period provided by the group health plan after the date of enactment of the Patients’ Bill of Rights Plus Act for purposes of offering such coverage option.

§§ 502(o)(2)(A) of such Act.’’

My hope is that in the course of these discussions everyone will set out on a comprehensive liability fix that includes the designated decision maker model presented in the Frist-Breaux-Jeffords bill. As many of my colleagues have said, that certainly seems to do the job. I agree it certainly seems to. In fact, I agree that the designated decision maker mechanism must be part of an amendment to successfully resolve the problems in the underlying bill.

However, while the designated decision maker model does present itself as the most reliable proposal for protecting most employers, there remains a small segment of the market that will continue to be unproctected. Ironically, the self-employed, and plans may represent the best of the best. These are the plans that we all should envy. They are plans better than we have in the Senate. They are referred to as the self-insured, self-administered employer plans. They comprise roughly 5 percent of the entire ERISA market.

Five percent is not a small number because that is still 6 million people, but the problem under the Kennedy-McCain direct participation model and even a designated decision maker model as we have been debating in the last few minutes is that these employers will have to dramatically alter their health plan because they do the plan administration in-house. That means they are part of everything, and it means they cannot just designate their third party administration insurance company because they don’t currently contract with such entities for the purpose of processing claims. That is the difference between the self-administered and the fully insured employer plan.

We can reasonably expect the fully insured employer plan to be able to designate the final decision on a claim for benefit because that is generally how they function now, having the insurance company administer the plan, with the employer participation ranging from full plan design to advocating for a sick employee. But that is not the way the self-administered plan operates. So none of the proposals protects them.

My fear is that none of the proposals even preserves that kind of a plan. Let me explain why that is a problem. These employers, who are few and far between, probably a dozen in the entire United States. But they are the big companies, the companies that operate probably in everybody’s State but mine. Usually I am the advocate for small businesses because all of my businesses are small. There is not a single company headquartered in Wyoming that would be considered big business by the Small Business Administration. This issue has come to my attention from companies that participate all over the United States, and they have brought me the stories of how it will affect their plan, what the costs will be. It does require a fair bit of capital to administer a health plan and also requires that the employer wants to be actively involved in the caliber and range of benefits their employees receive. They receive more benefits than almost anyone else. And they want to design a broad, often unique range of benefits to suit the specific needs of their employees. Because the employers have the in-house resources to do so, they are actually able to be more cost-effective in what they provide than if they provided a fully insured health plan. They would rather have the health benefits than the administration benefit. It is not that they can just provide the same benefits cheaper and more efficiently; they actually provide a richer benefit package for less.

The benefits some of these employers provide include extensive mental health counseling, on-site wellness programs, botox injections, Viagra, and the list goes on. These employers often use employee review boards to evaluate disputed claims for benefits, which is also a practice used by a number of employee union operated health plans. These are clearly benefits and administrative practices designed to help employees get the highest quality health care available. In fact, these employer plans are often referred to as Cadillac plans. As I said before, isn’t it ironic that these are the health plans hardest hit by this bill? That doesn’t make any sense to me. And it clearly doesn’t make any sense to me to leave these employers unprotected as we identify a way to protect employers.

For that reason, the amendment I offer today is a solution that I think is reasonable and will force us to ask ourselves a few tough questions about the purpose of a Patients’ Bill of Rights. The amendment would require a self-insured, self-administered employer to offer their employees one or both of the following options, in addition to the plans currently available, and thereby gain a “shield” around that self-administered plan from the new cause of action. The logic of this amendment is to provide employees with the option of choosing a different health plan, which would also afford them access to a cause of action. The employee chooses if he or she wants that to be a component of their health benefit.
Under the amendment, self-administered, self-insured employers would be required to offer at least one of the following options. The first would be a fully insured product, under which an employee could exercise the cause of action in this bill against the insurance company administering the health plan; or, the employer would provide additional protection in the form of an "individual health benefit," the amount of their employer's annual premium contribution under the self-administered employer plan. This would have to be used to buy health care, which is done in the State regulated individual market. They have the right to sue.

If an employer offers one or both of these choices to employees, then the employer would not be subject to the new laws that provide the self-insured Bill of Rights. Any new civil monetary penalties would apply to these employers for violations of the act, and the external appeals determination would be binding on the employer, but enrollees would not be able to pursue damage awards against the employer under the new cause of action. As under the Frist-Breaux-Jeffords bill, this provision would not preempt any medical malpractice action currently available in state court.

It would not do that. This is very clear. An employee makes the choice to either keep the caliber of benefits under the self-administered plan, or to choose a plan specifically for the right to sue. Those employees that choose the fully insured product will be able to hold their plan accountable under the new cause of action. And, those employees that choose to purchase their own plan through the "individual health benefit" are similarly able to hold their plan accountable under state law.

The argument has always been that ERISA is unfair because it "traps" employees in the employer sponsored plan, affording that option alone, where damage lawsuits aren't available. This proposal solves that dilemma without jeopardizing access to top-notch employer sponsored health care for those employees. Have any of you been hearing from the major companies about the self-administered employer plan? No, you have not. They have not been asking for that right to sue. They like the range of benefits they have. They like the personal way it is handled.

The arguments you will hear against the amendment, I believe, actually make the case for it. It is very simple. It will be argued that employees will never be able to get the right benefit packages that their employer's self-administered plan offers. If they opt into the individual market by taking the "individual benefit," and, while it may be better than the individual market under the fully insured option, surely it won't compare to the self-administered option.

That is not the right. If they spend the same amount of money and add a liability part to it, you do not get as much insurance. I am trying to preserve their insurance, not the right to sue, by giving them the flexibility. Any employer that ever had a bad actor incident in their company would have all of their people go out into the individual market under this plan.

This bill would eliminate the best employer plans out there because we feel compelled to sue them instead of making the decision to eliminate self-administered plans by a lawsuit from Washington. Why don't we let the employees make the choice for themselves? Every time a window of choice comes open they can opt into this other plan if they think it is a good way to go.

But I will tell you why the businesses cannot do what is being mandated under this bill. If they have to have a designated decisionmaker, they will hire somebody to take the liability risk. They are not just hiring somebody to administer the plan. That is only a 5-percent cost. This will drive their prices up dramatically if we do not give this option, and people who are receiving the best care in the United States at the present time will have to settle for something else.

I believe we have made a concerted effort through the amendment. It is one we talked about a lot last year in the Patients' Bill of Rights conference committees. We made an attempt to amend the process, to remedy the problems of the entire liability section under the underlying bill, including protecting employers and including protecting small employers.

It is not just the small ones; this is worry about the big ones who are providing the best of the best. I do not believe we will be doing a good job unless we include this amendment.

I yield the floor and reserve the remainder of my time.

The PRESIDING OFFICER. If no one yields time, time will be charged against both sides.

The Senator from North Carolina.

Mr. EDWARDS. Mr. President, I understand what my friend from Wyoming is trying to do. We appreciate his work on this issue. This is a subject matter that was covered previously by the Snowe-Nelson-De-Wine-Lincoln amendment on which we reached consensus on the floor a few hours ago. That amendment was specifically designed to strike the proper balance between protecting employers on the one hand and making sure we also protected the rights of employees. So this is a very fundamental principle of two things occurs, the employee, the family, and the patient lose their right to hold anybody accountable.

That principle is completely complied with in the amendment because in that amendment we create a situation where we protect the employees right to recover if, in fact, they are injured by a medi- cally reviewable decision, while at the same time providing protection for employers. So that is the reason that consensus was reached. That is the reason both Democrats and Republicans support it across party lines, and that consensus is consistent with the President's principle.

This is an issue about which we have already talked and an issue about which we have reached some agreement.

In addition to that, there are at least two other problems with this specific amendment.

No. 1, it provides the employees with a false option. It says for self-insured, self-administered plans if either of two things occurs, the employee, the family, and the patient lose their right to hold anybody accountable. One of those options is that they go out, get a voucher, and buy their own health insurance. But there is absolutely no requirement that the voucher be adequate to buy quality health insurance plans.

Second, they may provide a comparable plan. But there is nothing to require that the benefits of that plan be equal to the benefits the employee would otherwise have.

The bottom line is there are no pro- tections that require that under these options the employee or the patient end up with the same quality health care plan. In many regards, it is a false option that is being provided to them.

Another fundamental problem is that there is a provision in the amend- ment—this is the B-1 exclusion from the Internal Revenue Code of 1986 is amended by adding at the end the following. Of course, an amendment to
the Internal Revenue Code creates a blue slip problem. This issue has to originate in the House, which means, if adopted, this entire legislation could be sent back to the Senate from the House.

We have a number of problems. I understand what my colleague is trying to do. I think his purpose is very well intentioned. But I say to my colleagues, No. 1, this is an issue about which we have already reached consensus in the Snowe-DeWine-Nelson amendment. We have reached that consensus for an important reason. We have complied with the President's principle. We have complied with the fundamental principle, with which many of us on both sides of the aisle agree, which is we need to protect employees and provide the maximum protection possible but, in that process, not leave the patients behind. That is the reason we have an amendment to be able to reach consensus.

No. 2, the choices that are being provided in this particular amendment we believe are false choices, and they would not require that the employee or the patient receive the same quality plan they would get with the employer.

No. 3, it creates a blue slip problem, which means the entire Patient Protection Act could be sent back to the Senate since it involves an amendment to the IRS Code.

There are a number of fundamental problems. I appreciate my colleague's work on this issue. I think this does not move us in the right direction. We have an amendment that already addresses this issue. It is an amendment that provides protection for employers while at the same time keeping alive the rights of patients and employees.

I urge my colleagues to vote against this amendment. I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Wyoming.

Mr. ENZI. Mr. President, I want to quickly refresh the memory of the Senator from North Carolina.

I would not have entered into the time agreement had I known he wasn't listening when I debated the Snowe-DeWine arrangement where I clearly pointed out that it is not considered thereunder. I think this is a sticking point that the President would see as being very difficult.

We are talking about companies such as Hewlett-Packard, Firestone, Motorola, Caterpillar, Pitney Bowes—big companies that are providing this. I have checked on the costs. Their costs will go up from $40 million to $70 million if the Snowe-DeWine amendment is the only defense they have.

If I had the remaining time to the Senator from Texas.

Mr. GRAMM. Mr. President, first of all, this problem has not been fixed. The amendment we will adopt is window dressing and has no impact on this problem. What the Senator has proposed is a solution to an assault on the best health care plans in America. The biggest companies with self-insured plans that employees love will be destroyed by this bill.

All the Senator is saying is that if Wal-Mart employees love their plan, and they want to keep it and agree to not require Wal-Mart to be liable to be sued, and if Wal-Mart gives them the option of going into a fully-insured plan with liability so that they do not have to be in the Wal-Mart self-insured plan, they can choose to remain in it, and Wal-Mart will not be forced by liability costs to cancel their plan. This is an important issue that addresses a very real shortcoming in this bill. The incredible paradox is that this bill will do the most damage to the best health care plans in America—plans that are self-insured, that are large, and that provide terrific coverage. Under this bill, there is no question about the fact that the employee is liable. That liability fear will end up forcing them out of these plans.

The Senator has offered us a third way. The third way is if every employee is offered an alternative plan, there is liability available, then those who choose to stay in their health plan and say, I love my Wal-Mart plan and I don't want to sue Wal-Mart, would have a right to do it. That is what the Senator's amendment does. All of the rest of these arguments have nothing to do with the amendment.

Do you want to destroy the best health care systems in America? If you do, you want to vote against the Enszi amendment. If you do not, vote for the Enzzi amendment which guarantees that a Wal-Mart employee will have an option of another health care plan where everybody is liable. But if they choose a better plan with fewer lawsuits, aren't they better off by definition by choosing?

The Senator from North Carolina says if you do not get lawsuits, you ought not to be happy. Maybe not everybody agrees with the Senator from North Carolina.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows: The Senator from Texas (Mrs. Hutchison), for herself and Mrs. Cummins, proposes an amendment numbered 839.

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

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

The amendment is as follows:

(Purpose: To include information relating to disenrollment in the information provided to patients)

On page 101, between lines 14 and 15, insert the following:

(3) DISENROLLMENT.—Information relating to the disenrollment of a participant, beneficiary, or enrollee.

Mrs. HUTCHISON. Mr. President, this amendment is a very simple one. There are several things that must be reported to an enrollee in a plan before the company can implement those things. They are major changes to that person's plan because you don't want a person to go into the doctor's office or into the pharmacy and be told they have been dropped from their insurance or that their spouse has been dropped from their insurance or their child.

We are requiring under the basic bill 30-day notice of any material change. My amendment just specifies disenrollment as one of those items that must be given 30 days' notice.

I have had an experience in which a person's husband was dropped from a plan, was not told about it, and found out when the person went to pick up a prescription drug for the husband, and had no way to fight it in the pharmacy. Later in the week, when the person called to find out why the husband was dropped from her plan, they found it was a mistake. Of course it was a mistake.

So that is why you want the 30 days' notice, so that a person would not have to find out that they are not getting coverage they thought they had through a clerical error.

That is all this amendment does. I urge its adoption.

The PRESIDING OFFICER. Who yields time?

Mr. GREGG. Mr. President, I ask unanimous consent that the amendment be agreed to.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The amendment (No. 839) was agreed to.
Mr. EDWARDS. Mr. President, let me respond briefly to a couple of the comments that were made about the Enzi amendment.

First of all, no argument was made that I heard about the blue-slip problem, so I presume there is agreement that if this amendment is included, it would require the entire Patient Protection Act to be sent back.

Second, I say to my friend from Wyoming, I actually did listen to his comments in the debate. And not only that, I sat in hours of meetings with Senators SNOWE and DeWINE, and others, working out the language of the Snowe-DeWine-Nelson amendment.

The Senator is factually incorrect about one thing; that is, that what Snowe-DeWine-Nelson does is, No. 1, provide this country in the Snowe-Nelson for 94 percent of the employers in the country. Almost every small employer is totally protected. But we left in place for patients. The employers are completely protected.

For the self-insured, self-administered employers, we have also provided specific protections in this amendment, which we have been working on for several days now. No. 1, they are completely carved out. Self-insured, self-administered plans are totally carved out of the Federal cause of action in the Bipartisan Patient Protection Act. They cannot be held responsible for contractual, administrative responsibilities, period. They are out.

Second, we have provided that if they choose to do so, they can pick a third party designated decisionmaker and send all liability to that decisionmaker by which they are completely protected.

And finally, we have provided that if they have what many of these large employers have, which is a system where they simply make a decision, yes or no, on paying the claim after the treatment has already been provided—that the patient goes and gets the treatment; then they decide whether they are going to pay for it or not—they cannot be held responsible.

So I say to my friend and colleagues, what we have done is provide complete protection for 94 percent of the employers in the country in the Snowe amendment, while at the same time not removing the rights and protections of patients.

For the self-insured, self-administered employers, we provided three protections: No. 1, they are completely out on the Federal cause of action, which is contracts, administrative issues.

No. 2, we have specifically said they can use a designated third party decisionmaker and remove all liability by doing that if they so choose.

No. 3, we have said if they operate the plan by saying: we decide after the treatment just simply whether we are going to pay for it or we are not going to pay for it, they are completely protected.

So after lots of work, and many hours, I say to my colleagues, we believe we struck the right balance in both cases—for providing maximum protection for the employers and keeping in place the rights of patients, employees, and families.

So in addition to the blue-slip problem, which in and of itself would be enormous, we believe that we have dealt with this issue. We have dealt with it in a proper and adequate fashion. And we have addressed the concerns of the self-insured, self-administered plans, and the issues raised by small employers around the country who will be completely protected by this amendment.

I yield the floor.

The PRESIDING OFFICER. Who yields time on this amendment?

The Senator from Wyoming.

Mr. ENZI. I 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.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. It is my understanding that the managers of the bill, including Senator Frist, would ask that this vote be put over until a later time. So I ask unanimous consent that be the case.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Chair advises the Senator from North Carolina he has 4 minutes remaining in opposition to this amendment.

The Senator from Texas.

Mr. GRAMM. Mr. President, under the previous unanimous consent agreement, I believe I had 10 minutes to offer an amendment with Senator McCain, but he is not here. I am waiting for him to come back. So I would just like to suggest that perhaps we could modify the unanimous consent agreement so that when he does come back, whoever is speaking at that point, whenever they are finished, we would be recognized to do the amendment. But there is no reason we cannot conduct other business while we are sitting here.

Mr. KENNEDY. Why not talk now?

Mr. GRAMM. I am offering this with Senator McCain. I think he wants to be here as well. It is my understanding he is on his way.

Let me just suggest we let Senator Nickles speak, if he would like to speak. We could all learn something from listening to him. And then, when he is finished, hopefully Senator McCain will be back, and we will do this long-awaited amendment.

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

The Senator from Oklahoma is recognized.

Mr. NICKLES. Mr. President, I just appreciate my friend and colleague from Texas. I will be very brief. I understand the Senator from Pennsylvania wants to come and speak on his amendment. I would just like to make a couple general comments.

Just for the information of our colleagues, I believe at—6:30 we will have three votes. So people should be cognizant of the fact we are going to have two or three votes—three votes, I believe—at around 6:30.

One, I wish to compliment the Senator from Wyoming, Mr. Enzi, for his enrollee choice proposal. I think it is an outstanding proposal. I urge my colleagues to be in favor of it.

I would also like to make a couple personal comments with the designated decision maker. Some people are acting like this is a grand compromise, that this is going to save employers: Employers are going to be exempt now because we are going to give this decision to a third party.

When I ran a company, Nickles Machine Corporation, we had a third party administrator. They handled all the administrative claims. They did a decent job. So I didn’t have to do it, our company didn’t have to do it. We hired them to pay the benefits, to harass the providers, to make sure that benefits were paid or weren’t paid. They paid the right benefits, didn’t pay the right benefits. They were hired guns to run the plan, to make the decisions, to negotiate with the hospitals, negotiate with the doctors—all those kinds of things. That is what third party administrators do.

Now we are talking about saying: They have that responsibility, and now they have liability, too. That’s what this amendment does. Some people said: It is going to hold employers harmless. It will not. I will tell you, the net result is third party administrators are going to say: What am I liable for? Under the McCain-Kennedy-Edwards proposal, they are liable for anything and everything. They are liable for unlimited economic damages. They are liable for unlimited noneconomic damages, pain and suffering. They are liable for punitive damages—and to a cap of $5 million—in Federal courts. They are liable for unlimited economic and noneconomic damages in State courts.

It has never been said that State court limitations for doctors and so on would apply to the plans and/or to the States. So now we are saying to a third-party administrator, we want you to assume the liability but the extent of the liability is not defined. It is unlimited. One good lawsuit and they are going to have to write a great big check. What are they going to do? They are going to have to charge a lot of money. They are going to have to
charge as much money as they think this will cost, and they are going to guess because they don’t know.

It is kind of like playing Russian roulette. They might be lucky and not have any suits so whatever they charge will be profit. Conversely, if there is one bad suit and they are found liable, they are assuming this liability and they are going bankrupt. So they are going to be trying to err on the high side.

The net result, for everybody who thinks this is going to exonerate employers and all they have to do is designate somebody else to accept their liability, I tell my colleagues, as an employer, that is not going to happen. An employer may say: You handle this, third party; you assume our liability. And that third party is going to say: OK, I got you for it, and I am going to charge you more than enough to make sure that we don’t go bankrupt in the process. Maybe they can buy insurance themselves or maybe they can’t. My guess is we are going to find out. Some people have said: CBC says that the liability provision under this bill is .8 percent. I would be willing to bet anybody the premiums that are going to come out as a result of this liability in third party administrators assuming liability is going to be a lot more than .8 percent. My guess is you are going to be looking at premium increases of 4 and 5 percent just to cover the liability before someone will take this because the liability is not defined. It is unlimited, unlimited noneconomic, unlimited economic.

The contract coverage, well, you may have to cover just about anything. We never did tighten up medical necessity so if you are going to cover something, we tell employers that they have to cover just about anything. We don’t have contracts. This third party administrator, which is usually charged with enforcing a contract, does not have a defined contract and has unlimited liability. And we tell them they have to pay for everything. They are going to end up charging the employer more than they think it would cost so they don’t go bankrupt.

So we are going to find out how much this will cost. By the way, people should be aware of the fact that just having a designated decision maker with no limitations on liability, with no limitations on covering what is in the contract can be enormously expensive.

One other fact that people haven’t considered. If you are a designated decision maker and you are making these decisions on what to cover and not to cover and you are liable if things don’t work out, you are hardly ever going to say no. You will hardly ever say no because if you say no, you might be sued. Therefore, you are going to have more defensive medicine than you have ever had. Whereas before they were charged with the responsibility of enforcing a defined contract—this is covered; this is not covered; being more of an administrator of a contract and plan—they are now going to be faced with liability. And they can’t afford the ultimate price of being hit with a heavy lawsuit. So when the claim comes forward, if it is even close to being going to pay it, Pay it. Pay it. They don't want to take a risk or a gamble that they can be sued for unlimited damages. So you will have enormous increases through increase of what I would call defensive protections so people don’t have liability costs.

And then you will have people guessing what the liability will be, and that will increase the cost to make sure that they have enough that they don’t go bankrupt.

The net result is that this designated decision maker that some people think is going to exonerate employers will show that this is a very expensive provision, and the cost of this bill, the cost of medicare and health care and, therefore, ultimately the number of uninsured will rise dramatically as a result of this bill and because of this provision.

I urge my colleagues to vote no on the underlying amendment that deals with this provision.

I want to mention—I hope it gets fixed—I think it is outrageous we could exempt union plans from this provision. I hope it is fixed.

I yield the floor.

AMENDMENT NO. 843

The PRESIDING OFFICER. Under a previous order, the Senator from Texas is recognized, with the agreement that his 10 minutes will be equally divided, 5 minutes on either side.

Mr. GRAMM. 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 Texas (Mr. GRAMM), for himself and Mr. MCCAIN, proposes an amendment numbered 843.

The amendment is as follows:

(Purpose: To ensure the sanctity of the health plan contract)

Insert at the appropriate place:

Notwithstanding any other provision of this Act, any exclusion of an exact medical procedure, any exact time limit on the duration or frequency of coverage, and any exact dollar limit on the amount of coverage that is specifically enumerated and defined (in the plain language of the plan or coverage) under the plan or coverage offered by a group health plan or health insurance issuer offering health insurance coverage and that is disclosed under section 2701 of such Act shall be considered to govern the parties in compliance with the requirements of law.

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

Mr. REID. If the Senator from Texas will withhold, and no time will be charged against him, I would propose a unanimous consent request.

Mr. President, I ask unanimous consent that Senator SPECTER be recognized to offer an amendment regarding Federal courts with an hour for debate equally divided in the usual form; further, that Senator SNOWE be permitted to modify her amendment; further, that the Senate vote in relation to the Specter amendment at 6:50 p.m. this evening, with 10 minutes for debate prior to the vote equally divided in the usual form with no second-degree amendments in order prior to the vote; further, that following disposition of the Snowe amendment, there be 2 minutes for debate prior to a vote in relation to the Enzi amendment with no second-degree amendments in order prior to the vote; further, following disposition of the Enzi amendment, there be 2 minutes for debate prior to a vote in relation to the Specter amendment with no second-degree amendment in order prior to the vote.

The PRESIDING OFFICER. Is there objection?

Mr. GREGG. Reserving the right to object, as I understand it, as to the 10 minutes, because the amendment was itself divided into four parts, four holds of time will be given 21/2 minute segments.

Mr. REID. When I read that, I knew we should have a clarification. I appreciate the Senator clarifying that.

Mr. SPECTER. Mr. President, reserving the right to object, I entered the Chamber and I heard my name mentioned. I would ask that the unanimous consent be repeated.

Mr. REID. That the Senator from Pennsylvania agree to have 45 minutes for him and 15 for us? We have Members who want to know when they are going to vote.

Mr. SPECTER. That is not satisfactory. I am being importuned over here about what a good deal it is. This amendment, Mr. President, involves a question of whether there will be both Federal jurisdiction and State jurisdiction. It is a matter I have discussed with the managers of the bill again this morning and with Senator Edwards. I believe there is going to have to be some discussion. There are going to have to be some issues raised and
some questions answered. It simply does not lend itself to that kind of time constraint.

Mr. REID. If I could say to the Senator from Pennsylvania, how about if he has an hour and we have 20 minutes?

Mr. SPECTER. Mr. President, I am prepared to start the debate and to make it as expeditious as possible. But I am not prepared to negotiate time to an hour and 20 minutes total. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. SPECTER. Mr. President, I have sent an amendment to the desk. The amendment has been read.

Mr. GRAMM. Mr. President, I seek the Sergeant at Arms.

The amendment I have offered makes the contract binding. But then it makes those contracts binding unless they are subject to determination of medical facts and they are subject to medical review.

This creates an extraordinary ambiguity and, for all practical purposes, makes the contract not binding. That creates a situation where every health insurance company in America will realize that these outside medical reviewers, based on medical necessity, could invalidate every health insurance contract in America and, as a result, put everybody under the high option plan whether they pay for it or not. The net result would be an explosion in health care costs. In fact, if this provision is not fixed, it is at least as explosive in potential cost as the liability section, which we have talked about many, many times.

The amendment I have offered makes the contract binding, and it provides language that says the contract is binding as long as the contract does not violate the language of the bill. Let me explain very briefly what that means. If, as we do under the bill, we say that if you provide emergency room coverage, you have to have a prudent layperson standard for that emergency room coverage, so you have to do that if you provide the coverage no matter what this amendment says; or if we say under the bill that if the plan has pediatric care for children, that can be the primary physician, then it would have to be the law that would govern.

Within that very limited proviso, this amendment makes the contract binding. I think it is a dramatic improvement in the bill.

I thank our distinguished colleague and my old and dear friend from Arizona for helping me work this provision out. It is something I have worried about. I do think it improves the bill, and it certainly would not have happened without the reasonableness of our dear colleague from Arizona. I thank him for that.

I yield.

Mr. MCCAIN. Mr. President, I thank the Senator from Texas for causing this amendment to happen. It really is to ensure the sanctity of the health care contract. Concerns were raised that under the pending McCain-Kennedy legislation, independent medical reviewers can order a health plan to provide items and services that are specifically excluded by the plan.

That was not the intention of the law. The Senator from Texas pointed out that it could have been interpreted in another way, and clearly this amendment I think tightens that language to the point where it is clarified that the bill doesn't do this and its specific limitations and exclusions on coverage must be honored by the external reviewers.

There are numerous safeguards already in the bill to ensure that external reviewers cannot order a group health plan or health insurer to cover items and services that specifically are excluded or expressly limited in the plain language of the plan document and that do not require medical judgment to understand.

So I think this language is important in its clarification. I understand Senator Gramm's concerns. I know this will not bring him to the point where he is willing to vote for the bill, but I do hope it satisfies many of his concerns, and we will continue to work with him to try to satisfy additional concerns. I appreciate his cooperation and that of his staff. I believe my friend from Texas would agree this is probably the 35th draft we have of this maybe 9-line amendment, but each word is important nowadays as we work our way through this bill. I believe the appropriate place is on page 36, line 5.

By the way, I thank Senator Kennedy and Senator Edwards and their staffs for agreeing to this amendment. I share the opinion of the Senator from Texas that it is an important amendment.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, I urge that we accept this amendment. As in other areas, there has been a desire to provide clarification to the language we had in the bill. One of the issues that has been debated is the power and authority of the review medical officer in the review process. It was never the intention to include benefits that were not outlined in the contract. It was going to be limited to the contract, but it was also going to give discretion in terms of medical necessity. So this is a clarification of that, and I think it is a useful and valuable clarification. I hope the Senate will accept it.

Mr. GRAMM. Mr. President, I seek only to do good, not to have it recorded through a recorded vote. So I ask unanimous consent that the amendment be adopted.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered. The amendment (No. 843) was agreed to.

Mr. MCCAIN. The amendment that I offered today with Senator Gramm helps to clarify the intent of how this bill deals with medically reviewable decisions.

Mr. KENNEDY. The Senate should understand that the language in the McCain-Edwards-Kennedy bill is based on language from a bipartisan compromise between John Dingell and Charlie Norwood. Every member of our conference signed off on our approach the last Congress, from Don Nickles to Phil Gramm to John Dingell and me.

Our approach is based on a very important concept. It assures that the external reviewer cannot be bound by the HMO's definition of medical necessity. This does not mean that the reviewer cannot sign off on anything that is explicitly excluded by the health plan. If the plan covers 30 days in the hospital the reviewer cannot approve 100 days. However, where a coverage decision requires medical judgment to determine whether of not what the patient is requesting is the type of treatment or services that is explicitly excluded, we intend for that determination to be eligible for independent review.

Mr. MCCAIN. The amendment we are drafting here—that merely restates what is in the underlying bill—is not intended to change our fundamental approach, just to clarify our intent.

Our overall bill still clearly states that a coverage decision that are subject to interpretation or that are based on applying medical facts and judgment should be reviewed. This includes those decisions that require the application of plan definitions that require interpretation.

Mr. KENNEDY. Absolutely—the reviewer should be looking at those cases. The amendment is intended to clarify that we never meant to have the independent reviewer approving a benefit that is explicitly excluded in all cases. However, in the case where there is some dispute about whether it is a medically reviewable benefit, we do want the case reviewed.

Mr. MCCAIN. Right, just as in the case we have heard about a child with a cleft palate. The plan says they do not cover cosmetic surgery, but the doctor argues that there is specific health risks for not having this surgery. That is something the independent reviewer would look at to determine if it is covered in this case.

Mr. KENNEDY. Under the bill the external review process is first designed to determine whether a denial by the plan or issuer is based on a particular
definition, or a specific benefit exclusion or limitation under the plan or contract, whose meaning is unambiguous and does not turn on specific medical facts in an individual patient's case. An appeal will be dismissed in cases where the entity concludes that unambiguous plan language is the basis of a denial and that no set of medical facts is described or would result in coverage under the terms of the plan.

Mr. REID. Mr. President, we are going to have a vote sometime from 6:45 to 7:15, according to how much time is taken on the Specter amendment. We will have three votes at that time. Members should be ready to come and vote at or about 6:40 or 7:15, something like that.

The PRESIDING OFFICER. Under the previous order, the Senator from Pennsylvania is recognized to offer an amendment.

AMENDMENT NO. 844

Mr. SPECTER. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report the amendment.

The senior assistant bill clerk read as follows:

The Senator from Pennsylvania [Mr. SPECTER] proposes an amendment numbered 844.

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

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

The amendment is as follows:

(Purpose: To require that causes of action under this Act be maintained in Federal Court)

On page 153, strike line 9 and all that follows through page 154, line 2, and insert the following:

(10) STATUTORY DAMAGES.—The remedies set forth in this subsection (n) shall be the exclusive remedies for causes of action brought under this subsection. In such actions, the court shall apply the tort laws of the State in determining damages. If such damages are not limited under State law in actions brought under this subsection against a group health plan, or health insurance coverage, the torts and remedies set forth in this subsection shall apply, subject to the extent required by the limitations set forth in this subsection. Nothing in this subsection shall be construed to require Section 733 of the Employee Retirement Income Security Act of 1974.

(11) CONFORMING AMENDMENT.—Section 38, United States Code, is amended—

(A) by inserting “(1)” after the subsection designation; and

(B) by adding at the end the following:

(2) EFFECTIVE DATE.—(Paraphraph (1) shall apply to all actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act, and all actions that are filed not earlier than that date.

(2) RACKETEERING INFLUENCED AND CORRUPT ORGANIZATIONS ACT.—Section 1964(c) of title 18, United States Code, is amended—

(A) by inserting “(1)” after the subsection designation; and

(B) by adding at the end the following:

(2) No action may be brought under this subsection, or alleging any violation of section 1962, if the action seeks relief concerning the manner in which any person has marketed, provided information concerning, established, administered, or otherwise operated or provided a group health plan, or health insurance coverage issued in connection with a group health plan. Any such action shall not be brought under the Employee Retirement Income Security Act of 1974.

(II) In this subparagraph, the terms “group health plan” and “health insurance issuer” have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

(IV) By paragraph (A) shall apply to actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act, and all actions that are filed not earlier than that date.

(3) CONFORMING AMENDMENT.—Section

On page 156, between lines 2 and 3, insert the following:

(1) ACTIONS IN FEDERAL COURT.—(A) A cause of action described in subparagraph (A) shall be brought and maintained only in the Federal district court for the district in the State in which the alleged injury or death occurred, or in a State or local court of the State in which the alleged injury or death occurred, if the State or local court has jurisdiction.

(2) ACTIONS IN FEDERAL COURT.—(A) A cause of action described in subparagraph (A) shall be brought and maintained only in the Federal district court for the district in the State in which the alleged injury or death occurred, or in a State or local court of the State in which the alleged injury or death occurred, if the State or local court has jurisdiction.

I have long been a cosponsor for a Patients' Bill of Rights, and I was surprised to learn many years ago of the Federal preemption which precluded an injured patient—for example, where a family doctor recommended a specialist and the HMO refused to provide the specialist to the person and the person was injured, or perhaps died, and had no redress in the Federal courts because of the so-called preempt

AMENDMENT NO. 844

On page 156, strike lines 15 and 16 and insert the following:

(2) EFFECTIVE DATE.—(Paraphraph (1) shall apply to all actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act, and all actions that are filed not earlier than that date.

(2) RACKETEERING INFLUENCED AND CORRUPT ORGANIZATIONS ACT.—Section 1964(c) of title 18, United States Code, is amended—

(A) by inserting “(1)” after the subsection designation; and

(B) by adding at the end the following:

(2) No action may be brought under this subsection, or alleging any violation of section 1962, if the action seeks relief concerning the manner in which any person has marketed, provided information concerning, established, administered, or otherwise operated or provided a group health plan, or health insurance coverage issued in connection with a group health plan. Any such action shall not be brought under the Employee Retirement Income Security Act of 1974.

(II) In this subparagraph, the terms “group health plan” and “health insurance issuer” have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

(IV) By paragraph (A) shall apply to actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act, and all actions that are filed not earlier than that date.

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quagmire because if you have a case such as the following where a child is born to a mother who has a plan under an HMO which seeks to limit the hospital stay to 24 hours. The patient is then discharged and an unfortunate result happens to the child. There will be both claims under the so-called quantity interpretation of the contract and quality on medical malpractice.

That is illustrated in the case of Bauman v. U.S. Healthcare, 1 F. Supp. 2d 420, a case which was heard in the United States District Court for the District of New Jersey in 1998. In that case, and this illustrates the kind of an issue I am referring to, the HMO plan had policies which encouraged the discharge of a mother and a newborn within 24 hours after birth. Mrs. Bauman was discharged after that time elapsed and the next day the Baumans' daughter fell ill.

The Baumans contacted the HMO and requested a home visit by a nurse. The HMO refused to send a nurse, and the daughter died of meningitis the same day. The claim was brought against the HMO, the doctor, and the hospital, and they went into State court. The HMO removed the case to Federal court as they had a right to remove it under ERISA.

The district court made a determination that counts under the complaint relating to the discharge decision were "quality-of-care" decisions, and the counts would be remanded to the State court. The district court said that the failure to provide the nurse was a "quantity" decision and, therefore, was preempted totally.

On appeal, the United States Court of Appeals for the Third Circuit, in a case captioned In re U.S. Healthcare, Inc., 193 F.3d 151, reversed the district court holding that the claim was a quality decision.

The Bauman case illustrates the point about how hard it is to decide whether a claim is a "quantity" claim or a "quality" claim.

The amendment which I have proposed would bring if the McCain bill were enacted, would be in the Federal court on the issue of plan coverage because that is a determination of the "quantity" of medical care, but that the other claims would be brought in the State court. I suggest obviously that is a procedural quagmire.

The point is further illustrated by an opinion of the Court of Appeals for the Third Circuit in a case called Lazorko v. Pennsylvania Hospital, 237 F.3d 222, decided just last year, where the underlying facts show the plaintiff's wife was hospitalized for attempted suicide. She was released but continued to have thoughts of suicide. Her doctor refused to remove her from the hospital, and thereafter, regrettably and unfortunately, she killed herself.

In the State court, the plaintiff sued the HMO. The case was removed to the Federal court where the counts on direct liability against the HMO were dismissed. The case was then remanded to the Federal court and then removed again by the HMO to the Federal court.

The Federal court dismissed some of the counts against the HMO but remanded the case to the State court because of the various vicarious liability claims which the plaintiff had against the HMO. On appeal, the circuit court reversed the district court on one liability count and remanded the case to the district court.

That is legalese, obviously, and very hard to present in the course of a floor statement in a Senate debate on this subject, but it is illustrative of a point that where you have a situation where an HMO covers certain kinds of treatments for medical illness and you have a question as to the coverage, under the McCain bill that claim would go to the Federal court, but if there is a claim on malpractice, failure of the doctor to exercise ordinary care, that case would go to the State court.

There is no doubt that with the long history which the Federal courts have had on interpreting ERISA that there is going to be the first line of jurisdiction, and appropriately so, in the Federal court.

My amendment would provide that the Federal court would have exclusive jurisdiction over all of the claims. In a situation where the HMO would have its case heard in the Federal court, the Federal courts frequently will retain jurisdiction over the doctors, the nurses, and the hospital, and the other parties where the matter would ordinarily go to State court on what is called pendent or supplemental jurisdiction.

Again, it is very complicated. It does not lend itself to a short time agreement, but the upshot of it is that if you have the provisions of the McCain bill which give jurisdiction to the Federal court on contract interpretation or "quantity of care" and jurisdictions in the State court on malpractice or "quality of care", a plaintiff is going to have to go to two courts to get both of the claims adjudicated which is, as I say, a procedural quagmire.

The amendment which I have proposed would give the same deference to State law by providing that it would be the law of the State where the incident occurred which would govern the lawsuit. That is to say that the damages would be determined by State law and damages do vary among the 50 States.

Also, if the State had a cap or a limit on the amount which could be collected, that would be determinative when the case is brought in the Federal court.

This is very much like the diversity cases where jurisdiction resides in the Federal court, where the plaintiff is a resident of one State and the defendant is a resident of another State. A simple illustration would be if a patient from Camden, NJ, is treated in a Philadelphia hospital, and there is an allegation of malpractice, negligence on the part of the physician and the hospital, then the resident of the State of New Jersey sue in the Federal court with requisite jurisdiction amount, but it would be the law of Pennsylvania which would govern, or the plaintiff could sue in the State court of Pennsylvania. State courts would have jurisdiction.

Once you bring the HMO into the picture and you have what is traditionally under ERISA, it has to start out in the Federal court at least as the contract interpretation and "quantity of care." That is why it is my point, legal judgment, that it is necessary to avoid the procedural quagmire to have the Federal court have jurisdiction over the entire matter.

The question has been raised as to choice of law and venue, the question raised by my distinguished colleague from Tennessee, and I specified in the legislation that it would be the place of the incident which would determine the applicable law. Again, liability varies from State to State and venue has an important place. We want to avoid the potential of judge shopping so that the choice of law and the determination of venue would be where the incident occurred.

There is another important aspect to the litigation in the Federal court because of a feeling of a greater confidence in the Federal judicial system than in some State court judicial system. This is a tough point, but it is one which the Judiciary Committee examined in some detail last year in considering the question of amending diversity jurisdiction in class action cases. Class action is when plaintiffs join in a suit as a defendant, all you have to do to avoid diversity is to have the class action certified.

Diversity jurisdiction is easily defeated in a class action matter because if you have many plaintiffs, as you do in a class action, and a single defendant, all you have to do to avoid diversity jurisdiction is to have one of the plaintiffs a resident of the same State as the defendant. In order to have a diversity jurisdiction in the Federal court, all the plaintiffs have to be from a State other than the residence of a defendant.

In the Judiciary Committee report on this subject, the following facts of findings were made:

Some State court judges are less careful than their Federal court counterparts about applying the procedural requirements that govern class actions.
That appears on page 16 of the report of the Judiciary Committee reporting this bill, on page 17.

On the next page, page 17, appears the following statement:

A second abuse that is common in State court class actions is the use of the class device as "judicial blackmail." That is a fairly strong characterization in citing that criticism of the State courts. I do not suggest the impugning of all State court judges everywhere. But there is a considerable difference in magnitude of the quality of the courts where you have elecctor processes in many States, contrasted with the Federal system of life tenure, where I believe it is fair to say it is generally accepted that the caliber of the Federal courts is better, at least as a generalization.

There has been a great deal of concern expressed by some about the unlimited potential that would be present in a Patients' Bill of Rights in exposing defendants, HMOs, and employers to very high verdicts which would increase the cost of health care. So there is some assurance, I think fairly stated, by having the cases brought in the Federal courts.

I think it is useful to cite a couple of other illustrations about the underlying concern which I have about the procedural quagmire which occurs. One of the two cases I intend to cite additionally—but I shall not cite many of the other cases, and there are many illustrative of this proposition—is the case of Pzyrbowski v. U.S. Healthcare, Inc., 245 F.3d 266, decided by the Court of Appeals for the Third Circuit earlier this year. The plaintiff had back problems, sought surgical treatment, the HMO delayed a decision for months, the plaintiff went to State court, suing the HMO for medical complications occasioned by the delay. The HMO removed the case to Federal court, the Federal court dismissed the claims against the HMO, finding that they were "quantity determinations" and therefore preempted under ERISA section 502. The district court also found that claims against the primary care provider were expressly preempted by section 514 and dismissed those claims, as well. The Court of Appeals for the Third Circuit vacated the findings and remanded the case to district court to make further findings. The appellate court noted that the claims against the primary care provider raised both "quality" and "quantity" issues—so, on the record before it, the court could not decide which applied in that case.

So not only do you have the provisions of the pending bill, which would send a plaintiff to two different courts on what is essentially the same situation, but even have the courts unable to draw a bright line between what is "quantity" and "quality.

Another case which is illustrative of the problem is Corcoran v. United Health Care Inc., 965 F.2d 1321, heard in the United States Court of Appeals for the Fifth Circuit in 1992, where a patient was pregnant, and her doctor recommended complete bed rest and hospitalization, but there could be no monitoring of the fetus. The patient's doctor sought precertification from the HMO for a hospital stay. The HMO denied the request and authorized only 10 hours per day of home nurse services at home. Subsequently, the fetus regrettably went into distress and died at a time when the home health nurse was not on duty. The Corcorans, parents of the deceased child, brought suit in the State court which then had removed to the Federal court, with the HMO arguing that they had not made a medical decision on "quality" but only a decision as to what benefits were covered under the health plan which was preempted by ERISA. The court concluded that the HMO gave medical advice, but in the context of making a determination as to the available benefits under the plan, and as such the court found the Corcorans' claim was preempted by ERISA.

So there you have a curious situation of what is viewed as a medical decision but again, preemption, because it was held to relate to a determination of benefits under the plan.

The amendment would give jurisdiction to the Federal court on both of the claims so that when any one of these plaintiffs, such as a mother who is delivering a baby and has a limitation of 24 hours in the hospital and has a claim both as to coverage and as to malpractice, she could bring the case into Federal court, where State law would apply as to damages, and if there was a cap on damages in that State, that cap would apply.

I am a cosponsor of the bill and I, too, intend to support the bill. But I do not expect that the insurance contract interpretation of the insurance contract, would be more appropriate to discuss the matter with the Senator from North Carolina on this issue, but the question I have relates to the McCain-Kennedy-Edwards bill where you have a case, taking the insurance as to whether it would be more appropriate to discuss the matter with the Senator from North Carolina on this issue, but the question I have relates to the McCain-Kennedy-Edwards bill where you have a case, taking the insurance contract interpretation of the underlying facts that I gave in the Lazorko case. Where you have an HMO, which covers medical care, and a woman being in a hospital for attempted suicide being released and the HMO refusing to readmit her, and thereafter she killed herself—isn't it true that the claims which were brought, say in Lazorko, which raised questions of interpretation of the plan, would be brought in the Federal court and the cases on malpractice would be brought in the State court which is under our bill.

Mr. KENNEDY. Mr. President, I do not expect we will be able to litigate a case on the floor. I am not familiar with the facts in that particular situation.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The Senator from Pennsylvania has the floor; the Senator from Massachusetts does not.

Mr. SPECTER. Did the Senator from Massachusetts suggest the absence of a quorum?

The PRESIDING OFFICER. The Senator from Pennsylvania has the floor; the Senator from Massachusetts does not.

Mr. SPECTER. I do not intend to litigate a case on the Senate floor. So without referring to a specific case, I ask the Senator from Massachusetts, is it true under his bill a claim which calls for interpretation of coverage brought in the Federal court, and a claim which might—which would arise out of the same occurrence, which involved malpractice, or a "quality" case—would that not, under his bill, be brought under the State court?

Mr. KENNEDY. I say to the Senator, I am not familiar with the facts we have to date with that particular issue, following the Supreme Court holdings in the Pemigewasset case, this would be tried in the State court.

Mr. SPECTER. Madam President, I would press the question as to the interpretation of the insurance contract, which defined the rights of the parties under the contract. Isn't it true that under his bill, a claim brought in the Federal court, and that this is a matter which goes to the Federal court?

Mr. KENNEDY. The understanding of our position on this issue is that the Supreme Court in Pegram said, when there is a dual issue involved in terms of the medical decision and the contract decision, as the Senator knows, on medical issues decided in the State contract, in the Federal courts, and where there is a mix of those, the predominance of these issues being medical, it would be tried in the State court.

Mr. SPECTER. Madam President, I suggest that is at variance with the provisions of the Senator's bill. I will cite the exact citation here.

At page 140, if I might call it to the attention of the Senator from Massachusetts, section 502 of ERISA, which is brought in the Federal court, and at the bottom, line 24, (I) regarding whether an item of service is covered under the terms and conditions of the plan or coverage.

So that is a section where you have Federal court jurisdiction, and that
would be the issue, as to interpretation of a contract to determine coverage. I ask the Senator from Massachusetts if that is not an accurate citation of the Senator's bill?

Mr. KENNEDY. No. No, it is not. The Senator would be reading it out of context:

Cause of action must not involve a medically reviewable decision. The Federal cause of action excludes the medically reviewable decision. That is on page 142, line 6.

Mr. SPECTER. If I might have the attention of the Senator from Massachusetts, on the preceding page, 139, section 302 talks about the 'availability of civil remedies.'

(a) Availability of Federal Civil Remedies In Cases Not Involving Medically Reviewable Decisions

Mr. KENNEDY. Yes.

Mr. SPECTER. Going on to 140.

Mr. KENNEDY. The Senator is correct, and that is consistent with my earlier remarks.

Mr. SPECTER. If I may be permitted to finish my sentence, since I do have the floor——

Mr. KENNEDY. If the Senator wants a response, I am trying to respond to those highly technical questions the best way we can.

Mr. SPECTER. I do want a response, but not in the middle of my sentence or the middle of my question.

But to go forward here on the availability of Federal civil remedies in cases not involving medically reviewable decisions, this covers, line 24–25: regarding whether an item of service is covered under the terms and conditions of the plan or coverage, is the difference.

My question to the Senator from Massachusetts: Isn't that an explicit statement that, if it is a medically reviewable decision, this covers, line 24–25:

That is called quality of care, as I have said before, and is a malpractice issue. But the question which I have directed to the Senator from Massachusetts is a much narrower question.

To repeat, is this not a question on the interpretation of the contracts, specifically where an item of service is covered under the terms and conditions of the plan for coverage? That is my question. The interpretation of an item of service is covered under the terms and conditions of the plan for coverage is a matter for the Federal court.

I believe it is plain from the language on 139 to 141 that it is a Federal matter. But if you move to an interpretation of what is medical malpractice or a breach of duty by a doctor on what is a medically reviewable decision, then that is a matter which goes to the State courts. And this legislation does not continue the preemption of existing law.

If I might have the attention of the Senator from North Carolina, Madam President, this is an issue which my distinguished colleague from North Carolina and I have been discussing for several days. And this morning in my hideaway we discussed the complications, at least as I saw them, on having the provisions of the pending bill which deal with this complex dichotomy of an interpretation of contract coverage, which is set forth at line 24, 25 on page 140 over to lines 1 and 2 on 141, which comment regarding an item of service covered under the terms and conditions of the plan for coverage which comes under the category of availability for Federal civil remedies. Then if you move over to a medically reviewable decision on medical malpractice, there is the difference.

Is my interpretation correct that the legislation provides for cause of action in different courts, No. 1? It is the coverage of the contract, or what the courts have called quality malpractice and what the courts have called quality?

Mr. EDWARDS. If the Senator would repeat the question, it is difficult for me to hear.

Mr. SPECTER. I would be glad to repeat the question. As the Senator and I are in agreement, with is, how is it going to work? I characterized it, while the Senator was off the floor, as a procedural quagmire. If you have a case—and I cited a couple of them—where a child is born, and the mother has an HMO which encourages release from the hospital within 12 hours, and the child, unfortunately, dies—and I cited a specific case—and then you have a series of claims which were brought by the plaintiff and one of the claims involves interpretation of the contract, is that care covered by the contract?

Then if there are other claims for negligence on the part of the doctor or hospital, that would then fall under the amendment of the Senator from North Carolina under State court jurisdiction.

I cited another case where you had a woman who was suicidal, she was released from the hospital, the doctor was to put her on the ground that it wasn't covered. That went from
the Federal court. They dealt with the exclusive preemption under 502. But the aspect of “quality of care is a State court action. You have perpetuated that.

It is very difficult, obviously, to move totally away from Federal jurisdiction under ERISA on the interpretation of contract because there is so much law on the subject. I know my colleague will agree with me on that generalization.

What happens when you have the suicide? The mother of the infant is released from the hospital within 24 hours, and the claims are made. They are essentially the same claims. They are claiming that they are covered under the contract. They are claiming personal injuries, loss of earning potential, or for the woman who has committed suicide, loss of earnings, loss of consortium, the whole range.

Having litigated some of these cases, you more recently than I. But the essentiality of going to be the same: Personal injuries for both the claim for coverage and “quantity of care” as opposed to the claim for “quality of care” or malpractice.

So how is it going to be resolved with two separate courts, Federal court having jurisdiction over “quantity,” and State court having jurisdiction over “quality?”

Mr. EDWARDS. I think the PRESIDING OFFICER. The Chair reminds Members to address each other in the third person and to address the questions through the Chair.

Mr. SPECTER. Nunc pro tunc.

Mr. EDWARDS. I would answer the Senator's question by saying that under the examples given, if I understood them correctly, most of those examples would involve interpretation of contract language in the context of a medically reviewable factor—"whether an item or service is covered under the terms and conditions of the plan or coverage" and other aspects of the same set of facts are covered under medically reviewable factors.

Mr. GREGG. Madam President, will the Senator yield for a question?

Mr. SPECTER. I would be glad to yield as soon as I get this answer.

Mr. GREGG. It is just a technical question. The answer might be better if he has time to think about it.

Mr. SPECTER. Well, it is too late now to retain the continuity without yielding, so I do yield.

Mr. GREGG. I think the Senator and apologize for the continuation. I think building the record on this issue is very important.

We are trying to get a sense of the situation, so we can tell our membership what they are going to be doing concerned with. After your amendment is completed, we will have three votes lined up. I wonder if we could agree that we would begin the vote on those amendments at sometime around 6:45.

Mr. SPECTER. Madam President, I am not able to specify when because the Senator from North Carolina and I are in the midst of what I consider to be an important colloquy. But I will try to keep it as brief as possible.

Mr. GREGG. I thank the Senator.

Mr. SPECTER. The question, Madam President, that I ask the distinguished Senator from North Carolina is, in taking his conclusion that there are some cases which would involve contract interpretation, and the same case would involve malpractice determination, what do you do when the contract interpretation has jurisdiction in the Federal court and the medical malpractice has jurisdiction in the State court?

Mr. EDWARDS. Madam President, I would say, in answering my colleague's question, that in fact I am having difficulty imagining a case right now. The vast majority of cases similar to what we have just been discussing would fall within the category of a contract interpretation involving a medically reviewable factor. So I think, at least of all the examples that occur to me as I stand here, those cases would all end up in State court.

As the Senator and I have spoken about on a number of occasions, he has a concern—and I understand it—about the possibility of there being some confusion about which cases go to State court and which cases go to Federal court. We think we have defined that exclusive preemption under 502. But the possibility of there being some confusion about which cases go to State court and which cases go to Federal court, we think we have defined that exclusive preemption under 502.

Mr. SPECTER. Madam President, I agree completely with my colleague from North Carolina that when HMOs engage in the practice of medicine, they ought to be treated like physicians.

But coming back to the distinction in the Edwards bill, which does have a provision on coverage as distinguished from medically reviewable decisions, there are two thoughts which occur to me. You have a whole body of case law—dozens of cases—which have wrestled with factual situations on coverage, whether a plan covered the specific item: The infant in the hospital for 24 hours; or the woman who was suicidal, whether the plan covered further hospitalization for her. And then those cases also involved a question on medical malpractice, on “quality.”

So it seems to me it is very hard for my colleague from North Carolina to argue that it is not a commonplace occurrence to have specific cases arise where under his bill they would go to different courts. And then the express language of the Edwards bill has a delineation between medically reviewable decisions on malpractice and a category—"whether an item or service is covered under the terms and conditions of the plan or coverage."

So I would direct perhaps only two more questions to my colleague from North Carolina—and I say perhaps.

The first question is—able to address the question through the Chair—isn't it conclusive where the Edwards bill has language which distinguishes "whether an item or service is covered under the terms and conditions of the plan or coverage, as distinguished from medically reviewable decisions, that the Edwards bill contemplates these two categories, which under the Edwards bill are going to go to two different courts?"
Mr. EDWARDS. Again, if I correctly understand the Senator's question—
Mr. SPECTER. I can understand the difficulty. Madam President, when people are whispering to him all the time. That is why I keep my people off the floor.
Mr. EDWARDS. I am trying very hard to listen to the Senator.
Madam President, if I may respond to the Senator's question, the answer to the question is: I really think there is a fundamental question that the Senator and I may have some disagreement about, which is contract interpretations that involve medically reviewable facts under our legislation go to State court. I believe that all of the examples the Senator has mentioned and all the examples I can think of would fall in that category.
Specifically as related to his concern about the possibility of there being two separate courts with jurisdiction, I think, in fact, that is not only highly unlikely, but I can't think of a fact situation, as I stand here now, that would meet that criteria.
What we have done is to have a principle, and we have designed this bill around that principle. The Senator knows very well that this is the principle that was discussed in the Pegram case, a U.S. Supreme Court case, principle supported by the State attorneys general, the American Bar Association, this was a situation. It is a concept that makes sense in this context.
No legislation is perfect. We certainly can't eliminate the possibility that there may be in a hypothetical case some joint jurisdiction, but I can't think of such an example.
Mr. SPECTER. Madam President, I will direct this question to my colleague from North Carolina: How do you account for the many, many cases which we have litigated and distinguished between contract coverage, where really the language in the Edwards bill "whether an item for service is covered under the terms and conditions of the plan," and a medically reviewable decision, where so many courts on so many cases labored with those distinctions, if, in fact, there aren't many cases where they are going to end up in different courts under the Edwards bill?
Mr. EDWARDS. Madam President, if I may respond to the Senator's question briefly, I believe it is because we have created a presumption that if the contract interpretation involves a medically reviewable fact, which is going to be the majority of cases—all the cases I can think of, as I stand here—those cases go to State court.
Those are the kinds of cases to which I believe the Senator is referring. I don't think the problem the Senator is addressing is one that is likely to occur in real life. We have specifically dealt with the issue of when there is a question, if it involves a medically reviewable fact, those cases go to State court.
Mr. SPECTER. Madam President, if it is unlikely, even with the brilliance and conceptual imagination of the Senator, or the Senator's question—the Senator can't think of one—to occur in real life, why put this jurisdictional provision in the bill?
Mr. EDWARDS. Because there are two separate categories, if I may answer the Senator's question. There are two potential causes of action. If it involves any issue relating to medical care, specific medical fact, those cases go to State court. We treat the HMOs just as the doctor because they are engaged in the practice of medicine. If, on the other hand, the issue is one of were they covered for 60 days as the contract provided, do they meet some other specific contractual requirement, those are purely contractual issues that have been decided in Federal court for many years under ERISA. So we left those cases where they have traditionally been decided, which I think is the appropriate place to leave them.
Mr. SPECTER. Madam President, if you do have those contract decisions, isn't it entirely possible that there may be a factual situation arise where there is a matter of malpractice or a medically reviewable decision involved in the same occurrence?
Mr. EDWARDS. I would answer my colleague's question exactly the way I have before, which is, absent a presumption in our bill that if there is an involvement of a medically reviewable fact, I think the Senator's concern would be one that I would share. But we have dealt with that issue by specifically saying where the contract interpretation involves a medically reviewable fact, those cases go to State court. Those, in my experience and in my judgment, I believe will be the same cases as the Senator is describing as cases. I think he used the term, of medical malpractice.
Mr. SPECTER. Madam President, as they say in Oklahoma, we have gone about as far as we can go on this colloquy. I would advise the managers of the bill that I will be prepared to conclude my argument by 6:45.
Mr. SPECTER. Madam President, if you do have those contract decisions, isn't it entirely possible that there may be a factual situation arise where there is a matter of malpractice or a medically reviewable decision involved in the same occurrence?
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Mr. SPECTER. Madam President, if you do have those contract decisions, isn't it entirely possible that there may be a factual situation arise where there is a matter of malpractice or a medically reviewable decision involved in the same occurrence?
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come under Federal jurisdiction—such as the mother's stay covered for more than 21 hours, the suicidal woman's coverage extended for hospitalization under that circumstance—then a combination of failure to have a plan coverage and also medical malpractice. And you have both claims brought.

And under the McCain-Kennedy-Edwards bill, it is plain that those two claims would be brought in separate courts beyond any question. It is not a matter of what the distinguished Senator can imagine. You have case after case which have had these interpretations, contract interpretation and “quality of care,” and that goes to the Federal court. And then you have “quality of care,” and that goes to the State court.

I am not unaware of the realities of votes in this Chamber where a coalition has been formed, and there is a mindset. But I do hope that the managers of this bill will revisit this situation after this vote and when the bill goes to conference because having both these courts liable is going to double the burden on plaintiffs who are injured—to make a contract interpretation claim in the Federal court and to go to the State court to make a medical malpractice claim—and it is going to require double expenses by the HMOs, by the doctors, and by the hospitals—although you might have the doctors and hospitals eliminated from the Federal litigation, but the HMOs will certainly be there; and that is highly undesirable.

I have a grave concern about the speed of passage of this bill. Now, it is true we have been considering the Patients’ Bill of Rights for a long time—many years. Too long. But this bill has come, it is without the benefit of committee action, without the benefit of a markup; and what has been is sort of a moving target markup of this bill on the floor by the committee of the whole, as we have gone through many amendments. But it simply cannot be denied that there are two sections of this bill, one conferring Federal jurisdiction and one conferring State jurisdiction, and the same factual situation would raise questions under both court systems, and this bill would require litigation in two courts. That is very wasteful and very confusing. To call it a procedural quagmire is not an overstatement. The answer is fundamental, and that is to provide for exclusive Federal court jurisdiction, which I have in this legislation. You might argue that it could go to the State court and that would be an improvement rather than have both State and Federal courts. But it is very hard to move exclusively to the State court to extend the longevity of law built up under ERISA as to what is a plan’s coverage. So given the fact that you are going to inevitably end up in the Federal court, the Federal court ought to be exclusive jurisdiction. And as the amendment provides, the damages will be determined by State law. No two Federal caps, but whatever State caps there were would be in effect.

I see my colleague from Illinois on the floor. He commented to me that he agreed with the provision that there ought to be unitary jurisdiction. But I thought it ought to be in the State court. I will yield to the Senator from Illinois if he cares to use the limited time remaining.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. FITZGERALD. Madam President, I did want to, in part, agree with my colleague from Pennsylvania. I think he has identified an important problem that exists in the underlying bill. I have long favored creating liabil-

ity for HMOs that harm someone because of their negligence. Right now, HMOs are protected. They are immune from liability, and that is a protection that almost no other individual or corporation has in this country, and I don’t think it is defensible.

For the last 2 years, I have been voting regularly to make HMOs liable where they have been negligent. But I do think we have a problem in this bill in that we create State court tort liabil-

ity by repealing the ERISA immunity in one part of the bill. That is on page 157, I believe. But then, at the same time, we create also tort liability, as well as more contract liability, and there already is contract liability under ERISA in Federal court.

The problem I see is that there are tort causes of action authorized in this bill both in State court and in Federal court. I have always thought the playing field was tilted in favor of HMOs, and that playing field needs to be leveled. But I am concerned now that if this effect in the underlying bill is not remedied, the playing field will be tilted in the opposite direction.

The PRESIDING OFFICER. The hour of 6:45 having arrived, under the previous order, the Senator from Maine is to be recognized.

AMENDMENT NO. 831, AS MODIFIED

Ms. SNOWE. Madam President, I ask unanimous consent to modify the amendment that has been offered by Senator DeWINE, Senator LINCOLN, and Senator NELSON and send a modification to the desk.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered. The amendment is so modified.

The amendment (No. 834), as modified, is as follows:

(Purpose: To make technical corrections concerning the application of Federal causes of action to certain plans)

On page 2 of the amendment, between lines 9 and 10, insert the following:

“On page 144, lines 7 and 8, strike ‘or under part 6 or 7’.”

On page 3 of the amendment, strike line 14 and all that follows through line 21 and insert the following:

“(ii) DEFINITION.—A group health plan described in this clause is—

(I) a group health plan that is self-insured and self-administered by an employer (including an employee of such an employer acting within the scope of employment); or

(II) a multiemployer plan as defined in section 3(37)(A) (including an employee of a contributing employer or of the plan, or a beneficiary of the plan, acting within the scope of employment or fiduciary responsibility) that is self-insured and self-administered.

On page 11 of the amendment, line 16, insert after the period the following: “The provisions of this paragraph shall not apply in the case of a designated decisionmaker that is a group health plan, plan sponsor, or health insurance issuer and that is regulated under Federal law or a State financial solvency law.”

Ms. SNOWE. Madam President, it is modified in the following way. First of all, the question was raised about the original intent of the amendment in regard to the self-insured, self-administered plans. Specifically, in regard to contractual dispute, it will only exempt from liability employer and union plans that are self-insured and self-regulated, again applying symmetry to all of the plans regarding self-insured and self-administered, so we do not make any exceptions. So we address that by modifying it to ensure that both employer and union plans are consistent with the legislation.

Secondly, because insurance plans are already regulated at State and Federal level with regard to assets and other issues, we assure that these regulated plans are not subject to a new Federal solvency plan to qualify as a designated decisionmaker. As a result, the solvency standard in this amendment will apply to pre-existing non-health insurance designated decisionmakers.

Finally, we also make a technical correction in the legislation to ensure that the causes of action are not inadvertently opened to other statutes that are already a matter of law. This change reflects the intent of our amendment to prevent the filing of lawsuits in a broader, more undefined number of issues.

I urge adoption of the modification as well as the underlying amendment.

Again, I remind my colleagues that this was an effort to address many of the legitimate issues that were raised regarding employer liability. It was a consensus that was drafted along with the counties of Ohio, Senator DeWINE, Senator LINCOLN, and Senator NELSON. I also thank Senator MCCAIN, Senator KENNEDY, Senator EDWARDS, as well as Senator GREGG and Senator FRIST, for working together to make this amendment possible. We thought it essential that we develop precise and clear guidelines in terms of how we establish employer liability but at the same time protecting patients’ rights
with their ability to seek legal redress when there is inappropriate care or denial of care. We think we have developed and crafted the amendment in a way that creates the bright line and the firewall so that we do provide the necessary protection to employers, so that we limit and, in fact, in most instances I think prevent any exposure to liability. They can confer that liability and risk to the designated decisionmakers and therefore they will have that kind of responsibility, protection, and patients will have their ability to be able to sue in those instances where they have been denied care or there has been wrongful injury, personal injury, or even death.

I think it strikes the right balance. The consensus represents the optimum approach to providing the kind of basis for removing an employer’s exposure to litigation when they are not directly participating in medical decisions. We hope this will satisfy the concerns that have been raised by the original legislation. We think we crafted the best approach, borrowing both from the McCain-Edwards-McCain legislation as well as the Breaux-Frist-Jeffords approach.

Again, I urge adoption of this amendment, as modified, and I 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. BAUCUS. Mr. President, I am proud to cosponsor amendment No. 834 with Senator SNOWE and my other colleagues. It addresses an issue important to all of us here—protecting employees from undue liability. This amendment clarifies any confusion about who is responsible for medical decision-making.

Under this amendment, employers who provide health insurance do not make medical decisions anyway—will be able to name a designated decision maker. If they contract with an insurance company, that company is automatically given the status of designated decision maker. The employer doesn’t have to take any further action.

Once designated, this entity will have the authority to make medical decisions. And with this authority, the designated decision maker—not the employer—will have the responsibility for those decisions if they result in harm to the patient.

I believe this amendment serves as an important compromise. It enables employers to feel comfortable offering their employees health benefits. And that’s certainly something we want to encourage. But it also protects patients, and ensures that they receive all the protections provided under the Patient Protection and Affordable Care Act.

Mr. GREGG. Madam President, I understand the Parliamentarian has ruled that I have 5 minutes.

The PRESIDING OFFICER. There is 5 minutes in opposition.

Mr. GREGG. Madam President, unless someone else is seeking that time, I will speak. I congratulate the Senator from Maine and the Senator from Ohio for adjusting this amendment. The changes they made in this amendment are very positive. The amendment moves in the right direction.

However, it must be made clear this amendment targets one narrow aspect of the concerns of this bill, and, in fact, there are still some issues in that aspect. Specifically, employers are going to have a very difficult problem figuring out whether they are a direct participant or whether they fall under the designated decisionmaker safe harbor.

There are issues within this narrow issue that are very significant. The greater issues on the question of liability still remain very viable. It is of serious concern to those of us who look at this as extremely expensive legislation in the sense it will drive up health care costs and result in a lot of people losing their health insurance. Employers will drop the health insurance because of the liability aspects being thrown at employers in this bill and the costs employers simply are not going to bear. They will drop health insurance or reduce the quality of health insurance.

The estimates of CBO are in the range of 3.1 million, and OMB estimates are in the range of 1 million to 4 million people will lose health care. I think it will be literally tens of millions of people who will lose the quality of their health care insurance degraded as their employers start to adjust.

As to this specific amendment, which is a narrow amendment, not an expansive amendment, the movement by the Senator from Ohio is to be congratulated. I thank them for it.

I yield back my time, and I yield the floor.

The PRESIDING OFFICER. Time is yielded back. The question is on agreeing to amendment No. 834, as modified. The yeas and nays have been ordered. The clerk will call the roll.

The bill clerk called the roll.

The result was announced—yeas 96, nays 4, as follows:

{Rollcall Vote No. 205 Leg.}

YEAS—96

Akaka
Allard
Allen
Baucus
Bayh
Bennett
Biden
Bingaman
Bond
Boxer
Breaux
Brownback
Brown
Burns
Byrd
{DeWeese
Dodd
Domenici
Dorgan
Durbin
Edwards
Ensign
Enzi
Feingold
Feinstein
Fitzgerald
Frist
Graham
Gramm
Gregg
Hagel
Harkin
Hatch
Helms
Hutchison
Inhofe
Jeffords
Johnson
Kennedy
Kerry
Kohl
Kyl
Landrieu
Leahy
Levin
Lieberman
Lieberman
Lincoln
Lott
Lugar
McCain
McConnell
McMillan
Miller
Mikulski
Murkowski
Murray
Nelson (FL)
Nelson (NE)
Reed
Reid
Roberts
Rockefeller
Santorum
{Schumer
Sessions
Shelby
Smith (ND)
Smith (OK)
Snowe
Specter
Stabenow
Stevens
Thomas
Thurmond
Torrance
Voinovich
Warner
Wellstone
Wyden
YAY—96

NAYS—4

Grassley
Hollings
Huntsman
Johnson
Kennedy
Kerry
Kohl
Kyl
Landrieu
Leahy
Levin
Lieberman
Lieberman
Lincoln
Lott
Lugar
McCain
McConnell
McMillan
Miller
Mikulski
Murkowski
Murray
Nelson (FL)
Nelson (NE)
Reed
Reid
Roberts
Rockefeller
Santorum
{Schumer
Sessions
Shelby
Smith (ND)
Smith (OK)
Snowe
Specter
Stabenow
Stevens
Thomas
Thurmond
Torrance
Voinovich
Warner
Wellstone
Wyden

The amendment (No. 834), as modified, was agreed to.

Mr. GREGG. Madam President, I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER (Ms. STABENOW). There are now 2 minutes equally divided on the Enzi amendment.

The Senator from Wyoming is recognized.

AMENDMENT NO. 840

Mr. ENZI. Madam President, under the amendment we just agreed to, we made some progress on handling liability. But there is a group of businesses that were left out. You will never hear me in this Chamber talk about big businesses. I always talk about the small ones. None of these is headquartered in Wyoming. But I am compelled to put in an amendment that will take care of a major problem which will take care of health care at the level they know it for 6 million people in the U.S. who work for the big, self-insured, self-administered companies, such as Hewlett-Packard, Caterpillar, Wal-Mart, and Pitney Bowes.

This provides an option to allow one of two ways of providing insurance to their people so individuals can get the right to sue if they want that right or they can stay with the plan which they presently get all the benefits from without any difficulty. This provides that option for them.

This is providing an option so that the company can avoid liability by providing a liability option for their people.

I ask for your support on this amendment to clear up what the people in your State need.

I also believe it is my right to divide the amendment on page 3, line 12.

The PRESIDING OFFICER. The amendment is so divided.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, let me mention what this amendment is all about.

If an employer gives options to any employee, it can offer a program that
The motion was agreed to.

Mr. KENNEDY. Madam President, I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 840 DIVISION II WITHDRAWN

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Madam President, I ask unanimous consent to withdraw division II of the amendment.

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

The majority leader.

Mr. DASCHLE. Madam President, I announce to our colleagues that this will be the last vote of the evening. We will begin voting tomorrow morning at 9 o'clock on a series of votes on amendments that will be offered this evening. There is one more vote, but after that there will be no more votes.

AMENDMENT NO. 844

The PRESIDING OFFICER. There are 2 minutes now evenly divided on the Specter amendment.

Who yields time? Who seeks time?

The Senator from Pennsylvania.

Mr. SPECTER. Madam President, I announce to our colleagues that this will be the last vote of the evening. We will begin voting tomorrow morning at 9 o'clock on a series of votes on amendments that will be offered this evening. There is one more vote, but after that there will be no more votes.

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Mr. SPECTER. Madam President, I announce to our colleagues that this will be the last vote of the evening. We will begin voting tomorrow morning at 9 o'clock on a series of votes on amendments that will be offered this evening. There is one more vote, but after that there will be no more votes.
The amendment (No. 833), as modified, for consideration of the amendment until we get an agreement on that. There appears to be a sufficient second-degree amendment until we see the amendments, but we are going to operate on a good faith intention at this time to exercise those considerations any or all of the following factors:

- The experience, reputation, and ability of the attorney.
- The undesirability of the cause.
- The nature and length of the attorney's professional relationship with the client.
- The amounts recovered and attorneys' fees awarded in similar cases.

The amendment (No. 833), as modified, is as follows:

(1) LIMITATION ON ATTORNEYS' FEES.—

(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrangement, agreement, or contract regarding an attorney's fee, the amount of an attorney's contingency fee allowable for a cause of action brought pursuant to this subsection shall not exceed 1⁄3 of the total amount of the plaintiff's recovery (not including the reimbursement of actual out-of-pocket expenses of the attorney).

(B) DETERMINATION BY COURT.—The last resort in the district court in which the action was pending upon the final disposition, including all appeals, of the action may review the attorney's fee to ensure that the fee is a reasonable one. In determining whether a fee is reasonable, the court may use the reasonableness factors set forth in section 502(n)(11)(C).

(C) EQUITABLE DISCRETION.—A court in its discretion may decrease the amount of an attorney's fee determined under this paragraph as equity and the interests of justice may require.

(D) NO PREEMPTION OF STRICTER STATE LAW.—Subparagraph (A) shall not apply with respect to a cause of action under paragraph (1) that is brought in a State that has a more restrictive law with respect to the amount of an attorney's contingency fee that may be incurred for the representation of a participant or beneficiary (or the estate of such participant or beneficiary) who brings such a cause of action than the limitation on such fee under subparagraph (A).

Mr. WARNER. I ask for the yeas and nays on the amendment, as modified. The PRESIDING OFFICER. Is there a sufficient second? There appears to be a sufficient second.
The PRESIDING OFFICER. The clerk will report.

The legislation as read as follows:

The Secretary from Ohio [Mr. DEWINE] proposes an amendment numbered 422.

Mr. DEWINE. 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 amendment is as follows:

On page 171, between lines 14 and 15, insert the following:

**SEC. 303. LIMITATION ON CERTAIN CLASS ACTIONS.**

(a) ERISA.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 302, is further amended by adding at the end the following:

"(o) LIMITATION ON CLASS ACTION LITIGATION.—

"(1) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with such plan, as class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

"(2) EFFECTIVE DATE.—This subsection shall apply to all civil actions that are filed on or after January 1, 2002.

(b) RICO.—Section 1964(c) of title 18, United States Code, is amended—

(1) by inserting "(1)" after the subsection designation; and

(2) by inserting at the end the following:

"(2)(A) No private action may be brought under this subsection, or against any violation of section 1962, where the action seeks relief concerning, established, administered, or otherwise operated a group health plan, or health insurance coverage in connection with a group health plan. Any such action shall only be brought under the Employee Retirement Income Security Act of 1974. In this paragraph, the terms 'group health plan' and 'health insurance issuer' shall have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

"(B) Subparagraph (A) shall apply to private civil actions that are filed on or after January 1, 2002.

Mr. DEWINE. Mr. President, I allowed the clerk to read because I wanted my colleagues to hear the essence of the amendment. It is a very simple amendment.

My amendment in a very rational way separates class actions suits that could be filed as a result of this bill. The goal of the patient protection legislation under consideration, both the McCain-Kennedy bill and the Frist-Breaux-Jefords bill, is, of course, to protect patients. We cannot be unmindful of the cost. Obviously, we have to be concerned about the cost, and we have to worry if any parts of this bill do in fact drive up the cost because ultimately this will impact how many employers do in fact offer health insurance. It is something with which we have to be concerned.

I believe my amendment offers a very simple way to curtail some of these increased costs. The problem is that the underlying bill will increase the cost of health care because the bill currently contains no language to limit the scope of class action lawsuits. This very possibility could lead to increases in the filing of onerous, burdensome, costly class action suits.

My amendment ensures that class action lawsuits are filed in a very responsible way. I think my colleagues would agree that class actions can be very effective and can be efficient and can be a valuable tool to achieve justice.

As we also know, unfortunately, these suits sometimes are subject to abuse. That is why I believe we need to limit the target of these class actions. That is what our amendment does.

The reality is that within every company there exists unique relationships between the company, the employees, and the health care plans. Because of that, it is impossible to compare different companies that happen to offer similar health care plans. The fact is that every company negotiates every contract differently. There may be similarities. Every situation is, obviously, different.

Now, at the same time, employees within the same company, with the same health care plan, who suffer the same way as a result of being denied entitled benefits, should have the right to band together to form a class and to file suit. That is why our amendment would recognize class actions within one company against one plan.

Our language essentially says this: One employer, one health care plan, one class action suit. That is why our amendment works if adopted. Suppose Ford Motor Company offers its employees the hypothetical Aetna Health Care Plan A. General Motors has this plan. Assume, also, that Chrysler has the same plan. Now, if employees of Ford Motors band together in a class action against Aetna because they all believe they suffered harm because of the same denial in entitled benefits, they can go ahead under our amendment and do that. Similarly, if employees at GM or Chrysler also believe they suffered a result of denial of the same benefits, GM and Chrysler employees can file their own class actions against Aetna. But employees at Ford, GM, and Chrysler can’t join together in one suit against the health care provider.

This means class actions would be limited to employees within one company against one health care plan. Ultimately, we need this because abuse of class action lawsuits is not a road to assuring access to quality health care. If we want the bill before the Senate not to add unnecessary litigation and costs, I encourage my colleagues to adopt this amendment.

I reserve the remainder of my time. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is not a sufficient second.

Mr. MCCAIN. I repeat the request for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is not a sufficient second.

Mr. REID. If the Senator from Ohio wishes the yeas and nays, we would be happy to give those to him with the agreement that we will vote tomorrow.

Mr. DEWINE. I renew my request for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. Are Senators prepared to yield back time on the amendment?

Mr. DEWINE. I believe we have an understanding to reserve several minutes tomorrow morning for summation.

Mr. EDWARDS. Mr. President, there are a couple of issues here and I have just seen this amendment—a couple of issues raised immediately.

One, the entire Patients’ Bill of Rights is about treating everybody the same. This, of course, carves out a special treatment for HMOs on the issue of accountability.

Second, this amendment makes a special exception under RICO for HMOs and under rules of procedure.

Third, it has been some time since I looked at the rules, I confess, but I seem to recall under class action law, rule 23 of the Federal Rules of Civil Procedure, there is a numerosity requirement, that you have to have a sufficient number of employees involved to trigger the class action requirement, and I am not sure under the language the Senator has drafted that would be possible because I believe, if I understand the Senator’s amendment correctly, he has limited it to one employer for purposes of class actions.

Mr. DEWINE. Obviously, the amendment does not change what the rules say as far as the number of people required for a class action. The Senator...
Mr. DeWINE. I yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina has 10 minutes 48 seconds.

Mr. DeWINE. I wonder if I may inquire about the fundamentals of the RICO statute. An amendment I offered yesterday morning asked whether the RICO statute is something that would violate that principle of which I would want my colleagues to be aware.

I yield the floor.

The PRESIDING OFFICER. Do the Senators yield back time?

Mr. DeWINE. I inquire, how much time remains?

The PRESIDING OFFICER. The Senator has 2 minutes remaining.

Mr. DeWINE. I will respond briefly to the comments of my colleague, the one issue he did not address, at least in his last answer—he may have discussed it earlier—is the issue of civil RICO. I believe I am correct in saying there are some State medical societies that have pending actions against them, civil RICO actions against HMOs, where they believe, obviously, the requirements of that statute have been met and there have been improper and illegal activities by the HMOs. Particularly as we go forward, if any State medical society believes those problems continue to exist, they may want to avail themselves of the civil RICO statute, a law that exists in part for that purpose.

Again, we are trying to be careful to be aware of the numerosity requirement that means a class has to be of sufficient size to be able to be certified as a class action, and I am not certain, if you limit the actions to one employer, that you don’t effectively eliminate the possibility of a class action because that requirement cannot be met.

I confess to the Senator, that is from memory, and I will have to go back and look to be certain.

I have concerns about the fundamental question that the principle of this legislation is that we treat HMOs, for accountability purposes, as everyone else. And the notion of doing something specifically to protect them from class actions and to limit class actions and to limit the RICO statute is something that would violate that principle of which I would want my colleagues to be aware.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. DeWINE. Just to respond to my colleague—and I do appreciate his comments about RICO—again it is a balancing question each Member is going to have to decide.

Just to clarify things, I want to make it clear, the way this is drafted, we do not affect any pending issues, so those suits would not in any way be affected.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. DeWINE. I wonder if I may inquire whether or not there was an unanimous consent as far as the vote tomorrow morning at any time?

The PRESIDING OFFICER. There was no consent.

The Senator from Nevada.

Mr. Reid. Senator Daschle has indicated we are going to come in at 9 o’clock in the morning and start voting. The first vote will be 15 minutes, and if there are other votes stacked, which I am confident there will be, there will be 10-minute votes on whatever is debated tonight. There is 10 minutes for the subsequent votes. There would be 4 minutes between each vote to debate.

Mr. DeWINE. Would that include the first vote?

Mr. Reid. Yes.

Mr. DeWINE. So we would have in the morning then 4 minutes evenly divided prior to the first vote?

Mr. Reid. That is right.
to underwrite the costs of customs commercial operations. But today in this bill, the fees are not being used for customs operation costs; instead, they are being used to offset the costs of the Patients’ Bill of Rights to the tune of $7 billion. I think this is unacceptable and violates the comity that one committee ought to have towards the other.

It is unacceptable because when you have constituents who pay customs user fees for the purpose of having an efficient and effective operation of the Customs Service, so you can enter this country in an expeditious way, for those fees not to be used for what they were intended—for expedited entry to the country, to police illegal entry to the country, to police illegal drugs coming into the country, generally to make the customs agency’s personnel more efficient and better able to do their job so the United States can be a sovereign nation protecting its borders the way it should—if these fees are extended, and I want to emphasize the word “if,” they should be extended in a thoughtful way, not as some budget trick to make the costs of this bill fit within the confines of the Federal budget.

I am not the only one who thinks so. I have received numerous letters from companies, from associations that are very concerned about this—Liz Claiborne, Inc., the National Association of Foreign Trade Zones, the Joint Industry Group, the National Retail Federation, the American Electronics Association, and also a memo from the U.S. Customs Service. They are all raising concerns because these are folks who pay this customs user fee, a fee that is meant to pay for bringing things into the country. They believe since the Customs Service is so outdated, so slow moving in an expanding way, this revenue ought to be used for the improvements in the customs operation that were anticipated when these fees were put in place. I ask unanimous consent these letters and memos be printed in the RECORD.

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

LIZ CLAIBORNE INC.,
Hon. CHARLES E. GRASSLEY,
U.S. Senate, Hart Senate Office Building,
Washington, DC.

DEAR SENATOR GRASSLEY. We write in opposition to a provision in the Patients’ Bill of Rights (S. 1052) that would extend the merchandise processing fee, or “mpf,” for eight additional years. This is a trade-related measure, a user fee levied against importers like ourselves, that has no place in this legislation. We ask you to support efforts to delete the provision entirely.

First, it is important to underscore that neither S. 1052 nor the mpf are necessary at this time. The $7 billion in increased fee revenue annually is a non-trade-related measure that stands to further delay and deter the efficient functioning of the U.S. Customs Service, which would be detrimental to the nation’s competitiveness. If the Customs Service is to continue collecting this user fee it MUST directly fund improvements to Customs processing capabilities, which are greatly needed to improve the trade process. Improving Customs’ ability to handle trade will become more critical as the amount of commerce entering the United States is expected to continue its double-digit rate of growth. While Section 502 of S. 1052 does not earmark user fees for health care purposes, it does use the fee as de facto justification for the revenue neutrality of the bill. JIG is greatly concerned that this approach will prevent user fees from being applied to the commercial operations of the U.S. Customs Service for which they are intended.

Use of the fee to offset the revenue impact of S. 1052 could also increase potential for a WTO dispute. In the late 1980’s, a GATT panel found that the user fee was GATT-illegal because it was being collected in amounts exceeding the cost of Customs processing. While the U.S. addressed that problem by placing certain caps on the fee, it was clear from the Panel that such an adjustment of the fee to the cost of Customs commercial operations is of seminal importance to the question of GATT legality. If our trading partners believe Customs user fees are being used to fund health-care related goals, another GATT challenge is virtually certain to surface in the WTO.

Sincerely,
FRANK KELLY,
Vice President, International Trade
Compliance and Government Affairs.
NATIONAL ASSOCIATION
OF FOREIGN-TRADE ZONES,

Hon. CHARLES E. GRASSLEY,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR GRASSLEY. The National Association of Foreign-Trade Zones (NAFTZ) has learned that S. 872, Sec. 602 the “Bipartisan Patient Protection Act” provides for the extension of the Merchandise Processing Fee (MPF) through 2011. Congress established the fee to offset the cost of the commercial operations of the U.S. Customs Service. Not only does the proposed legislation continue the practice of allocating the MPF to the general fund of the U.S. Treasury with no relationship to the purpose of the fee, it completely eliminates the relationship of the fee to the Customs Service. We have serious reservations as to whether this is permissible through the General Agreement on Tariffs and Trade, and the World Trade Organization.

The NAFTZ is not opposed to the imposition of a fee for services rendered. We do believe, however, that any such fee must correlate to a discernible cost associated with the service provided. We are concerned that at a time when Congress is struggling to find the necessary funding to cover the cost of modernizing the Service, that funds already designated by Congress for that purpose are being diverted.

Since the purpose of the MPF, as established by Congress, is to underwrite the commercial operations of the U.S. Customs Service, we are strongly opposed to any extension of the MPF without designating the revenue to that purpose. We respectfully request that you drop the merchandise processing fee extension from S. 872.

Thank you for your attention and consideration of our views. If you have any questions, please feel free to contact me.

Sincerely,
RANDY P. CAMPBELL,
Executive Director.

JOINT INDUSTRY GROUP,
June 20, 2001, Washington, DC.

Hon. JOHN MCCAIN,
U.S. Senate, Russell Senate Office Building,
Washington, DC.

DEAR SENATOR MCCAIN. The Joint Industry Group (JIG) expresses its opposition to a provision in the Bipartisan Patient Protection Act (S. 1052) that would automatically extend the U.S. Customs user fee from 2003 to 2011. The Joint Industry Group represents over $350 billion in trade.

JIG members account for millions of dollars paid yearly in merchandise processing fees (MPF). Every year, Customs collects over $1 billion from companies importing goods into the United States. Additionally, companies are burdened by administrative costs associated with the fee, since Customs imposes complex reporting and accounting requirements on companies in the course of collecting fee payments. All this is occurring at a time when tariffs on products are declining and approaching zero.

The Customs Service is to continue collecting this user fee it MUST directly fund improvements to Customs processing, specifically the Automated Commercial Environment (ACE) and other initiatives that are greatly needed to improve the trade process. Improving Customs’ ability to handle trade will become more critical as the amount of commerce entering the United States is expected to continue its double-digit rate of growth. While Section 502 of S. 1052 does not earmark user fees for health care purposes, it does use the fee as de facto justification for the revenue neutrality of the bill. JIG is greatly concerned that this approach will prevent user fees from being applied to the commercial operations of the U.S. Customs Service for which they are intended.

Use of the fee to offset the revenue impact of S. 1052 could also increase potential for a WTO dispute. In the late 1980’s, a GATT panel found that the user fee was GATT-illegal because it was being collected in amounts exceeding the cost of Customs processing. While the U.S. addressed that problem by placing certain caps on the fee, it was clear from the panel that such an adjustment of the fee to the cost of Customs commercial operations is of seminal importance to the question of GATT legality. If our trading partners believe Customs user fees are being used to fund health-care related goals, another GATT challenge is virtually certain to surface in the WTO.

Sincerely,
EXECUTIVE DIRECTOR.

CONGRESSIONAL RECORD—SENATE
S. 1052 violates the WTO provisions to which the United States is a party. We therefore urge that the user fee extender be removed from S. 1052. We need the opportunity to debate the merits of this fee when it comes up for renewal in 2003. If you have any questions about our views on this issue or wish to discuss the matter further, please contact Alan Atkinson at (202) 466-5490. Thank you for your consideration.

Sincerely,

RONALD SCHOOF, Chairman, Joint Industry Group.


Hon. Chuck Grassley, Ranking Member, U.S. Senate Committee on Finance, Dirksen Bldg., Washington, DC.

DEAR SENATOR GRASSLEY, The National Retail Federation (NRF) was surprised to learn that section 502 of the Bipartisan Patient Protection Act (S. 1052) contains an eight-year extension of the Customs Merchandise Processing Fee (MPF). The MPF, which is an administrative fee levied on imports into the United States, through which U.S. retailers and other importers pay hundreds of millions of dollars per year.

NRF and the U.S. retail industry object most strongly to inclusion of this provision and, for the following reasons, we urge that the provision be stricken from the bill.

The Senate Finance Committee, which has jurisdiction over the MPF and other customs issues, was not consulted about this provision in S. 1052 and has had no opportunity to consider the merits of extending the fee as currently structured.

The MPF was created to offset the administrative cost of Customs’ commercial operations, and any attempt to use it for other purposes, as this bill would do, is against the rules of the World Trade Organization.

The Finance and Ways and Means Committees have been working for some time with Customs and the importing community on renewal of the MPF to reassure the industry that the fee will be used for its intended function—for commercial operations, including customs modernization funding.

In S. 1052, the reauthorization of the MPF has been slipped into a health bill without the approval of the Committee of jurisdiction or the knowledge of those in the private sector that will be most directly affected as a result. At the same time, we are struggling to provide Customs Service with sufficient funds for a new computer system to allow Customs to modernize its operations and protect our nation’s borders. If this provision in S. 1052 is allowed to stand, it will be impossible for the Senate Finance Committee to restructure the MPF program in the way it was intended—to finance the costs of Customs’ operations. Accordingly, we ask for your help in insisting on the removal of this provision when S. 1052 comes to the full Senate for consideration.

The National Retail Federation (NRF) is the world’s largest retail trade association with representation comprising all formats and channels of distribution including department, specialty, discount, catalog, Internet and independent stores. NRF members range in industry that encompasses more than 1.4 million U.S. retail establishments, employs more than 20 million people—about 1 in 5 American workers—and registers 2000 sales of $1 trillion. NRF’s international members operate stores in more than 50 nations. In its role as the retail industry’s umbrella group, NRF also represents 22 national and 50 state associations representing retailers abroad.

Sincerely,

STEVE PFISTER, Senior Vice President, Government Relations.


Hon. Chuck Grassley, Hart Senate Office Building, Washington, DC.

DEAR SENATOR GRASSLEY, AEA, the nation’s largest high-tech trade association, is opposed to the provision (section 502) in the Bipartisan Patient Protection Act (S. 1052) that would extend the application of the U.S. Customs user fee from September 30, 2003, to September 30, 2011.

The U.S. importing community currently has full expectation that this import tax will expire as scheduled in 2003. As the leading U.S. importing sector, the U.S. high-tech sector would be particularly impacted by such an extension. To the extent that U.S. companies will already pay tens of millions of dollars annually in customs user fees, in addition, there are additional administrative costs associated with the fee, since customs authorities impose complex reporting and accounting requirements on importers in the course of collecting the user fee payments. An unexpected, eight-year extension of the user fee, with its associated administrative costs, would be an unwelcome and unnecessary additional cost burden on our industry.

While section 502 of S. 1052 does not earmark user fees for health care purposes, it does use the fee as de facto justification for the revenue neutrality of the bill. We believe this provision introduces the potential that the U.S. Customs user fee will again be found contrary to U.S. international obligations under the WTO. In the late 1980’s, a GATT panel found that the user fee was GATT-illegal because it was being collected in amounts exceeding the cost of customs services rendered. While some U.S. states addressed that problem by placing certain caps on the fee, it was clear from the panel finding that linkage of the fee to the cost of customs services is of seminal importance to the question of GATT legality. If our trading partners believe customs user fees are being used to achieve health care-related goals, we believe the GATT challenge could well surface in the WTO.

For the reasons stated, AEA urges you to remove the customs user fee extender from S. 1052. This Patient Protection Act is an inappropriate forum for any consideration of extending the customs user fee. If you have any questions about our views on this issue or wish to discuss them further, please contact me at 202-682-4242.

Sincerely,

TIM BENNETT, Senior Vice President flowing of Affairs.

[From the Executive Office of the President, Office of Management and Budget, June 21, 2001]

STATEMENT OF ADMINISTRATION POLICY

THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.

S. 1052—Bipartisan Patient Protection Act.

agenda.

Policy

S. 1052—Bipartisan Patient Protection Act. (Sens. McCaskill (D) MO, En- wards (D) NC) The President strongly sup- ports passage of a patients’ bill of rights this year and has been working with members of both parties on an approach. The President has asked of the Ad- ministration to forge a compromise. Con- gress has been divided on this issue for far too long at the expense of patients and their families. The President believes it is of seminal importance to the question of GATT legality. If our trading partners believe customs user fees are being used to achieve health care-related goals, we believe the GATT challenge could well surface in the WTO.

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bill unless significant changes are made to address several concerns. In particular, the serious flaws in S. 1052 include:

—8. 1052 circumvents the independent medical review process in favor of litigation. The President believes that patients should be given a direct and immediate remedy should be the last resort. Patients should exhaust the medical review process first, allowing doctors, not trial lawyers, to make decisions about medical care.

—8. 1052 jeopardizes health care coverage for workers and their families by failing to avoid the self-insurance crisis. S. 1052 overrules more than 25 years of Federal law that provides uniformity and certainty for employers who voluntarily offer health care benefits for millions of Americans across the country. The liability provisions of S. 1052 would, for the first time, expose employers and unions to at least 50 different, inconsistent State law standards. The result will inequitably be that employers and unions will be forced to pay for different benefits from State to State, even within a particular State, based on varying precedents set in State courts and leading to inconsistent standards of care for patients. Further, S. 1052 imposes no limitations on State court damages, and it is not clear whether State law caps would apply to the broad, new causes of action in State courts that S. 1052 creates.

S. 1052 would also allow causes of action in Federal court for a violation of any treaty under the plan, creating open-ended and unpredictable lawsuits against employers for administrative errors. These new federal claims of tort are an infringement on the amount of noneconomic damages, creating virtually unrestrained damage awards that are limited only by an excess of $5 million cap on punitive damages.

Moreover, S. 1052 would subject employers and unions to frequent litigation in Federal court for a violation of any treaty under the plan, creating open-ended and unpredictable lawsuits against employers for administrative errors. These new federal claims of tort are an infringement on the amount of noneconomic damages, creating virtually unrestrained damage awards that are limited only by an excess of $5 million cap on punitive damages.

S. 1052 would fail to provide a fair and comprehensive remedy to all patients. The President believes the new Federal law should establish a comprehensive set of rights and remedies for patients. S. 1052 instead encourages costly litigation by providing no effective limitations on frivolous class action suits and allows trial lawyers to go on fishing expeditions to seek remedies under other Federal statutes.

S. 1052 subjects physicians and all health care professionals to greater liability risk. S. 1052 would expand liability for physicians and all health care professionals in State courts well beyond traditional medical malpractice by permitting new, undefined causes of action in State courts for denials of medical care. The plan would expand litigation against physicians and all health professionals will create an opportunity to circumvent State medical malpractice caps that may not apply to these new causes of action.

—Extraneous User Fee Provision. The Administration objects to inclusion in S. 1052 to an unnecessary raising of the Civilian (section 502), which extends for multiple years Customs charges on transportation,

passengers, and merchandise arriving in the country.

PAY-AS-YOU-GO SCORING

S. 1052 would affect direct spending; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB’s preliminary scoring estimate of the bill is under development.

U.S. CUSTOMS SERVICE
Memorandum

From: Acting Commissioner
Subject: Pay-Go Offset for the Patient Bill of Rights
Congress will soon consider passage of the Patient Bill of Rights. The Customs Service offers no opinion of the legislation. However, we have concerns with the bill’s potential impact on future Customs appropriations.

Section 502 of the bill would extend our collection of COBRA fees from 2003 to 2011, but would use the revenue to offset the cost of implementing this new legislation. Although we support extending the collection of COBRA fees, any scoring of the COBRA extension which assumes the Customs Service’s ability to fund or offset Customs activities would likely cause a critical funding shortfall for the Customs Service.

Section 502 of the bill states: Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 5601(j)(3)) is amended by striking “2003 and increasing the fee may not be charged under paragraphs (9) and (10) of such subsection after March 31, 2006”.

The COBRA fees collected by Customs are used here to reimburse Customs appropriations for certain costs, such as overtime compensation, and to offset a portion of the Customs Service Salaries and Expenses Appropriation (S&Ex). As an example, our FY 2001 collections will offset approximately $1 billion or almost 50 percent of Customs appropriation this year. Authorizing a COBRA extension to offset costs for something other than the Customs Service could negatively impact our available funding. Additionally, the Merchandise Processing Fee authorized in the COBRA extension is paid by importers for the processing of merchandise by the Customs Service. Directing the funds collected from this fee for something other than Customs operations could pose GATT interpretation issues.

While Customs supports the extension of the COBRA fees, we also acknowledge that changes are warranted with the manner in which we collect those fees. We intend to review this issue in the near term.

Mr. GRASSLEY. I want to speak specifically to what one company wrote:

"The merchandise processing fee has no place in this debate. The fee will not be viewed on the merits in this proceeding, but is instead being used—cynically—as a "pay-for" for a totally unrelated program."

Obviously, the totally unrelated program is the Patients’ Bill of Rights that is before us.

Our experience today—in other words, how we handle this issue of customs user fees today—will only hurt us in our deliberation of what ought to be. It is no use to us to go around the transportation, to build highways. When people pay Customs fees, they pay those Customs fees for facilitating entry of product into the country and Customs modernization is a very important priority.

My point is that there are important Customs modernization issues that should no longer be ignored. Let’s not have a rush to pay for this Patients’ Bill of Rights today and blind us towards the real public policy questions we have on the Customs Service and their problems tomorrow.

Are you concerned about drugs at our borders? Are you concerned about illegal transshipment of textiles, import restrictions on steel and lumber, and backup of trucks at our borders? If you vote for extending fees, there will be no committee consideration if Customs is using the fees for these or other Congressional priorities.

I would like to tell you that extending these fees will definitely have an impact on the Customs Service and its operations around the borders of our country, even in the interior of the country where we have Customs operations.

I would like to read what the acting Customs Commissioner had to say about this. He wrote on June 20, this year:

Any scoring which would limit in any way the ability to fund or offset Customs activities would likely cause—

And it is highlighted—a critical funding shortfall for the Customs Service.

Experience a critical funding shortfall when you want to get in and out of Chicago with some Customs operations and people are complaining because it takes so long to get it done because of a shortage of personnel and not having the technical equipment that ought to be there to help efficient operation. Then you know that maybe you made a mistake by raising one other issue, and that is it is not at all clear that using Customs user fees to offset revenue is consistent with the World Trade Organization rules.

Think about that. We are making a decision to take $7 billion out of Customs user fees under the jurisdiction of the Senate Finance Committee, and we may be doing this in a way that does not meet our obligation under the World Trade Organization. Under that organization, Customs fees are to be used both to reimburse Customs appropriations, and to offset a portion of the Customs Service.

Mr. GRASSLEY. I want to speak specifically to what one company wrote:

The merchandise processing fee has no place in this debate. The fee will not be viewed on the merits in this proceeding, but is instead being used—cynically—as a "pay-for" for a totally unrelated program.

Obviously, the totally unrelated program is the Patients’ Bill of Rights that is before us.

Our experience today—in other words, how we handle this issue of customs user fees today—will only hurt us in our deliberation of what ought to be. It is no use to us to go around the transportation, to build highways. When people pay Customs fees, they pay those Customs fees for facilitating entry of product into the country and
the policing of that entry of product into the country. A fee levied for a certain purpose ought to be used for that purpose or it might violate the WTO because it should not be a source of general revenue any more than taking money from the gas tax and putting it into the general fund of the United States.

Here is what the Customs Service writes on this issue.

The merchandise processing fee is a fee that is paid by importers for the processing of merchandise by the Customs Service. Dissecting the funds collected from the fee for something other than Customs' operations could pose GATT interpretation issues.

While it is not clear that a WTO case would arise or that a challenge would be successful, it seems to me that this is a warning bell that should certainly be heard.

No Senator should vote against this motion to strike unless they are prepared to face the possibility of a WTO challenge and take responsibility accordingly.

We should strike this provision from the bill. Before blindly supporting section 502, we should have time to consider its broader implications.

I urge my colleagues to support this amendment to strike.

Turning to the other provision of their bill that my amendment strikes, section 503, that would delay payments to Medicare contractors by one day thereby shifting $235 million in Medicare part B spending from fiscal year 2002 to fiscal year 2003 is simply a budget gimmick.

I am troubled by this provision because it comes within the jurisdiction of the Senate Finance Committee and also because we are trying to work to make Medicare a better program, not do things to harm it.

First, I point out to my colleagues that, again, the Finance Committee has jurisdiction, not the Committee on Health, Education, Labor and Pensions. It is the Finance Committee that authorizes and overseas the Medicare Program and the Federal agency that runs it, now known as the Center for Medicare Services.

It is the Finance Committee and not the Health, Education, Labor, and Pensions Committee that is in the best position to know how changes in the Medicare Program, such as this one-day payment delay in section 503 of the bill, that will affect our senior citizens, will affect our health care providers and will affect the integrity of the Medicare trust fund.

With all due respect, when it comes to Medicare and Medicaid and other Federal entitlement programs, it seems terribly ridiculous to ignore the committee that has the very expertise in these programs, meaning the Senate Finance Committee.

The second reason that I am proposing to strike the Medicare payment delay in section 503 of the bill is that the delay itself, which may not seem serious to some, could actually have some consequences for Medicare contractors and providers.

Delaying payments by one day and moving them into the next fiscal year just to finance this bill is fuzzy math, to say the least. But it unfairly subjects the already fragile Medicare Program and its health care contractors to accounting disruptions and to administrative uncertainties.

Medicare providers already have it hard enough just dealing with the Medicare Program in the first place. They are overwhelmed by paperwork, confused by conflicting regulations, and frequently left hearing that “the check is in the mail.”

Can you imagine the Federal Government saying “the check is in the mail” when it comes to timely payments of their reimbursements?

Subjecting those providers to any additional delay, even if just for a short period of time, is simply unfair. We need to make Medicare a better business partner to do business with Medicare.

Think about it. No one wants to do business with late payers, and health care providers are no exception.

Think about it for a minute. No one wants to do business with late payers, and health care providers are no exception. We should not be giving Medicare an additional opportunity to delay for one minute—let alone a longer period of time—their obligations to promptly pay providers.

For the last 3 months, Senator Baucus and I have been working hard to develop a Medicare reform proposal that strengthens and improves the program by adding prescription drug coverage and making the entire benefit package more responsive and accounting to both seniors and providers. We want to send a message to providers that they will be treated fairly and professionally by Medicare.

Unfortunately, the delay provision in section 503 does exactly the opposite. It sends an entirely wrong message and undercuts our bipartisan effort to make Medicare a better business partner for today’s providers.

For these reasons, I cannot support the inclusion of section 503 in this bill. Neither 502 nor 503 belong in this bill. They are both outside the jurisdiction of the Health, Education, Labor and Pensions Committee and a long way away from the subject of this debate, which is patients’ rights. Both sections should be stricken from this bill entirely.

Consequently, I urge my colleagues to support my amendment.

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

Who yields time in opposition?

Mr. KENNEDY. I am glad to yield back the time.

Mr. GREGG. I ask unanimous consent that this amendment and all amendments that have the yeas and nays ordered tonight be stacked for a vote tomorrow morning, with the appropriate time of 2 minutes to each
side, or whatever is agreed to, before each amendment is voted on.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. GREGG. Mr. President, at this time I would like to outline the remainder of the evening, if acceptable to the parties, relative to our side, which would be that Senator SANTORUM would go next with his amendment. He would have 10 minutes; the Senator from California, Mrs. BOXER, would have 10 minutes. Then we would go to Senator NICKLES. He would have 10 minutes; and 10 minutes to whoever is in opposition. Senator BROWNBACK would come next. He would have an hour divided, as is traditional. And Senator ENSIGN would then follow with two amendments, the physician pro bono amendment, and the genetic discrimination testing amendment.

I believe the Democratic membership has all these amendments. I would hope we could also agree there would be no second degrees.

Mr. KENNEDY. The Ensign amendment we have just received. I have no objection to the earlier request. I am sure we will agree with this, but we would like for that, as far as it being locked in in terms of no second-degree amendments, just to have an opportunity to——

Mr. GREGG. I would reserve my request on the second degrees relative to the Ensign amendments but ask unanimous consent that the unanimous consent agreement include that there be no second degrees on DeWine, Grassley, Nickles, Santorum, or Brownback.

The PRESIDING OFFICER. Is there objection?

The Chair hears none, and it is so ordered.

The Senator from Pennsylvania is recognized.

AMENDMENT NO. 814

Mr. SANTORUM. Mr. President, I have amendment No. 814 at the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Pennsylvania [Mr. SANTORUM], for himself, Mr. SMITH of New Hampshire, and Mr. DeWINE, proposes an amendment numbered 814.

Mr. SANTORUM. I ask unanimous consent reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To protect infants who are born alive)

On page 179, after line 14, add the following:

SEC. 8. DEFINITION OF BORN-ALIVE INFANT.

(a) In general.—Chapter 1 of title 1, United States Code, is amended by adding at the end the following:

"8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant.—"

"(a) In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words 'person', 'human being', 'child', and 'individual', shall include every infant member of the species homo sapiens who is born alive at any stage of development.

(b) As used in this section, the term 'born alive', with respect to a member of the species homo sapiens, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who after such expulsion or extraction breathing or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, birth by forceps, or vacuum extraction.

(c) Nothing in this section shall be construed to deny, delay, expand, or contract any legal status or legal right applicable to any member of the species homo sapiens at any point prior to being born alive as defined in this section.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 1 of title 1, United States Code, is amended by adding at the end the following new item:

8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant."

The PRESIDING OFFICER. Under the unanimous consent agreement, the Senator from Pennsylvania is recognized for 10 minutes.

Mr. SANTORUM. Mr. President, this is an amendment that I think really goes to the heart of this bill: Patient protection. This bill is purported to protect infants. What my amendment does is make sure that every living human being is protected by this act as well as all other acts of Congress.

This is a very simple amendment that says—I am quoting from the amendment—

"in determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words ‘person’, ‘human being’, ‘child’, and ‘individual’, shall include every infant member of the species homo sapiens who is born alive at any stage of development.

That is a rather simple amendment. Obviously, I think it is an amendment that should be broadly accepted.

The reason I offer this amendment is really twofold. No. 1 is the concern about how certain little children—little infants—are treated. Particularly those who are born alive after an abortion, an abortion that was not successful in the sense that the child was not killed before the child was delivered outside of the mother's womb.

So what we want to do is make sure those children in particular, as well as others, are treated with the same dignity and are covered by the same laws as all other people in America.

There are, unfortunately, many disturbing examples of how these little children are not treated the same and are not given the proper respect that is required under the laws that we have passed in this Congress.

I am going to use a couple of examples that were given by nurses in congressional testimony.

Last year, we had testimony from Allison Baker, who is a registered nurse, who witnessed three induced abortion survivor incidents. For one of them, she says:

I happened to walk into a "soiled utility room" and saw, lying on the metal counter, a fetus, naked, exposed and breathing, moving its arms and legs. The fetus was visibly alive, and was gasping for breath. I left to find the nurse who was caring for the patient and this fetus. When I asked her about the fetus, she said that she was so busy with the mother that she did not have a chance to wrap and place the [baby] in the warmer, and she asked if I would do that for her. Later I found out that the fetus was 22 weeks old, and had undergone a therapeutic abortion because it had been diagnosed with Down’s Syndrome. I did wrap the fetus and place him in a warmer and for 2½ hours he maintained a heartbeat, and then finally expired.

The second incident involved a 20-week-old fetus with spina bifida who lived for an hour and 40 minutes until she died.

She continued:

The third case occurred when a nurse with whom I was working was taking care of a mother waiting to deliver her 16 week Down’s Syndrome fetus. Again, I walked into the soiled utility room and the fetus was fully exposed, lying on the baby scale. I went to find the nurse who was caring for this mother and fetus, and she asked if I could help her by measuring and weighing the fetus. So I did. The chart indicated that the fetus was 22 weeks old, and had undergone a therapeutic abortion because it had been diagnosed with Down’s Syndrome. I did wrap the fetus and place it in the soiled utility room, the fetus was moving its arms and legs. I then listened for a heartbeat, and found that the fetus was still alive. I wrapped the fetus and in 45 minutes the fetus finally expired.

We have other stories, disturbing stories of cases where children were born alive and basically discarded as trash in soiled utility closets or laying on tables fully exposed at a very tender age.

This is a story from Jill Stanek, another registered nurse:

One night, a nursing co-worker was taking an aborted Down’s Syndrome baby who was born alive to our Soiled Utility Room because her parents did not want to hold him, and she did not have time to hold him. I couldn’t bear the thought of this suffering child lying alone in a Soiled Utility Room, so I cradled and rocked him for the 45 minutes that he lived. He was 21 to 22 weeks old, about ¾ pound, and was about 10 inches long. He was too weak to move and very much expending any energy he had to breathe.

This is the current problem, and this is the reason we are introducing this legislation. Frankly, I have concerns that this may be even more of a problem in the future based on court decisions. The court decision I refer to is
clearly draw the line, if that is called for. I am going to quote two things that should send a chill down the spine of every person when it comes to what the future could have in store for us if we do not pass legislation such as this.

This is what Justice Stevens said in this decision:

The holding [of Roe]—that the word “liberty” in the 14th Amendment includes a woman’s right to make this difficult and extremely personal decision—makes it impossible for me to understand how a State has any legitimate interest in requiring a doctor to follow any procedure other than the one he or she reasonably believes will best protect the woman in her exercise of this constitutional liberty.

For the notion that either of these two equally gruelling [abortion] procedures, if this late-stage gestation is more akin to infanticide than the other, or that the State furthers any legitimate interest by banning one or not the other, is simply irrational.

What that says very clearly is, according to these two Justices, that any procedure that the doctor determines is in the best “health interest of the mother” can be used without question. So if it gives the best way to safely perform this abortion is to deliver a live baby and then subsequently kill it because it is the safest way for the mother’s health to have that done, under this rationale, under this reasoning, that would be legitimate. I think we have to make it very clear that is not legitimate; that after delivering a baby, once the baby is out, however, the mother, it is no longer legitimate to consider that child just a piece of property, discarded of, or mas- sive cells to be disposed of, when it is a living, breathing individual.

Justice Ginsburg’s opinion says the following:

Such an obstacle [to abortion] exists if the State stops a woman from choosing the procedure her doctor “reasonably believes will protect the woman in [the] exercise of [her] constitutional liberty.”

Again, it is an open door to whatever procedure the doctor wants to use, irrespective of the baby, which again leaves the door open certainly for the doctor to say that he or she reasonably believes that the mother’s health will be served if the baby is delivered and then killed at that point. That is the way. This was not the majority opinion, thankfully, of the Court, but it does show that there is a possibility, at least, out there for this kind of ruling within our court systems at the highest level, much less what some district or appellate court might do.

I think it is important for us to clearly draw the line, if that is called drawing the line, that once a child is born, it is no longer a health threat to the mother, and that we have a legitimate interest in protecting this child from being killed at that point. We will say, treat that child within the context of the law as we would treat any other child or any other person in America.

With that, I reserve the remainder of my time.

The PRESIDING OFFICIAL. Who yields time in opposition.

The Senator from California.

Mrs. BOXER. Mr. President, my colleague, in his discussion of this amendment, does attack the landmark case of Roe v. Wade which simply said, in the 1970s—and women have had the right since then—that in the early stages of pregnancy, the government should play no role in the very personal, private, medical decision whether we need a woman and her family and her doctor and her God would make without the interference of government. But his amendment certainly does not attack Roe in any way.

His amendment makes it very clear that nothing in this amendment gives any rights that are not yet afforded to a fetus. Therefore, I, as being a pro-choice Senator on this side, representing my colleagues here, have no problem whatsoever with this amendment. I feel good about that. I feel good that we can, in fact, vote for this together. It is very rare that we can.

Simply put, this amendment says it all in its purpose: “To protect infants who are born alive.” Of course, of my colleague goes on to say that simple statement, which is very important, is in fact, he said, the heart of this bill. I think the heart of this bill is even more than that. The heart of this bill is yes, protecting infants; it is also protecting children, protecting teenagers, protecting people as they get older, until they are very old and very frail and are fighting for their life.

So this bill really should protect us all at every stage of our life, from the earliest days until the final days. I hope that my colleague will join with us in supporting this Patients’ Bill of Rights because it does, in fact, protect all of us. And it will, in fact, give all of us at any stage, at any age, the quality health care that we need, deserves, regardless of whether we are a helpless newborn baby or whether we are an elderly person who is fighting and struggling against illness.

If 100 people vote for this amendment, which I think will be the case, then 100 people should vote for the Patients’ Bill of Rights because it will afford the families of those vulnerable infants and all of us the protections that we need against HMOs that sometimes put dollar signs ahead of our vital signs. That is wrong to do. Some of the families who are in those HMOs who don’t have a lot of money, who don’t have a lot of power, who are going against HMOs where the CEO makes hundreds of millions of dollars. But they say: Gee, we are not going to give that little baby the care he needs. I had a case I talked about on the floor where a child was denied a medicine. She was 3 years old and had cancer. It was $54 for the medicine and the HMO denied that medicine. That child suffered so with nausea and all the rest, while the head of that HMO sits there, because of a huge merger—and I asked my staff to check this because I could hardly believe it—made $800 million in the course of that merger. But they denied a drug to a little baby suffering from cancer—$54.

I heard my colleagues on the other side—some of them against this bill—say: We can’t legislate by anecdote. Well, I have to tell you, when you hear one story, and then another and another, when people come to see you, and you hold hearings and the people come out and tell the stories, then we know there is a need to pass this Patients’ Bill of Rights. So I would vote
for this to protect the infants, and then I will vote to protect everyone in this country because everyone deserves protection. If the HMOs will put their bottom line ahead of people's health.

The PRESIDING OFFICER (Mrs. FEINSTEIN). The Senator from Massachusetts is recognized.

Mr. KENNEDY. Madam President, I am going to urge the Senate to accept the amendment tomorrow. I think we have had a good discussion about it. I hope that we will move ahead and accept it. I am prepared, when the Senators yield the time or use the time, to do that.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Madam President, I thank the Senator from California for her comments and support of this amendment. I 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.

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

The amendment is as follows:

(Purpose: To apply the bill to plans maintained pursuant to collective bargaining agreements to also apply for employees who happen to be in collective bargaining agreements to also apply to group health plans maintained pursuant to collective bargaining agreements relating to the plan terminations. They are exempt from the legislation. It says they “shall not apply to plan years beginning before the later of—(A) the date on which the last collective bargaining agreements relating to the plan terminations.”

Some of these plans may not terminate for months. Some may not terminate for years. As a matter of fact, looking at a couple of examples, one is the Plumbers and Pipefitters Union, with 2,200 employees, has a 128-month contract. It doesn’t expire until 2010. The International Union of Electric Workers, with 1,800 employees, has a 148-month contract that doesn’t expire until the year 2007. I could go on and on. There are many.

The point is that there are about 30 million lives that would be exempt from this bill for years. If we are going to make it apply to everybody else in the private sector, I think we should make it apply for collective bargaining plans as well.

There is also something else that is troubling to me. It says it would not apply until the plan terminates, and then the language says if they adopt these patient protections, that still doesn’t count as a plan termination, a collective bargaining agreement termination. So, in effect, even though a plan adopts it, it hasn’t terminated and, therefore, it is still not covered or enforced by the terms of this bill. I find that troubling. I also am troubled by the fact that when it says “relating to the plan terminations,” a lot of plans or contracts don’t terminate. They are renegotiated. So they never get to termination. They are actually renegotiated plans that is very good. That means there is peace and harmony and no labor shortages and so on.

My point is that it is very important for us not to be exempting 30 million workers who happen to be in collective bargaining agreements from the protections in these plans. If we are going to give these protections to 170 million workers in the private sector, in that 170 million are included 30 million who happen to be members of a collective bargaining unit. They should have the patient protections that Congress is in the process of determining which are so vital for everybody else in the private sector. They should not be exempt because they happen to be members of a collective bargaining unit. We are asking every other plan in America to comply by October 1. Why would we not ask members of collective bargaining agreements to also comply? Why should we have these gaps? They have different expiration dates, some of which might be 5, 10 years, or even longer?

Maybe this is an oversight, a mistake from a previous drafting; but, clearly, if these are such valued protections that we want to extend them to the private sector, we should certainly extend them to members of collective bargaining agreements as well.

I urge my colleagues to support this amendment.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Madam President, I direct my colleagues’ attention to the lines 15 and 16 on page 173. They talk about “for plan years.” That is an art of words that applies to insurance companies, and it says, “beginning on or after” plan years. As we know, the insurance starts generally at the first of every year. So with regard to insurance companies, the Senator is completely correct that we are going to be required to have insurance companies because there are existing contracts.

We have heard a great deal in this debate about the sanctity of the HMO contract and how we are not going to pull in terms of plans for the treatment of patients—they are going to be tied completely to the contract. I don’t know how many hours I listened to that. Now we see that we are respecting the contract in insurance and we expect the same—to respect the contract in terms of collective bargaining. It is simple as that.

This is boilerplate, Madam President. We did this in the HIPAA program, and there was no row about it at that time. People understood. There was a normal transition, and we didn’t have objections at that particular time. So that is what we have done here. There are existing contracts in insurance, and we take it to the next time when the insurance plans are going to be implemented. There are existing collective bargaining agreements. We are going to take it at the next time when they are going to be renegotiated because of the respect for the existing contracts.

So what is sauce for the goose should be sauce for the gander. Madam President, particularly when we are listening to so much about the importance of contracts and that we ought not interfere with them, even if it is going to be as a matter of medical necessity, and that we are going to be bound by them because they are so important and sacred. There is a sanctity of the contracts.

I listened to that for 5 hours, and now we find out in the final hours of this that, oh no, that is not true regarding collective bargaining. We are going to interfere with ongoing collective bargaining agreements. That just doesn’t make sense. This is what we have done at other times. It says insurance, generally, at the start of a year—some are longer and they will be respected in that way just as we do regarding collective bargaining. I hope this amendment will not be accepted.
Mr. NICKLES. Madam President, I appreciate my colleague's statement, but I totally disagree. Some of us have argued for bargaining agreements, but we haven't been totally successful. I might add. Almost all those contracts would begin, if not by October 1, certainly by January 1 of the year 2003. So maybe there are a few more months. But under any bargaining agreements, if you read the language on page 174, it is not until the contract or the agreement terminates. And then the second part of it says that even if they comply, it shall not count as a termination.

You could have collective bargaining agreements exempt under this provision indefinitely for 12 years. They may never terminate the agreement. They may continue rolling it over, so it is never terminate. Are we going to take 30 million Americans and say: You are not covered by these patient protections?

Some of these contracts will last 10 years, 15 years. The average contract I was looking at had a schedule of 5 to 6 years. One I mentioned does not expire until the year 2010. If they renegotiate it between now and next year, the duration of the contract will be exempt. We are telling everybody else in the private sector: Get your act in order, and by the end of next year you have to have these new patient protections, oh, unless you are a member of a collective bargaining agreement.

This is the only exemption we found. We did not cover Federal employees. Maybe I will have an amendment dealing with Federal employees. All these great patient protections do not apply to Federal employees. They do not apply to Indians in our hospitals. They do not apply to veterans.

These are patient protections that are so important for the country, but we do not give them to publicly funded plans; we only do it for private sector.

What about unfunded mandates?

What about unfunded mandates? What about union plans, collective bargaining? We leave them out. We leave out Government plans; we leave out union plans; but this is five we are going to hit the private sector. Unions, this does not apply for the duration of your collective bargaining agreement, and if it does not terminate, you are never covered. I think that is a serious mistake, so I urge my colleagues to support the amendment.

I thank my friend and colleague from Nevada for his support of the amendment as well.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, the Senator ought to read page 174 because this language is very clear, precise, and exact. It does not permit what he just said it permitted, and that is the rollovers. It just does not permit it. The Senator can state it, and he can misrepresent it, which he just has, but it is not the fact. On line 5, it says: "relating to the plan terminates," and that is when it ends. That is when it has to be implemented.

This idea that it can roll over and over for, for 10, 15 years, is not what the legislation says. The fact is, with insurance, many start in January, many others start in July. We have tried to say when that contract plan year, which is a term of art that refers to when that insurance transitions, we will implement it at that time, and the same should be true with the collective bargaining agreement.

I would think the overwhelming majority of the workers and employers would be eager to get these protections. We are going to find out many will work out arrangements so they get the protections.

The PRESIDING OFFICER. Who yields time?

Mr. NICKLES. I yield to the Senator from Nevada such time as he desires.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. ENGLISH. Madam President, I have a story that was told by the junior Senator from North Dakota on the Senate floor the other day. It is about a young man, Christopher Thomas Roe, who is from Nevada. He was attending Durango High School and was diagnosed with acute lymphocytic leukemia. As anybody who has had a child with that terrible disease knows, sometimes the treatments are not very successful.

During the course of his treatment, the doctors were recommending a certain type of experimental treatment, and the Bill would be dependent upon whether the States would supersede and not allow union workers who are covered under those collective bargaining agreements to be covered under this Patients' Bill of Rights.

I urge our colleagues to work with us and to make sure those union workers get the same protections as other people in America are going to receive.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, how much time do I have?

The PRESIDING OFFICER. Six minutes.

Mr. NICKLES. The Senator is correct. Federal employees are not covered by the underlying McCain-Kennedy bill.

Mr. KENNEDY. I understand he was talking about teachers in Nevada; public employees were not covered. Does he understand that to be the case?

Mr. NICKLES. The Senator is correct. Federal employees are not covered by the underlying McCain-Kennedy bill.

Mr. KENNEDY. I did not understand, did the Senator say that public employees were not covered? Does he understand that to be the case?

Mr. NICKLES. The Senator is correct. Federal employees are not covered by the underlying McCain-Kennedy bill.
we are going to have comprehensive coverage since day 1 of this program. Now they are being flyspecked because somehow the evil one who, under certain circumstances, are going to come into these protections on a different calendar.

Madam President, we have tried to include people who are going to have coverage from insurance. We are going to respect the contract. When those insurance contracts expire, whether it is in January, whether in July, the protections go into effect. The same is true of the collective bargaining agreement. We have done that in other times. It has worked, and worked effectively. As I say, I believe the consumers, as well as employers—the employers from whom we have heard, and we have had many examples—indicate that they want to wait to get their protection in place. It isn’t that people will delay getting in; it will be because they want to get in and get in more quickly.

The PRESIDING OFFICER. Leader time has expired.

Mr. NICKLES. I ask unanimous consent for 2 additional minutes.

Mr. KENNEDY. Then I ask for 4, 2 each side.

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

Mr. NICKLES. A couple comments. The average length of collective bargaining agreements is 66 percent of collective bargaining agreements with over 1,000 employees—that is over 1,200 collective bargaining agreements—the average length is 3 to 5 years; 28 percent are 2 to 6 years; an additional 7 percent are 6 to 8 years.

My point is these things last for years. People renegotiate their health care plan. Federal employees do this every year, as does everybody does it every year. So for the health care plan for everybody else in the private sector, you have to comply by next October, 12 months from now, maybe even January of next year; you will have to comply. But if you are in a collective bargaining plan, you wait until the plan terminates.

We asked the Department of Labor, does the plan terminate if renegotiated and rolled over? Not necessarily. In collective bargaining, you are talking about 30 million Americans who will not receive the so-called benefits under this bill. That is a fact.

Another fact: My colleague said we supported an amendment by Senator Collins that said let the States use their State protections. I strongly agree with that. That is a reason I will vote against the underlying bill, because I don’t think we should preempt States as the Kennedy-McCain bill does. I believe in that strongly. I know my colleagues from Massachusetts have a different belief. We could debate that for hours.

My point is, if the patient protections are so good—and I heard many sponsors say we should cover all Americans—the bill does not cover all Americans. As a result of the language we have, the collective bargaining agreements are exempt for years. The bill we are debating now does not cover public plans; it does not cover Medicaid; it does not cover Medicare; it does not cover public employees; it does not cover the military; it does not cover veterans; it does not cover Federal employees.

We have control over Federal employees. If the patient protections are so good for the private sector, why not for collective bargaining plans as well?

Mr. KENNEDY. Madam President, it is interesting to listen to my friend and colleague. The fact is, the last President, President Clinton, put those in through Executive orders to cover those, which is an important delay of the Republican leadership in letting us get through this bill over the last 5 years. So rather than wait and wait and wait, we had a Democratic President put them into effect.

Now if a collective bargaining unit or contract expires on October 2, they go in prior to the time of the insurance coverage. They will go in months ahead of the insurance. If the contract expires on October 5, that goes in before July of the next year. So they get more protections than those being covered by the insurance.

This is just a way of saying if the contracts are out there, we are going to respect the termination of those contracts, whether it is in the insurance or in collective bargaining. Evidently, the Senator wants to use this as a device to punish some of their enemies, the unions in this case, to try to use the legislative process to do so. I hope we will reject that.

Mr. NICKLES. I yield myself 5 minutes off the leader time.

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

Mr. KENNEDY. Madam President, it is so ordered.

Mr. NICKLES. I thank my friend, Senator BROWNBACK. I am the third Senator squeezed in front of him, and he has shown great patience. I will be brief.

My colleague from Massachusetts said President Clinton gave these protections to Federal employees because he couldn’t wait for the delay of the Republican Congress to pass them.

The facts are, Federal employees do not have patient protections that are nearly as expensive, as aggressive, as intrusive as we are getting ready to impose on the rest of the private sector. I may have an amendment tomorrow to address that so we can save that for tomorrow’s debate.

The patient protection that President Clinton gave these protections to Federal employees because he couldn’t wait for the delay of the Republican Congress to pass them.

Mr. KENNEDY. Madam President, I am prepared to yield back the time.

The PRESIDING OFFICER. All time is yielded back.

Mr. NICKLES. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second. The yeas and nays were ordered.

The PRESIDING OFFICER. The Senator from Kansas.

AMENDMENT NO. 87

Mr. BROWNBACK. I send an amendment to the desk for immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Kansas [Mr. BROWNBACK] proposes an amendment numbered 87.

Mr. BROWNBACK. I ask unanimous consent reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To prohibit human germine gene modification)

At the end of the bill, add the following:

TITLE—HUMAN-GERMINE GENE MODIFICATION

SEC. 01. SHORT TITLE.

This title may be cited as the “Human Germine Gene Modification Prohibition Act of 2001”.

SEC. 02. FINDINGS.

Congress makes the following findings:

(1) Human Germine gene modification is not needed to save lives, or alleviate suffering, of existing people. Its target population is “prospective people” who have not been conceived.

(2) The cultural impact of treating humans as biologically perfectible artifacts would be entirely negative. People who fall short of some technically achievable ideal would be seen as “damaged goods”, while the standards for what is genetically desirable will be those of the society’s economically and politically dominant groups. This will only increase prejudices and discrimination in a society where too many such prejudices already exist.

(3) There is no way to be accountable to those in future generations who are harmed
SEC. 03. PROHIBITION ON HUMAN GERMLINE MODIFICATION

(a) In general.—Title 18, United States Code, is amended by inserting after chapter 15, the following:

"CHAPTER 16—GERMLINE GENE MODIFICATION

"Sec.

"§ 301. Definitions

"(1) HUMAN GERMLINE GENE MODIFICATION.—The term ‘human germline gene modification’ means the intentional modification of a human cell (including human eggs, sperm, fertilized eggs, zygotes, blastocysts, embryos, or any precursor cells that will differentiate into gametes or can be manipulated to do so) for the purpose of producing a genetic change which can be passed on to future individuals, including inserting, deleting or altering DNA from any source, and in an any form, such as nuclei, chromosomes, nuclear, mitochondrial, and synthetic DNA. The term does not include any modification of cells that are not a part of and will not be used to create human embryos. Nor does it include the change of DNA involved in the normal process of sexual reproduction.

"(2) HUMAN HAPLOID CELL.—The term ‘human haploid cell’ means a single cell that contains only a single copy of each of the human chromosomes, such as eggs, sperm, and their precursors.

"(3) SOMATIC CELL.—The term ‘somatic cell’ means a diploid cell (having two sets of the chromosomes in all body cells) obtained or derived from a living or deceased human body at any stage of development. Somatic cells are diploid cells that are not parent of either eggs or sperm. A genetic modification of somatic cells is therefore not germline genetic modification.

"Rule of Construction: Nothing in this Act is intended to limit somatic cell gene therapy, or to effect research involving human pluripotent stem cells.

"§ 302. Prohibition on germline gene modification

"(a) In general.—It shall be unlawful for any person or entity, public or private, in or affecting interstate commerce—

"(1) to perform or attempt to perform human germline gene modification;

"(2) to intentionally participate in an attempt to perform human germline gene modification; or

"(3) to ship or receive the product of human germline gene modification for any purpose.

"(b) Importation.—It shall be unlawful for any person or entity, public or private, to import the product of human germline gene modification for any purpose.

"(c) Penalties.—

"(1) Any person or entity that is convicted of violating any provision of this section shall be fined under this section or imprisoned not more than 10 years, or both.

"(2) Civil penalty.—Any person or entity that is convicted of violating any provision of this section shall be subject to, in the case of a violation of subsection (a), a civil penalty of not more than $1,000,000, and not more than an amount equal to the amount of the gross gain multiplied by 3, if that amount is greater than $1,000,000.

"(b) Clerical amendment.—The table of chapters for part I of title 18, United States Code, is amended after the item relating to chapter 15 the following:

"‘16 Germline Gene Modification ........ 301’.

"Mr. BROWNBACK. Madam President, I rise today to offer an amendment to the Patients’ Bill of Rights. This amendment is about human germline gene modification. That is a long way of saying—and I will go into this for a period of time—stopping people from attempting to modify the human species with genetic material. It may seem strange. It happens in livestock, genetically modified organisms. Some people are researching and discussing doing this within the human species to create better people. I think it should be stopped, prohibited, removed.

I looked for a better vehicle for this amendment, for another bill that was a closer fit. It is a medical issue on the medical front. If we get an agreement that I will do it that way. Having not been able to do that, we offer it as an amendment now.

My amendment prohibits human germline gene modification. What is that? Technically, it is the process by which the DNA of an individual is permanently changed in such a way that it permanently affects his or her offspring. Normally this is a DNA modification in either the egg or the sperm within the human species, so when the DNA of the modification is carried in that person and in future organisms, in future people. So it starts at this single stage, the egg or the sperm, molded together and multiplied in future generations.

This is not about genetic therapy; it is not about stem cell research; it is not about human cloning. All those are other issues for another day that do need to be considered but not here. My amendment in no way hinders genetic therapy or other medical interventions that treat patients suffering from diseases.

My amendment is about eugenics. For those not familiar, that is the process or means of race improvement previously tried by many diabolical programs, that target nonreproductive deficiencies in organs of patients, again in somatic cell gene modification.

The Council states this:

We strongly oppose the use of germline gene modifications in humans.

They continue:

Today, public discussion in favor of encouraging the genetic constitution of future generations has gained new respectability with the increased public awareness of the advancements in biotechnology. Although it is once again espoused by individuals with a variety of political perspectives, modern eugenic programs are now defended as driven by individual need, as opposed to the older version. But the doctrine of social advancement through biological perfectibility underlying the new eugenics is even more potent than the older version. Its supporting data seem more scientifically sophisticated and the alignment between the state, through its support of the market and the individual exercising so-called free choice, is unprecenented.

The Council goes on to state further:

These considerations make the social and ethical problems raised by germline gene modification very different from those raised by human cell manipulations, that target certain nonreproductive deficiencies in organs of patients, again in somatic cell gene modification.

As the Council states in very clear terms:

The underlying political philosophy of those who support germline gene modification has been sanitized with new terms, but is in reality the same old eugenic message which the 20th century was defined by and directly afflicted. In numerous conversations that I have had with Dr. Francis Collins, who
heads the National Human Genome Research Institute in Washington, who has had a fantastic report that was out last year on the Human Genome Project, reported out a beautiful array of the complexity of the genetic structure and every one of our 10 trillion cells and if we printed out that genetic structure and had it in front of us, it would be a stack of paper 100 feet taller than the Washington monument.

We have talked about the beauty of the human genome and also talked about the potential for problems in its manipulation, as that could be carried onto future humans.

Mr. BROWNBACK. Thank you, Mr. President.

The PRESIDING OFFICER. Mr. KENNEDY.

Mr. KENNEDY. Madam President, I urge the Senate to adopt my amendment to prohibit this, and for all.

The PRESIDING OFFICER. Mr. BROWNBACK.

Mr. BROWNBACK. Thank you, Madam President.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, I want to express a great deal of respect for my friend and colleague for his concern and interest in a great variety of different public policy issues, and also their ethical implications. He studies these issues. He is concerned about them. He brings them into the public debate and discussion. We always listen to his presentations on these subjects. I think that he has given this a great deal of thought. Even so, I must rise to oppose this amendment. I can understand the good Senator's frustration that we do not have a real opportunity to have the kind of debate on a free-standing bill that could give the Senate the benefit of a good discussion on this issue. Unfortunately, we are here at 20 minutes of 10. There are just a few of us here at this time, and we will only have a few minutes tomorrow to deal with an issue of enormous importance and consequence.

Millions of American children are born with deadly diseases such as cystic fibrosis and muscular dystrophy that result from flaws in the DNA code. One of the most promising ways to cure these afflictions is to correct these DNA errors using gene therapy. If these flaws could be corrected before birth, millions of children could live their entire lives free of the debilitating symptoms of cruel genetic disorders.

Yet the Brownback amendment would ban any attempt to cure children of deadly disorders such as cystic fibrosis and muscular dystrophy by correcting their DNA flaws before birth.

It even goes so far as to imprison doctors who try to save their lives and relieve their suffering.

The Brownback amendment is opposed by a wide range of organizations representing patients, doctors, scientists, and the biotechnology industry. They know this amendment would have a chilling effect on the biomedical research that gives hope to millions of Americans at risk for genetic diseases. The amendment is so broad that it will criminalize several promising areas of biomedical research, even including gene therapy in adults.

This important, complex topic deserves a thoughtful and measured response, and not the indiscriminate prohibition that the Brownback amendment proposes.

The American people do not support the sweeping prohibitions that the Brownback amendment would impose. A recent study funded by the NIH conducted by the University of Michigan found that 65 percent of the public opposed a ban on prenatal gene therapy, and only one in five of those support such a ban.

There are great numbers of genetic diseases, and there are great numbers of inherited diseases. Those that come to mind quickly are cystic fibrosis and muscular dystrophy, Tay-Sachs, Cooley's disease, and many others in the cystic fibrosis area.

It is basically an issue involving a single gene. That is also true in muscular dystrophy.

Just think if we were able to get to the point where a parent would be able to see the alteration of that gene so that the child that was going to be born would be free from muscular dystrophy or from cystic fibrosis by altering the DNA.
We can easily understand where the language that is included may not be the purpose of the Senator, but certainly, I think is sufficiently vague as to prohibit some promising research.

At this time, I think this is a matter of enormous importance. I don’t think we really ought to be dealing with this issue on this bill. I can understand the Senator’s frustration in not being able to have the debate in the Senate and to hear the different views on this issue. But I believe we ought to defeat the amendment for now, have additional review and study and hearings, and that we ought to then consider the various public policy issues and the ethical issues that surround it.

Mr. REID. Madam President, will the Senate next day?

Mr. KENNEDY. Yes.

Mr. REID. I would like to ask the Senator a question. A couple of years ago when I was chairman of the Democratic Policy Committee, one of the issues with which time was cloning, for lack of a better description. We had a luncheon at the Democratic Policy Committee. This may not be directly in point, but it points out what the Senator is saying. This is a very complex issue. We need more time and medical expertise to respond to this.

But the Senator will remember that we had a hematology professor from Harvard. We had the leading expert on gene therapy at NIH. The Senator will recall a number of things. The thing that is so vivid in my mind is the Harvard professor, who was of course a practicing physician, gave an example of how progress is being made in the medical field and in the areas that need more study.

He related that a young woman with leukemia was referred to him. I do not know the scientific name nor the type of leukemia. He did the examination and looked at the information he had been given.

The Senator will recall that the doctor asked this young lady if she had a brother or sister. She said no. He said that right then he knew she was in big trouble. She probably couldn’t make it and would die.

The next day, the Senator will recall, another teenager came in with leukemia. It was the same process. He asked this young man if he had a brother or sister. He said no, and paused for a second. He said: I am a twin. The doctor said that he knew right then that the young man was going to live as long as anybody in this room because they could do a bone marrow transplant and regenerate those cells.

I do really understand what the Senator from Kansas is advocating with his amendment. I know he is candid and is well placed. I know after having listened to the woman from NIH and the professor from Harvard that I have great hope progress is being made on some of the most dreaded diseases that face, especially children in America today.

The Senator from Massachusetts and I know how well-intentioned the Senator from Kansas is. I think we should defeat this amendment and wait for a later day so we can have more opportunity to examine this more closely.

The Senator remembers that meeting in the room right down the hall here?

Mr. KENNEDY. I do remember. All of us as Members of this body get a chance to go out to NIH and visit with the researchers and listen, watch, and hear about those extraordinary, dedicated men and women who are dealing with so much of the cutting edge research.

I think we want to make sure that we are very careful in the steps we are going to take that in some way would inhibit research. There are obviously strong ethical issues which we constantly have to examine and consider.

But I am very much concerned about the kind of prohibition that this type of amendment would include.

I want to make it clear that the amendment that the Senator from Kansas puts forward does not ban cloning, but it would ban similar cutting edge research.

That is what our concern is and why we will oppose it tomorrow.

The PRESIDING OFFICER. The Senator from Kansas.

Mr. BROWNBACK. Madam President, I would like to correct some miscalculation with the Senator from Massachusetts. I want to read from the amendment because he represented a couple of examples that we specifically state in the bill we are not prohibiting.

On page 16, the amendment under the construction it states specifically that:

Nothing in this Act is intended to limit somatic cell gene therapy, or to effect research involving human pluripotent stem cells.

This somatic cell gene therapy is what you are talking about where you have already the sperm and egg, and you have a full chromosome. That is where you may want to make changes, and that is where the research is focused. Now they can deal with some of the dreaded diseases the Senator from Massachusetts says we should rightly try to deal with. I agree that we should.

We specifically added that. We covered that point the Senator raised and about which he has concern because we don’t want to impact that area. We talk about this on page 3. It says:

The term “human germline gene modification” means the intentional modification of DNA in a human cell for the purpose of producing a genetic change which can be passed on to future individuals.

In this amendment we are saying: Do we really want to change the human species without knowing what the impact is going to be down the road? Maybe we have a shot at changing this bill through to passage—I appreciate both his work and the work of the Senator from Nevada on just continuing to press forward. They have done a very good job. But I point out to them that we have significant limitations on doing this to animals. Right now, if you wanted to take a fish and put a tomato germline in it, or something from a tomato gene—actually this is being done—this is a heavily regulated area by FDA, and the USDA, as well it is very careful, and we want to get super fish out here that could swim and do things and take over a whole area of species? They are actually concerned. It may sound scientific, like this is just off the wall. But this is happening today.

We have these deep concerns within our society. You do not have to listen to me. The Senator from California knows what is taking place this week in southern California. People are deeply concerned about this being done with animals and plants.

All I am talking about with this amendment is to say, the careful thing for us to do right now is to prohibit it in humans.

As the Senator from Massachusetts knows, in any future legislative session we can remove that prohibition. We could do that next year. But wouldn’t the careful, thoughtful thing be to say right now: “We don’t want to modify the human species”? It has no regulation, no review on it today. People are out there doing these things.

Wouldn’t the really thoughtful position be that we should stop this because we don’t know its impact down the road—stop this now—and then, if the researchers really convince us this is the right thing to do, we can open it back up? I think we open up an incredible Pandora’s box if we allow this unregulated area of human experimentation to continue at this time. And that is what is being defended here.

I think this should give us some thoughtful consideration. This is limited in its drafting. We have worked with a number of groups on its drafting. It is very specific. This has to do with it being passed down to future generations. This is something that we should prohibit at this time.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, there are several organizations that draw different conclusions about the Senator’s amendment. You have the
Biotechnology Industry Organization that says:

Unfortunately, the Brownback amendment reaches far beyond germ line modification. It attempts to regulate genetic research—a complex and dynamic field of science that holds great potential for patients with serious and often life-threatening illnesses.

And from the Association of American Medical Colleges:

Much more troubling, however, the amendment extends beyond the germ line. Taken on its face, the amendment would prohibit other areas of research into gene therapy as well.

I ask unanimous consent an analysis be printed in the Record. There being no objection, the material was ordered to be printed in the Record, as follows:

MEMORANDUM

JUNE 28, 2001

To: Michael Werner, Esquire, BIO Bioethics Counsel

From: Edward L. Korwek, Ph.D., J.D.

Re: Some Initial Comments/Analysis of the Brownback Amendment

The Brownback Amendment is poorly worded and confusing as to its precise coverage. It uses a variety of scientific terms and other complex language both to prohibit and allow certain gene modification activities. Many of the sentences are composed of language that is incorrect or ambiguous from a scientific standpoint. A determination must be made of what each sentence of the Amendment is intended to accomplish. As to a few of the important definitions, the term “somatic cell” is defined in proposed section 301(i) of Chapter 16, as “a diploid cell (having two sets of the chromosomes of almost all body cells) obtained or derived from a living or deceased human body at any stage of development.” What does “of almost all body cells” mean? Is this an oblique reference to the haploid nature of human sex cells, i.e., sperm and eggs? Also, why is it important to describe in such confusing detail from where the cells are derived (in contrast to simply saying, for example, a somatic cell is a human diploid cell)? From a scientific standpoint, the definitions of a somatic cell is not dependent on whether the cell is from living or dead human beings. More importantly, as to this human source issue, when does a “human body” exist such that they will not pass this on. Yet this imprecision, the amendment’s impact is unclear and seemingly far reaching.

Mr. KENNEDY. Madam President, a memorandum by Hogan & Hartson says:

The Brownback Amendment is ... confusing as to its precise coverage. It uses a variety of scientific terms and other complex language both to prohibit and allow certain gene modification activities.

And it gives a several-page analysis of this.

The fact is, as I understand it, there is a moratorium now at NIH. NIH does not permit research in transferring the materials in terms of genes at the present time. I just mention quickly, on page 3 of the amendment, on lines 10 and 11, it talks about “for the purpose of producing a genetic change which can be passed on to future individuals ...” That ought to be a matter of concern to parents because that is an area of very great potential in terms of parents who have the gene—in terms of teratogenic effect—by by altering, by trying to impact that kind of DNA so that they will not pass this on. Yet this is talking about restricting the research for “producing a genetic change which can be passed on to future individuals ...” That very area is a matter of enormous importance and consequence.

I know the Senator has given this a lot of thought. It is enormously important. I respect him for it. I know that he revisits these issues continuously. We will look forward to continuing to work with him. I know he is incredibly concerned about the broad areas of ethical issues. In those areas of ethical concerns, I can offer easy answers. There is enormous division, significant divisions, in many different areas.

But it does seem to me that in the time that we have available to consider this, on this particular legislation, and with the very strong opposition of the research community generally, that it would be unwise for us to add this at this time to the legislation.

The PENDING OFFICER. The Senator from Kansas, Mr. BROWNBACK. Madam President, I would just note once more for my colleagues that the area of genetic manipulation, germ line therapy, is regulated in animals and in plants but is completely unregulated—there is nothing on this human.

Is that a responsible way for us to go? There is nothing on it. If we want to do it right now on the human species in the United States, go ahead, fine. If you want to do that, release that into us, into the human species, fine, go ahead. If you want to do it in fish, we have a series of hoops that you have to jump through and filings that you have to make and limitations on where this can take place all up and down, everywhere. But for humans, fine. I guess if we are going to eat it, we are concerned about it. But if it is one of us, OK.

I have deep respect for the Senator from Massachusetts. He is very thoughtful and one of the most productive Members of this body, probably in the history of this body. But I would really seriously ask him to look at this area. Is this something we want to do in this society? This is not only technologically or theoretically feasible today; it can be done today. It has been done in the animal line for years now. This has been going on for 10 years-plus, 15 years in animals. The genetic line in animal versus humans is not that much different. Totally unregulated, no limitations—go ahead and do it in humans, not in cattle.

I would hope we could at least get some agreement that this is going to be further considered during this legislative session. If we want more limited language, I am more than happy to work with individuals in drafting more limited language. If we want to work on gene therapy on it, I am willing to draft it as tight as they want to on gene therapy. That would be just fine by me. But to let this go on now, you are inviting people to step up. If we need to work with the groups the Senator listed to draft it more tightly, I am happy to do that.

This is a serious matter. We have more and more people in the streets protesting about this very thing. I think we should probably sit down on this particular point, if nothing else. We saw the protest that took place in Seattle. We saw what it did to the World Trade talks. That was on food. We are seeing what is taking place in the Biotechnology Expo in Southern California right now.

This issue is not going away. It is something that we are going to have to confront. I would hope and I would think we would be far wiser to do it sooner rather than later. I am happy to work with the Senator to craft the language to see that that takes place.

The PENDING OFFICER. The Senator from Massachusetts.
CONGRESSIONAL RECORD—SENATE

June 28, 2001

Mr. KENNEDY. I will include the regulations which are in existence now. I ask unanimous consent they be printed in the RECORD.

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

[From pages 90-92—NIH Guidelines for Research Involving Recombinant DNA Molecules]

Appendix K–VII–K. Pathogen. A pathogen is any microbiological agent or eukaryotic cell containing sufficient genetic information, which upon expression of such information, is capable of producing disease in healthy people, plants, or animals.

Appendix K–VII–L. Physical Barrier. A physical barrier is considered any equipment or engineering control, filter, physical barrier, or any other type of device, whether man made or natural, that is capable of producing disease in healthy people, plants, or animals.

Appendix M. Points to Consider in the Design and Submission of Protocols for the Transfer of Recombinant DNA Molecules into One or More Human Research Participants (Points to Consider)

Appendix M applies to research conducted at or supported by NIH/OBA that requires any support for recombinant DNA research from NIH. Researchers not covered by the NIH Guidelines are encouraged to use Appendix M (see Section I-C, General Applicability).

The acceptability of human somatic cell therapy research has been addressed in several NIH Guidelines and in numerous academic studies. In November 1982, the President’s Commission for the Study of Ethical Problems in Medicine and Biochemical and Behavioral Research published a report, Splicing Life, which resulted from a two-year process of public deliberation and hearings. Upon release of that report, a U.S. House of Representatives subcommittee held three days of public hearings with witnesses from a wide range of fields from the biomedical and social sciences to theology, philosophy, law, and ethics. In February 1984, the Office of Technology Assessment released a background paper, Human Gene Therapy, which concluded that civic, religious, scientific, and ethical issues all accepted, in principle, the appropriateness of gene therapy of somatic cells in humans for specific genetic diseases. Somatic cell gene therapy is seen as an extension of current methods of therapy that might be preferable to other technologies. In light of this public support, RAC is prepared to consider proposals for human somatic cell gene transfer. RAC will not at present entertain proposals for germ line alterations but will consider progress involving somatic cell gene transfer. The purpose of somatic cell gene therapy is to treat an individual patient, e.g., by inserting a properly functioning gene into the subject’s somatic cells. Germ line alteration involves a specific attempt to introduce genetic changes into the germ (reproductive) cells of an individual, with the aim of changing the set of genes passed on to the individual’s offspring.

The RAC continues to explore the issues raised by the potential of in utero gene transfer. However, the RAC concludes that, at present, it is premature to undertake any in utero gene transfer clinical trial. Significant additional preclinical and clinical studies addressing: vector transduction efficacy, biodistribution, and toxicity are required before a human in utero gene transfer protocol can proceed. In addition, a more thorough understanding of the development of human organ systems, such as the immune and nervous systems, is needed to better define the potential efficacy and risks of human in utero gene transfer. Prerequisites for considering any specific human in utero gene transfer procedure include an understanding of the pathophysiology of the candidate disease and a demonstrable advantage to the in utero approach. Once the above criteria are met, the RAC would be willing to consider well-rationaized human in utero gene transfer clinical trials.

Research proposals involving the deliberate transfer of recombinant DNA, or DNA encoding a transgene, to the entire genomes of humans (human gene transfer) will be considered through a review process involving both NIH/OBA and RAC. Investigation of information and data obtained at any stage of the research will be clearly identified as such. The cover letter (attached to the submitted material) shall: (1) clearly
indicate that select portions of the application are not included. If the information is determined proprietary or trade secret, (2) a brief explanation as to the reason that each of these items is determined proprietary or trade secret.

Public discussion of human gene transfer experiments (and access to relevant information) shall serve to inform the public about the technical aspects of the proposals, meaning and significance of the research, and significant safety, social, and ethical implications of the research. RAC discussion is intended to focus on ethical conduct of gene therapy experiments and facilitate public understanding of this novel area of biomedical research.

In its evaluation of human gene transfer proposals, RAC will consider whether the design of such experiments offers adequate assurance that their consequences will not go beyond their purpose, which is the same as the traditional purpose of clinical investigation, namely, to protect the health and well being of human subjects being treated while at the same time advancing the general knowledge. Two possible undesirable consequences of the transfer of recombinant DNA would be unintentional (i) vertical transmission of genetic changes from an individual to his/her offspring, or (ii) horizontal transmission of viral infection to other persons with whom the individual comes in contact. Accordingly, Appendices M–I through M–V request information that will enable RAC and NIH/OBA to assess the possibility that the proposed experiment(s) will inadvertently affect reproductive cells or lead to infection of other people (e.g., medical personnel or relatives). Information requested for revisions as experience in evaluating proposals accumulates and as new scientific developments occur. This review will be carried out periodically as needed.


Appendix M–I–A. Requirements for Protocol Submission

The following documentation must be submitted (see exemption in Appendix M–VI–A, Footnotes of Appendix M) in printed or electronic form to the Office of Biotechnology Activity (OBA), National Institutes of Health, 6705 Rockledge Drive, Suite 750, MSC 7895 Bethesda, MD 20892-7895 (20817 for non-USPS mail), 301-496-9838, 301-496-9839 (fax); E-mail: rosentgh-sod.nih.gov. NIH OBA will confirm receipt within three working days after receiving the submission. Investigators should contact OBA if they do not receive this confirmation.

1. A cover letter on institutional letterhead, signed by the Principal Investigator(s), that (1) acknowledges that the documentation submitted to NIH OBA complies with the requirements set forth in Appendix M–I–A, Requirements for Protocol Submission; (2) identifies the Institutional Biosafety Committee (IBC) and Institutional Review Board (IRB) as the proposed clinical trial site(s), responsible for local review and approval of the protocol; and (3) acknowledges that the research participant will be enrolled (see definition of enrollment in Section 1–E–7) until the RAC review process has been completed (see also RAC Review Requirements); IBC approval (from the clinical trial site) has been obtained; IRB approval has been obtained; and all applicable regulatory authorizations have been obtained.

2. The scientific abstract.

3. The non-technical abstract.

4. The proposed clinical protocol, including tables, figures, and the relevant manuscripts.

5. Responses to Appendices M–II through M–V, Description of the Proposal, Informed Consent, Privacy and Confidentiality, and Special Requirements. IBC approval (from the clinical trial site) has been obtained; IRB approval may be required either as an appendix to the clinical protocol or incorporated in the clinical protocol. If responses to Appendices M–II through M–V are incorporated in the clinical protocol, each response must refer to the appropriate Appendix M–II through M–V.

Mr. KENNEDY. Finally, the reason there is a law is there isn’t reason to believe that this kind of research is safe today. But it may very well be safe tomorrow or the next day. And the possibilities, as I say, are unlimited. The action of the Senator may effectively close that window, close that door. I do not think that we ought to be in the position of doing that. So I have included the current state of the regulations that are in effect now in NIH and the reasons for those regulations.

Unless there is someone else who wants to speak on this.

The PRESIDING OFFICER. The Senator from Kansas.

Mr. BROWNBACK. Madam President, I would like to respond on this point at such as well. The FDA is saying they have authority over this. One of the groups they are seeking to regulate is saying they do not have authority, and they are going to sue them to keep the FDA from regulating them. So we can put those on forward.

The fact is, this has not been dealt with, and it is of utmost importance to people in this country and around the world, and it should be. This should not happen.

The PRESIDING OFFICER. Does the Senator yield the remainder of his time?

Mr. BROWNBACK. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. The yeas and nays have been requested. Is there a sufficient second? There is a sufficient second. The yeas and nays were ordered.

Mr. BROWNBACK. Madam President, I yield back the remainder of my time.

The PRESIDING OFFICER. Does the Senator from Massachusetts yield back his time?

Mr. KENNEDY. I yield back the remainder of my time.

The PRESIDING OFFICER. Who seeks recognition? The Senator from Nebraska.

Mr. ENSIGN. Madam President, I call up amendment No. 849 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The senior assistant bill clerk read as follows:

The Senator from Nevada [Mr. ENSIGN] proposes an amendment numbered 849.

Mr. ENSIGN. Madam 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. ENSIGN. Madam President, the amendment that I have proposed really is entitled the “protection against genetic discrimination act.” The Senator from Massachusetts is one of the co-sponsors of a bill that contains this particular amendment, along with 22 other Senators.

The map of the human genome is one of the most amazing scientific breakthroughs in recent history. Information that is embedded in the genome holds the key to understanding the illnesses and diseases that affect millions of people across the world every day.

I would like to note, this has nothing to do with the amendment that Senator BROWNBACK just proposed. We want to keep the controversies separate. What our amendment deals with is whether or not you can take this genetic information and use it to determine whether or not to provide health insurance coverage.

When the map of the human genome is completed, we will have all of the information that is contained in the 23 pairs of chromosomes in the human body. This information will be instrumental for finding the cure for diseases such as breast cancer, cystic fibrosis, Alzheimer’s disease, and hundreds of other debilitating illnesses.

However, this breakthrough also carries great dangers. Current law does not provide any protections for individuals to keep their own genetic information private. Currently there is no law prohibiting a health plan from requiring an applicant to provide genetic information prior to the approval for insurance. In other words, any individual with a genetic marker for a specific disease would most likely not be able to receive health insurance coverage for the treatment of that disease.

A joint report by the Department of Labor, Department of Health and Human Services, the Equal Employment Opportunity Commission, and the Department of Justice summarized the various studies on discrimination based on genetic information and argued for the enactment of Federal legislation.

The report stated that:

Genetic predisposition or conditions can lead to work force discrimination, even in cases where workers are healthy and unlikely to develop disease, or where the genetic condition has no affect on the ability to perform work.

AMENDMENT NO. 849

(Purpose: To provide for genetic nondiscrimination)

Mr. ENSIGN. Madam President, I call up amendment No. 849 and ask for its immediate consideration.
Because an individual's genetic information has implications for his or her family members and future generations, misuse of genetic information could have intergenerational effects that are broader than any individual incident of misuse.

Dr. Francis Collins, the director of the National Human Genome Research Institute, has stated:

While genetic information and genetic technology hold great promise for improving human health, they can always be used in ways that are fundamentally unjust. Genetic information can be used as the basis for invidious discrimination.

The misuse of genetic information has the potential to be, and is, a very serious problem both in terms of people's access to employment and health insurance and the continued ability to undertake important genetic research.

This amendment takes the first step toward providing individuals with the protections they need for their individual genetic information.

This amendment, as I mentioned before, is part of a larger bill that Senator Frist has introduced. It is the very same subject. Simply put, this amendment prohibits health insurance companies from using genetic information when deciding whether or not to provide health insurance for an individual.

Insurance companies would not be able to use genetic information to deny an individual's application for coverage or charge excessive premiums.

Think about diseases such as Tay-Sachs, sickle-cell anemia, breast cancer, colon cancer, cystic fibrosis, and other diseases in which we have identified genes that predispose people to these diseases. Just think about how many Americans this affects now and will affect in the future as we discover new genes that predispose people to certain diseases. It is because of this that we must include this amendment if we are truly going to call this bill a Patients' Bill of Rights.

Madam President, my wife and I helped found the Breast Cancer Coalition of Nevada. Many of the women who are actively involved in this wonderful organization are breast cancer survivors or family members of women who have died from breast cancer. A wonderful friend of my wife and I, one of the most incredible women I have ever met, died in my wife's arms several years ago. She died of breast cancer.

To think about women such as her who have had a gene identified, or maybe her daughter the same, to think about someday being discriminated against getting health insurance is just unconscionable.

I encourage all of my Senate colleagues, including the sponsors of the bill, to accept this amendment. It is the right thing to do. I urge its adoption.

I yield the floor.

The PRESIDING OFFICER (Mr. CARPER). The Senator from North Carolina.

Mr. EDWARDS. Mr. President, we yield back the remainder of my time.

Mr. ENNSIGN. Mr. President, I ask that further reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To provide that health care professionals who provide pro bono medical services to medically underserved or indigent individuals are immune from liability)

At the end, add the following:

SEC. IMMUNITY.
(a) IN GENERAL.—Notwithstanding any other provision of law, no health care professional shall be liable for the performance of, or the failure to perform, any duty in providing pro bono medical services to a medically underserved or indigent individual.
(b) DEFINITIONS.—In this section:
(1) HEALTH CARE PROFESSIONAL.—The term "health care professional" means any individual that does not have health care coverage, or any other health care coverage or the failure to perform, any duty in providing pro bono medical services to medically underserved or indigent individuals are immune from liability.
(2) MEDICALLY UNDERSERVED OR INDIGENT INDIVIDUAL.—The term "medically underserved or indigent individual" means an individual that does not have health care coverage under a group health plan, health insurance coverage or any other health care coverage program, or who is unable to pay for the health care services that are provided to the individual.

Mr. ENNSIGN. Mr. President, this next amendment I am offering comes once again from personal experience. I have a very close friend, Dr. Tony Alamo. He is a few years younger than me, and is an internist in Las Vegas. Our parents have known each other for a long time. He graduated from USC medical school. I don't know that I have ever seen anybody work harder.

Internists today don't make nearly the money that a lot of surgical specialists make, but the compassion that they have for their patients is just incredible. I remember a few years ago talking to him and what he had to tell me was amazing. As a practicing veterinarian, we get to choose who we take, who we don't take, and when they come into our offices. But as a physician, when he happens to be there treating another patient, if somebody comes in and he happens to be the attending physician, he has to treat that person, regardless of whether they have insurance or no insurance, can pay or cannot pay.

He takes that person on as a patient, he cannot get rid of that patient. So he has to continue through the course of the disease, if he is in the hospital, has a heart condition, he has to continue regardless of whether he gets reimbursed or not.

The purpose of my amendment is to say we want them to continue that kind of care, but if out of the goodness of their heart they are treating for free, we just want to eliminate the possibility that they can be sued for such a matter.

We are looking at this as a situation that is similar to Good Samaritan laws. For example, when somebody stops on the side of the freeway because somebody is hurt and they don't know exactly what to do but they want to help and they happen to do more harm than good, we have passed laws across the country that helps a Good Samaritan in that instance.

The practice of medicine, as anybody who has practiced knows, whether it is veterinary medicine or human medicine, is both an art and a science. As a matter of fact, it is more art than science. Things go wrong. Sometimes things go wrong that may look like malpractice. And sometimes it is something the doctor had nothing to do with, yet they can still be taken to court.

Our amendment says that if health care professionals are going to do this, we want to protect those people from lawsuits. It seems to me that if somebody is providing something out of the goodness of their heart on a pro bono basis, they could not be sued. In fact, I would support a similar proposal that granted lawyers the same protection. If they are providing pro bono services, they could not be sued. If this was a lawyer's bill of rights, we would include that as well. But this happens to be a Patients' Bill of Rights, and for the physicians that are treating these patients, we want to make sure they are protected.

We have spoken to Senator McCain's staff and, apparently, they think the language is acceptable. I think in the long run this is going to go a long way. I have spoken to Senator Pryor, as many of you know, is a heart surgeon. He does volunteer work in clinics, both overseas and also here in the United States. He doesn't get paid for these services. Yet, he has to maintain medical malpractice premiums out of his pocket each year so that if he gets sued, he is covered.

This is probably the only amendment in this entire bill that actually will lower—it will only lower it slightly—the cost of health insurance. It would help lower both the cost of medical malpractice premiums and eventually the cost of coverage premiums for consumers as well.

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Mr. President, I don’t know if anybody is going to oppose this amendment. I can’t understand why they wouldn’t enact this, rather than having to engage in a debate on this if anybody has a problem with it.

I yield the floor at this time.

The PRESIDING OFFICER. The Senator from North Carolina is recognized.

Mr. EDWARDS. First, I say to the Senator from Nevada that Senator Coverdell had a bill that he passed called the Volunteer Protection Act of 1997. It specifically provides protection for volunteers, including physicians, who provide pro bono services. So I suggest to my colleague, I don’t know if he thinks there is a problem with that law or the way it is written. There is no way for me to know that based on this amendment. But a specific law already exists. It was passed by the Senate and signed into law in 1997. So, first, I suggest that my colleague look at that law and make sure what he is concerned about is not covered by it.

Secondly, the bipartisan Patient Protection Act is about HMO reform. It is not about physician liability or the lack thereof—either of those. We would certainly have a problem with adding an amendment to this legislation that is not related to the issue of HMO reform.

So I say to my colleague, again, understanding that we are just seeing his amendment, in fairness, I will be happy to talk with him about it, but those were my immediate concerns. There appears to be a law that already covers this subject matter. We would always be concerned, of course, even under those circumstances, about a health care provider who acted recklessly. I don’t know whether his amendment covers that.

Third, the general issue of adding these kinds of provisions to an HMO reform bill, which is what this bill is about, would also be a concern.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. First of all, physicians I have spoken to do not think the bill the Senator is talking about is worthy of passage. If I were to carry medical malpractice insurance, similar to what Senator Frist has to carry. My amendment insurance, similar to what Senator still have to carry medical malpractice the Senator is talking about adequate— I have spoken to do not think the bill form bill, which is what this bill is these kinds of provisions to an HMO re-

I am happy to work with my con-

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. REID. Mr. President, I ask unanimous consent that when the Senate resumes consideration of the Patients’ Bill of Rights on Friday, June 29, at 9 a.m., the Senate proceed to vote in relation to the following amendments, and it be disposed of in the following order, with no second-degree amendments in order prior to the votes; further, that each amendment be debated prior to each vote, and that the first rollcall vote be 15 minutes in length and subsequent rollcall votes be 10 minutes in length. The order of the votes tomorrow morning would be: Santorum, DeWine, Grassley, Nickles, Brownback, Ensign No. 848, and Ensign No. 849.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. REID. Mr. President, I indicated earlier in this debate that I would complete reading into the RECORD the names and titles of organizations that support the Patient Protection Act. Therefore the following is the final list:

Gateway; Gateways for Youth and Families in WA; George Junior Republic in Indiana; Gibault; Girls and Town in NE; Goodwill Industries of South Florida; Goodwill Homes for Boys; Greenbrier Children’s Center; Growing Home in St. Paul, MN; Haddassah; Heart of America Family Services; Hemochromatosis Foundation; Hereditary Colon Cancer Association; Highfields, Inc. in Onondaga, MI; Holy Family Institute of Pittsburgh, PA; Home on the Range in Sentinel Butte in Sentinel Butte, MT; Hubert H. Humphrey, III—Former Minnesota Attorney General; Human Services, Inc.; IARCA An Association of Children. Idaho Youth Ranch; Indiana United Methodist Children; Infectious Disease Society of America; International Association of Psychosocial Rehabilitation Services; Jackson-Feid Homes in VA; Jane Addams Hull House Association; Jeffrey Modell Foundation; Jewish Board of Family & Children in New York, NY; Jewish Community Services of South Florida; Jewish Family & Career Services; Jewish Family & Children Services of Los Angeles; Julia Dyckman Andrus Memorial Children’s Center in NY; June Burnett Institute; Kemmerer Village; Kentucky United Methodist Homes; KidsPeace National Centers, Inc. in PA; Lakeside, Kalamazoo, MI; LaSalle School, Inc. in Albany, NY; League of Women Voters; Leake and Watts Services, Inc. in Yonkers, NY; Learning Disabilities of America; Lee and Beulah Moor Children’s Home in TX; Lupus Foundation of America; Lutheran Child & Family Services in Bay City, MI; Lutheran Children & Family Services; Lutheran Social Services of Wisconsin; Manisses Communications Group in RI; Medical Savings Association; Mental Health America; Maryhurst, Inc.; Maryland Association of Resources for Families & Youth; Massachusetts Council of Family; Mental Fitness Center; Mental Health & Liaison Group; MentalHealth AMERICA, Inc.; Methodist Children’s Home in TX; Metropolitan Family Services of Portland, OR; Metropolitan Family Services of Chicago, IL; Michigan Federation of Private Child & Family Agencies; Mid-South Chapter of the

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Paralyzed Veterans of America; Milton Hershey School, PA; Mission of the Prince of Peace, Detroit, MI; Missionaries to the Poor; Missouri Baptist Children’s Home; Missouri Coalition for Children’s Agencies; Missouri Girls Town;-Mindful Childcare; Mountain Community Life Center; Montana Children’s Home in Natchez, MS; National Alliance for the Mentally Ill; National Association for Rural Mental Health; National Association for the Advancement of Orthotics and Prosthetics; National Association of Children’s Hospitals; National Association of Counties; National Association of County & City Health Officers; National Association of Developmental Disabilities Councils; National Association of People with AIDS; National Association of Private School for Exceptional Children; National Association of Private Special Education Centers; National Association of Protection and Advocacy Systems; National Association of School Psychologists.


National Rehabilitation Association; National Therapeutic Recreation Society; National Transplant Action Committee; National Urban League; National Voice on Mental Illness; Nazareth Children’s Home in Rockwell, NC; NETWORK; New Community Corporation in Newark, NJ; Newark Beth Israel Medical Center; New Jersey; NIH; Norris Adolescent Center in WI; Northeast Parent & Child Society in New York; Northern Virginia Family Services; Northwest Chapter of the Paralyzed Veterans of America; Northwest Children’s Home, Inc.; Northwood Children’s Services in Duluth, MN; Oak Grove Institute Foundation; Oakland Family Services; Olive Crest Treatment Centers; Organization of Specialists in Emergency Medicine; Outcomes, Inc. in Albuquerque, NM; PA Alliance for Children and Families in Hummelltown, PA; PacifiCare Youth Services; Paget Foundation; Pain Care Coalition; Palmer Home for Children in Columbus, MS; Paralyzed Veterans of America; Patient Access Coalition; Patient Access to Responsible Care Alliance; Pediatric Orthopedic Society of North America; Pennsylvania Council of Children’s Homes; Person-to-Person Family Counseling Service of New Philadelphia, OH; Philadelphia Health Management Corporation in PA; Planned Parenthood Federation of America; Prevention of Suicide Foundation; Providence Children, Inc. in St. Louis, MO; Rehabilitation Engineering and Assistive Technology Society of North America; Religious Action Center of Reform Judaism; Research Institute for Independent Living; Riverbend Head Start & Family Service; Salem Children’s Home; Salvation Army Family Service, Springfield, OR; SCAN of the Berkshires, Inc.; Schaumburg, IL; Schindler Children’s Foundation; Scarsdale Edgemont Family Council in NY; School Social Work Association of America; Self-Help Children’s Home in碉c; Seedco/Non-Profit Assistance; Service Net, Inc. in PA; Sheriffs Youth Programs of Minneapolis; Sipe’s Orchard Home in Conover, NC; Sjogren’s Syndrome Foundation; Society for Excellence in Eye Care; Society for Women’s Health Research; Society of Cardiovascular & Interventional Radiology; Society of Excellence in Eye Care; Society of Genetic and Metabolic Society; Society of Maternal-Fetal Medicine; Southmountain Children’s Homes of America; St. Anne Institute of Albany, NY; St. Colman’s Home in Watervliet, NY; St. Joseph’s Children’s Home; St. Joseph’s Indian School in SD; St. Mary’s Home in Beaverton, OR; St. Vincent’s Services, Inc. of Brooklyn, NY; Starr Commonwealth; Sunbeam Family Services of Oklahoma City, OK; Sunny Ridge Family Center.

Tabor Children’s Services, Inc. of Doylestown, PA; The Children’s Home in Marquette, MI; Texas Association of Leaders in Children & Family; Texas Medical Association; Arc of the United States; The Bradley Center; Brother & Sister Families, Inc.—Shreveport, LA; The Endocrine Society; The Family Center; The Hutton Settlement in WA; The Learning Disabilities Association of America; The Mechanical Children’s Home of Mechanicsburg, PA; The Mill; The Omaha Home for Boys in NE; The Organization of Specialists in Emergency Medicine; The Paget Foundation for Paget’s Disease of Bone and Related Disorders; The Presley Ridge Schools in PA; The Village Family Service Center in Faryn, ND; The Woodlands of New Hampshire; Title II Community AIDS National Network. Tourette Syndrome; Tourette Syndrome Association; Treatment Access Expansion Project; Triangle Family Services in Raleigh, NC; Tulsa Boys’ Home in Tulsa, OK; Turning Point Center; Ulrich Children’s Home; United Community & Family Service; United Methodist Children’s Home; United Ostomy Association; United Methodist Children’s Home Community Care Group; Vera Lloyd Presbyterian Home & Family Services in AR; Vera Lloyd Presbyterian Home; Verdeau Mental Health Center; Village for Families & Children; Virginia Home for Boys; Webster-Cantrell Hall; Whaley Children’s Center; Wisconsin Association of Family and Children; Wisconsin Paralyzed Veterans of America; Woodland Hills in Duluth, MN; Yellowstone Boys and Girls Ranch in Billings, MT; Youth Haven, Inc.; Youth Service Bureau; and YWCA of Northeast Louisiana.

Mrs. FEINSTEIN. Mr. President, I rise today in support of the Bipartisan Patient Protection Act of 2001. Put simply, I believe this is a good bill.

If the Senate approves this bill, we could offer protection to all 190 million Americans in private health plans within a week. It’s that simple.

Congress has a duty to pass a comprehensive Patients’ Bill of Rights to make sure patients have rights and to ensure less HMO interference with medical decision making. We need to ensure, for example, access to emergency rooms, specialists, and clinical trials. Patients should be able to go to the emergency room closest to their home in the event of a medical emergency. This bill does just that.

Each day, 10,000 physicians see patients harmed because a health plan has refused services. Patients and doctors feel that getting quality care is a constant battle. It is time for this to stop. And the time is now.

Each day we wait to approve a comprehensive Patients’ Bill of Rights, 35,000 patients are denied access to the specialty care they need to manage or diagnose their illness.

I want to read to you a heart-wrenching letter I received from a California mother who has had difficulty getting her health plan to approve medically necessary services for her disabled daughter.

I believe this letter really highlights the humane reasons Congress must enact a strong Patients’ Bill of Rights this year. This mother writes:

My daughter is a total-care patient. She was in a terrible car accident approximately 14 years ago and sustained serious injuries and is a quadriplegic. I chose to keep her at home. Her licensed care coverage is to be 24-hour care. In the past two years, her insurance company has unilaterally cut back on her nursing care to 5.5 hours a day.

This is one of many unilateral decisions the insurance provider has made regarding her care—disregarding her doctor’s and other medical providers’ assessments.

I, as her mother and conservator, who is not trained in medical practices or care, am expected to cover the remainder of the 18.5 hours a day. This has caused me to quit my job, file bankruptcy, and most importantly, it has seriously affected my health.

I am a senior citizen and am not supposed to lift, however, because of the practices of the insurance company, I have no choice. I cannot tell you when I last had a full night’s sleep in the past several years.

The insurance company not only cut back on her nursing care, they stopped approving her other coverage, which included physical, speech, and occupational.

I received a letter from her current insurer stating that she was considered to be a normal employee and in August of 2001 all the aforementioned items would be stopped.

This is not based on my daughter’s current doctor’s orders nor her needs. This is not based on an assessment from an independent medical establishment or by an experienced, licensed nurse that was approved by the insurance company for a complete assessment which supported the necessity of 24-hour nursing care.

The decision is being made unilaterally by the insurance company officials. Is this what insurance companies can do to critically ill patients without any accountability or liability on their part?

I commend this mother for her commitment to providing her daughter with the best care available.

This letter highlights the importance of giving doctors the power to make medical decisions for patients, and to ensure less HMO interference with patient care rather than the “green eye shade” of the insurance companies.

I strongly believe that doctors should be making the medical decisions. This
At the same time, this bill protects employers. If an employer does not make medical decisions, the employer can’t be held liable. It is that simple. This bill does not overturn or preempt existing State liability laws. It specifically exempts doctors and hospitals from new causes of action. These are reasonable provisions. In States like California that have strong patient protections there has not been an explosion of lawsuits.

In fact, since the inception of California’s right-to-sue law in January 2001 and the unlimited damage it provides for, there has not been a single lawsuit filed.

Instead, HMOs appear to be deferring more to patients’ requests for treatment, according to the first data to emerge from the State’s HMO regulator.

California has the longest history in managed care and the highest number of insured people in HMOs nationwide. Over 70 percent of Californians are enrolled in either a commercial HMO or a preferred provider organization. PPP plans. Approximately 20 million non-elderly Californians have access to health insurance through their job or privately purchase coverage.

So for California, these protections are critical.

Due in part to the high penetration of managed care, California’s health care system is on the verge of collapse. Resources are stretched to the limit and patients, as a result, are not getting the services they need.

For example, California’s capitation rate, the rate paid to doctors for treatment, is one of the lowest in the Nation. The average capitation rate in California reached its peak in 1993 at $45 per month. Last year, the rate dropped to $29 (Price-Watertouse Coo菲s).

These low reimbursement rates undoubtedly impact quality of care and access to services.

Many California hospitals and other health care providers have been forced to limit hours of operation and discontinue services. The burden to provide care is put on those that have remained open, and many of these facilities are now facing financial problems of their own.

I know that California’s health care system is not unlike other systems across the country. The bottom line is that patients should not be the one’s made to suffer at the hands of a failing health care system.

People pay monthly premiums. They expect their health insurance to be there when they need it. That is what insurance is. It insures against loss from an unforeseen illness or injury.

But with HMOs today, the certainty of good health care is being seriously eroded. Many people feel that every time they need care, it is a tremendous hassle.

The bottom line is that people feel they have to fight to get the quality care they have paid for. Americans are tired of jumping through hoops to get good care.

People should not have to fight for their health care. They pay for it out of their monthly paycheck. It should be there for them when they need it.

I would like to close with a very tragic story about a young, 16 year old girl from Irvine, California who did not get the care she needed from her HMO in a timely manner. I think her story provides a poignant summary of the problem with managed care providers.

Unfortunately, her story does not have a happy ending.

Serenity Silen was diagnosed with acute myeloid leukemia, or AML, in late February 1998. She had gone to her HMO four times, to four different HMO doctors, since the beginning of 1998. Each time she complained of the exact same symptoms, all of which could indicate leukemia.

Over the course of the four visits, Serenity's condition was never diagnosed. Finally, in the middle of February 1998, Serenity was taken to the emergency room of an out-of-network hospital because her mother was so frustrated with the care at their HMO.

The emergency room doctor was the first doctor, in the five weeks since the symptoms arose, to order a complete blood count test. The blood count test indicated a dangerously high white blood cell count that was symptomatic of leukemia. With a much delayed diagnosis, Serenity’s leukemia was now going to be much more difficult to treat.

Fed up with the HMO, Serenity’s parents sought a second opinion from a highly recognized oncologist at an out-of-network hospital. Serenity was transferred to that hospital to be under the oncologist’s care. After being at the new hospital only a few days, Serenity explained to her parents that she did not realize how much pain she was in until the new hospital helped to take it away. After 2½ months at the new hospital, Serenity died. The disease had not been diagnosed in time.

I urge my colleagues to support this bill. I support this bill for the children, like Serenity in your State. The constituents who battle with their HMOs daily to get the quality care they need and deserve. Many of these patients are too sick to fight with their HMOs to get access to the services necessary to treat their illnesses. How many more lives are we going to have to lose to the HMO battle before Congress wises up and passes a Patients’ Bill of Rights that protects the patient?

This bill has been a long time in the making. Let’s get it done this session.