come to be used for something that constitutes a main support or depend- 
ence, especially a dweller. Of danger. Truly, then the Constitution is not just the organizing construct of our government, but also, as Jefferson saw it, the tool by which our Nation would preserve our liberties. It is fitting, then, to close with the words of the poet Edgar Allan Poe, who wrote about the republic in “The Building of the Ship.”

Thou, too, sail on, O Ship of State! 
Sail on, O Union, strong and great! 
Humanity with all its fears. 
With all the hopes of future years, 
Is hanging breathless on thy fate! 
We know what Master laid thy keel, 
What Workmen wrought thy ribs of steel, 
Who made each mast, and sail, and rope, 
What anvils rang, what hammers beat, 
In what a forge and what a heat 
Were shaped the anchors of thy hope! 
Fear not the blow of thunder, and shock, 
’Tis but the wave and not the rock; 
’Tis but the flapping of the sail, 
And not a rent made by the gale! 
In spite of rock and tempest’s roar, 
In spite of false lights from the shore, 
Sail on, nor fear to breast the sea! 
Our hearts, our hopes, are all with thee. 
Our hearts, our hopes, ours prayers, our tears.

Our faith triumphant o’er our fears, 
Are all with thee—are all with thee! 
Mr. President, I yield the floor. 
(Applause.) 
The PRESIDENT. 
Mr. Warner, the Senator from Virginia.

Mr. WARNER. Mr. President, I certainly join my colleagues in expressing our warm appreciation for our senior colleague, our President pro tempore, for addressing the Senate in such a stirring manner. It lifts the hearts of all of us in this late hour on a Friday afternoon, which has, I guess, a degree of uncertainty as to the manner in which we are going to proceed.

BIPARTISAN PATIENT 
PROTECTION ACT—Continued

AMENDMENT NO. 833, AS FURTHER MODIFIED

Mr. WARNER. Mr. President, I have an amendment which has been pending. I send to the desk a modification of that amendment. The PRESIDENT. 
Mr. Warner, the Senator from Virginia.

Mr. WARNER. Mr. President, I have an amendment which has been pending. I send to the desk a modification of that amendment. The PRESIDENT. Without objection, the amendment is modified. The amendment (No. 833) as further modified, is as follows:

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

“(11) 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 DISTRICT COURT.—
The last Federal district court in which the action was pending upon the final disposition, including all appeals, of the action shall have jurisdiction to review the attorney’s fee in accordance with subparagraph (C) to ensure that the fee is a reasonable one and may decrease the amount of the fee in accordance with subparagraph (C).

(C) DETERMINATION OF REASONABLENESS OF FEES.—

(1) INITIAL DETERMINATION OF LODestar ESTIMATE.—

(I) IN GENERAL.—To determine whether the attorney’s fee is a reasonable one, the court shall first, with respect to each attorney representing the plaintiff in the cause of action, multiply the number of hours determined under subparagraph (II) by the hourly rate determined under subparagraph (III).

(II) NUMBER OF HOURS.—The court shall determine the number of hours reasonably expended by each such attorney.

(III) HOURLY RATE.—The court shall determine a reasonable hourly rate for each such attorney, taking into consideration the actual fee that would be charged by each such attorney and what the court determines is the prevailing rate for other similarly situated attorneys.

(II) CONSIDERATION OF OTHER FACTORS.—A court may increase or decrease the product determined under clause (i) by taking into consideration any or all of the following factors:

(i) The time and labor involved.

(ii) The novelty and difficulty of the questions involved.

(iii) The skill required to perform the legal service properly.

(iv) The length of the employment of the attorney due to the acceptance of the case.

(v) The customary fee of the attorney.

(vi) Whether the original fee arrangement is a fixed or contingent fee arrangement.

(vii) The time limitations imposed by the circumstances of the representation.

(viii) The amount of damages sought in the cause of action and the amount recovered.

(ix) The experience, reputation, and ability of the attorney.

(X) The undesirability of the case.

(XI) The nature and length of the attorney’s professional relationship with the client.

(XII) The amounts recovered and attorneys’ fees awarded in similar cases.

(D) RARE, EXTRAORDINARY CIRCUMSTANCES.—Notwithstanding subparagraph (A), in rare, extraordinary circumstances, the court may raise the attorney’s fee above the 1/3 cap imposed under subparagraph (A) to ensure a balance of equity and fairness to both the attorney and the plaintiff.

(E) NO PREEMPTION OF STATE LAW.—Subpar- graph (A) shall not apply with respect to a cause of action under paragraph (1) that is brought in a State that has a law or framework of laws 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.

Mr. WARNER. Mr. President, I want to comply with the wishes of the distinguished leaders.

Mr. DASCHLE. Mr. President, may we have order.

The PRESIDENT. The Senate is not in order. The Senate will suspend. Please take your conversations off the floor.

Mr. WARNER. Mr. President, I wish to accommodate the managers, but I am ready to proceed. I think I can describe my amendment in about 10 or 15 minutes or less. I urge colleagues to accept that offer to move ahead and give equal time to each side.

Mr. REID. I am sorry. I say to my friend, the distinguished Senator from Virginia, we have had trouble hearing over here.

The PRESIDENT. The Senator from Virginia will be in order. The Senator from Virginia is entitled to be heard.

The Senator from Virginia.

Mr. WARNER. I say to my good friend, the distinguished majority whip, I am seeking now to address my amendment. It has been pending for some several days. I am perfectly willing to enter into a time agreement. I need but, say, 15 minutes.

Mr. REID. Say 30 minutes evenly divided?

Mr. WARNER. I am quite agreeable to 30 minutes equally divided.

Mr. REID. Our anticipation now—we will work this out, speaking with the managers of the bill—is to offer side by side with yours, or second degree, whatever your manager wishes to do, but you should go ahead and proceed. We are available during our 15 minutes to accommodate.

Mr. WARNER. Mr. President, might I have clarification? If I understand it on the second-degree, in the event it seems we need some adjustment in the time agreement with which to address this amendment?

Mr. REID. Why not take an hour evenly divided, and if we don’t need it, we will yield back the time?
Mr. GREGG. Mr. President, I am not sure what the Senator from Virginia wishes to do. I hope they will not be a second-degree amendment. I think, rather, offer an amendment which would be a stand-alone, side-by-side amendment.

Mr. REID. I am sorry, did you say you wanted to offer it side by side? That is what you want to do.

Mr. WARNER. That is perfectly acceptable. Could my amendment be voted on first?

Mr. REID. Of course—well, let me not get my mouth ahead of my head.

In the past what we have done, Mr. President, is the second-degree amendment could be a second-degree amendment that appears to be the one we would ordinarily vote on first. Through all these proceedings, the stand-alone was the one we would vote on first. In other words, that could have been a second-degree. That is what we have done in the past.

Mr. GREGG. Actually, we did reverse the order on the Snowe—

Mr. REID. It is not important whether it is first or second. Do you agree?

Mr. EDWARDS. We should go first.

Mr. REID. Through these entire proceedings—I don’t know how many votes it has been now, but certainly it is lots of them—the one that would have been the second-degree should be voted on first. We think we should do it in this instance.

Mr. WARNER. Mr. President, I believe I have the floor. I believe the amendment is up. We are simply discussing a time agreement. I am not prepared to yield the right that I believe I have now with respect to proceeding with this amendment. But I want to accommodate my distinguished friend. He has been most helpful for 4 or 5 days, as I have worked on this amendment.

Could you be more explicit exactly what you think you would like to have? I understand you have to consult with others.

Mr. REID. What we would like to do is offer an amendment that would be voted on, a companion to yours.

Mr. WARNER. Fine.

Mr. REID. The only question now, it seems, is which one would be voted on first. What we have done during these entire proceedings has been a bipartisan amendment that was offered by the Senator from Maine, the one that would have been a second-degree is voted on first. We think we should follow that same order.

Mr. WARNER. I simply ask as a matter of courtesy—some 3 days I have been working with you—just allow mine to be voted first. Certainly we could have discussion on the one that is in sequence. I am confident Members will very quickly grasp the basic, elementary framework that I have in my amendment. And I presume any companion amendment you or others wish to introduce would likewise be very elementary. We could quickly make decisions, all Senators, on it and proceed with our business this afternoon.

Mr. REID. Mr. President, I know some of our friends would rather we went first. We feel pretty confident of our vote, so we will go second.

Mr. WARNER. Mr. President, I like a man who is audacious, I accept that challenge. We will proceed on mine. I need only about 10 minutes to address it.

Mr. DASCHLE. Will the distinguished senior Senator from Virginia yield for a unanimous consent request?

Mr. WARNER. Oh, yes.

Mr. DASCHLE. We were able to reach this agreement with the cooperation of all our colleagues. I think we are now prepared to propound the agreement.

Mr. President, I ask unanimous consent that the following be the only amendments to be considered in the Senate except the Warner and Ensign amendments which have been laid aside and which now are being debated that they be subject to relevant second-degree amendments; all amendments must be offered and disposed of by the close of business today; and that upon disposition of these amendments the bill be read a third time and a vote on final passage of the bill occur without any intervening action or debate:

Frist substitute: Frist, liability; Craig, long-term care; Craig, nuclear medicine; Kyl, alternative insurance; Santorum, unions; Nickles, liability; Bond, punitive; Thompson, regarding point of order; Kennedy, two relevant; Daschle, two relevant; Carper, relevant, to be offered and withdrawn.

The PRESIDING OFFICER. Is there objection?

Mr. GREGG. Reserving the right to object, I ask if the majority leader would be willing to adjust his unanimous consent so Senator Ensign could modify his amendment, which is pending, and also, because we have not seen the Kennedy, Daschle, or Carper amendments, we would have to reserve the right to have a second-degree amendment?

Mr. DASCHLE. The amendments are subject to second degrees, of course. I ask consent the Ensign amendment be allowed to be modified.

Mr. CRAIG. Reserving the right to object.

Mr. GREGG. Reserving the right to object.

Mr. THOMPSON. Reserving the right to object, a simple point: My amendment was listed as one having to do with a point of order. If we could correct that, it actually has to do with venue.

Mr. DASCHLE. I ask consent the clarification be made with regard to the Thompson amendment.

Mr. GREGG. I also ask that the Nickles amendment be defined as relevant, rather than liability, and, since the majority leader has asked to reserve two relevant amendments, the Republican leader be given two relevant amendments.

The PRESIDING OFFICER. Does the majority leader modify the request?

Mr. DASCHLE. I ask unanimous consent that the request be so modified.

The PRESIDING OFFICER. The request is modified.

The Senator from Idaho.

Mr. CRAIG. Mr. President, may I inquire of the majority leader, is it your intent to at least shape the field of amendments into a set number but there is no time tied to those? Is that correct?

Mr. DASCHLE. That is correct.

Mr. CRAIG. Thank you.

The PRESIDING OFFICER. Is there objection to the request. Without objection, it is so ordered.

Mr. DASCHLE. I thank our colleagues.

The PRESIDING OFFICER. The Senator from Virginia is recognized.

Mr. WARNER. Mr. President, if I may just proceed, my understanding is that we have 30 minutes equally divided under the time agreement. Is that correct?

The PRESIDING OFFICER. That has not been propounded.

Mr. WARNER. Mr. President, I suggest we just leave it open. I want to give adequate opportunity to those who wish to address this subject. I will proceed.

Mr. President, for some time I have followed this bill very carefully. I am, of course, quite aware of the name of it—the Patients’ Bill of Rights. I want to ask the Senate to give serious consideration to protecting the right of a patient to receive what I regard as a fair return on such awards as a court may approve, presumably, by a jury finding the negligence of the defendant has merit and assigns an award figure.

The McCain-Kennedy-Edwards bill provides new rights. But there is nothing in there to give the patients the protection from what could well be perceived by many as an unfair allocation of that award between attorneys and patients. Therefore, I think there should be a framework of caps on the maximum amount of the award to be made.

May I explain it.

It is kind of complicated because we have a Federal court and a State court. While I don’t know the ultimate finality of this legislation, at this point the amendment provides for the treatment of caps in both courts, and they are somewhat different.

In addition, I believe very strongly that there is in rare instances and under extraordinary circumstances a case where an attorney would be entitled in excess of the one-third cap that I am proposing in both Federal and State courts. An allowance has to be made for the exceptional type of case.
I am proposing a framework of caps. It would be giving the court the right to only approve attorney's fees in a case if the attorney—up to one-third of the award to which he or she is entitled for their services—not this proportionate share by someone with no cap.

We have reposed confidence in our judicial system. Indeed, we have reposed confidence in those members of the bar. Many years ago, I was privileged to be an active practitioner before the bar and had extensive trial experience as assistant U.S. attorney and some modest trial experience in other areas.

I recognize that the vast majority of the bar will work out a fee schedule with their client in such a way that there will be an equitable distribution. But there are instances where the patient could well be deserving of the award by the court and then prohibited from getting what I perceive as a fair and proportionate share by someone who does not follow the norm.

The norm in most cases does not exceed one-third. Contingent fees are usually one-third or less. Therefore, we put in the cap of the one-third.

I also want to make it clear that there is a good deal of expense to a lawyer associated with representing a client. The norm is one-third to one-half in many instances; the experience and reputation of the attorney, and on it goes. But it is carefully worked out through many years of following these cases.

Therefore, I believe that we are giving protection to the patient. For rare and extraordinary cases, the court can go above it. In some instances, the court will decide that the one-third is not appropriate, and that it should be some fee less than a third, again protecting the interests of the patient.

I find this a very reasonable amendment. It certainly comports with the basic objectives of this law; namely, to give some benefits to those who have suffered the grievances which are designated in this law.

I also recognize the Federal-State law; that is, what we call States rights. I have been a strong proponent of that throughout my career in the Senate.

I provide that in the case of a State court, if the State in which that court is sitting is a State which has a cap for its own fees and the fee is less than one-third, then this amendment does not apply.

I repeat that the State law would govern the return to the attorney of that amount to which he or she is entitled for their services—not this proposed amendment.

Mr. President, I see my colleague in the Chamber.

I yield the floor for the moment.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, I have a unanimous consent request I am going to propose in just a minute—or in even less than a minute.

Senator ORRIN G. GILDEREISEN is in the Chamber, and I appreciate his listening.

Mr. President, I ask unanimous consent that I be recognized to offer an additional amendment, with 30 minutes for debate in relation to the Warner amendment and the Reid amendment to run concurrently prior to a vote in relation to the Warner amendment—which the Senator from Virginia indicated he wanted first—followed by a vote in relation to the Reid amendment, with no second-degree amendments in order prior to the vote.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

AMENDMENT NO. 852

Mr. REID. Mr. President, Senator Warner and I have worked side by side all the time I have been in the Senate on the Environment and Public Works Committee. I have been his subcommittee chairman; he has been my subcommittee chairman. Twice I have been chairman of the full committee. I have been the ranking member of that committee.

There is no one I have worked with in the Senate who is more of a gentleman than the Senator from the Commonwealth of Virginia, Mr. WARNER. He has been a pleasure to work with. We tried to work this out on the attorney's fees. We have been unable to do that. But his amendment is, in my opinion, very complicated. It is going to create litigation, not solve it.

We have a fair way to address this issue. Even though personally as an attorney, I had done a great deal of defense work where I was paid by the hour and a significant amount of work where I was paid on a contingency fee basis many years before I came back here, I think contingent fees should be based upon whatever the States determine is appropriate.

But I am willing to go along with the basic concept of the Senator from Virginia; and that is we will go for a straight one-third, no complications. It is very simple: A straight one-third.

Senator WARNER's proposal introduces a complex calculation in every case and ignores the agreements between injured patients and their lawyers. This proposal portends to tell State judges how to apply State law. We do not need to do that here in Washington.

This proposal ties only one side's hands in litigation. HMOs can hire all the attorneys they want and plaintiffs cannot. There is no restriction on how much money the attorneys for the HMOs make. We are not going to get into that today. We could. It would be a very interesting issue to get into.

But what we are saying is, when you walk down in the well to vote on the amendments, we have a very simple proposal: It is one-third, period. Under Senator WARNER's proposal, it is something, and we will figure it out later based on how many hours, and where you did it, and what kind of case it was. Ours is simple, direct, and to the point. It would only complicate things to support the amendment of my friend from Virginia.

Mr. President, at this time, after explaining my amendment, I call my amendment forward and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Nevada (Mr. REID) proposes an amendment numbered 852.

Mr. REID. Mr. President, I ask unanimous consent reading of the amendment, 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:

"(3) Limitation on Award of Attorneys' Fees—

(a) In general.—Subject to subparagraph (B), with respect to a participant or beneficiary (or the estate of such participant or
Mr. BIDEN. Mr. President, I always find these debates about attorney’s fees fascinating. I find my friends on both sides of the aisle who usually are seeking to restrict attorney’s fees are the folks who told us that in California—when you have utility companies gouging the public—that we should not, even though we have authority under Federal law, put on some limitations. They are folks who tell us that, notwithstanding the fact that a drug company may be able to manufacture a pill for one-quarter of 1 cent and sell it for $75, there should not be any relationship between the amount of cost involved and the profit made.

I find it all kind of fascinating. For example—I am not going to do it—a great amendment to the amendment by my friend from Virginia would be the following: That any fee charged by an HMO for health care coverage must bear direct relationship to their costs and cannot exceed a profit rate of X amount. That would be fair, right?

All these folks who can’t afford health insurance, who are getting banded around and battered, we are trying to help, but I imagine I would not get many votes for that. I bet my friend from Virginia would not vote for that because that is free enterprise. My grandfather Finnegan used to have an expression. He said: You know, it’s kind of fascinating. There’s free enterprise for some people, free enterprise for the poor, and socialism for the rich. You find yourself in a position where, if you are representing the right interest, we talk about free enterprise; if you don’t like the interests that are involved, we talk about socialism. You should have imposed limitations on fees or on profits, based on whether you like what is going on.

In the case of a case that you should have to justify, on an hourly basis, exactly what you do, and all of these things, not calculate the rate, not calculate the cost, then fine, have at it.

But I don’t know; what is good for the goose isn’t good for the gander. If we do this with regard to attorney’s fees and we don’t do this with regard to health care costs and fees, what is the fundamental difference? Tell me the fundamental difference, not a sudden change in the great interests of my friends to protect the poor, aggrieved plaintiff, who has been wronged by the insurance company. At any rate, I am as anxious to get out of here as everybody is. I wanted to make it clear; I think this is bad law, bad policy, a bad idea, and it is, in a literal sense, discriminatory.

Mr. REID. Mr. President, this legislation that is now before the body is not about attorney’s fees. It is about patient protection, making sure people in America have certain rights. Some employees have been taken away from them. We want to reestablish something that is kind of old-fashioned in the minds of many—that is, when you go see your doctor, the doctor determines what kind of medicine you need and what kind of care you need. That is what this legislation is all about. It is not about attorney’s fees.

If the people on the other side were interested in saving money, one of the amendments they should have would address the compensation of some of these employees. There is a list, and you can go to the top 10. The first one, including stock options, made
$411,995,000 last year. That is just a little item they might be concerned about a little bit, but we have a lot of money that isn't necessarily needed.

This is not about how much money people make. What it is about is trying to pass a Patients' Bill of Rights. I ask that we move forward as quickly as possible and vote and get on with the rest of the legislation.

The PRESIDING OFFICER. Who yields time?

Mr. REID. The Senator from Tennessee may have some of mine.

Mr. THOMPSON. A couple of minutes, if I may, Mr. President.

I have been listening to the debate. We are making it much more complicated than it needs to be. We are talking about whether or not this is a good idea. The sponsors of these two amendments I think are good ideas. I will not debate that these are possibly a couple of those good ideas.

I am afraid we are not permitted to get that far because not every good idea is constitutionally permissible. I simply do not see our authority, even if we want to do this under the Constitution, to say to a State court, having lifted the preemption that was there before, that in its deliberations and in its lawsuits it will be trying, that we have, in a government of enumerated powers, the authority to reach in and do that. This is not raising an army. This is not copyrights and patents. This is not interstate commerce. I simply see no basis of authority for the Congress to do this, whether it is a good idea or not in our system of enumerated powers.

If I am incorrect about that or there is something I am not thinking about, I will stand corrected. That is a concern of mine.

I yield the floor.

Mr. WARNER. Mr. President, if I could reply to my distinguished colleague, that very question I entertain. I have, in a government of enumerated powers, the authority to reach in and do that. This is not raising an army. This is not copyrights and patents. This is not interstate commerce. I simply see no basis of authority for the Congress to do this, whether it is a good idea or not in our system of enumerated powers.

If I am incorrect about that or there is something I am not thinking about, I will stand corrected. That is a concern of mine.

I yield the floor.

Mr. WARNER. Mr. President, if I could reply to my distinguished colleague, that very question I entertain. I take pride in my record of some 23 years in this body to protect State laws.

The first thing I did under my amendment was say, if there is a body of State law, then my amendment doesn't apply to those decisions in State courts. So I think there is some dozen or so that have a statutory framework for the regulation of attorney's fees. Those States are the one side. But we find authority that it is within the power of the Congress to regulate interstate commerce. We have a proposed bill giving new rights to litigants. We believe that comes within that clause. That is how I proceed to do it.

We are just very fearful, I say to my distinguished colleague, that patients will not be able to, without this authority of some cap, obtain a fair allocation of these proceeds in some few cases. I myself have a high confidence in the bar and the courts to exercise equity and fairness. In some instances, it might not prevail. We have here cases where some lawyers are getting $30,000 per hour, in some of these tobacco cases. Mind you, $30,000 per hour. I just think it is time that we, the Congress of the United States, do what we can within the framework of our constitutional law to exercise and put a cap on that.

I say to my good friend from Nevada, he has marked up an earlier version of my bill. And at least you started with a pretty good base here, but you took out the essence of it. We did remain with a one-third fee, but giving the court the right to raise or lower this fee without any guidance whatsoever, even without the guidance of the word ‘reasonableness’ put into the proposal by myself, and not taking that out.

It seems to me that, while we are apart, we could possibly bridge our differences, if I could have the assurance that a patient, as we now call them or any other representative of a patient, have some pretty good base here, but you took out the essence of it. We did remain with a one-third fee, but giving the court the right to raise or lower this fee without any guidance whatsoever, even without the guidance of the word ‘reasonableness’ put into the proposal by myself, and not taking that out.

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I am afraid we are not permitted to get that far because not every good idea is constitutionally permissible. I simply do not see our authority, even if we want to do this under the Constitution, to say to a State court, having lifted the preemption that was there before, that in its deliberations and in its lawsuits it will be trying, that we have, in a government of enumerated powers, the authority to reach in and do that. This is not raising an army. This is not copyrights and patents. This is not interstate commerce. I simply see no basis of authority for the Congress to do this, whether it is a good idea or not in our system of enumerated powers.

If I am incorrect about that or there is something I am not thinking about, I will stand corrected. That is a concern of mine.
original amendment is it takes away from State law, from what States can do. It seems interesting to me that we are so in tune with States rights around here all the time, unless it comes to something dealing with injured parties—whether it is product liability cases or whatever. We suddenly want to take away what the States have so worked on for all these decades. I think my friend's amendment takes away a lot of what we have with our States.

Mr. WARNER. Mr. President, I will read to my friend section (E) of my amendment, page 6:

NO PREEMPTION OF 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 law or framework of laws with respect to the amount of an attorney's contingency fee that may be incurred for the representation of a participant or beneficiary—

And so forth. In other words, if the State has a framework of State laws, we in the Congress should not be trying to amend them, as I fear you are doing through an omission in yours. I have protected it in mine.

Mr. REID. Well, I understand what the Senator's intent is. When you are looking for intent, you want to be as precise and direct as possible. I respectfully say we should get on with the vote. I think we have said everything, but may not everyone has said it. You and I have.

Mr. WARNER. Let me point out one other thing. Again, there is a difference as to how these things are treated under Federal and State. As I said, ERISA gives certain protections that are involved in the Federal court. There Federal law requires relief grievance under ERISA and that is not found in mine amendment's. You say it is implicit in every court in the land; therefore, it is not needed to be expressed. Is that your point?

Mr. REID. The reason we took your basic amendment and made it directly to the point as to the one-third it becomes too complicated for a court to determine attorney's fees based on the complicated program you have set up. Ours is simple and direct. In rare instances, a judge can step in and raise them or lower them.

Mr. WARNER. I wanted to make sure they were explicit. That is my view. We have a difference of opinion on that.

Mr. President, I will soon suggest the absence of a quorum so I have some period of time to reflect on perhaps other suggestions I might have. I am willing to all amendments to be laid aside if the Senator would agree to proceed with others.

Mr. REID. We have been laying aside things so long—

Mr. WARNER. If that is of no help, we need not do that.

Mr. REID. I have no problem having a quorum call and we can talk. I really think we have to move on. I am willing to take my chances, whatever they might be. Other people are waiting around to offer amendments. We should move on if we can.

Mr. THOMPSON. Mr. President, I am prepared to move forward with an amendment, if that is desired by my two colleagues, while you have your discussions. If you want to go into a quorum call, we will wait.

Mr. REID. I would be happy to set these two amendments aside and let my friend from Tennessee, who offered probably the best elucidation on attorney's fees today—No. 1, he was concise and to the point. I think probably both of these are unconstitutional. I am willing to go forward.

I ask unanimous consent that the two amendments by Senators REID and WARNER be set aside and that the Senator from Tennessee be allowed to call up an amendment. The Senator's amendment is on the improved list, correct?

Mr. THOMPSON. Yes.

The PRESIDING OFFICER. Without objection, it is so ordered. The amendments are laid away.

The Senator from Tennessee is recognized.

AMENDMENT NO. 835
(Purpose: To clarify the law which applies in a State cause of action)

Mr. THOMPSON. Mr. President, I send to the desk an amendment.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Tennessee (Mr. Thompson) proposes an amendment numbered 835.

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

"(9) CHOICE OF LAW.—A cause of action brought under paragraph (1) shall be governed by the choice of law rules of the State in which the plaintiff resides.""

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

Mr. THOMPSON. Mr. President, I let the amendment be read because it is probably the shortest amendment that will be considered tonight. It is very simple and straightforward. Basically, what it says is that in these lawsuits that we are dealing with, we apply the law of the State of residence and citizenship of the plaintiff in this case.

Let's go back just a bit and understand the lawsuit scheme that we have created by this litigation. We have created a Federal cause of action in Federal court for matters that are essentially contract; and we have created a State cause of action in State court for matters that have to do with medically reviewable situations.

What that has left us with is the ability of a claimant to bring a State court claim in any State where the defendant is doing business. If you have a medical insurer and they are doing business in several States, even though you live in Tennessee, you could bring your lawsuit in any of those States where that insurer is doing business. That is simply known as forum shopping.

The reason people do that is different States have different laws in terms of limitations on recovery. They have different rules of evidence. Some allow punitive damages—most do. Some cap those punitive damages, and don't allow punitive damages at all. So I don't believe we want to create a situation where if we are going to have this liberal litigation scheme that we have set up, that we allow it to occur anywhere in the country, which might be the case with regard to some big defendants.

Now, employers in some cases are going to be defendants also, I believe it is quite clear. You not only have the insurance companies, but you also have the employers to look at and to see whether or not they are doing business in these various States and, if they are, then you could bring your lawsuit in all those States for they are doing business. I don't think that serves the purposes that we are trying to serve with this legislation.

Therefore, we have the authority, and I think it would be a wise exercise of our authority and discretion, to limit those lawsuits. If you are from the State of Tennessee and you have a legitimate claim and you want to bring a lawsuit, you ought to be bound by the law in the State from which you come. You should not be able to forum shop.

Now, there might be some Federal causes of action that are also of the medically reviewable kind. We have been talking in this debate for several days about State causes of action, but we are really dealing with the laws of those States. They are causes of action based on the laws of individual States. So if a person wants to bring his lawsuit, he can still bring it in Massachusetts if he lives in Tennessee and he is bound by the law of Tennessee.

If there is a diversity situation in Federal court, where the Federal court has jurisdiction and you have a doing-business requirement satisfied as far as the corporate defendant is concerned, for example, you have diversity. You still are bound by the law of your home State. So that would prevent forum jumping.

I believe this is desirable. I heard several expressions of agreement with the proposition we did not want to create a system of forum shopping in this litigation. We are going to have this law apply to all 50 States there will be lawsuits produced in all 50 States, and all 50 States have laws that will be applicable in the suits wherever they are brought. A citizen ought to be bound by the laws of his or her State and not be able to shop all over the country for a potentially better situation than what they have in their State. It is a State cause of action. They should be bound by the laws of their home State.
That is the amendment. I hope my colleagues will see the wisdom of it and will agree to amendment on it.
I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, I say to my friend from Tennessee, his argument is persuasive enough that all the managers on our side left the floor, so I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call as the roll was read.

Mr. AKAKA. 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. AKAKA. Mr. President, I ask unanimous consent that I may be permitted to speak as in morning business for 5 minutes.

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

The remarks of Mr. AKAKA are located in today's Record under "Morning Business."

Mr. KENNEDY. Mr. President, I express great appreciation also for the Senator's strong support for our Patients' Bill of Rights. This has been an issue in which he has taken a great personal interest. He has been one of the strong supporters of this legislation for many, many years. Although he has not been a member of our committee, this is a matter I know he cares deeply about. He has been a strong supporter of all the amendments that have protected patients, and I don't think there has been a member who has been a stronger advocate for the patients and their rights than our good friend, the Senator from Hawaii. I thank him very much for his statement and all the work he has done to help bring the bill to where it is.

Mr. President, I understand the Senator from Nevada will modify his amendment and we will have a voice vote, and the Senator from Tennessee will have an amendment agreed to, also. Hopefully, we can dispose of those two amendments right now.

The PRESIDING OFFICER. The Senator from Nevada.

AMENDMENT NO. 59, AS MODIFIED

Mr. ENSIGN. Mr. President, I call up amendment numbered 59 and I send a modification to the desk.

The PRESIDING OFFICER. Without objection, the pending amendment is laid aside.

The amendment will be so modified.

The amendment (No. 59), as modified, is as follows:

Subtitled C of title I is amended by adding at the end the following:

SEC. 122. GENETIC INFORMATION.

(a) DEFINITIONS.—In this section:

(1) the spouse of the individual; and

(2) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

(3) all other individuals related by blood to the individual or a family member of such individual described in subparagraph (A) or (B).

(2) GENETIC INFORMATION.—The term "genetic information" means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member of such individual (including information about a request for or the receipt of genetic services by such individual or a family member of such individual).

(3) GENETIC SERVICES.—The term "genetic services" means health services, including genetic tests, provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

(4) GENETIC TEST.—The term "genetic test" means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including any gene, gene product, or inherited characteristic, including a cholesterol test, such as a chemical, blood, or urine analysis of an individual, including a cholesterol test, or a physical exam of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.

(5) GROUP HEALTH PLAN, HEALTH INSURANCE ISSUER.—The terms "group health plan" and "health insurance issuer" include a third-party administrator or other person acting for or on behalf of such plan or issuer.

(6) PREDICTIVE GENETIC INFORMATION.—

(A) IN GENERAL.—The term "predictive genetic information" means—

(i) information about an individual's genetic tests;

(ii) information about genetic tests of family members of the individual; or

(iii) information about the occurrence of a disease or disorder in family members.

(B) LIMITATIONS.—The term "predictive genetic information" shall not include—

(i) information about the sex or age of the individual;

(ii) information about chemical, blood, or urine analyses of the individual, including cholesterol tests, unless these analyses are genetic tests; and

(iii) information about physical exams of the individual, and other information relevant to determining the current health status of the individual.

(b) NONDISCRIMINATION.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—A group health plan, and a health insurance issuer offering health insurance coverage, shall not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on genetic information (or information about a request for or the receipt of genetic services by such individual or a family member of such individual) in relation to the individual or a dependent of the individual.

(2) NO DISCRIMINATION IN RATE BASED ON PREDICTIVE GENETIC INFORMATION.—A group health plan, and a health insurance issuer offering health insurance coverage, shall not deny eligibility or adjust premium or contribution rates on the basis of all the predictive genetic information concerning an individual (or information about a request for or the receipt of genetic services by such individual or a family member of such individual).

(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

(1) LIMITATION ON REQUESTING OR REQUIRING PROVIDER'S GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan, or a health insurance issuer offering health insurance coverage, shall not request or require the provider's genetic information concerning an individual or a family member of the individual (including information about a request for or the receipt of genetic services by such individual or a family member of such individual).

(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

(A) IN GENERAL.—The term "information needed for diagnosis, treatment, or payment" includes the following:

(i) information about the sex or age of an individual; and

(ii) information about the occurrence of a disease or disorder in family members.

(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the health insurance issuer offering health insurance coverage, shall provide the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.

(1) NOTICE OF CONFIDENTIALITY PRACTICES.—A group health plan, or a health insurance issuer offering health insurance coverage, shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan or issuer's confidentiality practices, that shall include—

(A) a description of an individual's rights with respect to predictive genetic information; and

(B) the procedures established by the plan or issuer for the exercise of the individual's rights; and

(2) COMPLIANCE WITH CERTAIN STANDARDS.—With respect to the establishment and maintenance of safeguards under this subsection, the plan or issuer shall ensure that each group health plan, or health insurance issuer, shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan or issuer.

(e) SPECIAL RULE IN CASE OF GENETIC INFORMATION.—With respect to genetic information concerning a request for or the receipt of genetic services by an individual or a family member of such individual, the confidentiality practices of the plan or issuer shall be deemed to be in compliance with such subsections if such plan or issuer is in compliance with the standards promulgated by the Secretary of Health and Human Services under—

(A) part C of title XI of the Social Security Act (42 U.S.C. 1320d–2 note); or

member of such individual) shall not be con-
structured under any provision of State law that establishes, implements, or con-
tinues in effect a standard, requirement, or remedy that more completely—
(1) protects the confidentiality of genetic information (including information about a request for or the receipt of genetic services by an individual or a family member of such individual) or the privacy of an individual or a family member of the individual with re-
spect to genetic information (including information about a request for or the receipt of genetic services by the individual or a family member of such individual); or
(2) prohibits discrimination on the basis of genetic information than does this section.

At the end of title II, insert the following:

SEC. 203. ELIMINATION OF OPTION OF NON-FED-
ERAL GOVERNMENTAL PLANS TO BE
EXCEPTED FROM REQUIREMENTS
CONCERNING GENETIC INFO-
RATION.

Section 7271(b)(2) of the Public Health Service Act (42 U.S.C. 300gg-21(b)(2)) is amended—
(1) in subparagraph (A), by striking “If the plan sponsor” and inserting “Except as pro-
vided in subparagraph (D), if the plan spon-
sor”;
and
(2) by adding at the end the following:

“(D) ELECTION NOT APPLICABLE TO REQUIRE-
MENTS CONCERNING GENETIC INFORMATION.—
The election described in subparagraph (A) shall not be available with respect to the pro-
visions of subsections (b), (c), and (d) of section 122 of the Bipartisan Patient Protec-
tion Act and the provisions of section 2702(b) to the extent that the subsections and sec-
tion apply to genetic information (or infor-
mation about a request for or the receipt of genetic services by an individual or a family member of such individual).”.

Mr. ENSIGN. I ask that the yeas and nays be viti-
ated.

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

Mr. ENSIGN. Mr. President, I understand both sides have agreed to this amendment. It has to do with genetic testing. We debated it last night. I ap-
preciate Senators KENNEDY, GREGG, and MCCAIN working together, along with the White House, to make sure we are moving forward against people based on genetics; that people with the breast cancer gene or colon cancer gene, or whatever gene they may have been born with, will not be discrimi-
nated against in the future. I appre-
ciate everybody working with us on this matter.

Mr. KENNEDY. Mr. President, we are prepared to accept this amendment.

The PRESIDING OFFICER. The question is on agreeing to the amend-
mendment (No. 849), as modi-
fied, was agreed to.

Mr. KENNEDY. I move to reconsider the vote by which the amendment was agreed to.

Mr. GREGG. I move to lay that motion on the table.

The motion to lay on the table was agreed to. 

AMENDMENT NO. 853

The PRESIDING OFFICER. The Sen-
ator from Tennessee.

Mr. THOMPSON. I believe I am cor-
rect in saying my amendment has been accepted and it is agreeable to have a voice vote.

Mr. KENNEDY. The Senator is cor-
rect.

The PRESIDING OFFICER. The question is on agreeing to the Thomp-
son amendment, No. 853.

The amendment (No. 853) was agreed to.

Mr. KENNEDY. Mr. President, I sug-
gest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

AMENDMENT NO. 852, AS FURTHER MODIFIED

Mr. REID. Mr. President, I ask that the amendment of the Senator from Virginia be called up, the yeas and nays be withdrawn, and it be agreed to by voice vote.

Mr. WARNER. Reserving the right to object, should we lay out a full understand-
ing of our agreement?

Mr. REID. I think we should just
vote.

Mr. WARNER. Your amendment is withdrawn?

Mr. REID. Yes.

Mr. WARNER. I send a modification to the desk.

Mr. REID. This is the Warner sub-
stitute.

Mr. WARNER. Mr. President, my modification has been sent to the desk.

The PRESIDING OFFICER. The amendment is so modified.

The amendment (No. 853), as further modified, 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 ATTORNEYS’ FEES.—
“(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrange-
ment, agreement, or contract regarding an attorney’s fee, the amount of an attorney’s con-
tingency fee allowable for a cause of action brought pursuant to this subsection shall not exceed ¼ of the total amount of the plaintiff’s recovery (not including the reimburse-
ment of actual out-of-pocket expenses of the attorney).

“(B) DETERMINATION BY COURT.—The last Federal district court in which the action was pending upon the final disposition, including all appeals, of the action shall have jurisdiction to review the attorney’s fee to ensure that the fee is a reasonable one.

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

“(9) LIMITATION ON ATTORNEYS’ FEES.—
“(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrange-
ment, agreement, or contract regarding an attorney’s fee, the amount of an attorney’s con-
tingency fee allowable for a cause of action brought under paragraph (1) shall not exceed

”

Mr. WARNER. We have worked it out together. I ask that the yeas and nays be withdrawn.

The PRESIDING OFFICER. Without objection, the yeas and nays are viti-
ated.

Mr. WARNER. Mr. President, I understand will proceed to a voice vote and the amend-
ment of my distinguished colleague will be withdrawn.

The PRESIDING OFFICER. The question is on agreeing to the amend-
ment (No. 833), as further modified.

The amendment (No. 833), as further modified, was agreed to.

Mr. WARNER. Thank you, my distin-
guished colleague from Nevada.

Mr. WARNER. Mr. President, I move to reconsider the vote and move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 852, WITHDRAWN

Mr. REID. I ask unanimous consent my amendment be withdrawn.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The PRESIDING OFFICER. The Sen-
ator from New Hampshire.

Mr. GREGG. As I understand it, we are down to two amendments on our side: Senator KYL’s and Senator PRIST’s, which will be the substitute.

I hope we can get a time agreement on Senator KYL. How much time does the Senator need? He does not know. And Senator CARPER, on the other side, is going to make a statement and maybe offer an amendment.

Before they go, since people are a lit-
tle confused, so they can get ready, we are heading toward the finish line. Be-
fore we get to the finish line, I want to mention that a lot of people do a lot of work around here. They are called the staff. They are extraordinary. I espe-
cially want to thank my staff, Senator KENNEDY’s staff, Senator PRIST’s staff, who have worked so hard on this. I am sure there are many folks on the other side, but I specifically want to thank Colleen Cresianti, Steve Irizarry, Kim Monk, and Jessica Roberts for all they have done to make this process move smoothly for me and allow me to be successful. They really have put in extra-

ordinary hours. I greatly appreciate
Mr. CARPER. Mr. President, the amendment is as follows:

(Proposed by Mr. CARPER)

Amendment No. 855

Mr. CARPER. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The amendment is as follows:

The amendment is as follows:

(Proposed by Mr. CARPER)

Amendment No. 855

Mr. CARPER. Mr. President, I send an amendment to the desk and ask for its immediate consideration. The amendment is as follows:

The amendment is as follows:

(Proposed by Mr. CARPER)

Amendment No. 855

Mr. CARPER. Mr. President, I send an amendment to the desk and ask for its immediate consideration. The amendment is as follows:

The amendment is as follows:

(Proposed by Mr. CARPER)

Amendment No. 855

Mr. CARPER. Mr. President, I send an amendment to the desk and ask for its immediate consideration. The amendment is as follows:

The amendment is as follows:

(Proposed by Mr. CARPER)

Amendment No. 855

Mr. CARPER. Mr. President, I send an amendment to the desk and ask for its immediate consideration. The amendment is as follows:

The amendment is as follows:

(Proposed by Mr. CARPER)

Amendment No. 855

Mr. CARPER. Mr. President, I send an amendment to the desk and ask for its immediate consideration. The amendment is as follows:

The amendment is as follows:

(Proposed by Mr. CARPER)
which allows forum shopping for the best punitive damage opportunities; whereas, under today's law, punitive damages are radicidally distributed, and should be because the purpose is to create quality health care, and punitive damage awards would drive up insurance costs. That is passed on to the consumer, which means fewer people can afford health care.

As a practical matter, I want to say that I think the Senator from Delaware is on the right track, and I hope the conference will listen to his comments.

Mr. CARPER. Mr. President, will the Senator yield? I say to my friend from New Hampshire that my fervent hope is that when the bill passes the Senate and later the House, and the conference committee is established, the conference will see that this is a compromise revisited on this issue. My hope is that the final compromise will reflect this amendment.

I also want to express to the Senator from New Hampshire my heartfelt thanks for the leadership he has provided to the Republican side of the aisle on this issue, and my appreciation for a chance to work with him, as well as the Senator from Massachusetts.

Thank you.

Mr. GREGG. I thank the Senator from Delaware.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Amendment No. 854

Mr. KYL. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The senior assistant bill clerk read as follows:

The Senator from Arizona (Mr. KYL) proposes an amendment numbered 854.

Mr. KYL. Mr. President, I ask unanimous consent that the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To permit choices in costs and damages)

On page 156, between lines 15 and 16, insert the following:

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(17) DAMAGES OPTIONS.—

(A) IN GENERAL.—In addition to plans or coverage that are subject to this Act, a plan or issuer may offer, and a participant or beneficiary may accept, a plan or coverage that provide for the following remedies, in which case the damages authorized by this section shall not apply:

(1) Equitable relief as provided for in subsection (a)(1)(B).

(2) Unlimited economic damages, including reasonable attorneys fees.

(B) PROTECTION OF THE REGULATION OF QUALITY OF MEDICAL CARE UNDER STATE LAW.—Nothing in this paragraph shall be construed to preclude any action under State law against a person or entity for liability or vicarious liability to the delivery of medical care. A claim that is based on or otherwise relates to a group health plan's administration or determination of a claim for benefits (notwithstanding the definition contained in paragraph (2)) shall not be deemed to be the delivery of medical care under any State law for purposes of this section. Any such claim shall be maintained exclusively under this section.

On page 179, between lines 21 and 22, insert the following:

(9) DAMAGES OPTIONS.—

(A) IN GENERAL.—In addition to plans or coverage that are subject to this Act, a plan or issuer may offer, and a participant or beneficiary may accept, a plan or coverage that provide for the following remedies, in which case the damages authorized by this section shall not apply:

(a) Equitable relief as provided for in section 502(a)(1)(B).

(b) Unlimited economic damages, including reasonable attorneys fees.

(B) PROTECTION OF THE REGULATION OF QUALITY OF MEDICAL CARE UNDER STATE LAW.—Nothing in this paragraph shall be construed to preclude any action under State law against a person or entity for liability or vicarious liability to the delivery of medical care. A claim that is based on or otherwise relates to a group health plan's administration or determination of a claim for benefits (notwithstanding the definition contained in section 502(a)(2)) shall not be deemed to be the delivery of medical care under any State law for purposes of this section. Any such claim shall be maintained exclusively under section 502.

Mr. KYL. Mr. President, it has been requested that the time agreement on this amendment be 30 minutes on my side and 10 minutes in opposition, with an up-or-down vote at the conclusion of the debate. I propose that unanimous consent request.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Reserving the right to object, Mr. President, that is fine with no second degrees in order. Is that right?

Mr. KYL. That would be my understanding. I thank the Senator from Nevada.

The PRESIDING OFFICER. Does the Senator so modify his request?

Mr. KYL. I do indeed modify my unanimous consent request.

The PRESIDING OFFICER. Is there objection?

Mr. KYL. Mr. President, I rise to introduce the consumer health care choice amendment. This amendment would amend section 302 of the underlying legislation to provide that employers and health plan issuers would be free to offer, and participants and beneficiaries free to choose, health plans with two remedy options, in addition to the underlying plan: equitable relief—the benefit or value of the benefit; and unlimited economic damages.

The bill provides damages as provided under S. 1052 unlimited economic and non-economic, and up to $5 million in punitive damages.

This amendment applies only to the new remedies established by S. 1052 for Federal contract actions and states "medically reviewable" claims. It explicitly protects the regulation of medical care delivery under state law.

The problem: Increased premium costs lead to greater numbers of uninsured. The Congressional Budget Office predicts that S. 1052 could result in a 4.2 percent increase in premiums costs. This predicted increase is in addition to the 10–12 percent increase employers are already facing this year.

The CBO report illustrates the cold truth about a critical, but often overlooked, public policy issue: The irrefutable link between health care premium increases and the number of Americans without insurance. As the Congress debates the various health care proposals, we must keep this linkage in mind.

Supporters of S. 1052 are quick to claim that their bill will improve health care, but not so quick to admit that it will also raise costs and cause this legislation to pass. We know this will happen, because cost increases will cause some employers to stop offering health care coverage, making insurance unaffordable for more Americans. This fact is politically inconvenient. We should keep an important statistical fact in mind. According to the Lewin Group consulting firm, for each one percent premium increase, an additional 300,000 citizens lose their insurance.

As I mentioned, the Congressional Budget Office predicts that S. 1052 will increase premiums by 4.2 percent. A premium increase of this amount would cause about 1.3 million Americans to become uninsured as a result of S. 1052. The Office of Management and Budget recently predicted that between 4–6 million more Americans would become uninsured as a result of S. 1052.

How can we call this a Patients Bill of Rights when it will result in fewer patients?

I believe our first goal should be "do no harm"; or, at a minimum, to reduce the harm, as my amendment will do.

My amendment would allow employers or plans to offer two options for employees to voluntarily choose, in addition to the general plan covered by this bill, Option No. 1: A mid level premium policy with a remedy limited to the benefit, or the value of the benefit; Option No. 2: A mid level premium policy that would allow for full economic damages only.

There are in addition to the higher premium policy that would allow for the full range of damages provided under S. 1052.

This amendment should be appealing to employers and plans as a way to control their costs and appealing to employees as a way to hold down their premiums by voluntarily limiting their risk to the insurer.

Data from the CBO and the Kaiser Family Foundation estimate that S. 1052 would cost a typical family with health care coverage roughly $300 per year.
Certainly, we should promise not to pass legislation that would reduce or completely consume the $300 billion or more that Americans will be receiving sometime this summer as a result of the tax-relief bill just signed into law by President Bush.

If adopted, this amendment would afford Americans a chance to recoup some of the loss imposed by S. 1052.

Some have argued that so-called patients’ rights legislation that includes an unlimited right to sue is overwhelmingly popular with Americans. It is worth noting that a Kaiser Family Foundation/ Harvard School of Public Health Survey from January 2001 asked the following question to voters: “Would you favor a law that would raise the cost of health plans and lead some companies to stop offering health care? I will probably do more to this question, only 30 percent voiced support, and 70 percent voiced opposition to such a law.

Fortunately, we don’t have to force people to make that choice. We can give them a chance. For those who prefer the right to sue and are willing to pay they have their plan. For those who are willing to forgo lawsuit, they can buy their plan. And, state remedies apply in any event—so called “quality of care” suits.

Certainly, enhancing a patient’s right to sue is cold comfort to those who currently can’t afford health insurance, or those who lose their coverage due to increased costs.

Clearly, the proposed legislation to reform health care comes with a steep price tag attached. Before we commit to passing legislation, perhaps we should first promise not to pass a bill that will lead to more uninsured Americans.

My amendment would merely reduce this price tag, and reduce the harm we will do by enacting S. 1052.

This amendment is very simple. I ask for my colleagues’ attention because I can’t imagine that anyone would want to oppose this amendment if the concern is really about patients rather than lawyers.

Let me restate that. If we are really concerned about health care for patients rather than fees for lawyers, this amendment makes that possible. For those who prefer to this question, only 30 percent voiced support, and 70 percent voiced opposition to such a law.

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My amendment would merely reduce this price tag, and reduce the harm we will do by enacting S. 1052.

This amendment is very simple. I ask for my colleagues’ attention because I can’t imagine that anyone would want to oppose this amendment if the concern is really about patients rather than lawyers.
health care, we should make it available, affordable, and safe. One of our greatest concerns about this bill in its present form is health insurance for patients, and what they have available through managed care is not going to be affordable. Rates are going to go up. They are going to lose coverage for a variety of reasons. So it is a question of availability and affordability.

This is a good, viable alternative. This provides a low-cost option that will, hopefully, result in more people keeping their coverage. But it is an option. It is not in place of; it is in addition to what will be available otherwise. It just gives plans the option of offering a low-cost alternative that forgoes lawsuits damages under the law. The State court would still have the “quality of care” damage available. Those revenues would still be there. You don’t replace that.

So I want to emphasize, it is not in lieu of but it is in addition to the plans offered under the bill. This really is about patients, and it really is about the freedom to have a choice, to have an option to choose to have this coverage but not going to lawsuits later on. By paying less, they will be able to afford it. That will give them an option. I think this would be a very attractive way to make sure it is available and affordable.

I would like to speak at greater length on this myself, but in the interest of time I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, I commend the Senator from Arizona, Mr. KYL, for his amendment, which is strikingly similar in concept—as he and I discussed off the floor earlier—to the Auto Choice proposal I have introduced last year. Two Congressmen, cosponsored by Senator Moynihan and Senator LIEBERMAN.

Essentially what is envisioned in these kinds of choice proposals is giving the consumer the option of opting out of the litigation lottery in return for a lower premium and lower cost. I want to ask the Senator from Arizona if it is his view that this is similar in concept to the Auto Choice measure that I just described that we have discussed.

Mr. KYL. Mr. President, if I may answer the question of the Senator from Kentucky, I am remiss for not acknowledging that my idea for this amendment came exactly from the proposal the Senator has just discussed. It seemed to me that if it worked well in that context, it would also work well in this context. I should have mentioned that earlier. I know the Senator did not ask the question to get credit, but credit certainly is due him for this idea.

Mr. MCCONNELL. I cannot announce the support of others, but I wanted to mention that on the Auto Choice bill there was also the support of Michael Dukakis, Joe Lieberman, Pat Moynihan, the Democratic Leadership Council, the New York Times, and the Washington Post.

I cannot say for sure that they would support the amendment offered by the Senator from Arizona, but the concept he describes of giving the consumer the option—the consumer gets the option of leaving aside the litigation lottery in return for a lower premium and defined benefits provided for that lower premium. It does not really deny anybody. It does not deny them the right to sue. It does not put a cap on damages. It does not tell the lawyers what to charge. It simply says to the consumer: You have a choice.

What the Senator from Arizona is suggesting is to take what is a sound idea for the personal insurance market, Auto Choice, and apply it to the health insurance market.

Under his amendment, employers would have the option of offering their employees up to two additional insurance plans. It is given the additional causes of action permitted under this bill, I believe giving consumers the option not to participate in the personal injury litigation lottery is only appropriate.

It is important to note, just like my Auto Choice option, choosing Senator KYL’s “Health Choice” option would be completely voluntary to both the employer and the employees. An employer who offers his employees health insurance would not be allowed to offer only the limited-litigation health policies. Nothing in the Kyl amendment would. The employer must offer the plans envisioned in the Kennedy-McCain bill. Therefore, nothing in the Kyl amendment would take away any right. It would allow employers who don’t want to sue their health insurance plan, a lower cost health insurance option.

While we have made significant progress at improving this legislation, many of us on this side of the aisle have lingering concerns that this bill will dramatically increase the number of uninsured Americans. We ought do everything possible to minimize this impact and that is why I wholeheartedly support the amendment of the Senator from Arizona. Patients need more choices and should not be forced into a system of jackpot justice without their consent.

As the Senator from Arizona has pointed out, we hope not to have a greater number of uninsured when this is all over. One of the great fears many of us have who are going to be voting against this bill is that that is exactly what the result of it will be. But the Senator from Arizona has astutely offered an amendment that will certainly provide an opportunity for a number of people to receive lower premiums and thereby, hopefully, reducing the increase in the number of uninsureds which so many of us fear.

So I express my strong support for the Senator’s Amendment. I tell him, I think it is a very good idea. I hope the Senate will support it. It seems to me it is entirely consistent with the theme of the underlying bill. I commend the Senator from Arizona for his fine amendment.

Mr. KYL. I thank the Senator.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, as I listened to the proposal by the Senator from Arizona, the thought came to my mind about the right of an individual to waive rights. That is deeply ingrained as part of the law of the United States, so much so that when you talk about constitutional rights in a criminal case—where the rights are much more deep-seated, much more profound, based on the Constitution—that right to waive does exist.

In a sense, what the Senator from Arizona is proposing is that an individual could have health care insurance would have the right to waive certain rights, which is recognized in law.

The keyword which I found persuasive in what the Senator from Arizona had to say was the word “voluntary.” I would add to that—I think this is part of his concept—that it be a knowing waiver—a voluntary, knowing waiver. And I would expect that, as part of that, the individual would have counsel to understand his rights, because you cannot understand your rights for damages—the complexities unless you know what they are, and whatever may be said about lawyers on this floor, you need a lawyer to tell you what your rights are. Then the individual would be in a position to evaluate the reductions in premiums and thereby which savings would be passed on to him for what he was giving up.

In that context, I think the proposal passes muster.

Mr. KYL. I thank the Senator.

Mr. SPECTER. I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, I, too, thank the Senator from Arizona, Mr. KYL, for bringing this amendment to us.

This debate has been framed as though everybody had all of their insurance paid for by the company for which they work. I know that is not the case. Throughout America, most people participate in the cost of their insurance. So it is going to be very important for every individual who has to participate in the cost of their insurance to be searching, with their employer, for a lower cost way of doing it.

The concept of those options. This is very innovative. It will fill a void we have left by doing the bill, particularly if the estimates are true on how much insurance is going to go up based on
this ability to sue. If it goes up dramatically, there are going to be a lot more people who are going to hope there is some kind of an alternative around.

So I congratulate the Senator from Arizona for this approach.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. THOMPSON. Mr. President, I also join in congratulating the Senator from Arizona. This seems to be the most commonsense amendment we have seen since we have been discussing this issue. It provides choice and provides an opportunity for lower cost insurance, and it allows people to choose what they want to pay for, for what they get.

So I urge support for the Senator’s amendment and thank him for it.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. THOMPSON. Mr. President, I also urge support for Senator KYL’s amendment because I think it deals with the essential nature of what this whole debate is about; this is, the tradeoff between coverage and cost. That is what the whole debate is about.

Some would have us believe we can have additional coverage without additional cost. It cannot happen. Somebody pays the freight sooner or later. We all know it is going to result in additional health care costs.

So what this amendment does is recognize that tradeoff, and it provides the individual the opportunity to make that choice—recognizing that tradeoff—which results in a very good approach and a very good amendment.

So I urge my colleagues to give serious consideration to supporting this amendment.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Mr. President, I join with my colleagues in congratulating Senator KYL for bringing this amendment forward. It is exactly one of the items we need to improve this bill significantly. This bill has a lot of problems. We all know that. But an amendment such as Senator KYL’s will at least help it out in some parts. It will be very constructive to the whole process. I certainly hope my colleagues in the Senate support Senator KYL for bringing this amendment forward.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. How much time do we have?

The PRESIDING OFFICER. The opponents have 10 minutes under the previous order.

Mr. KENNEDY. I yield myself 5 minutes.

Mr. President, having been on the floor for the better part of the last 8 or 9 days, I rarely have heard such wonderful statements and comments about any amendment as have been given to the Senator from Arizona. I have gone back over the tradeoff and thought that somehow I must be making a mistake in thinking that this amendment just didn’t make it, but in any event, the Senate is going to make that judgment.

Mr. GREGG. Will the Senator yield? That quote would be much better if it were read in French.

Mr. KENNEDY. Petite a petite, l’oiseau fait son nid.

Mr. GREGG. It says that any employer can go out and sell an insurance policy that is consistent with this bill. It doesn’t indicate what contribution the employer has to make. It doesn’t indicate that the employer has to make any contribution at all. It all says is he has to sell it.

On the other hand, they can sell it and provide the choice—what is cheap—which the employer can help subsidize for that employee. And that basically undermines this whole bill and denies all of the workers all of the protections that we have talked about. That is a great choice. That is really a wonderful choice to have. And we all know what can happen. This basically undermines the whole concept of this legislation.

There is no guarantee under the Senator’s proposal that there is going to be a comparable and that the employer is going to do it. All they have to do is just sell the policy. So this is an extremely harmful and weighted alternative. Basically, it will provide a way, a vehicle for millions and millions and millions of hard-working American families to lose the benefits of this legislation, and it just doesn’t make sense.

The PRESIDING OFFICER. The Republican leader.

Mr. LOTT. I believe that perhaps if Senator KYL or others can yield back their time, we are ready to go to the Frist-Breaux substitute. Senator Frist is here ready to proceed. Is that acceptable on all sides?

Mr. REID. We would vote on the KYL amendment subsequent to the Frist-Breaux amendment being offered.

Mr. LOTT. That is correct. We would vote in stacked series, KYL, Breaux-Frist, and then I presume we would be ready for final passage.

Mr. KYL. Mr. President, if I could just conclude my remarks in support of my amendment and in response to Senator KENNEDY, how much time remains under my time?

The PRESIDING OFFICER. The Senator has 12 minutes.

Mr. KYL. I understand that Senator Frist would like to quickly proceed. There are several people who would like to speak in favor of my amendment. Therefore, what I would like to propose is that we lay my amendment aside, go to Senator Frist, and I take up the remainder of my time prior to the vote.

Mr. REID. I have no objection.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered. The amendment is laid aside.

AMENDMENT NO. 856

Mr. FRIST. Mr. President, I call up amendment No. 856 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The senior assistant bill clerk read as follows:

The Senator from Tennessee (Mr. FRIST), for himself and Mr. BREAUX, proposes an amendment numbered 856.

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

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

(The text of the amendment is printed in today’s Record under “Amendments Submitted.”)

Mr. FRIST. Mr. President, I will be brief, given the late hour.

At this juncture, I have introduced an amendment which is a comprehensive approach to the Patients’ Bill of Rights. Essentially this bill is the Frist-Breaux-Jeffords bill which was introduced on May 15 of this year, modified with several of the amendments, which we will speak to shortly in the introduction either now or, if we have an interruption, we will speak to them in the 15 minutes on this side.

What I wish to stress is that this amendment is a comprehensive replacement for this bill. It involves strong patient protections, access to specialists, access to specialty care, access to emergency rooms, elimination of gag clauses, continuity of care.

It has a strong appeals process, internal and external appeals. It requires full exhaustion of the internal and external appeals process. If the external decision—an independent physician, unbiased, independent of the plan—overrides the plan, then and only then does one go to court for the extraordinary damages. At any time during the appeals process you can go for what is called injunctive relief. Once you go for these damages, what are the extraordinary damages? One is, noneconomic damages are unlimited; noneconomic damages are $750,000 or three times economic damages. And that is a change from the underlying Frist-Breaux-Jeffords bill.

There are no punitive damages. In other words, I mention that we require full exhaustion of the internal and external appeals process. We go to Federal court. We have not had much debate over the last week on the Federal
versus State court. Senator Breaux will be speaking more directly to that. It is critical, we believe, that we work this out and get some motion to the Federal courts. There are strong timelines.

The purpose of this amendment is to make sure people get the care they need when they need it—not a year later in 2 years later or 5 years later. It is a balanced approach. The amendment itself is the Frist-Breaux-Jeffords of May 15. We have included the amendments put forth by Senator Thompson and modified by Senator McCain on the exhaustion of internal/external appeals. We have also included the Snowe-DeWine language. That is the direct decisionmaker language that they drew upon from our bill, the Frist-Breaux-Jeffords bill. But we took the specific Snowe-DeWine amendment and placed it in our bill; in addition, the amendment of Senator Bond, with the 1 million uninsured, then the liability would be repealed, which passed on the floor, is also a part of our bill.

Secondly, we did raise the non-economic caps from $500,000 to $750,000 or three times economic damages.

As a physician, as someone who has taken care of patients, as someone who recognizes that the purpose of a Patients’ Bill of Rights is for patients to get the care when they need it, not extraordinary lawsuits, not frivolous lawsuits and skyrocketing costs, all of which will be absorbed by the 170 million people, we believe this bill is the balanced, responsible way of delivering a strong enforceable Patients’ Bill of Rights.

I yield to Senator Breaux.

Mr. BREAUX. Mr. President, do we have a time agreement on this amendment?

The PRESIDING OFFICER. There is no time established on this amendment.

Mr. BREAUX. Let’s try it without an agreement. We will see how it goes without any kind of agreement.

Mr. President, I rise to comment on the bill that is now before the Senate. It is the Frist-Breaux-Jeffords substitute bill.

Before doing so, while the Senator from Tennessee is still on the floor, I want to say something about how enjoyable it has been to work with him. While none of us are going to be leaving this Chamber tonight or tomorrow sometime to spend time with our family on vacation or have an enjoyable period of time that we can rest and relax, the Senator from Tennessee, because of what he does professionally and what he believes in, is going to be leaving on a flight tonight to go to Africa. He is going to Africa to do surgery on women and children and families who cannot afford health care on the continent of Africa.

I want to say how proud all of us can be of one of our colleagues who has that type of attitude. He not only serves his constituents in Tennessee in this body but also serves so much of humanity in various places in the world by volunteering at his own cost, on his time, with his medical expertise, serving people who have no healthcare. We are talking about a Patients’ Bill of Rights on the floor of the Senate. He really, truly is practicing that by providing medical services people who can’t afford it in various parts of the world.

For those who are interested in getting a Patients’ Bill of Rights enacted into law, let’s do without the amendment that we have offered, the bill will not become law because the President has clearly indicated he will veto a bill that does not contain some of the main principles that you can find in the Frist-Breaux-Jeffords substitute.

What I am talking about is not that complicated. The White House has said we are creating new Federal rights, Federal remedies, and we are amending a Federal statute—the ERISA laws of the United States. If there is going to be any litigation dealing with these new Federal rights, they ought to be handled in the Federal courts. Why do we recommend that? Why does the President say that is important? So we can have one consistent way of handling all of these potential suits that will be filed. Instead of having 50 different courts, with 50 different jurisdictional rules of evidence and 50 different procedures on how to handle litigation, you would have any disputes dealing with these Federal rights handled in the Federal court systems of the United States.

Our opponents argue that the Federal courts don’t want any more suits to be filed. Neither do the State courts. There is not a State court or district court anywhere in the United States that is going to say we need more litigation, come sue on a State level. Neither the Federal nor State courts want any additional litigation because they are as full as they possibly can be. So the argument that the Federal courts don’t want them—well, neither do the State courts. The real reason of trying to make sure we have a system that works, that is, a national system that protects Federal rights, it should be in Federal court.

If this is not part of the final package, the final package, indeed, will not become law, and that would be a very serious mistake for the people in this country.

Second, we have recommended some type of caps—a reasonable amount of caps on noneconomic damages. We have not been asked to do so, of course, but we suggested a cap of $750,000 for pain and suffering, for noneconomic damages, or three times the amount of economic damages, whichever is greater. We tie it to inflation. I think that is reasonable to sign this bill.

We had also suggested something I think would be very important for the patients and, indeed, the lawyers who are concerned about litigating cases. There are no caps on our bill for gross negligence. At an earlier time we had offered that there would be no caps for wrongful death if a person was killed as a result of some decision made dealing with medical necessity. Then there would be no caps whatsoever either for gross negligence or wrongful death.

Those two ingredients are very important. What happens when this bill leaves this body, if we are truly interested in getting an agreement, is that somehow between now and the time it all gets down to the White House, these concerns are going to have to be addressed in a fashion that I think means they are going to have to be adopted. It does us no good to have a bill that is going to be vetoed. We will help no patients. They get a good political issue, but they don’t get any help, any guarantees. We will have spent all of this time arguing about things that cannot become law. So I think the clear thing that our bill provides, which I think is absolutely essential either now or at some time, is that we have a degree of Federal jurisdiction that enforces the Federal rights that we are creating in this legislation, and that we address the question of unlimited damages in a way that allows the White House to be able to sign this bill.

I will tell you that in reading what we have done with all of the amendments—the Snowe, Thompson, and DeWine amendments—where we have split jurisdiction, and the Kennedy-McCain bill which says some of the suits will be in State court and some in Federal court, our suggestion is just the opposite. The new rights will be in Federal court, and all the previous ones in the State courts will remain.

We or on this. We have created something that is as complicated as the Egyptian hieroglyphics. If you had a flowchart on what we are suggesting in the bill now before the Senate, we could not figure out where you go and when you go to the different courts and for what rights. That is unacceptable. This thing needs a lot of work before it can become law because I am afraid that what we have created tonight in this bill is unmanageable and reasonable suggestion makes it a great deal better.

I am under no illusions about what is going to happen, but I know I am also not under any illusions about what can
be signed into law and what cannot. I fear that what we have tonight cannot be signed into law without the recommendations we have made.

I yield the floor. I see my colleague from Vermont is also with us.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

Mr. President, for nearly 5 years, Congress has debated how best to enhance protections for patients enrolled in managed care plans without unduly increasing health care costs, imposing significant burdens on America’s employers, and adding to the ranks of the uninsured. Our debate over the last two weeks has given us ample opportunity to thoroughly discuss these critical issues.

Through the amendment process the McCain-Edwards-Kennedy bill has been significantly improved. I particularly commend Senator SNOWE for her amendment on employer liability and Senator THOMPSON for his amendment on exhausting the appeals process.

However, I believe the McCain-Edwards-Kennedy bill is still fundamentally flawed in two critical areas. First, the bill would subject plans to excessive damages in the new federal cause of action. And second, by subjecting plans and employers to a new State cause of action, the bill destroys the current national uniformity for employers. The bill would subject employers or their designated agents to lawsuits in 50 different States.

The better alternative to the McCain-Edwards-Kennedy bill is our amendment. It is based on the legislation that I introduced with Senator FRIST and Senator BREAUX. It has much in common with the McCain-Edwards-Kennedy bill. They share 11 provisions that are protecting the new patient protections. Each provides for information to assist consumers in navigating the health care system. Most importantly, the bills provide for an internal and external independent review process with strong new remedies when the external view process fails. Our primary area of disagreement lies in the degree that employers are protected from multiple causes of action in multiple venues and the provision of a reasonable cap on damages.

President Bush has made clear that our amendment meets the principles he has outlined for patient protection legislation that he would sign into law. This balanced legislation also is supported by a wide range of groups representing nearly 400,000 of America’s physicians and health professionals.

Our amendment protects all Americans in private health plans and at the same time, it gives deference to the States to allow them to continue enforcing nation-wide laws consistent with the new federal rules.

Under our amendment health plans that fail to comply with independent review decisions or that harm patients by delaying coverage will be held accountable through expanded federal court remedies, including unlimited economic damages. In addition, patients can go to court at any time to get the health benefits they need through injunctive relief if going through the internal or external review process would cause them irreparable harm.

We hope that everyone who is committed to passing legislation that can become law this year will join us in supporting this amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Mr. President, over the course of the last 2 weeks, during the course of this debate, we have made great progress and consensus has been reached on many issues, beginning with the issue of scope, how many Americans would be covered by this patient protection legislation.

We have worked with Senators across the aisle and have been able to resolve that issue and resolve it in a way that all Americans are covered and there is a floor of protection for all Americans.

Second, we were able to resolve the issue of access to clinical trials, an issue on which there has been some disagreement in this body.

Third, we have been able to resolve the issue of employer liability in a way that protects employers from liability without completely eliminating the rights of patients. We have done it in a balanced way so that 94 percent—every small employer in America—are 100 percent protected.

We have also resolved the issue of exhaustive appeals so patients will go through the appeals process to get the care they need before they go to court.

Medical necessity is another issue resolved during this debate.

All of these issues are the issues of great work many days, many hours of compromise, negotiation, and consensus reached in the Chamber of the Senate. This substitute abandons a number of those consensus agreements, starting with the issue of scope.

On the issue of scope, the Senator from Louisiana and I were able to fashion a provision that provides a floor and protects all Americans. That provision was voted on and consensus was reached. That consensus provision is not in this substitute.

Second, on the issue of exhaustion, the Senator from Tennessee and I worked to fashion a provision that provided a floor and assures that appeals before they go to court in a way that does not prevent patients who have an extended appeal from being harmed by that extended appeal. In other words, if it goes on 31 days or 90 calendar days, the law works simulatenous with the appeal. That exhaustion provision on which there was a huge vote in favor of it in the Senate is not in this substitute.

Third, the independence of the review panels: I concede I have not seen the language, but assuming it is the same language that was originally in the Frist-Breaux bill, it has no provision specifically requiring the so-called independent review panel be, in fact, independent; nothing requiring that the panel be independent; nothing requiring that it was not be controlled by the person who, in fact, is on the appeals panel. It is like the HMO being able to pick the judge and the jury. So there is not established to anyone’s satisfaction that, in fact, that appeals panel will be independent.

Finally, on the issue of going to Federal court versus State court, the American Bar Association, the Federal judiciary, the U.S. Supreme Court, the State attorneys general, all the objective, large legal bodies in this country have said that these cases should go to State court.

That is what our legislation provides. Unfortunately, under this substitute, a vast majority of cases would, indeed, go to Federal court.

Many Americans live hundreds of miles from the closest Federal courthouse. It would be much more difficult for these injured patients to get a lawyer to represent them in a Federal action, particularly one that might take place hundreds of miles away, and most important, and the reason so many of these objective bodies said these cases belong in State court, is that it will take so long to get the case heard. There is such a backlog already, it makes no sense to send these cases to Federal court.

What we have done instead is say: Yes, HMO, if you are going to overrule doctors, if you are going to make health care decisions, we are going to treat you exactly as we treat the other health care providers. We treat them exactly the same. It is the reason this is a critical provision, the American Medical Association, to all the doctors groups across this country and to the consumer groups across America.

There are fundamental differences in our underlying legislation, as amended, and in the substitute, starting with the issue of scope, about which we have reached consensus, going to the issue of exhaustion of administrative remedies, which is not in this substitute; the required independence of the review panel is not in the substitute; the requirement that the cases that every objective body says should go to State court, including the U.S. Supreme Court, those cases go to Federal court instead under this proposal.

We have made tremendous progress. I am very pleased with the work of all of our colleagues—Republicans, Democrats, and Independent—in this process. The work has been productive. We have done important work in the Senate, but it is not important to us. It is important for the people of this country, the families of this country who
Mr. KENNEDY. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

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

The PRESIDING OFFICER. There is no time limit.

Mr. KENNEDY. Mr. President, I thank my good friend, Dr. Frist. Senator Frist has been the chairman of our Public Health Subcommittee and he and I have worked on a lot of different health care issues together.

I thank Senator Jeffords who has been a strong ally on many health care issues over a long period of time.

I have also worked extensively with the Senator from Louisiana, Mr. Breaux, on many health care issues.

The fact is, when you have this combination of people making a strong recommendation, it is worthy for the Senate to give a true examination of their product and their recommendation this evening.

Having said all of that, it is worthwhile in the final minutes of this debate and before action that we give special consideration to the viewpoints of the doctors, the nurses, and the patients who have followed this issue and have really breathed life into this issue over a long time.

Tonight, at this time, there is only one matter that is before us that has the complete support of the medical profession, the nurses, the doctors, all of the groups that represent the children in this country, all the groups that represent the disability community, all of the groups that represent the Cancer Society, all the groups that represent the aged, all the groups that represent the special needs of people who have special medical challenges. They have had a chance to review each and every provision. They know every aspect of every page of the legislation and the amendments, and they come down virtually unanimously in support of the McCain-Edwards legislation.

Senator Edwards has already outlined and Senator McCain will further outline the various concerns.

Let me mention matters we have focused on during this debate.

The clinical trials: We are in the century of life sciences, and we are putting resources into and investing in the NIH. We are never going to get the benefits of the research in the laboratory to the bedside unless we have effective clinical trials. We have strong commitments on clinical trials; Breaux-Frist is short on that, and it will take up to 5 years to begin the clinical trials.

Specialty care: We guarantee specialty care. Any mother who brings in a child who has cancer will be able to get the specialty care. Breaux-Frist does not provide it. If it is not within that particular HMO, then it is not a medically reviewable decision. There are restrictions in the bill.

We have debated the issues of the appeals. Breaux-Frist still has provisions where the HMO will be selecting the appeal organization, which is effectively selecting the judge and jury in these appeals.

Liability: As has been pointed out, Breaux-Frist brings all the liability into the Federal system. Every patients group and every group that concerned itself about getting true accountability for patients understands the importance of keeping liability in the State court.

Even though the words are similar, although we have the issues of medical necessity, although we use the words of specialization, although the words of appeals are used in both bills, there is a dramatic and significant difference. Those are the two choices before the Senate.

I thank our colleagues and friends on the other side. There really is only one true Patients’ Bill of Rights that is going to protect the patients in this country, the families, the children, the women, the workers in this Nation, and that is the McCain-Edwards bill. I hope we support that shortly.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. I ask unanimous consent to bring up an amendment that was defeated by the Senate vote in relation to the amendment following the disposition of the Kyl amendment, with up to 10 minutes equally divided for debate prior to that vote.

Mr. LOTT. Reserving the right to object, I hope the Senator will withhold. I think a continued effort is underway, and if he will withhold at this point — I prefer not to object — let’s see if we can’t work it out.

Mr. ENSIGN. I withdraw my unanimous consent request.

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

The Senate reconvenes. The Senator from Arizona.

Mr. MCCAIN. Mr. President. I thank Senators BREAUX and KENNEDY, point out some of the very important changes to this legislation. I remind Members that the amendment does provide very limited relief in Federal court and would only allow a handful of cases to be addressed. Only those patients who receive approval from the external medical review can go to court.

Numerous States, including my home State of Arizona, have enacted laws that permit injured patients to hold plans legally responsible for their negligent medical decisions. I believe this substitute nullifies these laws. My colleagues may assert they do not preempt State law, but I respectfully disagree. Delaying and denying care by an HMO is not a contract issue for Federal court. Delaying and denying care is a medical malpractice and should be determined in State court.

As we know, this is a substitute. Over the last 2 weeks we have made some very important changes to this legislation, which is the appropriate way to legislate. We have made important changes on employer liability thanks to Senator Snowe and Senator DeWine and others; exhausting administrative procedures thanks to Senator Thompson and Senator Edwards; limits on legal fees, an effort undertaken by Senator Warner; reasonable scope, protecting all Americans, limitations on class action suits, and some form of shopping, in which Senator Thompson and others were involved.

Some of these have been included in the substitute, and some have not. I believe all of these changes that have been made through open and honest debate on this legislation should be included.

Again, we still have avoided the fundamental issue of State and Federal court. I believe that issue is not resolved to the satisfaction of the patient as opposed to the HMO.

I take an additional minute to thank a number of people including the White House staff, Josh Bolton and Anne Helsinki; Senator Gregg’s stewardship on this side has been exemplary; Senators Frist and Breaux have obviously been very helpful; Senators Snowe, Lincoln, DeWine, Nelson, and Thompson. I thank both leaders, Senator Frist and Senators Nickles, who have been involved in this issue for a long time, as well as Senator Edwards and Senator Kennedy.
Soon we will vote on this legislation. I believe we will prevail. I think this, like the campaign finance reform bill, has a lot of substance. It is a bill on which all sides have been heard, and I think, again, the Senate can be proud, no matter what the outcome, of the way we proceeded to address this issue which is important to so many millions of Americans.

This is an important issue to American citizens. This is an important issue to the person who cannot contribute a lot of money to American political campaigns. This is an important issue to average citizens whose voices are oftentimes drowned out in Washington, in my view, by the voices of the special interests, whether they be trial lawyers, insurance companies, HMOs, or others.

When putting patients first and the HMOs second, as we crafted this legislation, is an important outcome and why I have to oppose the substitute and urge my colleagues to vote favorably when we reach final passage. I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. I will make two or three comments. First, I compliment and congratulate Senator KENNEDY and Senator GAZZLE for their patience and leadership in managing this bill and also managing the education bill. Also, I congratulate Senator MCCAIN and Senator EDWARDS for their contribution because they are going to pass a bill, and Senator DASCHLE, as well.

This has been a battle that some have been wrestling with for a long time. As a matter of fact, a year ago we passed legislation that was called Patients' Bill of Rights Plus. In my opinion, the language is superior to the legislation we are getting ready to pass tonight. It was legislation that allowed every plan to have an appeal, internal and external, and it was binding—not binding by lawsuits, but if you did not comply with external appeal, you could be fined $30,000 a day—a different approach. I think it is far superior.

In looking at the language we have today and in the underlying bill, the so-called McCain-Edwards-Kennedy bill, maybe some modest improvements have been made. It is the bill that will finally pass, but it is a bill that the President will not sign and the President shouldn't sign.

I hope we will pass good legislation but not pass legislation that will dramatically increase health care costs, as I am afraid it will. There has to be some reason that employers that voluntarily supply health care, purchase health care for their employees, that employers of all sizes are almost unanimously in their opposition. They are not compelled to buy health care for employees, but they want to. Now we are getting ready to threaten them with unlimited liability. We keep hearing that suing the HMOs, but suing the HMOs and/or employers and threatening them with unlimited liability, will somehow non-economic damages, pain and suffering—there are costs included.

Somebody said we solve that because we have a designated decisionmaker. If there is a designated decisionmaker, the net result is yes, if you are going to hand off your liability to me, what am I protecting? What am I insuring?

With contracts that can be abrogated or breached, an independent reviewer can say, you have to cover other things, and you have a lot of liability if things do not work out. The net result will be the independent reviewer will say, defensive medicine, we will pay for anything because they don't want to be sued. They don't want to be liable. Then the Courts say, you know, because whatever the liability is, they don't know how much it is or how expensive it is, and they will increase their rates. They don't plan on losing money and they don't want to go out of business, so there will be a lot of defensive medicine and they will charge extra premiums to the employer to make sure they don't go out of business.

So the cost estimates, some people have said, are 4- or 5-percent per year increases on top of the already 19- or 20-percent increases built in, in increased costs for health care. They are probably much more. The costs of the bill could increase the cost of health care by 8 to 10 percent. We should know that.

Again, we should do no harm. We should not pass legislation that will not work, that will do harm. It will do harm if you increase the number of uninsured. It will do harm if you price insurance out of the realm of affordability for many Americans. I am afraid that is what we are doing.

There is one other issue that has not received maybe enough attention. Senator COLLINS and Senator NELSON raised that. That is the issue of scope: Should the Federal Government be taking over regulating that the States do? I am concerned about the language. It was modified modestly. It said the States have to be substantially compli-ant with these new Federal regulations. Everyone agrees that really the States are going to have to adopt almost identical language to what we have put in this bill. The net result? If they don't, HCFA takes over—the Health Care Financing Administration.

A couple of points: HCFA can't do it. HHS can't do it, the Department of Labor cannot do it. I want to make that point one final time.

We are ready to pass this mandate and say to the States: If you don't do it, Federal Government, you do it. If the States don't, you do it.

The Federal Government does not have the wherewithal to do it. Every State has hundreds of personnel involved in enforcing insurance regulation, and we are saying, you do it or we will. I am afraid that one of the largest unfunded mandates ever proposed by Congress.

I am a little mad at myself for not being able to offer a point of order that this is an unfunded mandate. One of the reasons I cannot is that it was not reported out of committee.

The unfunded mandates bill, the Congressional Accountability Act, says we have a report that comes out with the committee report and we can raise a point of order if you have an unfunded mandate on cities, counties, States, and the private sector. We cannot do that because we don't have a committee report because the bill was not reported out of committee. It was a year ago, but it is not now.

My point is this is an enormous unfunded mandate on counties and cities and States. We are mandating this on those employers. I know best, the Federal Government knows best. States, we know you have an emergency room procedure, but we are going to dictate a more expensive one.

I could go all the way down the list. My point is, even though we haven't done it, we cannot enforce it. You have non-enforceable provisions. There is no protection there. It may make us feel better, we may tell the American people we have provided the protections, but we cannot enforce it because the Federal Government cannot and should not take over State regulation of insurance. That is a mistake.

I am afraid the combination of the two, the expanded liability—you can sue employers and the providers for unlimited damages in State and/or Federal court for economic and non-economic, unlimited in both cases. You can jury shop. You can find a place that would work. Then we scare employers. Employers beware, the bill we are passing tonight makes you liable. You are going to have to pay a lot more in health care costs as a result of the bill we are passing tonight.

Again, my compliments to the sponsors. They worked hard. The opponents worked hard. We will pass a bill tonight. But I hope it will be improved dramatically in conference so we will have a bill that is affordable, will not scare people away from insurance, will not increase the number of uninsured by millions. My prediction is this bill would increase the number of uninsured by millions and cost billions and billions of dollars. I hope that is not the case. I hope this is a lot and improved in conference and we will have a bill that President Bush can sign and become law and of which we will all be proud. Unfortunately, I think the underlying bill does not meet that test.

We great reluctance to voting no on the underlying McCain-Kennedy-Edwards bill. I urge my colleagues to do likewise.
Mr. KYL. Mr. President, I ask unanimous consent Senator Nickles be shown as a cosponsor of amendment No. 854.

The PRESIDING OFFICER. Mr. President, there was no objection, it is so ordered.

Mr. KYL. There are two people I know of who would like to speak briefly on my amendment. I would like to respond briefly to what Senator Kennedy said and then summarize.

May I begin by congratulating the authors of the underlying legislation and expressing appreciation for all those who have worked with me. Especially I want to thank my colleague, John McCain, and congratulate him for his successful efforts in moving this legislation forward. It is not always easy when colleagues from the same State are not in total agreement on everything, but he let me know early on when I first came to the Senate he didn’t expect to agree with me on every issue. He said he might even be in disagreement on some matters with me from time to time.

I appreciate his efforts and the efforts of all of those who have worked with me.

Just to summarize for those who were not here earlier, my amendment is very simple. It merely provides an option for employers that offer plans that are covered by this bill to also provide an alternative for their employees. That would be the employees to have as their remedy the receipt of the health care or for the cost of that health care rather than going to court and getting damages as they are permitted to do under the bill. This should provide a lower cost alternative that could be made available to them. That, in turn, should provide a way for employers that might otherwise have to reduce the number of employees covered, or not have insurance for their employees at all, to continue to provide that coverage.

As I pointed out before, according to the Congressional Budget Office information, and the Lewin Group, probably over a million American citizens will lose their health care as a result of the increased expenses that could result from this legislation.

The effort that we have all tried to engage is to find ways to reduce those costs so premiums won’t go up as much and so employers can continue to provide the care. The best way to do that is to allow them to provide a purely voluntary option for their employees to accept, which would not have the same lawsuit damage option but would...
provide them the health care for which they have contracted. It is about health benefits rather than lawsuits. We think this would provide the remedy for that.

The only comment that Senator KENNEDY made in opposition was that we are not regulating how the employer would go to and contribute toward the insurance policies for their employees. That is very true. We are not doing that in the underlying bill. We are not doing it in the Breaux-Frist amendment. We are not doing it in my amendment. I don't think anybody here has suggested we should be mandating from the Federal Government how much money the employers have to pay for their insurance option that they provide for their employees. I do not think that is a relevant point. I reserve the remainder of my time for those who wish to speak to it. Then I will be prepared to yield back.

Mr. KENNEDY. Mr. President, I will just take 1 minute. The Kyl amendment will permit a company to offer a sham policy and a real policy. To get the real policy, an employee will have to weigh all of his or her rights under the liability provisions in the McCain-Edwards bill. Those are the alternatives. It basically undermines the whole concept of this legislation because it will permit employers and HMOs to escape any kind of accountability upon which this legislation is built. That creates a massive loophole which is undermining the whole purpose of this legislation. I hope the amendment will be defeated.

The PRESIDING OFFICER. The Senator from Idaho.

Mr. CRAIG. Mr. President, the hour is late, but the Kyl amendment is important. There is no sham here at all. It is the marketplace at work—voluntarily to provide the employee with options. The employer must provide health care programs if they are going to provide health care programs that fit this bill, that fit the Patients' Bill of Rights, but in doing so they also can provide a voluntary option if the employee chooses to take it, which simply says you waive your rights to a lawsuit. And guess what? It might cost the employee less money. Yet he and she, and their families, might still be covered.

Isn't that a reasonable option and a voluntary option to provide to the marketplace?

How dare we say that every attorney ought to have a right here? Why not say that the employee has a right to a marketplace of options that this voluntary approach that the Senator from Arizona provides gives to the health care system of our country? I support the amendment.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, over the past 8 days we have had amend-

ment after amendment that have created massive loopholes in the very basic and fundamental fabric of this legislation, which is to protect patients, protect families, protect doctors, and protect medical decisions against the bottom line of HMOs. This is another one of those in the parade, and it should be rejected.

The PRESIDING OFFICER. Who yields time?

The Senator from Alabama.

Mr. SESSIONS. Mr. President, I ask for 1 minute.

Mr. President, the option provided by Senator Kyl is not a loophole. It is an option. Under his plan, all policies that an employer would offer would provide the external and internal reviews that we have in all of the plans. The option to go to specialists, the gag rule protection that we have made a part of this bill—all of that would be in the plan. It would simply give the employee an option, if he thought it would save him money and he or she didn't intend to sue for benefits, to choose a policy that could be cheaper and simply not have certain lawsuit rights but, in fact, that operate for liability purposes under current law. It is no worse than current law. It is no better than current law. That is an option that could save a working family money that they need for their budget.

For those who want all matters to be exactly the same, I don't see why they would resist such an option. I think it is good for the employees.

I salute Senator Kyl. I also note that Senator Jeffords had a hearing recently on the uninsured in America. We know there are over 40 million uninsured and that every 1 percent increase in insurance costs causes 300,000 people to drop off the insurance rolls. It is a good move. I support it.

Mr. LOTT. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. The yeas and nays are ordered. There is a sufficient second.

The result was announced—yeas 42, nays 54, as follows:

[Rollcall Vote No. 218 Leg.]

YEAS—42

Allard (Mr. BELL), the Senator from New Mexico.

Baucus (Mr. MURKOWSKI), and the Senator from Alaska (Mr. AKAKA). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 42, nays 54, as follows:

VOTE ON AMENDMENT NO. 856

The amendment (No. 856) was rejected.

Mr. KENNEDY. Mr. President, I move to reconsider the vote.

Mr. LEAHY. I move to lay that motion on the table.

The motion to lay on the table was agreed to.
The amendment (No. 856) was rejected.

Mr. STEVENS. Mr. President, I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

Mrs. LINCOLN. Mr. President, I wish to enter into a colloquy with the distinguished manager of the bill to clarify the intent of the sponsors.

Section 202 of the bill amends the Public Health Service Act with a new section 2733 that applies all of the requirements of title I of the Patients Bill of Rights to every health insurance issuer in the individual market.

Current law, at section 2763 provides that none of the preceding requirements of the “individual market rules” apply to health insurance coverage consisting of “excepted benefits”.

Similar provisions exist in current law at section 2721 of the Public Health Service Act for the group insurance market. A parallel provision exists in ERISA at section 732 for “excepted benefits”.

Is it the intent of the managers of the bill that current law section 2763 and the parallel provisions for the group market in the Public Health Service Act and ERISA remain in full force notwithstanding the language of new section 2753?

In other words the requirements of title I of the Patients Bill of Rights would apply to individual and group health insurance other than “excepted benefits” coverage.

Mr. KENNEDY. The Senator is correct. It is the intent of the managers of the bill that the requirements of title I do not apply to insurance coverage consisting of “excepted benefits.”

Ms. CANTWELL. Mr. President, I rise today to speak in support of the bipartisan McCain-Edwards-Kennedy Bi-partisan Patient Protection Act. Managed care reform, particularly the enactment of a comprehensive Patients’ Bill of Rights, is one of the most important issues currently before either body of the U.S. Congress. After all the debate we have had on the floor in the last two weeks, I believe we are at the cusp of providing true, meaningful protections for every American in every health insurance plan.

Unfortunately, while over 160 million Americans rely on managed care plans for their health insurance, HMOs can still restrict a doctor’s best advice based purely on financial costs. The fact is, we know that the great promise of managed care—lower costs and increased quality—has in all too many cases turned into an acute case of less freedom and greater bureaucracy.

I want to tell my colleagues about the Malone family from Everett, Washington. Their son, Ian, was born with brain damage that makes it very difficult for him to swallow, to even cough and gag properly. He cannot eat or breathe without being carefully watched. He’s fed through a tube in his stomach since he can’t swallow.

The doctors at Children’s Hospital in Seattle—one of the best pediatric care institutions in the world—said that Ian could leave the Intensive Care Unit but would need home nursing care a day for Ian. And while initially the Malone’s health insurance company paid for this care, they decided to cut it off. Ian’s father says that “The insurance company told us to give Ian up for adoption and let the taxpayers step in and pay for his care. They didn’t care. It was all about saving money.”

It seems that the week’s rhetoric has centered on the idea of business and employers versus patients—as if these two interests are inherently antithetical, rather than complementary. But they are not. In fact, I believe the Bi-partisan Patient Protection Act is a balanced approach to protecting patients and protecting the business of managed care.

My home State of Washington has been a leader in providing health care to all of its citizens and has enacted strong patient protections at the state level. Under Washington State law, patients have the right to accurate and accessible information about their health insurance; the right to a second opinion; timely access to services by qualified medical personnel; the right to appeal decisions to an independent review board; and the ability to sue providers for damages if they are substantially harmed by a provider’s decisions.

I believe that States are the laboratories of democracy and I do not take lightly the possibility that any federal legislation would undermine the pre-empt state law. I spent six years on the Health Care Committee in the State House of Representatives and just this last year Washington passed a comprehensive Patient’s Bill of Rights. In issues such as the one before us this week, it is paramount that federal legislation enhance state protections, not undermine them.

And that is what this bill does. The McCain-Edwards-Kennedy compromise explicitly preserves strong state patient protection laws that substantially comply with the protections in the Federal bill. This is an extremely important point. The standards for certifying state laws that meet or exceed the Federal minimum standard ensure that only more protective State laws replace the Federal standards.

But I find it ironic that opponents of a strong, enforceable, Patients’ Bill of Rights have traditionally limited the scope of the patient protections in their managed care reform legislation to those individuals in self-insured plans, which are not regulated by the States, and assert that the States are responsible for the rest.

This approach denies Federal protections to millions of Americans—teachers, police officers, firefighters and nurses who work for State and local governments; most farmers and independent business owners who purchase their own coverage; most workers in small businesses who are covered by small group insurance policies, and millions more who are covered by a health maintenance organization. We need federal protections to ensure that all Americans are guaranteed basic rights.

In fact, no state has passed all the protections in the bipartisan McCain-Edwards-Kennedy Patients’ Bill of Rights. To fail to enact this bill would mean that neighbors, and sometimes workers in the same company, will have different protections under the law. The scope of this legislation simply ensures that all Americans in all health plans have the same basic level of patient protections.

Let me focus for a few minutes on what this bill does.

This bill protects a patient’s right to hear the full range of treatment options from their doctors, and it prohibits financial incentives to limiting medical care.

This bill allows patients to go to the first available emergency room when they are facing an emergency—regardless of the Federal minimum standards. E.R. is in their managed care network.

This bill allows women to go directly to their obstetrician or gynecologist
Mr. FEINGOLD. Mr. President, I was prepared to offer an amendment to S. 1062 concerning mandatory arbitration to ensure that HMOs are held accountable for their actions, which after all is one of the primary purposes of this bill. I have been asked not to offer that amendment, so I wanted to discuss it with the lead sponsors of the bill and ask them to clarify their intentions.

Some managed care organizations currently require patients to sign mandatory binding arbitration contracts before any dispute arises. These provisions effectively deny injured patients the right to take their HMO to court. Instead they are forced to go into binding arbitration, which can be a stacked deck against patients. We have spent much of the past 10 days debating whether injured patients should be able to go to court to vindicate their rights. It is clear that a majority of the Senate supports such rights, otherwise we would not be about to pass this legislation. So I am asking my colleagues to clarify that it is the intent of the sponsors that injured patients are granted legal rights under this legislation that federal courts or a federal court to pursue compensation and redress, notwithstanding a mandatory arbitration provision in an HMO contract. Can they further clarify that it is not the intent of the sponsors of this legislation that patients can lose the legal rights we are providing in this bill by being forced into mandatory binding arbitration? In these arbitrations, the HMO chooses the arbitrator, there are substantial up-front costs that the patient has to bear, there is limited discovery, no right to appeal, and no public record or predecisional value of the decision.

Mr. MCCAIN. I thank my friend from Wisconsin for raising this very important issue. I take it as wholly consistent with this legislation. We have come very far on this legislation. It is the intent of the bill's sponsors and of the majority about to pass this bill that patients will have the full legal rights provided under this historic legislation. It is not our intent to provide these important legal rights on the one hand and then allow them to be taken away by mandatory arbitration contracts entered into before a dispute arises. We have said that this bill gives patients the right to an external appeal process and to go to court, and we intend that cases arising under these rights should be heard by the external reviewer in court, and not by private arbitrators.

Mr. KENNEDY. If the Senator would yield, I agree that our bill would be severely undermined if health insurers could avoid the protections we have tried to guarantee in this bill by inserting a clause in the fine print of the contract to require binding arbitration of disputes that might arise. Mr. EDWARDS. I agree with my distinguished colleagues that HMOs should not be permitted to revoke the protections we have worked so hard to provide in this bill through the use of mandatory binding arbitration provisions in their contracts. Patients have no ability to bargain over the fine print of the health insurance contracts. That is why we have had to provide federal standards in this bill, and it is to close this gap in the approach of this bill to allow a backdoor route for these standards and protections to be avoided.

Mr. FEINGOLD. I thank my colleagues, the prime sponsors of this legislation for these clarifications. Based on these assurances, I will not offer my amendment. I yield the floor.

Mr. ROCKEFELLER. Mr. President, during the past five years, we have debated the merits and faults of assorted patient rights legislation. We have offered statistics, we have shared stories, and we have reduced strong legislation—legislation that held the real possibility of protecting all Americans—to weaker law that protects a minority of the population. Our work at times spoke of this issue in the abstract, yet it is nothing abstract about it. The 180 million Americans enrolled in health care plans have always understood exactly what it means to have insufficient coverage. However, they are not sitting on the edges of their seats, watching our heated arguments and waiting breathlessly for an outcome. Instead, they are engaged in the battles they have fought for far too long, and their disputes have far higher stakes. They are, quite literally, fighting with managed care organizations for their lives. The American people are tired, Mr. President, and deserve relief from these battles. They deserve good health and the peace of mind that comes with quality care. It is time we cast aside our partisan bickering and give the American people the right to health care, as well as the right to seek redress if denied quality health care. It is time to pass the Patients' Bill of Rights.

Recognizing that 43 million Americans go without health insurance each day, and millions more partial to inadequate health coverage, I have worked with my colleagues both in committee and on the floor to deliver quality care that truly benefits patients. I am convinced that such health care coverage must include the right when needed care is denied, resulting in injury or death. Quality care must also include patients' access to medical specialists, and an appeals and review process when such access is denied. The McCain-Edwards-Kennedy legislation includes these stipulations and goes one step further. It ensures that, for the first time, all Americans enrolled in health plans will be given access to the care they need.

With this in mind, I would like to enthusiastically endorse the McCain-Edwards-Kennedy Patients' Bill of Rights. A bipartisan effort in all regards, the legislation before us will ensure access to the quality of care that all Americans need—access which they deserve. First and foremost, it grants every individual with health coverage the same quality care. Under this McCain-Edwards-Kennedy legislation, for example, women, children, and the critically ill—often, the groups that are denied the care they need—will be given access to doctors who will determine their best medical interests.

If denied such care, patients will also be given the opportunity to immediately appeal decisions. By employing independent review boards, victims will be able to seek second opinions prior to the denial of care. The McCain-Edwards-Kennedy legislation ensures that patients are able to access to medical treatments, before it is too late. To date, thousands of patients have died as a result of decisions made by non-medical HMO personnel who...
merely sought to reduce cost and increase profits. With this legislation, that need not happen ever again.

We have reached an agreement so that the pending legislation will allow employees to seek punitive damages only if their employers willfully and negligently deny medical care that results in injury or death. Though some might argue that this will increase the cost of health care and, by extension, increase the number of uninsured in America, studies in states that have implemented similar protections have shown that this just is not the case. This right serves as a check against irresponsible decision-making and is critical to the legislation before us.

Finally, the McCain-Edwards-Kennedy Patients' Bill of Rights provides hope for those suffering from chronic illnesses who have long and have endured too much. They deserve quality care—they deserve the Patients' Bill of Rights, and we must give it to them. I urge my colleagues to vote for the McCain-Edwards-Kennedy Patients' Bill of Rights.

Mr. KOHL. Mr. President, I rise today in support of S. 1062, the Bipartisan Patients Protection Act. After nearly 5 years of debate and partisan fighting, I am pleased that the Senate has reached a real, meaningful bipartisan Patients Bill of Rights. It is a step that is long overdue.

For many years, the growth of managed care arrangements helped to rein in the rapidly growing costs of health care. That benefits all patients across the Nation and helps to keep health care affordable. However, there is a real difference between making quality health care affordable and cutting corners on patient care. In Wisconsin, we are lucky that our health plans do a good job in keeping costs low and providing quality care. But too often across this nation, HMOs put too many obstacles between doctors and patients. In the name of saving a few bucks, too many patients must hurdle bureaucratic obstacles to get basic care. Even worse, too many patients are being denied essential treatment based on the bottom line rather than on what is best for them.

The Patients Bill of Rights will ensure that patients come first—not HMO profits or health plan bureaucrats. It makes sure that doctors, in consultation with patients, can decide what treatments are medically necessary. It gives patients access to information about all available treatments and not just the cheapest. Whether it’s emergency care, pursuing treatment by an appropriate specialist, providing women with direct access to an OB-GYN, or giving a patient a chance to try an innovative new treatment that could save their life—these are rights that all Americans in health plans should have. And questions concerning these rights should be answered by caring physicians and concerned families—not by a calculator. This bill puts these decisions back in human hands where they belong.

This legislation will also make sure these rights are enforceable by allowing patients to hold health plans accountable for the decisions they make. First, all health plans must have an external appeals process in place, so that patients who challenge HMO decisions may take their case to an independent panel of medical experts. The External Reviewer must be independent from the plan, and they must be able to take valid medical evidence into account when deciding whether a treatment was inappropriately denied. The vast majority of disputes can and will be resolved using this external review process.

I was pleased that during the course of this debate, the Senate adopted an amendment that further clarified the rules of the external review process. I shared the concerns of Wisconsin employers and insurers that the original version could have potentially allowed an external reviewer to order coverage of a medical service that the health plan specifically disallowed in its plan. I strongly support the creation of a strong, clear, external review process to address disputes between a patient and their insurer over whether a service is medically necessary. At the same time, I believe employers who offer their employees health care coverage and enter into a contract with a health plan should have a level of certainty as to the services that are not covered under the plan.

That is why I voted for the McCain-Bayh-Carper amendment, which preserves the sanctity of the contract and makes it crystal clear that a reviewer may not order coverage of any treatment that is specifically excluded or limited under the plan. At the same time, it still allows reviewers to order coverage of medically necessary services that are in dispute. In addition, if a health plan felt that a reviewer had a pattern of ordering care of questionable medical benefit, the plan could appeal to the secretary to have that reviewer decertified.

I recognize that some preferred the accountable—offered by Senators NELSON and KYL in addressing this issue. However, I opposed the Nelson-Kyl amendment because it went a step too far. By attempting to have the Federal Government create a national definition of “medical necessity,” it would create a regulatory nightmare for patients and providers, and could potentially result in a definition that nobody supports and is too rigid to move with the advances in medical technology and treatment. The compromise amendment offered by Senator MCCAIN struck a more appropriate balance by protecting the sanctity of health plan contracts while allowing patients real recourse through an external appeal for medical necessity disputes.

Beyond the external review process, if a health plan’s decision to deny or delay care results in death or injury to the patient, this bill ensures that the health plan can be held accountable for its actions. And this bill, as amended, includes strong protections for employers. I was pleased to support the amendment offered by Senators SNOWE and NELSON which further clarified the difficult issue of employer liability.

Let me make it clear that our main objective is to make sure that patients have access to the treatments they need and deserve, and that if a health plan wrongly delays or denies treatment that causes injury or death, that patients can hold their health plans accountable. I think it’s critical that we shield employers from being sued by allowing them to choose a “designated decision-maker” to be in charge of making medical decisions and to take on all liability risk. In the case of an employer
who offers a fully insured health plan, the health insurance company which the employer contracts with is deemed to be the designated decisionmaker, and the employer is therefore protected from lawsuits. In the case of an employer that offers a self-insured health plan, that employer may contract with a third-party administrator to administer the benefits of the plan. That third party administrator would agree to be the designated decisionmaker and the employer is shielded from lawsuits.

Only those employers that act as insurers and directly make medical decisions for their employees can be held accountable. This group accounts for only approximately 5 percent of all employers in the country.

This bill now makes it clear that employers—who voluntarily provide health coverage to their employees and the vast majority of which do not act as insurers by making medical decisions—are shielded from lawsuits. This is in total agreement with President Bush’s stated principles of a Patients Bill of Rights which would sign, where he said, and I quote: “Only employers who retain responsibility for and make final medical decisions should be subject to suit.” That is exactly what this bill does. It is one of the main keys to making the rights in this bill enforceable, and I strongly urge that this right be retained in any bill that is sent to the President.

Most importantly, this bill gives all of these protections to ALL Americans in managed health care plans, not just a few. All 170 million Americans in managed health plans deserve the same protections—no matter what State they live in.

As someone who comes from a business background, I understand the concerns of employers. Some of my colleagues on the other side have claimed that our bill will increase health care costs so much that it will make it impossible for employers and families to afford coverage. But the Congressional Budget Office reported that the patient protections in our bill will only increase premiums by 4.2 percent over 5 years. This translates into only $1.19 per month for the average employee. CBO also found that the provision to hold third-party administrators accountable—the provision the other side opposes—the most and claim would cause health care costs to skyrocket—would only account for 40 cents of that amount. An independent study by Coopers and Lybrand indicates that the cost of the liability provisions is potentially less than that, estimating that premiums would increase between three and 13 cents a month per enrollee, or 0!3 percent. This is a small price to pay to make sure that health plans which cover the health care we all deserve.

I believe this bill meets the President’s principles for a real Patients Bill of Rights, and I hope that when the House passes its bill, we can come together and send a bill to the President he will sign. The time has come to put this President to act and make sure they receive the health care they need, deserve, and pay for.

Mr. FEINGOLD. Mr. President, the lobbying on this bill has been intensive. There’s been a great deal of coverage in recent weeks about the wealthy interests that have collided over whether the nation should have a Patients’ Bill of Rights, and what that bill should look like.

I think even the media has had a tough time figuring out who’s on which side of this debate has the power of the “special interests” on their side. Some have said the money is on the side of the McCain-Kennedy-Edwards bill, since interests supporting the bill include the American Medical Association, the American Association of Health Plans, the trade association for HMOs and PPOs, spent a total of nearly $2.5 million on lobbying in 1999 alone. According to a recent New York Times article, AAHP has budgeted $3 to $5 million to make their case against the Patients’ Bill of Rights, and they are determined to defeat this legislation, whatever it takes,” unquote, to get the job done.

The Business Roundtable also has spent money on an ad campaign against the bill, and so has the Health Benefits Coalition itself.

One of the ironies of these expenditures, lobbying expenditures, soft money, PAC money and ad campaigns, from some of the biggest and most powerful organizations in Washington, hasn’t gone unnoticed. This is an all-out blitz.

And this bankroll wouldn’t be complete without a description of some of the interests giving their support to provisions in this bill: The American Medical Association, the Association of Trial Lawyers of America, and labor unions like AFSCME.

Others say that the special interests are weighing in against the Patients Bill of Rights, because of the powerful business and insurance coalitions fighting to defeat this legislation.

Who is right? Where is the money in this debate? The answer is simple, there are donors on both sides. Wealthy interests aren’t aligned exclusively on one side or the other. So for the information of my colleagues and the public, I thought I would take a moment to call the bankroll by examining the donations the interests on both sides have given in the last election cycle. And I will start by trying to defeat this legislation, brought to us by a coalition of insurance and business interests that represent some of the most powerful donors in the campaign finance system today.

Opposition to McCain-Edward Kennedy is being spearheaded by the Health Benefits Coalition. An analysis by the Center for Responsive Politics puts the cumulative donations of the members of the Health Benefits Coalition at more than $14 million in the last election cycle. That figure includes soft money, PAC money and individual contributions made by the members of the Coalition.

The Coalition includes corporate members such as Blue Cross/Blue Shield, Aetna Inc., and Humana Inc. But perhaps more importantly, the Coalition also includes major business and insurance associations. These organizations include the Chamber of Commerce, the Business Roundtable, the American Association of Health Plans, the Health Insurance Association of America, the National Retail Federation, the National Restaurant Association, and the Food Marketing Institute, to name just a few. And of course whenever organizations like these join together, they carry with them the collective clout of all the major political donors they represent.

The Health Insurance Association of America is an enormous coalition of the insurance industry. The insurance industry itself gave nearly $70.7 million in PAC, soft, and individual donations in the 2000 election cycle.

The American Association of Health Plans, the trade association for HMOs and PPOs, spent a total of nearly $2.5 million on lobbying in 1999 alone. According to a recent New York Times article, AAHP has budgeted $3 to $5 million to make their case against the Patients’ Bill of Rights, and they are determined to defeat this legislation, whatever it takes,” unquote, to get the job done.

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Mr. LEAHY. Mr. President, today’s passage of the Bipartisan Patient Protection Act marks a major—up for ward in the struggle for a meaningful Patients’ Bill of Rights. I am hopeful that with the adoption of this landmark legislation, patients throughout the country can feel a sense of relief knowing their rights will now be protected.

Over the past two decades, our Nation’s healthcare delivery system has seen a seismic transformation. Rapidly rising healthcare costs have encouraged the development and expansion of managed care organizations, specifically health maintenance organizations. Unfortunately, the zealous efforts of HMOs to contain these costs have ended up compromising patient care and stripping away much of the authority of doctors to make decisions about the best care for their patients.

During the past several years, many Vermonters have let me know about the problems they face when seeking primary health care for themselves and their families. Like most Americans, they want: greater access to specialists; the freedom to continue to be treated by their own doctors, even if they switch health plans; health care providers, not accounting clerks at HMOs, to make decisions about their care and treatment; HMOs to be held accountable for their negligence.

The Bipartisan Patient Protection Act is the solution that Americans have called for—patient protections that cover all Americans in all health plans by ensuring the medical needs of patients are secondary to the bottom line of their HMO.

Too many times, I have heard from Vermonters who have faced difficulty in accessing the most appropriate healthcare professional to meet their needs. This legislation will solve that problem by giving Vermonters—and all Americans who suffer from life-threatening, degenerative and disabling conditions—the right to access standing referrals to specialists, so they do not have to make unnecessary visits to their primary care physician for repeated referrals. These patients will also be able to designate a specialist as their primary care physician, if that person is best able to coordinate their care.

This legislation makes important strides in allowing patients access to a health care provider outside of their plan when their own plan’s network of physicians does not include a specialist that can provide them the care they need. This is especially important for rural areas, like many parts of Vermont, which tend to not have an excess of health care providers. Women will now be able to have direct access to their OB/GYN and pediatricians, if designated as primary care providers for children.

If an individual gets hurt and needs unexpected emergency medical care, the Bipartisan Patient Protection Act takes important steps to ensure access to emergency room care without a referral. If a woman is suffering from breast cancer, this bill will protect her right to have the routine costs of participation in a potentially life-saving clinical trial covered by her plan. This bill puts into place a wide range of additional protections that are essential to allowing doctors to provide the best care they can and to allow patients to receive the services they deserve.

Many of our States have already adopted patient protection laws. My home State of Vermont is one state that currently has a comprehensive framework of protections in place. This Federal legislation will not prohibit Vermont or any other state from maintaining or further developing their own patient protections, but the laws are comparable to the Federal standard. I am pleased that this bill will allow states like Vermont to maintain many of their innovative efforts, while also ensuring that patients in states that currently have no laws in place will receive the basic protections they deserve.

Each of the important protections I have highlighted will only be meaningful if HMOs are held accountable for their decisions. The key to enforcing these patient protections rests in strong liability provisions that complement an effective and responsive appeals process. The Bipartisan Patient Protection Act provides patients with the right to hold their HMO liable for decisions that result in irreparable harm or death. Managed care organizations are one of the very few parties in this country that are shielded from being held accountable for their bad decisions. The time has come for that to change. Opponents of patients’ rights legislation have been vocal in suggesting that by allowing patients to hold HMOs liable in court, there will be an explosion of lawsuits, causing the costs of healthcare insurance to skyrocket. This has not been the case in states like Texas, that have already enacted strong patient protections. Rather, it has been shown that most cases are resolved through the external appeals process and that only a very small fraction reach the court room. Under this legislation, a patient must exhaust all internal and external appeals before going to court.

I have heard from many Vermonters concerned about the potential impact of new HMO liability provisions on employers. I am disappointed that the opponents of this legislation have exploited and misrepresented this part of the bill. Rather than attempting to alleviate concerns by explaining the liability provisions, they have instead resorted to a scare tactic strategy. If you listen to some opponents of this bill, you would think that any employer who offers health coverage will be sued. I would like to take this opportunity to clarify some of the facts. The Bipartisan Patient Protection Act provides employers with a strong shield that only makes the employer accountable when he or she directly participates in health treatment decisions. The bill also clearly states that employers cannot be held responsible for the actions of managed care companies unless they actively make the decision to deny a health care service to a patient. This only occurs in about five percent of businesses—generally those employers large enough to run their own health plan. Those few companies that directly participate in the decision to deny a health care benefit to a patient, should accept legal responsibility for those decisions.

After nearly 5 years of debate in Congress for the closest emergency room, a judge finally closing in on the patients’ rights and protections they deserve. But there is still more work to be done. The House of Representatives must consider this important issue in a timely manner and I hope that they will include provisions similar to the bipartisan patient protection legislation passed in the Senate. Most importantly, I am hopeful that President Bush will hear the voices of Americans and not those of the special interests and their well-financed lobbyists, and sign this important legislation into law. The American people have spoken; the time for enacting strong patient protections is long overdue.

Mr. KERRY. Mr. President, I am proud to support the bipartisan McCain-Kennedy Patients Bill of Rights. It is legislation that is long overdue. Time and again, we have heard the 180 million Americans enrolled in managed care demand patient rights. Time and again, we have heard the Senators of this Senate have promised to provide them those rights. Finally, with the Patients Bill of Rights legislation before us, we stand ready to deliver.

The McCain-Kennedy Patients Bill of Rights ensures Americans that they can receive the very health care they pay for. In exchange for their monthly premiums, patients deserve a guarantee that they can see their own doctor, visit a specialist, and go to the closest emergency room; a guarantee that their doctor can discuss the best options for treatment, not just the cheapest; and a guarantee that their doctor’s orders will be followed by their HMO. The McCain-Kennedy bill guarantees all of those rights.

When those rights are violated, and harm results from the delayed application or outright denial of treatment, the McCain-Kennedy bill guarantees patients that they can hold their health plans accountable. And, that is what all of the rights to access care hinge upon—the ability to hold a health plan liable if access to care is denied.
June 29, 2001

We have spent days on the floor of the Senate debating the issue of liability. But, the argument here is simple. In this decision that affects every individual or corporation results in harm or death to a consumer, the decision-maker is held accountable. That holds true for every individual, and for every company except an HMO. HMOs, businesses who make countless decisions daily that affect the health of millions of Americans, do not face this same accountability. The number of patients who are suffering as a result is staggering.

Every day, 35,000 patients in managed care plans have necessary care delayed. Too many of these patients pay the ultimate price for the callousness displayed by these managed care plans. I would like to share the story of one woman from my state of Massachusetts who lost her life after being denied care by her HMO.

Mrs. White was diagnosed with leukemia in October 1997, and was unable to find a bone marrow match for transplant plans for 2 years of battling the disease she went into remission. She then learned that Massachusetts General Hospital was working with a newly-developed anti-rejection drug which would allow patients like herself, with less than perfectly-matched donors, to have bone marrow transplants. But, her HMO denied her care the day before she was due to be admitted to the hospital.

Six months later, Mrs. White enrolled in a new health plan which covered the costs of the transplant. However, during the 6-month impasse, Mrs. White fell out of remission, and her body was less able to sustain the new bone marrow. She died 3 months after the procedure was performed.

Recent stories like these demonstrate why HMOs must be held accountable for their decisions. Real people like Mrs. White are the reasons why there are liability provisions in the McCain-Kennedy Patients Bill of Rights—liability protections that allow patients to sue their health plans in state court when an HMO’s decision to withhold or limit care results in injury or death. My colleagues on the other side of the aisle seek to misconstrue that point.

Mr. President, let’s be clear: this bill establishes a right without legal recourse fails to exist. The liability provision in this legislation simply establishes a mechanism by which to enforce the very patient protections it provides. Managed care must avoid any liability, as long as they act responsibly and ensure that their patients receive the quality medical care prescribed for them by their physicians.

Let’s be clear about another issue.

As chairman of the Small Business Committee, I am well aware of the substantial challenges small businesses face in providing employee benefits while holding down costs. I understand the concerns small business owners have over the Kennedy-McCain bill’s potential to expose them to liability for the sole, laudable initiative of offering health insurance coverage to their employees. But that is not the intent of this legislation.

The McCain-Kennedy bill only holds accountable those employers who directly participate in the medical decisions governing an employee’s care if harm or injury occurs. The logic here is simple. If we like HMOs, it is only fair that they be held to the same accountability standards. For employers who do not directly participate in these medical decisions there should be no liability.

I understand that many businesses remain wary of the safeguards against employer liability that are included in the Kennedy-McCain legislation. Negotiations are underway to strike a compromise and strengthen these safeguards so that we may arrive at a Patient Bill of Rights that we all can support. I join all of my colleagues in hoping that those negotiations bear fruit.

Another attack on this Patients Bill of Rights legislation that we have heard—not just in this chamber but across the television airwaves—is that this bill will cause insurance premiums to increase dramatically. Nothing could be further from the truth. According to the most recent estimate from the Congressional Budget Office, this legislation will cause premiums to increase an average of 4.2 percent a year. For the average employee, that equates to $1.19 per month in additional premiums, a small price to pay for meaningful patients rights extended in this bill.

Many of my colleagues across the aisle argue that this minor increase will cause large numbers of Americans to become uninsured when, in fact, no evidence exists to support this. Nevertheless, I am encouraged by the concern for the uninsured in our country, the 43 million Americans—the 15 percent of our population—who have no health care coverage at all. I challenge my colleagues on both sides of the aisle to continue the discourse on this critical issue and look forward to working towards extending health coverage to every American once we have passed this bipartisan Patients Bill of Rights.

The McCain-Kennedy Patients’ Bill of Rights legislation has widespread support from patients groups and health care providers—the two parties that we should really be focused on in this debate. To date, over 500 health care provider and patients’ rights groups have endorsed our bill.

An April 2001 Kaiser Family Foundation poll found that 85 percent of Americans supported a comprehensive Patients’ Bill of Rights that includes provisions to hold HMOs accountable. Mr. President, patients and health care providers have spoken loud and clear. They want expanded rights for patients now, rights that our legislation will provide. I urge all of my colleagues to pass the McCain-Kennedy Patients Bill of Rights.

Mr. CORZINE. Mr. President, I rise to talk specifically about how important the Patients’ Bill of Rights is to improving the mental health care Americans receive.

For far too long, mental health consumers have been discriminated against in the health care system—subjected to discriminatory cost-sharing, limited access to specialists, and other barriers to needed services.

This is particularly true of the mental health care that children receive. More children suffer from psychiatric illness than from Leukemia, AIDS and diabetes combined. Yet, while we recognize the human costs of these physical illnesses, we often forget the cost of untreated psychiatric illness. For young people, these costs include lost occupational opportunities because of academic failure, increased substance abuse, more physical illness, and, unfortunately, increased likelihood of physical aggression to themselves or others.

This is why I am so pleased that McCa...
often only one component of effective treatment for mental illnesses, access to the most novel and most effective of these medications is crucial to successful treatment and recovery. These new medications are more effective, have fewer side effects, and save money in the long run. Yet unfortunately, all too often managed care organizations prevent patients from accessing these life-saving drugs.

How? They use restrictive formularies that restrict access to preferred drugs—often the newer and more effective ones. The HMO’s are, in effect, undermining our own drug regulations and approval processes.

Fortunately, the bipartisan McCain-Edwards-Kennedy Patients’ Bill of Rights protects patients by providing exceptions from the formulary when medication is necessary in the treatment of a patient, that patient will get that medication. Also—and this is a critical difference with the Breaux-Frist alternative—our bill requires that non-formulary medication be subject to same cost-sharing requirements. Breaux-Frist does not—continuing the discriminatory treatment of mental health treatments.

The McCain-Edwards-Kennedy proposal is also superior for mental health care because it ensures access to specialists. The bill allows standing referrals—so that primary care providers do not have to continue authorizing visits. It also requires plans to allow patient access to non-participating providers if the plan’s network is insufficient. So that patients can see the provider who can best meet their needs. The Breaux-Frist plan—in another contradiction—does not allow access to out-of-network specialists.

In the end, this can result in more costly treatment. And for some illnesses, the longer the duration or the greater the number of significant episodes, the harder to treat and more intractable the disease becomes.

Finally, the McCain-Edwards-Kennedy proposal, unlike Breaux-Frist, provides the right to a speedy and genuinely independent external review process when care is denied.

Let me just tell you a personal story of a constituent of mine to illustrate the importance of these protections. Earlier this year, a mother in Gloucester County, NJ wrote to me about a problem she had encountered getting treatment for her daughter. Her teenage daughter had attempted suicide, and been hospitalized for 8 days. She was diagnosed with depression and borderline personality disorder, and both her physician and therapist recommended intensive outpatient therapy, called “partial care” therapy. But the managed behavioral care organization determined that this treatment was not “medically necessary.” Instead of the intensive five and a half hour, twice a week therapy program, the insurance company mandated one hour a week of therapy. This, despite the recommendation of her physician and therapist.

Like any loving parent would, the mother fought back, calling the company many times. She was told to wait—even though, to quote her letter, her daughter “was self-mutilating and her behavior was becoming dangerous to herself and possibly others.” The mother finally enlisted the help of several people at the treatment program, who also wrangled with the company, and she even wrote to my office, and I wrote to the company on their behalf. Eventually, the company relented, and her daughter is now doing well in that intensive eleven hour a week program. But it shouldn’t have to be like that for families. Doctors, not insurers, should decide what treatment a patient receives. When a physician says that a certain medication is necessary to help a suicidal teenager, an insurance company should cover it. As my constituent so poignantly wrote to me about her daughter, and I quote: “This treatment is important and necessary [because] by learning the skills she needs to cope with her illness she can have a safe, normal, adolescence and adult life. If we address this illness now instead of waiting until the next time she hurts herself we have a better chance of her leading a happy and normal life.”

Unfortunately, a study by the National Alliance for the Mentally Ill found that less than half of surveyed managed behavioral health care companies defined suicide attempt as a medical emergency.

This year, 2,500 teenagers will commit suicide in the United States. Over 10 million children and adolescents have a diagnosable psychiatric illness that results in a academic failure, social isolation and increased difficulty functioning in adulthood. Only one out of five will get any care and even less will get the appropriate level of care they need and deserve.

So unless we provide critical patient protections, including the right to a fair and independent appeals process for review of medical necessity decisions, more families like my constituent will have to wonder if an insurance company will cover critical care that a doctor has prescribed for a loved one.

In sum, the McCain-Edwards-Kennedy bill will provide people access to the mental health care they need to lead healthy, productive lives. I am pleased to support it.

HARKIN FEE-REVIEW AMENDMENT

Mr. HARKIN. Mr. President, for too long, American families have been left in the waiting room while HMOs refuse to provide the health care services that families need and deserve. The results have often been tragic.

Now we are on the verge of a big victory for the American people—passing the meaningful Patient’s Bill of Rights. S. 1052 represents the culmination of five long years of bi-partisan work to ensure that patients in managed care get the medical services they need, deserve, and have paid for. We have debated this issue for years, with well-intentioned differences of opinion to find common ground, and worked across party lines to develop the best bill possible. S. 1052 truly represents the best of all our collective ideas and most important, meets the needs of the American people.

Let me say that again. This bill—the McCain-Edwards-Kennedy bill—meets the needs of the American people. And when you cut through the rhetoric and political posturing, that is what this debate is all about—guaranteeing the American people basic and fundamental health care rights.

One of the cornerstones of a meaningful patients’ bill of rights is access to a swift internal review and a fair and independent external appeals process. Without a strong review system in place—where real medical experts make the decisions and not the HMO accountants—all the other protections would be compromised.

Our amendment would strengthen the review system to ensure the integrity of the appeals process and protect patients by requiring that the appropriate health care professional makes the medical decision. It ensures that health care professionals who can best assess the medical necessity, appropriateness, and standard of care, make determinations regarding coverage of a needed service.

As currently drafted, S. 1052 only requires that physicians participate in the review process. While the bill does not prohibit non-physician providers from participating at a physician’s discretion, it does not guarantee their involvement in relevant medical reviews.

I think we all agree that the intent of the appeals process is to put medical decisions in the hands of the best and most appropriate health care providers. In many cases, this will undoubtably be a physician. However, when the treatment denied is prescribed by a non-physician provider, it is critical that the case be reviewed by a provider with similar training and expertise.

For example, when a 59-year-old man fell in his home, he experienced increased swelling, decreased balance, decreased range of motion, decreased strength and increased pain in his right ankle and knee. A physical therapy treatment plan would have included specific exercises to increase strength, range of motion, and balance—enabling the patient to better perform activities of daily living and to prevent further deterioration of his health.

A reviewer who was not a licensed physical therapist, and did not have
the expertise, background, or experience as a physical therapist, denied physical therapy coverage.

Without physical therapy intervention, the patient was severely limited in activity and spent significant time in bed. The time in bed resulted in further deterioration of the original problems and the development of wounds from the prolonged static position in bed.

A physical therapist reviewer would have recognized the importance of patient mobility while in bed to prevent bedsores and interventions to improve the patient’s function with his right ankle and knee to enable him to independently walk.

Utilizing health care professionals with appropriate expertise and experience in the delivery of a service that has been adopted, I worry that we will fall short of developing their best possible review process.

My amendment is supported by a wide range of health care professionals, including:

- American Association of Nurse Anesthetists
- The American Chiropractic Association
- The American College of Nurse Midwives
- The American College of Nurse Practitioners
- The American Occupational Therapy Association
- The American Optometric Association
- The American Pharmaceutical Association
- The American Podiatric Medical Association
- The American Speech-Language-Hearing Association
- The National Association of Orthopaedic Nurses
- The National Association of Pediatric Nurse Practitioners
- The National Association of Social Workers
- The Center for Patient Advocacy

I do not believe that non-physician providers were deliberately excluded from the review process. In fact, just the opposite is true—I believe it was the intent of the bill’s authors to develop the best possible review process. However, unless my amendment is adopted, I worry that we will fall short of our shared goal of giving patient’s access to the best and most appropriate health care services in every instance.

In response to these concerns, the Senate has considered several bills to provide sensible patient protections to Americans in managed care plans. During the last Congress, the Senate took at least 19 rollcall votes and passed two pieces of comprehensive patient protection legislation. Like many of my colleagues, I believe health care items are insufficient, in that they called the Senate’s attention to the numerous areas where there already exists a great deal of bipartisan agreement.

I believe that every American ought to have access to an emergency room. No parent should ever be forced to consider bypassing the nearest hospital for a desperately ill child in favor of one that is in their health plan’s provider network. If you have what any normal person would consider an emergency, you should be able to go to the nearest hospital for treatment, period.

I believe that every American ought to be able to designate a pediatrician as their child’s primary care physician. This common-sense reform would allow parents to provide them with one of their plan’s pediatricians without having to get a referral from their family’s primary care physician.

I believe a doctor should be free to discuss treatment alternatives with a patient, and involve them with their best medical advice, regardless of whether or not those treatment options are covered by the health plan. Gag clauses are contractual agreements between a doctor and an HMO that restrict the doctor’s ability to discuss freely with the patient information about the patient’s diagnosis, medical care, and treatment options. We all agree that this practice is wrong and have voted repeatedly to prohibit it.

I believe that consumers have a right to know important information about the products they are purchasing, and health insurance is no different. Health plans ought to provide their enrollees with written information about the plan’s benefits, cost sharing requirements, and definition of medical necessity. This will ensure that informed consumers can make the health care choices that are in their best interests and hopefully prevent disputes between patients and their plans.

In addition, the following examples highlight areas of bi-partisan agreement:

- Cancer Clinical Trials—Health plans ought to cover the routine costs of participating in clinical trials for patients with cancer.
- Point Of Service Options—Health plans for large employers ought to offer a point of service option so that patient’s can go to a doctor outside their plan’s network, even if it means paying a little more; Continuity of Care—We ought to ensure that pregnant and terminally ill patients aren’t forced to switch doctor’s in the middle of their treatment; Formulary Reform—Health plans ought to include the participation of doctors and pharmacists when developing their prescription drug plans, commonly known as formularies; and Self-Pay for Behavioral Health Services—Individuals who want to pay for mental health services out of their own pockets ought to be allowed to do so.

The answer is very simple, lawsuits. The Kennedy-McCain bill insists on vast new powers to sue. Leafing with abandon through the yellow pages under the word “attorney” is not what most Americans would call health care reform.

The proponents of these costly new liability provisions contend that you can’t hold plans accountable without expanding the right to sue employers and insurers. I couldn’t disagree more. The proper way to ensure that plans are held accountable is to provide strong, independent external appeals procedures to ensure that patients receive the care they need. Far too many Americans are concerned that their health plan can deny them care. I believe that if a health plan denies a treatment on the basis that it is experimental or not medically necessary, a patient needs the ability to appeal that denial, and have their plan’s benefits, cost sharing requirements, and definition of medical necessity reviewed by an independent, medical expert with expertise in the diagnosis and treatment of the condition under review. In routine reviews, the independent reviewer must make a decision within 30 days, but in urgent cases, the must do so in 72 hours. After all, when you are sick, don’t you really need an appointment with your doctor, not your lawyer.

As if driving 1.26 million Americans out of the health insurance market wasn’t reason enough to oppose the Kennedy-McCain bill, I am also strongly opposed to expanding liability because it exacerbates the problems in our already flawed medical malpractice
system. I might not be so passionate in my opposition to new medical malpractice lawsuits, if lawsuits were an efficient way of compensating patients who were truly harmed by negligent actions. Unfortunately, the data shows just the opposite. In 1996, researchers at the Harvard School of Public Health performed a study of 51 malpractice cases, which was published in the New England Journal of Medicine. In approximately half of those cases, the patient had not even been harmed, yet in many instances the doctor settled the matter out of court, presumably just to rid themselves of the nuisance and avoid lawyer’s fees and litigation costs. In the report’s conclusion, the researchers found that “there was no association between the occurrence of an adverse event due to negligence and the overall cost of apiece and payment.” In everyday terms, this means that the patient’s injury had no relation to the amount of payment received or even whether or not payment was awarded.

The lawsuits drag on for an average of 64 months—that is more than 5 years. Even if at the end of this 64 months, only 43 cents of every dollar spent on medical liability actually reaches the victims of malpractice, source: RAND Corporation, 1993. Most of the rest of the judgement goes to the lawyers. That is right, over half of the injured person’s damages are grabbed by the lawyers. Why would anyone want to expand this flawed system, which is so heavily skewed in favor of the personal injury lawyers?

Prior to the first extensive debate on this legislation in the Senate in 1999, The Washington Post said that “the threat of litigation is the wrong way to enforce a credible and mainly medical type and payment.” In everyday terms, this means that the patient’s injury had no relation to the amount of payment received or even whether or not payment was awarded.

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when I say this could result in employees losing health coverage. Employers will not want to choose between offering health insurance to their employees and opening themselves up to liability and huge court costs. I find it ironic that my colleagues on the other side of the aisle, who always claim they are trying to find ways to lower the uninsured population, are actually pressing for legislation that will dramatically increase the uninsured population.

And if you don’t believe me, talk to any expert who is not a trial lawyer because the message is loud and clear that unless the bill is improved, health coverage will be severely jeopardized, and employees will lose their insurance. Is this the result we want, especially in legislation that claims to be a Patients’ Bill of Rights? I think not.

As far as damage caps are concerned, the Frist-Breaux-Jeffords legislation is a step in the right direction. The McCain-Kennedy language is not.

The problem with the current McCain-Kennedy legislation is that it allows patients to go both to federal and state court to collect damages. For federal causes of action, economic and non-economic damages are unlimited. And even though the bill’s proponents claim there are no punitive damages provisions, as a former medical malpractice attorney, I know punitive damages when I see them.

Supporters of the McCain-Kennedy approach claim their bill doesn’t allow punitive damages in federal court. That is absolutely not true. Under their bill, a defendant in federal court can be hit with up to $5 million in “civil assessment” damages. Let’s call it like it is. The purpose of the civil assessment is to punish providers, plain and simple. The bill includes no limits on state law damages. It is very apparent to everyone in this chamber that the trial lawyers have been principally involved in drafting these liability provisions and they have done so with their own interests in mind. This provision is simply not in the best interest of the American people.

The McCain-Kennedy language allowing for unlimited damages is unworkable. Economic and non-economic damages are uncapped. In my opinion, non-economic damages should be capped.

Another issue that is extremely important is class action. The McCain-Kennedy language had no restrictions on class actions on its newly permitted state causes of action nor for its newly created federal causes of action for damages. Fortunately, the DeWine language attempts to restrict the litigation nightmare that would have resulted from the McCain-Kennedy language.

Finding common ground on these issues—exhaustion of appeals, employer liability, caps on damages and class action—is crucial to the success of the Patients’ Bill of Rights legislation. It is incumbent upon us to do this right and to do what is in the best interest of patients, not trial attorneys. I am confident that if we are all willing, we can make these provisions legally sound. We have spent far too many years on this issue not to do it right. We have the real opportunity to create meaningful patients’ rights legislation. Let’s not squander this opportunity by acting expeditiously.

Mr. CORZINE, Mr. President, I rise to speak about an issue that has been touched upon by many people during this debate on the Patients’ Bill of rights, the problem of the uninsured.

Let me first say that I am very pleased that today we are passing a strong, enforceable Patients’ Bill of Rights.

I commend the bill’s authors, Senators MCCAIN, EDWARDS and KENNEDY, for the tremendous job they have done in crafting a bipartisan bill that will provide strong patient protections and curb insurance company abuses.

This legislation is an example of how, working together, we can improve the health care Americans receive. But it is just the first of many steps we should be taking to ensure that all Americans receive quality health care.

During the debate on the Patients’ Bill of Rights I have heard many Senators argue that this legislation will lead to more uninsured Americans. Indeed, some of my colleagues have faulted supporters of the bill for not doing anything to help the uninsured.

As someone who have been talking about this issue for several years, I am thrilled to hear that my colleagues are concerned about the problem of the uninsured.

It is a national disgrace that 42 million Americans do not have health insurance.

Who are the uninsured? They are 17.5 percent of our nonelderly population. A shameful 23 percent are children. The majority—83 percent—are in working families.

The consequences of our Nation’s significant uninsured population are devastating. The uninsured are significantly more likely to delay or forego needed care. The uninsured are less likely to receive preventive care. Delaying or not receiving treatment can lead to more serious illness and avoidable health problems. This in turn results in unnecessary and costly hospitalizations. Indeed, my own state of New Jersey is in fact leading the way on the issue of enrolling parents with their kids.

Finally, I was pleased to be an original cosponsor of Senator BINGAMAN’s bipartisan legislation, the Start Healthy, Stay Healthy Act, which would expand coverage for children and pregnant women. It is based on the common sense principal that children deserve to start healthy and stay healthy.

I often say that we are not a nation of equal outcomes, but we should be a nation of equal beginnings.

Until we give all Americans access to health care, however, we cannot live up to that promise. But although we cannot get to universal access this year, I believe we can and should be doing all that we can to make incremental progress.

In conclusion, I am heartened that in this debate on the Patient’s Bill of Rights so many of my colleagues have expressed concern about the problem of health care access for all Americans.

We ignore the issue of the uninsured at our peril and at a great cost to the quality of life—and to the very life—of our fellow Americans.

That is why I am developing legislation that will provide universal access to health care for all Americans.

My legislation will have several main components:

Large employers would be required to provide health coverage for all their workers. The private sector must do its part—a minimum wage in America should include with it minimum benefits, among them health insurance. But unfortunately, the current system puts the responsible employer who provides health insurance at a disadvantage relative to the employers who do not.

Small businesses, the self-employed and unemployed would be able to buy insurance in the Small Business and Employee Health Benefit Program. If it is good enough for Senators, it is good enough for America.

Those who are between the ages of 55 and 64 would be able to buy-in to the Medicare program.

And we would provide help to small businesses and to low-income workers.

But although I am passionate about universal access to health care, I realize we can’t get there yet. Not because the popular will is not there, but because the political will isn’t.

So I support incremental changes, starting with the most vulnerable populations, and building on Medicaid and CHIP, success public programs.

I am working on a proposal that would expand Medicaid to cover all persons up to 200 percent of the Federal poverty level—an efficient way to reach nearly two-thirds of the uninsured.

I am also a strong supporter of the Family Care proposal, which would cover the parents of children already enrolled in the CHIP program. My own state of New Jersey is in fact leading the way on the issue of enrolling parents with their kids.

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the uninsured. Indeed, I am hopeful that we have turned a corner on this critical issue.

As we move forward, I welcome the opportunity to work with any of my colleagues, on either side of the aisle, to find ways to significantly address the problem of the uninsured. There can be no greater purpose to our work in the Senate.

Mr. LIEBERMAN. Mr. President, I rise to speak about the McCain-Edwards-Kennedy Patients' Bill of Rights. It has been 4 years since the first managed care reform bill was introduced in Congress. After years of unyielding and unproductive debate, we came together this week to find common ground for the common good, and pass a bill that will significantly improve the quality of medical treatment for 90 million American families. We have worked very hard to get to this day, and with the unflailing commitment of my colleagues on both sides, we have produced a bill that I am very proud to support.

This bill does more than just provide new assurances to patients. It will provide a whole new framework for the delivery of health care in this country, helping to transform our managed care system from one in which health plans are immune for the life and death decisions they make every day to a more fair and accountable system for America's families.

The purpose of this legislation has broad—and I emphasize broad—bipartisan support. According to a CBS news poll from 6/20/01, 90 percent of Americans support a Patients' Bill of Rights. Two years ago, 68 Republicans in the House of Representatives voted for the Norwood-Dingell Patients' Bill of Rights that allows patients to sue HMOs if they are denied a medical benefit that they need. The Ganske-Dingell bill in the House of Representatives currently has strong support from both Democrats and Republicans. I urge my colleagues in the House to take up the Ganske-Dingell Patients' Bill of Rights and pass it without delay so that we can send a bill to the president for signature.

We need to enact a patients' bill of rights now. Every day that goes by, nearly 600 American people with private insurance have benefits delayed or denied by their health plans. These critical decisions made by health plans impact thousands of families at times of great stress and worry. Our most fundamental well-being depends on our health. Anyone who has had a sick family member can tell you of the anxiety they experience during a medical emergency or prolonged illness. It is our obligation and within our ability to make it easier for these families. This bill will do just that.

Opponents of this legislation express concern that if this bill is signed into law, we will see a flood of lawsuits. I would like to point out that in the 4 years since Texas enacted legislation allowing patients to hold their health insurers accountable, there have been very few lawsuits filed. Four million people in Texas are covered by that State's patient protection law. Only 17 lawsuits have been filed.

The appeals process in this bill is fair and binding. With a strong and swift appeals process, patients should be able to receive the care they need, when they need it. The need for recourse in court should be minimal. It was never the intent of this legislation to encourage more lawsuits. The sole purpose for this bill is to deliver health care to the people who need it. I remain hopeful that as it is the case in Texas, there will be very few lawsuits once this bill becomes law.

Rathbun's Patients' Bill of Rights, patients will get the care they need and deserve with less delay and less dispute. No longer will a cancer patient have to worry about access to clinical trials for new treatments. No longer will a family with a sick child have to worry about access to a pediatric specialist. No longer will a pregnant woman have to worry about switching doctors mid-pregnancy if her doctor is dropped from a plan.

Doctors will be able to prescribe the care they feel is necessary without feeling pressured to make cost-efficient decisions. And managed care companies will be held responsible when their denials of care threaten the lives of patients.

In sum, under this legislation, our health care system will better reflect and respect our values, putting patients first and the power to make medical decisions back in the hands of doctors and other health care professionals.

We can all be proud of this outcome and the path we followed to get here. The Senate worked through a lot of complicated issues and problems, reconciling legitimate policy differences, and reached principled compromise where we could. The result is real reform, and a bill of rights that is right for America.

Mr. LEVIN. Mr. President, I support the strong, enforceable Patients' Bill of Rights which the Senate is finally going to vote on today. After years of consideration, and a hard legislative battle over the last few weeks, the bipartisan vote which this bill is about to receive on final passage reflects the overwhelming support the bill has from the American people.

The Patients' Bill of Rights assures that medical decisions will be made by doctors, nurses and hospitals, not by someone in an insurance office sometimes with no personal knowledge of the patient and no professional background to make medical judgments. It guarantees access to needed health care specialists. It requires continuity of care protections so that patients will not have to change doctors in the middle of their treatment. And, the bill provides access to a fair, unbiased and timely internal and independent external appeals process to address denials of needed health care. This legislation will hold HMOs accountable for their decisions like everyone else in the United States. The Patients' Bill of Rights also assures that doctors and patients can openly discuss treatment options and includes an enforcement mechanism that ensures these rights are real.

We have taken a big step forward today on comprehensive managed care reform for 190 million Americans. I am hopeful that the House of Representatives will again pass a real Patients' Bill of Rights and that the President will sign it.

Mr. McCAIN. Mr. President, I thank all my colleagues, both supporters and opponents of our legislation, for their patience, their courtesy, and their commitment to a full and fair debate on the many difficult issues involved in restoring to doctors and HMO patients the right to make the critical decisions that will determine the length and quality of their lives.

I think we are all agreed on one premise, that the care provided by HMOs has been inadequate in far too many instances. This failure is attributable to the fact that virtually all the authority to make life and death decisions has been transferred from the people most capable of making medical decisions to those people most capable of making business decisions. I do not begrudge a corporation maximizing its profits, exercising due diligence regarding its fiduciary responsibility to its shareholders. The bottom line is their primary responsibility, and I respect that. But that is why, we should not grant them another, competing responsibility, especially when that secondary responsibility is the life and health of our constituents. I know that even the opponents of our legislation are agreed on returning more authority to doctors and their patients, and addressing many of the most distressing failures of managed health care reconsider his stated intention to veto the legislation.

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several issues, from employer liability to class action suits to establishing a reasonable cap on attorney fees, and exhaustively study and exhaustively study every avenue going to court. We have addressed small, but important issues like protecting from litigation doctors who volunteer their time and skill to underprivileged Americans. I want to thank all senators their involved in reaching those compromises. Senators DeWINE, Snowe, Lincoln, Thompson, and Nelson especially, for their diligence and good faith. I know they want to pass a bill that the President will sign, as do I, and they have worked effectively toward that end.

I know that we have outstanding differences remaining. I know that the President is not persuaded that the legislation that we have adopted today is the legislative solution to the urgent national problem we all recognize. I pledge to continue working with the administration and with our friends on the other side of the Capitol to see if we might yet reach common ground on all the important elements of this legislation. I am convinced that we can get there, and I appreciate the President’s dedication to that same end.

I thank the sponsors of this legislation, Senator Edwards, the always formidable Senator Kennedy, Senators Specter and Chafee, and all the other cosponsors for their skill, hard work, and dedication. I thank them also for their patience. We are not always on the same side of a debate, and I suspect that working at close quarters with me can prove challenging even when we are in agreement.

I thank Senators Frist, Breaux, and Jeffords and all those who supported their alternative legislation. Throughout this debate they have been motivated by a desire to do the right thing. I believe that this is in the best interests of the American people, as have Senator Nickles, the Republican manager, Senator Gregg, and all Senators who have disagreed with the majority over some provisions in this legislation. I commend them all for their principled opposition.

I am grateful for the leadership of Senators Lott and Daschle, and the assistant majority leader, Senator Reid, for their skill, courtesy, and fairness in managing this issue.

Finally, let me thank those who do most of the work around here but get the smallest share of the credit for our accomplishments, our staffs. I want to thank the minority staff director of the Commerce Committee, Mark Buse, committee counsel Jeanne Bumpus, and most particularly, my health care legislative assistant, Sonya Sotak for their extraordinary hard work, and talented counsel to me and other members. Staffs of Senators Edwards, Kennedy, leadership staff for the majority and minority, and all staff who have made our work easier and more effective.

This has been a good, long, open, and interesting debate, distinguished by good faith on all sides. It has been a serious debate, but we have moved past it. We have achieved an important success today in addressing the health care needs of our constituents. We have much work to do, and I want to continue working with other Members, our colleagues on the other body, and with the President and his associates to make sure that we will enact into law these important protections for so many Americans who have waited for too long for them. We have been negligent in addressing this problem, but today we have taken an important step forward in correcting our past mistake.

With a little more good faith and hard work, we will give the American people reason to be as proud of their government as I am proud of the Senate today.

Mr. Daschle, Mr. President, it has been more than 5 years since we began this effort to make sure that Americans who have health insurance get the medical care they have paid for. It has been more than three years since the first bipartisan Patients’ Bill of Rights was introduced in the House and nearly 2 years since the last time we debated a real Patients’ Bill of Rights in the Senate.

Today—at long last—the Senate is doing what the American people want us to do. Today—at long last—we are standing up for America’s families.

Today—at long last—we are telling HMOs they are going to have to keep their promises and provide their policyholders with the health care they’ve paid for.

The bill we are about to vote on provides comprehensive protections to all Americans in all health plans.

It is a remarkable example of what we can achieve in this Senate when we search together in good faith for a principled, workable compromise.

Over the past 10 days, we have stood together—Republicans and Democrats—and rejected amendments that would have made this bill unworkable. And we have accepted amendments that made it better.

Thanks to the hard work of Senators Snowe, DeWine, Lincoln and Nelson, we provided additional protections for employers who offer health insurance.

With help from Senators Breaux and Jeffords, we agreed that states can continue to use their own standards for patient protection.

With Senator Bayh and Senator Carper’s help, we strengthened the external review process to ensure the sanctity of health plan contracts.

At the same time, we turned back an array of amendments designed to weaken the protections in this bill.

We live in an amazing time. Some of the most remarkable advances in health care in all of human history are occurring right now. Polio and other once-feared childhood diseases have been all but wiped out in our lifetimes because of increased immunization rates. We are seeing organ transplants, bio-engineered drugs, and promising new therapies for repairing human genes.

But medical advances are useless if your health plan arbitrarily refuses to pay for them—or even to let your doctor tell you about them.

This bill guarantees that people who have health insurance can get the care their doctors say they need and deserve.

It ensures that doctors, not insurance companies, make medical decisions.

It guarantees patients the right to hear of all their treatment options, not just the cheapest ones.

It says you have the right to go to the closest emergency room, and the right to see a specialist.

This bill says that women have the right to see an OB/GYN—without having to see another doctor first to get permission.

It guarantees that parents can choose a pediatrician as their child’s primary care provider.

It allows families and individuals to challenge an HMO’s treatment decisions if they disagree with them.

And, it gives families a way to hold HMOs accountable for their decisions because serious injury or death—because rights without remedies are no rights at all.

This bill achieves every goal we set for it over the past 5 years, and we owe that to the stewardship and commitment of Senators McCain, Edwards, and Kennedy.

During these last 10 days, they have shown a seemingly limitless ability to find the workable middle ground without sacrificing our core rights. They have put the Nation’s interests ahead of their own partisan interests. I thank them for their service to this Senate, and to our Nation.

I also want to thank Senators Nickles and Gregg for being honest with us about their disagreements with this bill, and fair in the way they handled those disagreements.

This is the way the Senate should work. A Senate that brings up important bills and allows meaningful debate on them is a tribute to us all.

One final reason I found this debate so encouraging is the great concern we heard expressed by many opponents of this bill for the growing number of Americans who have no health insurance. We agree that this is a serious problem, and look forward to working with those Senators to address it as soon as possible.

I want to pass a Patients’ Bill of Rights now returns to the House.

Last year, 68 House Republicans joined Democrats to pass a strong patient protection bill very much like...
this one. We urge our colleagues in the House to resist the special interests one more time. Together, we can send a strong enforceable Patients’ Bill of Rights to President Bush.

We hope that when that happens, the President will reconsider his threatened veto. We hope he will remember the promise he made last fall to the American people to pass a national Patients’ Bill of Rights.

Texas has proven that we can protect patients’ rights—without dramatically increasing premiums. It is time—it is past time—to pass a Patients’ Bill of Rights to protect all insured Americans.

The PRESIDING OFFICER. The bill having been read the third time, the question is, Shall the bill, as amended, pass?

Mr. STEVENS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The clerk will call the roll.

Mr. NICKLES. I announce that the Senator from Colorado (Mr. CAMPBELL), the Senator from New Mexico (Mr. DOMENICI), the Senator from Texas (Mr. GRAMM), the Senator from Alaska (Mr. MUKOWSKI), the Senator from Mississippi (Mr. LOTT) are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 59, nays 36, as follows:

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Mr. REID. I ask unanimous consent the Senate proceed to the consideration of H.R. 1668, which is now at the desk; that the bill be read three times, passed; and the motion to reconsider be laid upon the table with no intervening action.

Mr. NICKLES. Mr. President, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. NICKLES, Reserving the right to object, I will object on behalf of other Members. This bill has not yet been referred to committee. I personally have no objection to the bill, and I expect I will be supportive of it, but it should be referred to the committee so interested Members who have an interest in this particular issue can vet it, maybe improve it, maybe we can pass it. I hope we can pass it as expeditiously as possible.

At this time I object.

Mr. REID. I say to my friend, the distinguished Republican whip, I regret this, especially in that I have just completed reading John Adams, the new book of that great author. I recommend it to my friend.

I regret there is an objection to clearing this legislation. This bill, as my friend indicated, authorizes the Adams Memorial Foundation to establish a commemorative work on Federal land in the District of Columbia and its environs to honor former President John Adams and his legacy.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I share my colleague’s enthusiasm, both for President Adams and also for David McCullough’s book. He is a great historian. I have not finished it. I started it. I look forward to completing it and learning a little bit more about the history of one of America’s great Presidents, one of our real founding patriots.

Again, this is going to be referred to the Energy Committee where I and others, I think, will try to be very supportive in a very quick and timely fashion so the entire Senate can, hopefully, vote on this resolution.

CONGRESSIONAL RECORD—SENATE

June 29, 2001

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 legislative clerk proceeded to call the roll.

Mrs. FEINSTEIN. Madam President, we are all waiting for the majority leader to come to the floor and deliver the reorganization message. As part of that, I believe he is going to announce that Senator LEAHY, the chairman of the Judiciary Committee, is going to make public the blue slip process.

As a member of that committee, I would like to take a few moments and make a few comments about my experience with the blue slip—in essence, what I think about it.

For those who do not know what the blue slip is, it is a process by which a Member can essentially blackball a judge from his or her State when that Member has some reason to do so.

Why would I object so much? I object so much because there is a history of this kind of thing. Historically, many private clubs and organizations have enabled their board of directors to deliver what is called a blackball to keep out someone they don’t want in their club or organization. We all know it has happened. For some of us, it has even happened to us.

The usual practice was, and still is in instances, to prevent someone of a different race or religion from gaining access to that organization or club. This is essentially what the blue slip process is all about.

The U.S. Senate is not a private institution. We are a public democracy. I have come to believe the blue slip should hold no place in this body. At the very least, the use of a blue slip to stop a nominee, to prevent a hearing and therefore prevent a confirmation, should be made public. I am pleased to support my chairman, Pat LEAHY, and the Judiciary Committee in that regard.

Under our current procedure, though, any Member of this Senate, by returning a negative blue slip on a home State nominee, or simply by not returning the blue slip at all, can stop a nomination dead in its tracks. No reason need be given, no public statement need be made, no one would even know whom to blame. With a secret whisper or a backroom deal, the nomination