Miller	Santorum	Stevens
Murkowski	Sarbanes	Thomas
Murray	Schumer	Thompson
Nelson (FL)	Sessions	Thurmond
Nelson (NE)	Shelby	Torricelli
Nickles	Smith (NH)	Voinovich
Reed	Smith (OR)	Warner
Reid	Snowe	Wellstone
Roberts	Specter	Wyden
Rockefeller	Stabenow	

NOT VOTING—2

Inhofe	McConnell

The motion was agreed to.

Mr. REID. I move to reconsider the vote by which the motion was agreed to.

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

The motion to lay on the table was agreed to.

Mr. MCCONNELL. Madam President, on rollcall vote No. 193, I was unavoidably detained and was unable to cast a vote. If I had been present, I would have voted in the affirmative on the motions to proceed.

BIPARTISAN PATIENT PROTECTION ACT

The Senate proceeded to consider the bill.

The PRESIDING OFFICER. The clerk will report the title of the bill.

The legislative clerk read as follows:

A bill (S. 1052) to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

The PRESIDING OFFICER. Under the previous order, the time until 12 noon shall be for debate only, with the time to be equally divided between the two leaders or their designees.

Mr. REID. Madam President, this has been cleared with both the managers of the bill and the two leaders: I ask unanimous consent the first half hour be that of the majority, the second half hour be that of the minority, the third half hour be that of the majority, and the fourth half hour be that of the minority.

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

Mr. REID. That works out almost perfectly. It is almost 10 o'clock now.

Is that order entered?

The PRESIDING OFFICER. The order has been entered.

Who yields time?

Mr. MCCAIN. Will the Senator yield?

Mr. KENNEDY. I yield such time as the Senator desires.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. Madam President, after years of delay—and I want to emphasize years of delay—and blocking of consideration of this legislation, this important issue, the Patients' Bill of Rights, we are now, finally, going to take up this issue. I am very pleased to hear of the new-found commitment on the part of those who had blocked consideration of this legislation to seeing this legislation through to its completion. I point out again, it is long overdue that we address this issue. I am glad we are going to address it in a format where amendments are offered, we have debate, and votes are taken without filibustering and without obfuscation of the issue.

There are important issues, there are important negotiations, and important amendments that need to be discussed and debated. Again, I appreciate the commitment on the part of those who blocked—who blocked—consideration of this legislation for years on the floor of the Senate and am pleased to be bringing this issue to a conclusion. I applaud the majority leader who has stated we will not leave for the Fourth of July recess until we resolve this issue and have a final vote on it. I believe it deserves that attention. I hope all of my colleagues will devote their efforts and good-faith energies towards resolving it.

Our personal health and the health of our loved ones is the most valuable thing we possess. Unfortunately, we often take good health for granted until tragedy strikes and the health or well-being of a family member is jeopardized by disease, accident, or infirmities associated with aging.

When one of us or a loved one becomes ill, the obstacles of daily life become insignificant in comparison to ensuring the best health care services are available to our families.

Unfortunately, too many Americans are powerless when faced with a health care crisis in their personal life. Too many Americans have had important, life-altering medical decisions micromanaged by business people rather than medical professionals. Too many Americans believe they have no access to quality care or cannot receive the necessary medical treatment recommended by their personal physician.

Many Americans work hard and live on strict budgets so they can afford health insurance coverage for their family. But the moment they need it, they are confronted with obstacles limiting which services are available to them. They are confronted by frustrating bureaucratic hoops; and confronted by health plans that provide little, if any, opportunity for patients to redress grievances. This happens too often and can be attributed to several factors.

Our health care system is very complicated and can be attributed to several factors.

Our health care system is very complicated. Its language is comprised of thousands of acronyms and codes. Even its acronyms have acronyms. Our overly complex health insurance system intimidates and confuses many Americans. Many of us fail to fully examine the coverage provided by our health plans until we become ill, and then it is difficult to understand the plan's legalese. Health care has become increasingly depersonalized, focused more on profits than on proper patient care.

I am not embarrassed to admit that I am often overwhelmed by the complexity of the health system. I can certainly relate to the majority of Americans who are overwhelmed by a system which does not meet their basic needs in a simple, efficient and affordable manner.

Over the last few years I had an invaluable opportunity to travel around our great country; meeting and speaking with people from all sectors of life and regions of our nation. No matter how small or large a community I visited or where I held a town hall meeting, I repeatedly heard complaints that people's health plans denied or delayed the appropriate medical care, resulting in injury or even death to a loved one.

This is why I began working with my colleagues on both sides of the aisle over a year ago to craft a bipartisan bill that truly protects the rights of patients in our nation's health care system.

The following are the core principles I insisted be contained in our bipartisan bill:

First, our bill is about getting patients the health care they need and not about promoting lawsuits. We have worked hard to ensure that our bill focuses on getting patients the medical care they need. This is not about promoting frivolous lawsuits that could drive up health care costs and increase the number of uninsured in our country. Our bill provides a fair and independent grievance process in the event an HMO denies or delays medical care. A mother should have options when she is told her son or daughter's cancer treatment is not necessary and will not be covered by her insurance. She must have access to both internal and external appeals processes which are fair and readily available and which use neutral experts who are not selected, or otherwise beholden to the HMO. In life-threatening cases, there must be an expedited process.

Our bipartisan bill puts Americans in charge of their own health care. Patients and their doctors should control health care decisions, not HMOs or Washington bureaucrats. Physicians utilizing the best medical data must make the medical decisions, not insurance companies or trial lawyers. We need to put in place a balanced system that allows managed care companies to reduce costs but also reinvigorates the patient-doctor relationship, the essence of quality health care.

This bill protects employers from liability. We protect employers from being exposed to any liability unless they are directly participating in medical decisions. This bill will not make employers vulnerable for health care decisions they are not directly making and will not cause them to drop health care coverage for their employees out of fear of exposure to frivolous and unlimited liability.

Our bipartisan bill provides all Americans with patient protections. Our compromise includes strong patient protections that will ensure timely access to high quality health care for the

millions of Americans with private health insurance coverage either through their employer or through the individual market place. The protections include: access to emergency care, access to specialty care, access to non-formulary drugs, access to clinical trials, direct access to pediatricians and ob-gyns, continuity of care for those with ongoing health care needs, and access to important health plan information. The bill also protects the doctor-patient relationship by ensuring health professionals are free to provide information about a patient's medical treatment options.

Our bipartisan bill empowers states. It allows states to develop their own patient protection laws, and empowers the Governors to certify that they are comparable to federal law. If the State law is comparable to those at the Federal level, the State law will remain in effect. We allow States to enforce their own laws for their citizens while ensuring that a minimum level of protections are available for all Americans. We want to ensure that a mother in Arizona can take her son directly to a pediatrician in the same way a mom in Texas can.

Our bill allows Americans to seek reasonable relief once all options to receive medical care have been exhausted. I find it incredible that HMOs and their employees are able to avoid responsibility for negligent or harmful medical care. Americans covered by ERISA health plans should have the same right of redress in the courts as those who are enrolled in non-ERISA plans if they are unable to receive a fair resolution through an unbiased appeals process. We must ensure that patients receive the benefits for which they have paid and rightfully deserve. We must also ensure that unscrupulous health plans not go unpunished when they act negligently, resulting in harm or death to a patient.

Out bill protects state laws that allow patients who have been harmed or killed due to the medical decisions of an HMO to seek redress in state court. However, we worked hard to strike a compromise and help employers by allowing contract disputes to be handled in federal court. This will help employers and insurance companies have that offer multi-state plans have uniformity without obviating state laws.

Finally, we must improve access to affordable health care. It is simply disgraceful that 44 million Americans cannot afford health care coverage. This is the largest number of uninsured citizens in over a decade, despite our solid economy and past actions to provide greater access to medical care. We must continue building upon already enacted reforms by expanding medical savings accounts, providing full tax deductibility for self-employed health insurance costs, and allowing tax credits for helping small businesses provide access to health care coverage for their employees.

These provisions continue to be a crucial component of the bipartisan compromise I reached with Senators EDWARDS and KENNEDY. I am working with both of them and my colleagues on both sides of the aisle, including Finance Chairman BAUCUS to ensure that these provisions are addressed as a part of this bill or in the next legislative vehicle that the Senate deliberates.

America has been patiently waiting for far too long for Congress to pass a Patients' Bill of Rights that will grant American families enrolled in health maintenance organizations the health care protections they deserve, including the right to remedy insurance disputes through the courts if all other means are exhausted.

For far too long, this vital reform has been frustrated by political gridlock, principally by trial lawyers who insist on the ability to sue everyone for everything, and by the insurance companies who want to protect their bottom line at the expense of fairness.

If I have ever seen a more living, breathing argument for campaign finance reform, it is in the failure to act on this legislation.

Both sides hope to continue affecting their agenda with ''soft money'' contributions they hand over to the political parties, while neither represents the hopes, expectations, and best interests of the American people.

I have always found the American people to be reliable counsel when Congress attempts to assess the gravity and urgency of a problem affecting the entire nation. I have listened to countless thousands of Americans demand immediate action on a Patients' Bill of Rights. I have heard countless thousands demand a reasonable standard of accountability for health insurers who have too long and too often escaped virtually all accountability. I have heard countless thousands demand, what any American recognizes as basic fairness, that their most precious possession, their health, not be subordinate to profits for insurers or lawyers, or to political advantage of one part or another.

I have heard from very few people who claim that HMOs should continue to be the sole decisionmakers for who gets decent health care and who does not, for who lives and who dies. I have heard very few people defend an HMO's right to escape all accountability for those decisions. I have heard from very few people except those starring in radio and television ads underwritten by insurers who say HMO reform is unnecessary. I have heard from very few people who have claimed that their health, or their child's health is less important to them than the amount of damages they can recover from negligent health insurers.

But in every reliable public survey, and in every conversation I have had with the American people, in groups of ten or crowds of a thousand, everyone recognizes that a Patients' Bill of Rights is an urgent, necessary improvement if America is to have the kind of health care that befits a great and prosperous nation.

Men and women of good will, on both sides of the aisle, in Congress and in the administration, are working to bridge differences between our different remedies to this problem. I am encouraged by that, and pledge my cooperation in any sincere effort to reach fair compromises on the outstanding issues that still divide us. Whether in the amendment process or in discussions with colleagues and members of the administration, the sponsors of this bill want to reach agreement on genuine reform that will be enacted into law. But we cannot compromise on our resolve to return control of health care to medical professionals, and to hold insurers to the same standard of accountability that doctors and nurses are held to. That is all we seek today and all that the American people expect from us, a fair and effective remedy to a grave national problem. I urge all my colleagues to join us.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina is recognized.

Mr. EDWARDS. Madam President, I rise today to speak in support of the Bipartisan Patients' Protection Act. I thank my colleague from Arizona with whom I have worked for many months to help draft this legislation. I also thank my colleague from Massachusetts who has worked on this issue for many years. It is a critically important issue to the American people.

Let me talk a little bit about this issue, what this legislation does, and what this debate is about. We start with a very simple idea. That idea is to put the law on the side of patients, doctors, and health care providers. For many years, the law has given privileged status to HMOs and big health insurance companies in America. They are treated differently than any other group in this country is treated. They can do whatever they want. They can make decisions solely on the basis of cost and money, the bottom line and the profit, and they cannot be held accountable in any way. If they deny coverage for treatment that a child needs, or for a test that someone needs, or a visit to the emergency room by a family who had a true emergency, there is nothing that family can do. There is nothing that child can do. There is nothing that patient can do. They are stuck with whatever decision is made by the HMO. They are privileged citizens.

Not surprisingly, they like their privileged status. They want to stay right where they are. They do not want the law changed. They do not want to be treated like everyone else. They do not want to be treated like others. They do not want to be treated like any other small business or big business in this country.

It is time to change that. It is time to give real rights to patients.

That is what this legislation is about. It is time to put the law on the side of families, patients, and doctors.

We have some very specific protections that are critical in this bill. We start with the simple principle that every American who is covered by health insurance or an HMO is covered by our legislation. If you have HMO coverage, or if you have health insurance coverage in this country, our Bipartisan Patient Protection Act covers you, period.

If a State has a stronger protection law, if a State has a provision that is stronger than the provisions of our bill, that State law will remain in effect. But our law provides the floor below which no State can go. We cover every single American who has health insurance or HMO coverage.

Second, we also provide that women can be seen by an OB/GYN as their primary care provider. Women across this country have had this issue come up over and over where they have to go through a gatekeeper in order to go see the physician who is, in fact, their primary care provider, an OB/GYN. We eliminate that problem. We provide direct access to specialists.

For example, if a child who has developed cancer needs to be seen not by a general cancer doctor—just a general oncologist—but by a child specialist, a pediatric oncologist, we specifically provide that the child can see the specialist the child's family believes their child needs to see.

That is what we mean when we say we provide direct access to specialists so that people can see the specialist they need.

Emergency room care: If a family has an emergency at home, in an automobile—wherever—and needs to go to the emergency room, the last thing in the world they want to be thinking about is, Do I need to call my insurance company? Do I need to call my HMO before I go to the emergency room to get the treatment I need?

We have eliminated that—no 1–800 numbers; no trying to look through the drawers to figure out where your insurance company is and how to call them. If somebody gets hurt, and they need to go to an emergency room, it is very simple. You go to the nearest emergency room, and you are covered. That is the way it ought to be. Unfortunately, it has not been as it should have been. We protect patients in emergency situations.

These rights: Access to specialists, emergency room care, women being able to be seen by an OB/GYN, access to clinical trials—we specifically provide that if a patient participates in a clinical trial, the costs that are not covered by the sponsor of the trial, the attendant costs, the hospital care or other things, in fact will be covered by the HMO and the insurance company.

Clinical trials are critical, not only to patients for whom they are often the last hope, but they are also critical to our Nation in continuing to lead the way in this world in advancements in medicine. We make sure clinical trials are covered.

In the area of specialist care, clinical trials, access to emergency rooms, and access by women to an OB/GYN, we have real substantive patient protection. But those rights are meaningless unless they are enforceable. It is not a Patients' Bill of Rights unless there are enforcement provisions. Without meaningful strong enforcement, it is not a Patients' Bill of Rights. It is a patients' bill of suggestions.

We want a real Patients' Bill of Rights. That is what our bill is. We have real enforcement. The entire bill is designed to get patients the care, the treatment, and the tests they need and should have gotten to begin with from the very outset.

We want the insurance company and the HMOs to know that if they do something wrong, their decision can be reversed.

The first thing we have is what is called an ''internal review process'' within the HMO. If a child needs a test, and the HMO says they are not paying for it, and the family doctor says the child still needs it and they overrule the doctor—if that occurs, that family has somewhere to go. They go to an internal review process within the HMO. If that is unsuccessful, and for a second time the HMO says no, then the third step is an external independent review. We set up a system, a panel of doctors and experts who have no connection at all with the patient or the doctor involved—no connection at all with the HMO that can then look at the medical facts and determine whether that child needs that test and can reverse the decision of the HMO.

So there are three stages through which the right decision can be made. Hopefully, the HMO will do the right thing to begin with, as on many occasions in the past. If they do not, then they can be reversed by an internal review process. If that is unsuccessful, then you can go to an independent appeal board. This is all before anybody goes to court. You can go to an independent appeal board that can reverse the decision of the HMO.

So we have set up a system designed to make sure the patients get the care they need, and get it as quickly as they possibly can. That is what our whole system is designed for. It is designed to avoid anybody ever having to go to court.

Unfortunately, there will be occasions where that system does not solve the problem—they are rare, but they will occur—and where a patient has been hurt because of some arbitrary or intentional decision by an HMO, where an HMO says: We are not paying for that. We don't care what the doctor said. We don't care what this child needs. We're not paying for it. And a child suffers a serious injury. As a result, those cases can then go to court.

We have heard lots of arguments in the public debates on this issue in relation to the creation of lawsuits. That is not what this legislation is about. This legislation is about real patient protection. It is about a system to reverse a bad decision by an HMO, and then ultimately treating HMOs like everyone else in this country—every other business, every other American.

You and I, when we do something, we are responsible for it. We believe in that in this country. We believe in individual responsibility. When we make a decision or we take some action, we believe we ought to be held accountable for that and we ought to be responsible for it. We believe it all the way down the line.

That is the concept this bill enforces. We take away the special protections HMOs have had in the past, where they can in no way have their decision reversed. If they deny coverage to a family, they are stuck with that decision. It cannot be appealed, cannot be challenged, cannot be taken to court. They are stuck with that decision.

We change all that. Now, under this legislation, they are treated exactly the same. If all the appeals have failed—if an HMO denies coverage, and the internal appeal fails, the external appeal fails, and someone is hurt, then we treat them like anybody else. They have made a medical decision. They have overruled the doctor, who has years of training and experience and who has actually seen the patient. So we put them in the shoes of the doctors. If they want to make medical decisions, they ought to be treated like people who make medical decisions.

For that reason, we send the majority of the cases to State court, which is where doctors and hospitals and businesses go.

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

Mr. EDWARDS. Yes.

Mr. McCAIN. Is it true that we have significant protections for employers with regard to liability, including the self-insured? But isn't it also true—because allegations will be made to the contrary—that we are interested in actively pursuing further agreements with all parties to try to address and tighten this language so we can achieve the goal we seek; and that is, to remove employer liability where the employer had no voice in the medical decision and to make sure the self-insured are able to avoid unnecessary lawsuits and be protected as well?

Mr. EDWARDS. I thank the Senator for his question.

The Senator knows, of course, because he and I have worked on this issue over a period of many months, that we both believe very strongly that we ought to protect employers from liability, period. What we have done in our legislation is we have followed the outline of the President's principle. The President has said, in his principle, that he does not want employers held responsible for liability unless they actually make individual medical judgments, which, of course, is extraordinarily rare. Our bill does exactly the

same thing. It specifically protects employers unless they make an individual medical decision.

But the Senator is also correct that we start with the idea that we want employers protected, and to the extent our colleagues have ideas on this subject, we welcome those ideas and are willing to talk about this. The Senator and I have talked about this not only from the outset but over the course of the last several days. So we are more than willing to consider other possible ideas on this subject that will more strongly protect employers from liability.

Basically, the entire legislation is intended to do two things: One, give real rights to patients, so the law does not continue to be just on the side of the big HMOs; and, two, to make those rights enforceable, so that when a patient or family is denied coverage, they can do something about it. It is just about that simple. And it is designed to get the care to the patient as quickly as we possibly can.

My colleague from Arizona just asked a question about employer liability, which we have just talked about. We believe very strongly that employers ought to continue to provide coverage, and we want to protect employers from liability.

Second, there is an argument made that this will result in lots of lawsuits. The truth of the matter is, all we are doing is taking away the shield, the privileged status HMOs have today that makes them different from all the rest of us. We just want them to be treated like every other American, which I think is fair and equitable.

But what we have learned from the three States—Georgia, California, and Texas—that have similar laws, is that almost all claims are resolved either with the internal appeal or the external appeal. In those three States, I think there has been a total of about 17 lawsuits. In the State of Georgia, Senator MILLER indicated yesterday there has been none. And those are three large States.

So the evidence does not support the argument that this is going to result in lots of lawsuits. In fact, we believe that is not true. Senator MCCAIN and I have worked very hard to design this bill to avoid that occurrence. But rarely it will occur. And if it does occur, we just want the HMOs treated like everybody else.

There are real differences between our legislation and the competing legislation. I will not go through the details of those differences, but let me just say they begin from the very outset of the bill and flow to the end.

We make it clear that every American is covered, and their language is less clear about that. We allow patients to have direct access to specialists outside the plan. They allow the HMO to make those decisions. We make clear that people have access to clinical trials, including FDA-approved clinical trials. They do not. We have a clearly independent review process where no one, including the HMO, can be involved in who is on the appeal panel. They do not. We send cases to State court, so HMOs are treated just like the doctors and the hospitals and all the rest of us. They give them special, privileged treatment by sending their cases to Federal court, where they are less likely to get hurt and it is harder for the patient to actually have a determination of their case or their claim.

So in every single case where there is a difference, they favor the HMOs, we favor the patients. That is the reason that the American Medical Association and, I think, over 300 or 400 medical groups in this country support our legislation. Virtually every medical group in the Nation supports our legislation—and consumer groups. There are a handful that support both.

But there is a reason that all those groups favor our legislation. There is a reason the HMOs favor their legislation. The reason is very simple. We have real and strong patient protection. And in every case there is a difference, their bill favors the HMOs, our bill favors the patients.

I would like to tell you a quick story about a patient in North Carolina. He is a young man named Michael Gray Whitt, who is shown in this photograph. Today he is a beautiful, happy 2-year-old little boy. He and his family live in Fleetwood, NC. His parents are Marc and Terri. Unfortunately, at the time he was born, he was not as healthy and happy as he is here shown in this picture.

He was born 4 weeks early at Watauga Medical Center in Boone, NC, because of a blood disorder.

The PRESIDING OFFICER. The 30 minutes controlled by the majority has expired.

Mr. EDWARDS. Madam President, I ask unanimous consent for an additional 5 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Reserving the right to object, as long as the opponents of the bill get 5 minutes also.

Mr. EDWARDS. Absolutely.

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

Mr. EDWARDS. I thank my colleagues.

Madam President, when Michael Gray Whitt was born, he suffered from a blood disorder known as RH isoimmunization, which occurs when the mother has one blood type and the baby has another. The mother's body reacts by producing antibodies that attack the baby's blood. It can cause anemia, jaundice, enlargement of the liver and spleen, and it can even cause death.

It is usually prevented by taking a drug, which Michael's mother took, but it did not work in her case.

When baby Michael was born, he was at risk for liver failure, seizures, and brain damage. A newborn medical specialist recommended that he remain in the hospital where he could be watched in case any of these problems developed. He was very much at risk, very much in peril. The doctor specialist who was taking care of him knew he needed to be in the hospital so if anything went wrong they would be able to do something about it. He was right to be worried.

Michael's liver was not working properly, and he was kept in the hospital, in fact, for treatment. You can imagine how his parents Marc and Terri felt when less than 72 hours after he was born the HMO wanted him discharged from the hospital. Luckily for Michael, his doctor refused to follow the HMO's order. But when he showed some marginal, slight signs of improvement after 2 days, the HMO insisted that he be discharged. So he was sent home.

His parents were in shock. Why in the world would their HMO send a sick baby home who everyone knew needed to be watched carefully in case problems developed?

Less than 24 hours after the HMO sent him home, he got sicker than he had ever been. He was lethargic. He had jaundice, and he was eating poorly. Tests showed his liver problems had gotten worse. So less than a day after he was sent home against his doctor's wishes, he was back in the hospital.

I would like to share some words of Michael's dad, Marc Whitt, about his ordeal. This is what he said:

> I could never put into words the amount of stress and anxiety my wife suffered throughout this first week of our child's life.
>
> It was hard to deal with a helpless, sick newborn but impossible to understand and tolerate an insurance company's total disregard for our child's life.
>
> I wonder how many people's lives will be ruined by the actions of an HMO before HMOs are held accountable for their behavior.

That is a good question. How many more children will suffer serious injury or death before we do something about what these HMOs are doing?

A couple of days ago one of the chief spokespeople for the HMOs was quoted in the New York Times as saying: We are prepared to spend whatever is necessary on public relations, on lobbyists, on television ads. But they were not prepared to spend what was necessary for this young child to get the care his doctor knew he needed and his parents knew he needed.

We have a message for the HMOs. Whatever millions of dollars they are willing to spend, whatever the power of their lobbyists here in Washington, we are prepared to stand and fight along with Michael and families like his all around America, as long as is necessary, to ensure that finally in this country HMOs, just like all the rest of us, will be held responsible for what they do.

I yield the floor.

Mr. REID. Madam President, I ask unanimous consent that the last order entered by the Chair be revised to take the 5 minutes or whatever time the

Senator from North Carolina used from our next 30 minutes. That way we will still be able to start the amendment process at noon. Does the Chair understand the request?

The PRESIDING OFFICER. The Chair does understand. Without objection, it is so ordered.

Mr. REID. I thank the Chair. I knew the Chair would understand, if I made sense in explaining. I wanted to make sure I had done that.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. I yield myself 15 minutes.

Madam President, I rise in support of a Patients' Bill of Rights. We need a Patients' Bill of Rights in this country. I spent most of last year working on a conference committee to get a Patients' Bill of Rights. I am told by more senior colleagues that we spent more time meeting as members than on any other bill they could remember. We got that close to having an agreement.

In fact, people could see that we were going to get agreement on a Patients' Bill of Rights. There were some people who chose to have it as an issue instead of a solution. That is why we are back again working on a Patients' Bill of Rights. We do need a Patients' Bill of Rights but not this one, the way it reads.

I will give some rebuttal to a McCain-Kennedy factsheet on protecting employers. The sponsors of the bill distributed a white paper to the Democrat caucus, and I can't let that go unrebutted. This is the assertion: Employers are explicitly protected from liability in almost every case. But that is not what the bill says.

For the record, let me say that you would need a bushel basket of breadcrumbs to weave your way through this bill without getting lost. I tried at first with string, but it got so interwoven I thought it was macrame.

This is going to be extremely hard to follow. It is much easier to give examples, as we just heard of people who have been wronged by the system. We need to clear that up.

It is much more difficult, though, to make sure it reads properly in the details. You will be able to see why the average person is not entirely clear on how this bill fails to meet the assertion that employer-sponsored health care is protected. I am not a lawyer so my explanation may go a little more slowly than the compelling presentation made by my colleagues Senators GREGG and GRAMM on Tuesday. But I can assure you that I will lead you through the language of the McCain-Kennedy bill and show that it clearly sues employers and, therefore, threatens Americans' access to employer-sponsored health care.

I was a small businessman. Small business does not have the experts and specialists to interpret all of this, but they are going to have to abide by this stuff, too. See if you can follow this.

Here's what the bill language in S. 1052 actually says. On page 144 line 18, there is a subparagraph entitled, ''Cause of Action Against Employers and Plan Sponsors Precluded.'' Nice title. This is subparagraph (A). It literally begins with, ''Subject to subparagraph (B).'' In other words, the provision whose title implies that employers are protected from lawsuits begins with an exception tot hat protection. As you can probably already guess, subparagraph (B) is entitled, ''Certain Causes of Action Permitted,'' which started out with, ''Notwithstanding subparagraph (A),'' which means, despite the protection from lawsuits they just said they were giving employers in the preceding paragraph, here's how ''a cause of action may arise against an employer.'' We're still on page 145 still under subparagraph (B). On line 7, there is a reference back to page 140, where you're sent to paragraph (1), subparagraph (A), which is all captured under a new subsection of ERISA, entitled ''Cause of Action Relating to Provision of Health Benefits.''

This subparagraph first identifies who would be subject to liability, saying: ''In any case in which a person who is a fiduciary of a group health plan''—meaning an employer under ERISA—a health insurance issuer offering health insurance coverage in connection with the plan, or an agent of the plan, issuer or plan sponsor.'' Then the paragraph goes onto page 140 and lists what actions would make that category of employers and health plans liable, saying, ''upon consideration of a claim for benefits of a participant or beneficiary under section 102 of the Act, or upon review of a denial of such claim, fails to exercise ordinary care in making a decision.'' Section 102 captures any consideration of a claim for benefits—whether its written or oral—and section 103 is the entire internal appeals process. Confusing? Intentional?

Then page 140 goes on to list the following actions with respect to making a decision. It reads, ''regarding whether an item or service is covered under the terms and condition of the plan or coverage; regarding whether an individual is a participant or beneficiary who is enrolled under the terms and conditions of the plan or coverage; as to the application of cost sharing requirements or the application of a specific exclusion or express limitation on the amount, duration, or scope of coverage of items or services under the terms and condition of the plan or coverage; or, otherwise fails to exercise ordinary care in the performance of a duty under the terms and conditions of the plan with respect to a participant or beneficiary. Then the employer must prove that none of those actions were the ''proximate cause'' of the patient's personal injury. If they can't, then the employer is liable for economic and non-economic damages, and punitive damages of $5 million will be awarded, see page 153, line 23, for ''bad faith and flagrant disregard for the rights of participants.'' I am told that is a fairly high legal standard to meet.

But then I remind myself that there is a band of trial lawyers right now trying to sue health plans under Federal racketeering laws. That is what we use to prosecute mobsters. If I were an employer—particularly a small employer—that kind of zeal by lawyers sure would not make me feel any better, and trying to read this bill would not make me feel any better.

I am running a little low on breadcrumbs, but let me skip back for a minute to the ''liable actions'' listed on page 140. In particular, the last one I mentioned, which refers to ''fails to exercise ordinary care in the performance of a duty under the terms and conditions of the plan.'' This phrase, ''terms and conditions of the plan,'' is defined in the bill on page 122, line 14—another page—as ''to include, with respect to a group health plan or health insurance coverage, requirements imposed under this title with respect to the plan or coverage.''

Well, page 122 falls into title I of the bill. Title I of the bill includes a plan's utilization review activities, which cover everything from disease management to quality-of-care decisions to cost-benefit analysis; all claims-related activity, including internal and external review; all of the patient protections, from allowing patients direct access to the nearest emergency room to paying the cost of an employee's participation in a clinical trial, and on, including nine more separate patient protections; five additional rights for health care providers, including a whistleblower protection provision, which I will take issue with later; and a series of broad new definitions of provider categories and plan functions, coverage of limited scope plans, which are the dental and eye care plans, and a blanket inclusion of any and all new regulations—listen to that; pay attention here because, besides all of the stuff actually in print, you are going to be subject to any and all new regulations that the Secretary, who is completely at will to draft anything in relation to the act.

I would like to note that also included in title I is the overriding of existing State laws that deal with the standards in this bill. I guess that is now also a part of the health plan contract.

Confusing? Intentional? Now, after saying all of that, we need to tie all of these duties, obligations, named functions of the employer which again is voluntarily providing health coverage, back to the original trigger, into the employer liability section of this bill. If you remember, that is back on page 145. You will notice that it skips around. That is the subpart of subparagraph (B) I mentioned before, starting on line 7, which says the employer is liable to the extent there was direct participation by the employer or other plan sponsor in the decision of the plan under section 102 of the act upon consideration of a claim for benefits or under section 103 of such act upon review of a denial of a claim for benefits,

or to the extent there was direct participation by the employer or other plan sponsor in the failure described in clause (ii) of paragraph (1)(A)—paragraph (1)(A), of course, being when a plan ''fails to exercise ordinary care in the performance of a duty under the terms and conditions of the plan.''

Heard that before? You heard me read that definition a moment ago from page 122, line 14, as being essentially everything under the Sun with which an employer has to comply.

OK, we are almost there. So bear with me. We still have a breadcrumb or two left here.

The employer liability provision in the bill goes on to further define direct participation, found on page 145, line 21, as meaning ''in connection with a decision described in clause (i) or a failure described in clause (ii).''

These are the two things I just described to you; remember, it was either the consideration of a claim for benefits or the failure to exercise ordinary care. Direct participation means, ''the actual making of a decision''—we all agree on that—''or the actual exercise of control in making such a decision''—we all agree on that—''or in the conduct constituting the failure.''

We didn't know they were going to increase the decision so much, though. It sounds to me like every activity in this bill legally requires employers to do that which they are already legally bound to do under the fiduciary obligations of ERISA, which under Federal law businesses have to meet, which is now included in this, and it would constitute direct participation and, therefore, exposure to unlimited new liability.

Now, the sponsors have tried to define what direct participation is not. There are a whopping four things, all of which—and this is important—are conditioned by the clause found on page 146, line 12 and line 16, which reads: ''conduct that is merely collateral or precedent to the decision or failure.'' In other words, this so-called employer protection only applies if any ''actual'' action by the employer occurred long before or away from the decision. I read that to mean that if an attorney links any employer activity covered in the four exceptions to the lawsuit against the employer, then the ''exceptions'' do not apply.

But let me tell you what they are anyway. Starting on page 146 and going to 147, they include, an employer's selection of health plan, or third party administrator; an employer engaging in cost-benefit analysis when choosing or maintaining a plan; the employer creation, modification, or termination of the plan; the employer participation in benefit design, and copayments, or limits on benefits. Show me an employer that probably isn't doing all four of those things and I will show you an employer that doesn't have a health plan. You have to do those things; it is a business requirement. If you are going to pick a plan or a third party administrator, you probably have to have some involvement in that. You have to do some cost-benefit analysis. You have to do at least the creation of the health plan, or you don't have a health plan. It sounds like a lot of upfront paperwork as well. That may be what it is all about, too. All other plan administration by an employer is subject to liability. But then so are these functions if we are to apply the ''collateral or precedent'' limitation on the employer protection I just referenced.

I mentioned this to show you that it isn't quite as easy as some might be trying to purport here. This is seriously complicated, and it appears that around every corner in this bill there is an exception that swallows the rule. And the exceptions purported to protect employers are swallowed, too. There is no way anybody is going to convince the American people this bill doesn't sue employers, and for just about anything.

The PRESIDING OFFICER. The Senator has consumed 15 minutes.

Mr. ENZI. I yield myself 1 more minute.

The PRESIDING OFFICER. The Senator is recognized for 1 more minute.

Mr. ENZI. Madam President, I am not a lawyer; I am an accountant, and I can tell you that this adds up to employers scaling back, even dropping the coverage they now provide. Is this how we propose to protect patients? The problem, at the end of the day, is that there is no fairy tale for hard-working Americans who currently receive health care from their employer. Instead, they are left with the nightmare of more expensive care, reduced benefits, or, in the worst case, losing access to care altogether. That is unacceptable for insured Americans. The logical question is, How in creation does this address the problem of uninsured working Americans? I leave my colleagues to mull that over.

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

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. Madam President, I yield myself 15 minutes off of the time of the Senator from New Hampshire.

The PRESIDING OFFICER. The Senator is recognized for 15 minutes.

Mr. BROWNBACK. Thank you, Madam President. I thank my colleagues for presenting this bill on the floor. I appreciate taking up this topic—the key topic facing the United States, the Government, and the health care industry within this country.

I strongly believe and I strongly urge that this should have gone through a committee process so we could have had amendments taking place and could have had this dealt with in depth in a committee. I think that it did not is regretable, particularly on such a large piece of legislation that affects so many people. But that wasn't the choice of the majority that is running the floor. They decided not to go through that process, and so we are here as we are today.

I hope, since this bill did not go through the normal committee process, we can have an extended amendment process to improve the bill in substantial ways as we proceed through this debate and consideration of this key legislation affecting much of health care delivery in this country. Through a good, strong, open amendment process, we can, hopefully, at the end of the day, vote on this bill and have something with which we are all pleased.

Having made those initial comments, I want to point out legitimate and serious concerns I have about the effects of this legislation on people throughout the country.

Make no mistake about it, I shed no tears for the HMOs. My colleagues have brought to the Senate Chamber for consideration some shocking photographs and anecdotal information of treatment at its worst by the HMOs. Like everybody else who has heard these anecdotes and seen the photographs, it offends my sensibilities.

We need to examine the organization of the health maintenance organizations established by the Congress over the past few decades and how they were established and why they were established.

The truth of the matter is, over the past few decades Congress created and charged the health maintenance organizations with keeping down the cost of health care, and the tool with which we have entrusted them is a bureaucracy.

The truth of the matter is, using a bureaucracy to control a system is inefficient, many times difficult, unwieldy, and certainly not very personal.

The truth of the matter is, patients and physicians are sick and tired of dealing with this unresponsive bureaucracy and its difficult system. We need to make changes to provide personalized decisionmaking in health care. We need to change the system Congress has created. We need to make it work better. We need to do it in such a fashion that it does not drive up the cost to the point that we start increasing, again, the number of insured in America.

There has pretty much been an iron rule on health care that as we drive up cost, the number of insured goes down, and that is a policy trend we do not want to cause with this bill. There are ways we can amend it to reduce that overall cost factor to limit the drop in the number of insured.

We want people to get insurance. We want people to be insured. We do not want people to be uninsured in this process. We can change HMOs to make it a more personal decisionmaking process between patient and physician so that they are the ones making the choices rather than a large, unresponsive bureaucracy.

As the blues song goes, ''Before you accuse me . . . take a look at yourself.'' HMOs and private sector insurance are not the only ones who rely on a heavy-handed bureaucracy in the health care field. The truth is Medicare, the health insurance we are responsible for administering, has been one of the most difficult bureaucracies in the Federal Government. If you want to talk about bureaucracy, let's talk about PPSs, DRGs, and NSFs. Let's talk about a system that tells physicians: Provide the care, and then we will tell you whether we are going to pay for it or not.

HCFA is a bureaucracy that has gotten so out of control that this administration has wisely decided they cannot reform it, they have to completely remake it and rename it. This is a bureaucracy unto itself that is unresponsive. I get complaints on a regular basis. HCFA is getting right up there with the IRS on complaints, and that is a bureaucracy, which we run, which manages health care in the country, which clearly needs fixing.

For the past several decades, this Nation has relied almost solely on bureaucracies of one type or another, either ones we run or others, to hold down the cost of health care. That is the heart of what we are debating today: health care costs.

Many of us believe the solutions offered by some of my colleagues do not adequately address this problem. We are going to drive that cost up, and the number of insured is going to go down. That is a genuine concern of a number of people.

Who feels this way? Some of my colleagues have stated that the people are saying: You have a bureaucracy that has been unresponsive. Let's make these changes and drive the cost up, not noting they are driving the number of insured down in that process. We need to avoid that result.

I want to read a letter my office received, as well as a number of other offices, on June 15, regarding who feels this way about health care. This is a quote from this letter:

> We urge Congress to oppose this legislation—

That is, the pending bill—

> and avoid the dire consequences it would have on our employer-based health care system.

The letter went on to say that the Kennedy-McCain Patients' Bill of Rights—

> would discourage employers from offering health care coverage and make coverage more difficult for workers to afford.

Who signed that letter? It is interesting, not a single HMO appeared on that letter. The letter came to my office signed by the National Federation of Independent Businesses, U.S. Chamber of Commerce, Associated Builders and Contractors, Printing Industries of America, Business Roundtable, and 14 other business associations representing virtually everyone in this Nation who voluntarily provides health care coverage to their employees and wants to continue to provide that health care coverage. They are saying: Do not change this in such a way that we cannot afford to make these changes and they are going to drive us out of health care; don't do that.

We do not need to do that; we should not do that. We can amend this bill to make it so that does not happen.

I suggest my colleagues follow the Kansas tradition and take these groups at their word.

The nonpartisan Congressional Budget Office has suggested the Kennedy-McCain-Edwards bill will increase premiums for employer-sponsored health plans by an average of 4.2 percent, with a 1.7-percent increase being passed through to workers.

What about the remaining 2.3 percent? CBO says 60 percent of the increase would be offset by, among other things, ''purchasers switching to less expensive plans, cutting back on benefits, or dropping coverage.''

Is that the conclusion we want to produce from this legislation? I certainly do not think the directors and people who are putting forward this bill want that conclusion, and yet that is what CBO is citing.

It is not just the CBO or national business organizations that have this grave concern. On June 6, I received a letter from Harvey Young. Harvey owns Young's Welding, a small welding shop that has been in Chanute, KS, since 1934. Harvey wrote this ''health care legislation would be a disaster for small employers in the Nation.''

In addition, while they do not know it yet, the 3,200 Kansans and nearly 340,000 Americans who could lose some health insurance as a result of this legislation are going to have a big problem with this bill.

We do not need to go there if we amend this legislation to reduce those areas that will drive people from getting health insurance.

I understand it is not the intent of my colleagues to increase the cost of insurance and drive employers and workers out of the health insurance marketplace. My friends are pure in their intentions to address the problems that have arisen from the bureaucratic state of our health care economy.

The cases of denied coverage they bring before the Senate are disturbing to all of us. However, I hope my colleagues will concede that the concerns we raise about the manner in which this bill addresses the problem are just as genuine.

Many are concerned adding new liability and legal cost to an already large cost of health care will create problems in the system. We are worried by reports that 44 insurers have pulled out of Mississippi citing large jury verdicts as the reason. Considering that the cost of health insurance has risen for 7 straight years, and considering that last year the cost of insurance was up a whopping average of 13 percent, I hope supporters of this legislation will understand my concerns.

No Senator has risen in defense of bureaucratic health care either of the United States through HCFA, or health maintenance organizations. None has risen to defend the indefensible actions of some HMOs that have denied necessary coverage to a child; nor shall we, nor should anyone. Rather, we rise to express concern about a bill that could result in more harm than good in driving up the number of uninsureds in America rather than giving more coverage, and actually at the end of the day producing less.

On Tuesday, addressing a rally in front of the Capitol, my colleagues expressed there was room for compromise on this issue. They expressed the hope we could send a bill to the President that the President would be able to sign. I share my colleagues' hope and dream we will be able to do that. Generally, as we saw with the historic education package we passed last week, the bulk of the work reaching compromise is done in the committee process. However, due to the circumstances the Senate now finds itself, the majority has decided that may not be possible. Such is the privilege of the majority. However, it is my hope before we move to final passage, we can work out a bill to address some of the problems our Nation's health care economy is truly facing without wrecking the Nation's health care economy in total, and without driving up the number of uninsureds.

At that point, we will have a bill I can support and I believe the President can sign and, hopefully, we can be proud of in providing more health care coverage to Americans, not less. We are not there yet.

I yield the floor.

The PRESIDING OFFICER (Mr. CORZINE). The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I yield myself 10 minutes.

I listened with great interest to the points made by my friend from Wyoming, Senator ENZI, on the issues regarding employer responsibility. It was a good discussion. I hope he will have an opportunity to read what the President of the United States urged Members to do: Only employers who retain responsibility for making final medical decisions, should be subject to the suit.

I know what he is against; I am not quite sure what he is for.

Here is the principle to which we are committed, and to which the President is committed. If he has some problems, or suggestions on how to achieve it, we welcome that. We strongly support what the President has stated is his objective in terms of employer responsibility. We will have more of an opportunity to address that issue.

I listened to just about every speaker from that side talk about their concern for the growing number of the uninsured. That is mentioned in every speech. I yield to no one in my strong

commitment towards getting coverage for the uninsured. However, I remind them of their own priorities. They believe the best way to extend coverage is to try and provide tax credits and tax incentives. I have a real concern about that because the people who don't have that insurance don't pay the level of taxes to benefit from the credits or the deduction.

We can debate that another day. However, 75 to 80 percent of those who do not have insurance will not benefit. It will benefit others who have the insurance, but it will not extend the coverage.

Nonetheless, that is a debatable point. The Republicans had provisions in their budget to extend coverage. They dropped them all. They dropped them all in conference with the House of Representatives. They didn't fight for those provisions. They fought for greater tax breaks for the wealthiest individuals in the country, but they cast those provisions aside. I hope they do not continue raising this issue in the Senate. I wish they had fought for this issue in their conference. They let those provisions go. That bill had anywhere from $60 to $70 billion in provisions to extend coverage when it left, and those provisions were wiped out.

If they were committed to it, we want to know what they intend to do now. It is a nonissue because, as was pointed out yesterday by the Senator from North Carolina and others, when the States have enacted a strong Patient's Bill of Rights, the actual number of the uninsured has gone down. The total number of insured has gone up. That is true in California, that is true in Georgia, and that is true in Texas. They can use whichever argument they want, but they have to get their facts straight. The facts are, even in the States which passed tough HMO bills, there have not been the increases that some expressed concern about. We have seen that expansion of coverage to the uninsured has not been their priority. These are effectively smokestacks. We want to keep focused on the target.

I listened to my good friend, Senator BROWNBACK, talk about the Business Roundtable and their concerns about the legislation. He feels that we ought to heed their concerns. We heard their concerns when we were dealing with the Family and Medical Leave Act. They said it would cost anywhere from $25 to $27 billion; we cannot do it. We will lose; we will have more people laid off; it will be the end of the free enterprise system, they said.

Guess what. It is working. We intend to try and expand it. It has made a big difference. It still has not done all the things many who supported the program desired. There are too many workers who will not take the family and medical leave because they lose their pay. They lose pay because they are always caught between the child who is sick, the parent who is desperately ill, and taking the family and medical leave to tend to that. These are hard-working Americans who need that paycheck every week, and many of them cannot take the leave. Most other industrial nations have paid family and medical leave. We don't.

The Business Roundtable opposed that legislation, but it is working today. I don't hear a single Republican trying to repeal it. They are not out there trying to repeal it. Then we had the Kassebaum-Kennedy bill to provide portability on health insurance for disabled. We heard premiums would go up from 25 percent to 31 percent, and that this would be the end of the employer-based health insurance program. It has not happened. It has gone up 2.7 percent over a 3-year-period, which was the estimate at the time that was used by those who supported the program. The other estimates were widely off base.

Regarding the increase in the minimum wage, the last time we had an increase in the minimum wage they said we would lose 400,000 workers. In the first quarter, we increased employment by 300,000 workers. They were wrong. They said it would add to rates of inflation, and we had the greatest rate of growth in the country. They were wrong. Three for three, they were wrong.

Rather than listening to their theories, look at what is happening in the country today. Look at the States where they have a tough, effective, Patients' Bill of Rights and what has been the result of the employer-based system. We find still that the number of insured or uninsured is not related to this issue. The increase in the numbers covered are primarily a result of the expansion of the CHIP program. It has been a modest change.

Second, there have not been great abuses of employers' liability. The most recent example is the State of California which passed a very good, effective, tough, HMO bill that has been in effect 9 months. There has not been a single case that has actually gone to trial. There have been over 200 cases that have gone to appeal, and they have been decided 65 percent for the HMO, and the rest for the patient. The HMOs, as well as the consumer groups, are incredibly impressed by the way it is working. That is what we want this bill to do.

It is a favored technique around here: If you are opposed, distort it, misrepresent it, exaggerate different provisions on it, draw up all kinds of smokescreens and red herrings. But these distortions won't work because we have practical experiences to draw upon. We can see in the States how this can work, how we can function, and what the impact will be.

I will spend a few minutes talking about what this bill is about. There are efforts to bring the Senate off message on this but it is important to remember what the debate is about. It is not about lawyers. It is not about insurance companies. It is about patients. It is about people who are mothers, daughters, fathers and sons, sisters and brothers. It is about families all over the country who will some day face the challenge of serious illness and deserve the best in health care. They deserve the same care that all Members of the Senate would want for themselves and their loved ones. Too many of those families are denied the care they need and deserve because of the abuses of HMOs and the other insurance companies.

The legislation we are considering today will end those abuses, and, as we enter this debate, I would like to spend a few moments talking about the importance of three of its provisions—access to needed specialty care, access to clinical trials, and access to needed prescription drugs. In each of these areas, needed care has too often been delayed and denied by insurance companies that are more interested in profits than in patients. In each of these areas, the opponents of our bill want to create loopholes that will make these guarantees only an empty promise.

Access to specialty care when serious and complex illnesses strike is a critical element of good health care. Denial of access to needed specialists is also one of the most common abuses in the current system. According to a survey by the University of California School of Public Health, 35,000 patients every day are denied specialty referrals. One of those patients was little Sarah Pederson of San Mateo, California. This is her picture.

Sarah was born with a brain tumor. When she was three, it became clear that she needed aggressive treatment to save her life, including brain biopsies and chemotherapy. Her neurosurgeon knew that Sarah needed to be seen by a doctor specializing in brain tumors in children—and there was no qualified doctor in the plan. When Sarah's mother, Brenda, a nurse, asked to go outside the network, her HMO said, ''No.'' The HMO told her, ''We're not giving you second best, we're giving you what's on the list.'' After months of fighting with the HMO, it finally agreed to let Brenda see someone qualified to treat her condition.

When Sarah finally got to the right doctor, her chemotherapy began. Everyone knows chemotherapy causes severe nausea and vomiting. The HMO denied Sarah's $54 prescription for antinausea medication, because it was ''too expensive.'' Finally, Sarah's family was able to switch insurance companies and get proper care for their child.

So there you have it. Two parents facing one of the worst nightmares a family can have—a child with a cancer—and instead of being able to focus on dealing with the terrible stress and working to give their child all the comfort and assistance they can—they have to spend their energy fighting with an insurance company simply to get the child to an appropriate specialist. Sarah was lucky, in the sense

that the HMO's delays did not kill her. But what a burden for her family to face. What a travesty of common decency. Passage of our legislation will assure that every family with a child who has cancer can get the specialty care they need without dangerous delays.

Women with cancer face special burdens. They must cope with a dread—and often deadly—disease. They need prompt specialty care. And often, their best hope for a cure or precious extra months or years of life is participation in a clinical trial. But, too often, both are lacking.

In one of the many forums we held on the issue of access to specialists for cancer patients, we heard from Dr. Mirtha Casimir, a distinguished Texas oncologist. Dr. Casimir talked about the heartbreaking stories of cancer patients whose HMOs delay and deny access to specialty care—often until it is too late. She said that when she gets a patient whose cancer has progressed substantially from initial diagnosis to the time they are allowed to seek needed specialty care, she often flips to the front of the chart—and nine times out of ten the insurer is an HMO. Every centimeter a cancer grows can mean the difference between a good chance at life—and the likelihood of death. Every centimeter represents potentially devastating—and avoidable—pain, suffering, and death for a patient and a family. Dr. Casimir's message was clear: pass the Patients' Bill of Rights so that more cancer patients will not die needlessly.

Mr. President, I see my colleagues who wish to speak.

I think we have about 15 minutes.

The PRESIDING OFFICER. Twelve minutes.

Mr. KENNEDY. Twelve minutes. I yield 6 minutes to the Senator from California and 6 minutes to the Senator from Florida.

The PRESIDING OFFICER. The Senator is recognized.

Mrs. BOXER. I thank the Chair. I thank Senator KENNEDY for his courageous leadership with Senators EDWARDS and MCCAIN, Senator DASCHLE, and others in fighting for this bipartisan bill.

Mr. President, this is a new day in the Senate. We promised a new day when we saw the leadership change and we meant it. We have this bill in front of us because we want to do something to help the American people. There is no more important issue than this one. The American people have been waiting too long to have their grievances addressed.

Our bill offers real protection to those patients. It is in fact bipartisan. The compromises have been made, and when the President says he will veto it, I say to the people in this country: Do not stand by silently. This bill protects you against the abuses of the HMOs. The President stands with the HMOs. We here pushing for this bill stand with you, the people. And I keep coming back to that because the HMOs oppose our bill and they support the Bush principles.

Let me tell you why it is so important to pass this bill. Every day, 35,000 patients do not have access to the specialty care they need. Every day, the delay results in 10,000 patients being denied the diagnostic tests they need.

Let me talk about a couple of cases in the time I have. One such case is that of Joyce Ching from Agoura, CA.

Mr. President, 5 years ago I told her story—5 years ago when we should have passed this bill. I am going to tell her story again.

In the summer of 1994, Joyce got sick. She suffered from severe abdominal pain. She could not get out of bed to play with her son. She goes to her HMO, and the doctor says: we don't need any tests; change your diet; something is wrong with your diet. So Joyce changes her diet. She is in agony. She calls again and again. The doctor says, oh, just give this diet a chance to work. Still, she begged him for tests. She was afraid maybe something would happen, that she would not be able to have another child.

Finally she receives the referral to a gastroenterologist she had asked for months before, but it was too late. Joyce was in the late stages of colon cancer, and there was nothing anyone could do for her. Thirty-four years old. Why did it happen? If you look at the structure of the HMO, what happened was they capped her monthly expenses at $27.94. Why? Because she was only 34; actuarial tables said she was healthy. And the HMO said to her clinic, if you pay any more than that for that patient a month, you will get ''fined.'' You will have to pay for it at the end of the year. So the effort to keep the costs down cost Joyce her life. It took away a mother from a little boy. This bill will stop that because this bill will allow a referral to a specialist. This bill will allow us to make sure you see the doctor that you need.

How about the story of Sarah Pedersen of San Mateo, CA, born with a brain tumor? When she turned 3 years old, the doctor determined that she needed to see a doctor who had expertise in brain tumors in children. Now, I have to say something. I am a little adult. I am only about 5 feet tall. Some even question if that is exactly accurate. I am not a child, though. A child is different. They are little and they are different. Their bodies are changing and growing. Their hormone levels are different and they need specialized care. So her doctor said she needed the expertise of a doctor who specialized in brain tumors in children.

When Sarah's parents tried to get the appropriate referral, here is what they were told by the HMO: What difference does it make? Cancer is cancer.

And by the way, I had the same incident in another case in San Mateo, a little girl who had a Wilms' tumor, which is a tumor of the kidney, and the HMO again said: We don't have a pediatric surgeon who deals with cancer. Just go see the surgeon who deals with adults.

Had they ever operated on a child before? No. So Sarah's parents tried to get the appropriate referral, and they could not do it. Now, finally after too long a period, this little child with a brain tumor was allowed to see a specialist and her chemotherapy began. And as many of you are aware, my friends, chemotherapy causes severe nausea and vomiting, and the little girl suffered greatly. But when her parents tried to get the medicine to quell the nausea and the vomiting, Sarah was denied a $54 prescription because it was ''too expensive,'' says the HMO. A little girl of 3 years old is vomiting; she is nauseous; she is sick; she cannot get a prescription through the HMO.

The PRESIDING OFFICER. The Senator's time has expired.

Mrs. BOXER. I ask unanimous consent that I be given 1 additional minute and Senator NELSON 1 additional minute.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. We will give 2 additional minutes to the Republicans.

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

Mrs. BOXER. I thank my friend and I will talk even faster.

This HMO that denied a $54 prescription for a very sick little girl paid its chief executive officer $895 million in a merger.

I ask you, where is the justice and the fairness in this? In her battle with cancer she is denied hope with a $54 prescription.

One time during their battle, Sarah was denied a dose of a common chemotherapy drug, by her HMO because the HMO clerk did not know the computer code for the drug. Do you want people other than doctors making medical decisions about the fate of your loved ones?

Luckily, her parents were able to switch insurance plans in the middle of their daughter's medical crisis. They believe that if they had not had this option that Sarah never would have made it.

Sarah is now eight years old, but she still has a tumor and continues to be monitored.

Or take the story of cancer patient, Ed Mycek of La Quinta, California. In 1997, Ed was diagnosed with prostate cancer. He discussed treatment options with his doctor and together they decided that the best option was a proton and 3–D conformal radiation treatment.

His doctors then contacted the insurer about the treatment. The insurer agreed to pay for the full treatment and said that the authorization was on the way to the facility. But the authorization never arrived. When Ed contacted the insurance company about the delay, he was told that their decision had been reversed because the treatment was experimental.

Patients that undergo this form of radiation treatment have a 98 percent chance of recovery, vs. the 83 percent recovery rate associated with prostate surgery.

After weeks of tossing and turning, Ed decided to pay for the treatment up front in an attempt to save his own life. Ed survived, but he now faces a huge financial burden as a result of his insurance company's unwillingness to pay for his treatment.

The stories I have just relayed to you are just a few examples of the tragedies that my constituents have endured as a result of healthcare in this country. They are strong reminders of why this nation needs a Patients' Bill of Rights now more than ever.

I believe that the McCain-Edwards bill offers the best possible option for preventing these kinds of senseless tragedies from occurring in the future.

The McCain-Edwards bill would provide coverage to 190 million Americans, including those in state and local government-sponsored plans and church plans.

McCain-Edwards provides access to specialists even if such care isn't covered by a patient's plan.

It also provides patients with other essential protections, like access to specialty care, women's health care services, emergency care—including emergency ambulance services, needed drugs, and clinical trials.

The bill bans the use of financial incentives to health care providers to limit medically necessary services.

It also prohibits plans from providing compensation to employees for encouraging denials.

It holds HMOs accountable, and permits a patient to sue in state and federal court without preempting those states with laws regarding caps on damages.

The bill allows a participant to designate a pediatrician as the primary care provider for a child.

It allows a woman to obtain gynecological and pregnancy related care from an OB/GYN without requiring a referral or authorization by a primary care doctor.

McCain-Edwards provides for inpatient hospital care for a patient following a mastectomy, lumpectomy or lymph node dissection for the treatment of breast cancer.

It bans health care plans from prohibiting or restricting medical providers from freely communicating with their patients regarding their medical care and treatment.

The McCain-Edwards bill requires the prompt payment of claims with respect to covered benefits and contains important whistleblower protections.

Nearly every doctors' and nurses' association and patients' rights group in the country supports a strong, enforceable Patients' Bill of Rights.

S. 1052 is supported by some 300 consumer and health care provider advocates.

It has garnered this support precisely because it represents a balanced and even-handed approach and because it will ensure patient safety and health plan accountability without significantly raising employer costs or health plan premiums.

In conclusion, the American people have waited far too long for a Patients' Bill of Rights. We have been debating this issue for 5 years. And far too many of our people are suffering as a result.

I'm all for having a fair and open debate here in the Senate on this issue. The American people expect no less of us.

But what the American people do not deserve and will not tolerate is an unnecessarily protracted debate cluttered with offers of ''poison pill'' provisions intended to cripple passage of this critically needed legislation. Unfortunately, I fear that this is exactly what will happen—a filibuster by amendment, as amendment after amendment after amendment is offered in an attempt to kill this bill, while its opponents talk about compromise.

In reality, this bill is already a compromise. A balanced and fair compromise. Here's why:

It strengthens protections for employers, ensuring that they are not liable unless they have participated directly in a health plan decision; it increases a state's flexibility, allowing it to maintain or develop its own patient protection laws if they are substantially equivalent to those in S. 1052; and it protects a patient's right to sue for damages in State and federal court, while including key compromises on liability.

The American people not only deserve a strong, enforceable Patient's Bill of Rights. They deserve this bill to be passed as swiftly and as fairly as possible.

Today is truly a new day in the Senate because today we have the opportunity to deliver on a promise—a promise to help our people live longer, healthier lives free from the horrors of red tape and litigation. A promise to make it a little easier for Americans to get the help they need from their doctors at the times when they need it the most.

Today we have a chance not only to deliver on the promise that we have made to our constituents—our promise to take up this bill—but a chance to restore the promise of health care in this country.

I say to my friend in the chair, who is such a fighter, that this is about why we are here, who we are, whom we represent, for whom we fight, and in whom we believe.

Let's pass this bipartisan bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. NELSON of Florida. Mr. President, I rise today in strong support of this bipartisan Patients' Bill of Rights. I rise on behalf of thousands of Florida consumers who would like to see control over their medical care returned to their doctors.

As the former elected insurance commissioner in Florida, I have talked with many of these consumers. And I've seen first-hand what some of the big insurance companies will do to them, if you let them.

For too long, these same insurers have killed efforts in the Congress to hold them accountable.

These lobbying efforts would merely be tiresome, if it were not for the real life horror stories that prove the industry's claims that this is a bad bill are false claims.

Over the last two days, all of us have heard the horror stories from many of these consumers—stories of HMOs denying care to sick patients; stories of accountants, not doctors, making decisions about medical treatment.

Some of these stories involve injury, harm, and even death.

Let me tell you about a couple of examples from Florida.

One 62-year-old south Florida woman began complaining of headaches and was referred to a neurologist, who ordered a CT scan and MRI of her brain.

The HMO refused the request.

The doctor persisted, but to no avail.

The appeals went on for 6 weeks, until the woman was admitted into the hospital paralyzed on her left side.

There, she underwent a CT scan that revealed a tumor the size of an orange. She was immediately taken into surgery. She remains paralyzed. Two days after the surgery, her HMO finally approved the procedures requested by her doctor.

Sadly, current law only allows this patient to sue her HMO for the cost of the scan. She has no other legal recourse.

I will give you another example. A Pensacola woman was told by her HMO that she must see a network physician for a referral to a special hospital that could treat her rare cancer.

After switching to this new doctor, who concurred with the need for treatment, the HMO again denied her coverage.

Her medical bills are expected to reach $180,000. And despite her life-threatening illness, her HMO continues to deny full coverage.

The newspapers are full of such stories. And the common denominator seems to be that none of these patients have any recourse against their HMO.

This is unacceptable.

Medical decisions should be made by doctors, not accountants. HMO accountants are making life-threatening decisions, and the patients are suffering the consequences.

These stories from Florida illustrate the need for Federal legislation.

We must stop the practice of denying care, denying claims and putting profits ahead of patients.

The legislation we are finally debating lets people and their doctors—not HMO accountants—decide on the best medical treatments, not the cheapest.

Sick patients should not have to battle an illness and their HMO at the same time.

The issue before us in this debate is simple: either you are for protecting patients, or you are for maintaining the status quo, which protects HMOs.

I support this legislation because it provides patients with the protections they currently lack. This bill guarantees access to necessary medical care.

It puts the decisionmaking back in the hands of doctors.

Under this legislation, patients can participate more easily in life-saving clinical trials.

Chronically ill patients can receive the care they need because doctors will determine what is necessary medical treatment.

Patients will be able to change doctors without facing delays because they will have more choices.

Under this bill, patients will receive prescription drugs on a timely basis.

Doctors and patients won't be bound by red tape, and patients will get the drugs prescribed by their physicians, not their HMO accountants.

Patients also will be able to designate a specialist as a primary care provider. This means that a cancer patient could use a radiologist as a primary care physician.

For sick patients, this makes sense.

This Patients' Bill of Rights also allows someone to seek emergency room care, without first contacting their health plan.

This bill also addresses another critical issue; that is, financial rewards for doctors.

HMOs will no longer be able to offer financial incentives to doctors who limit care.

This legislation also prevents HMOs from punishing doctors who advocate on behalf of their patients. By putting the medical decisions back in the doctor's hands, this bill protects the doctor-patient relationship.

As expected, insurance companies and managed-care companies are lining up against the proposal that consumers should be able to sue them for harmful treatment.

Insurers say the McCain-Edwards-Kennedy bill will drive up premiums, increase the number of people without insurance and cause employers to drop coverage for their employees.

In Texas, where a right-to-sue law has been in effect since 1997, it's been reported that premiums actually declined last year.

Further, the Congressional Budget Office says that under this reform legislation, litigation costs related to the patients' right to sue would increase less than 1 percent during 5 years.

I ask the assistant Democratic leader if there is any chance for any additional time so I can complete my statement.

Mr. REID. I say to my friend, we need to get to the amendment process. How much more time do you need?

Mr. NELSON of Florida. I think I can conclude in 1½ minutes.

Mr. REID. Mr. President, I ask unanimous consent that the Senator from Florida be extended another 2 minutes, and the minority be extended 2 minutes, which will give them an extra 4 minutes.

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

Mr. NELSON of Florida. I thank the Democratic leader.

Mr. President, I end by saying our health care delivery system is failing, and it is failing doctors and nurses and providers as well as the patients.

Only recently I learned of a doctor in Boca Raton who has started charging his existing patients a $1,500 annual membership fee in order to continue his patients' medical care. This is outrageous, and it is symptomatic of the need for reform of the entire health insurance system.

Clearly, we need reform. This Patients' Bill of Rights is just a first step, but a necessary step, toward health care reform. We cannot afford to miss the opportunity. We cannot allow the special interests to stall and delay any longer. We must act now. The people deserve no less.

I thank you, Mr. President, for your indulgence, and I thank the Democratic leader very much for the additional time so I could conclude my statement on this very important piece of legislation.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. THOMAS. Mr. President, I ask that I be yielded 10 minutes of the time of the Senator from New Hampshire.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. THOMAS. Mr. President, we have been involved now all week—and, I am sure, will be involved for some time longer—on the Patients' Bill of Rights. It is an issue that is very broad. Quite frankly, there are different points of view. I cringe a little bit when I constantly hear from the other side of the aisle that special interests are what is guiding it. I have to tell you, if there are special interests on one side, there are special interests on both sides. But I really do not think that.

There are different points of view as to how we best help deliver health services. I am getting a little weary of this special interest idea, when it is perfectly legitimate for us to have different ideas about how we do it. That is what this is all about. I think we ought to maybe go back to some basics and talk about it a little bit.

I do not think it ought to be a political issue. I do not think people on this side, who are concerned about driving up the costs or who are concerned about having an excess of litigation, are driven by special interests. They have views on that. I respect that. And I respect it on both sides.

We have been dealing with a very complicated issue. In fact, this issue has been around the Senate now at least for 3 years. We have passed bills very similar, as a matter of fact, to what we are talking about now. We have tried to put them together with bills over in the House and have not succeeded in doing that.

So there are differences of view in how you do it. It seems to me that it might be useful for us to take a little bit of time to go back to some fairly basic things and, I guess, examine, more than anything else, what our goals are, what it is, when this is over, we want to have accomplished.

I get concerned sometimes that we get so involved in the details of everything, and get argumentative about this and about that, when really the purpose ought to be to achieve certain goals when we are through. I think from time to time we should go back and sort of refresh ourselves as to what our goal is. That would be very important. Everybody in this body wants to promote and provide for better health service. Is there a question about that? Of course not. Everybody wants to do that.

I argue a little bit with the idea that our health care is not good. I think our health care is quite good, as a matter of fact. Could it be better? Of course. Should we have a Patients' Bill of Rights? Of course. We ought to ensure that people receive what they are entitled to receive.

Everybody wants patients to be treated by medical providers and not by accountants. We agree on that, certainly. Everybody wants to pass a bill that will improve the fairness and ensure that patients receive what they are entitled to under their health contract. I say ''contract'' because I want to remind ourselves that those of us who have insurance buy a service. That service is defined, and what we should expect to receive is the service that we have purchased, the service that is in that contract.

From the conversation that goes on in this Chamber, sometimes I get the notion that if this bill passes everything in health care will be provided. That is not the case. What this does is seek to ensure that what you are entitled to under your insurance is provided, and the definitions are made by medical providers and not by attorneys. I think all of us would support that.

There are quite different views, of course. Indeed, that is legitimate. That is why we have debate. That is why we have discussion.

Yesterday we had a little back and forth on whether we were holding this bill up. I do not think it has been held up at all. It is a very complicated issue. We talked about it all day. We should talk about it. We need to know what is in the bill. The newest bill was only put in the RECORD on Tuesday. So it is quite a healthy bill and, in fact, needs to be reviewed. That is what we are doing. Should we stall it? Of course not. But we should have a thorough discussion about it.

What are our goals? I guess one of the obvious ones, as I mentioned, is to ensure, to the best of our ability, that

whatever you are entitled to in your insurance coverage is made available to you. I think, along with that, we ought to say: made available to you as quickly as possible. This idea that somehow you feel as if you are being held up by some other decision, that you have to go to court to figure it out—I can tell you what, it may be a long time before you come to that decision, so there needs to be a method and methodology, of course, for coming to a nonbiased third party decision before you go to court. I think that should be one of them.

What are some of the techniques that we ought to have? That is what we are really talking about. Are we talking about an independent medical appeal? It seems to me that makes a lot of sense. Or do we continue to talk about the fact that you have to go to court? Court is not a very satisfactory remedy for some kind of an argument in terms of health benefits. You usually need those resolved more quickly than would come from that.

I think we have to talk a little about the costs. We talk all the time about the cost of insurance going up. We had what we called a series of 20/20 meetings in Wyoming, trying to get a vision of where we wanted to be over time, so that the decisions we make in the interim could help, hopefully, to get us there.

I recall in one of the meetings—one of the last meetings we had in Casper, WY—the big emphasis was on small employers that couldn't afford insurance. Part of that is insurance. Part of that is the cost of health care, of course.

So I guess my point is, health care can be the best in the world, but if we can't afford it, and it is out of our reach because it is unaffordable, then we have not accomplished a great deal.

One of our goals ought to be to find ways to keep the costs of health care within a manageable range so that people can indeed take advantage and participate. We need to ensure that the insurance coverage used by many people—maybe most people—comes from their employer, that it is part of their job benefits. There are some disadvantages to that, of course. That is one of the reasons we find ourselves where we are with HMOs to some extent. The employees do not normally have much input into what kind of coverage they have. If the coverage is not what they choose, then that is something between them and the employer.

But we need to make sure that we don't price, particularly small businesses, out of that coverage that people have become accustomed to and, indeed, is really a better way to provide it. The more we can bring people together, large employers, makes insurance coverage easier. The idea of health insurance was to bring together a number of people into a group so that those who are healthy and those who are a little less healthy could share the costs.

Again, in my experience, I remember the Farm Bureau in Wyoming started Blue Cross. And after a little bit, we found that generally agricultural people were a little older and the costs that we had were higher. Our least expensive participants were finding cheaper insurance somewhere else and were selecting against us. That didn't work. So you need to have larger groups that employers help provide.

These are some of the things that are part of this. We act like it doesn't matter what the system is, that we can make these changes and they will fix it. We do have to be a little more aware of how this thing is handled and what is going on.

Again, we want employers to continue to provide insurance, but we have to ensure that they are not subject to all kinds of litigation, all kinds of liability. That is not clear in the bill. We hear from one side that it is one way; we hear from the other side that it is another way. What is our goal? Is our goal that we should, to the extent possible, eliminate the liability from employers in terms of them carrying and providing insurance? It seems to me that ought to be one of the results we seek.

There are lots of pretty basic issues that we need to address and then take a look at the details to see if, in fact, those details are going to produce the kinds of a outcomes for which we are looking.

Again, we ought to try to make certain that every patient, every covered person gets those things they are entitled to under their contract. Certainly that is what we need to do. We need to find the simplest, easiest, least expensive technique for ensuring that that is the way that it is done. We need, along with that, to ensure that we do not have an excessive cost which causes people to stop providing insurance and that we have a higher number of uninsureds than we now have.

In order to do that, we have to make sure that unless there is an involvement in that decision with regard to the contract, employers should not be liable.

Those are the kinds of things we hear from the sponsors of each of these bills. I appreciate the opportunity to talk on it. I hope we will move forward. I hope we end up with a bill that will provide the provisions we seek.

The PRESIDING OFFICER. The Senator has used his 10 minutes.

Mr. THOMAS. 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.

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

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

Mr. CAMPBELL. Mr. President, the Senate has begun to consider sweeping legislation which, if passed and enacted, will have significant consequences for all Americans and our health care system. This is an unprecedented opportunity to frame the debate for improving the quality of health care in this country.

As most Americans know, we here in America have the best medical care in the world. The question is how to make that excellent care accessible and affordable for all Americans.

We have an excellent health care system in our Nation, yet there are those who are not able to get good care when they need it. And, there are many in our Nation who tax and over-use the system. Somewhere between the excellence of our medical procedures and the demands placed upon them, we have a problem with delivery.

In the debate now underway, we will be grappling with big questions. How do we make that excellent care available to everyone? Who gets the care? Who pays? Who is accountable? Those are the questions that need to be answered. Common sense demands we act reasonably in answering those questions.

The debate is about the American right to have access to the best health care available. It is not a Republican or Democrat issue. It is a national issue as important as any we face, and to keep score now does not address our Nation's best interest.

Let me be very clear: the best thing we can do for Americans is to ensure, and when possible, expand their access to quality, affordable health care. Let's use the debate on the differing proposals pending before us to work toward this goal.

Mr. JOHNSON. Mr. President, this week the Senate began discussion of the Patients' Bill of Rights, a long overdue bill which patient advocates have fought to pass for nearly 5 years. I am disappointed that we were not able to move directly to a full discussion of the bill earlier this week as Majority Leader DASCHLE attempted to do, but I am pleased that we finally began this critically important discussion. I also want to commend the distinguished Senate Majority Leader DASCHLE for his leadership in bringing this crucial legislation to the floor and making this top priority legislation his first directive as Senate Majority Leader.

The Senate begins debate of a bipartisan bill that was introduced in both the House and Senate which covers all Americans and holds HMOs accountable when they make medical decisions. I am proud to be cosponsoring the Senate Bipartisan Patient Protection Act which is sponsored by Senators MCCAIN, EDWARDS, and KENNEDY. Approximately 500 provider and patients' rights groups have endorsed this bipartisan legislation which achieves overwhelming support because it represents a balanced approach to ensuring patient safety and health plan accountability without significantly raising health plan premiums or employer costs.

The last time the Senate debated this legislation was in July of 1999. At that time, the Senate ended up passing a much weaker patient protection bill while the House passed a strong bipartisan patients' bill of rights by a vote of 275 to 151. The McCain-Edwards-Kennedy bill that we will be debating this week and next is a carefully, crafted bipartisan compromise and the only patients' rights legislation currently under consideration that assures patients the protections they need.

Although penetration of HMOs in South Dakota is not all that prevalent as it is in other parts of the country, South Dakotans still deserve the same patient protections as individuals living in New York, Washington or California.

The Bipartisan Patient Protection Act will guarantee access to essential prescription drugs; allow access to needed health care specialists; ensure patients can access emergency room care where and when the need arises; require continuity of care protections so that patients will not have to change doctors in the middle of their treatment; provide access to a fair, unbiased, and timely internal and independent external appeals process to address health plan grievances; assure that doctors and patients can openly discuss treatment options; and includes an enforcement mechanism that ensures these rights are real.

Also, the McCain-Edwards bill ensures that States have flexibility while protecting all Americans in all health plans. This compromise legislation clarifies that in the case of a State that has enacted protections that are ''substantially equivalent,'' the State may seek certification from the Department of Health and Human Services to use its standard rather than the Federal one. The standards for certifying State laws that meet or exceed the Federal minimum standard ensure than only more protective State laws will replace the Federal standards while providing for strong oversight.

The McCain-Edwards-Kennedy bill is a true bipartisan compromise and should not be watered down or weakened before passage. The McCain-Edwards-Kennedy bill builds on the progress made by the Norwood-Dingell bill—which had the votes of approximately 60 Republicans in the House—on a number of key provisions, including strengthening protections for employers to ensure that they are not liable unless they have directly participated in a health plan decision; compromising on liability and placing suits based on administrative plan decisions in Federal court to ensure that insurers have uniform standards; and increasing State flexibility and allowing them to keep their own patient protections if they are substantially equivalent.

I am concerned that opponents of this bill will want to load up the bill with proposals that will weigh down its chances for passage. They will propose inefficient tax credits that do little to expand health insurance coverage, medical savings accounts, and association health plans and include other tax cuts to try and make it a tax-break Christmas tree for the special interests. I hope that we can avoid parliamentary maneuvers that serve only to sink this long-overdue legislation. I believe that Americans deserve a bill that assures them the patient protections they need.

Nearly every doctors' association, every nurses' association, and every patients' rights group in America agrees that we need a strong, enforceable, Patients' Bill of Rights now. Recent polls indicate overwhelming support for this legislation. As the Washington Post reported today, ''Patients' Rights Debate Opens On Angry Note,'' June 20, 2001, a recent Pew Research Center said that 77 percent of those surveyed favored passage of a bill giving patients the right to sue HMOs, with overwhelming support across all party lines. We need to put people's interests ahead of the special interest here on Capitol Hill and move forward with passage of this critical legislation. I am looking forward to an open and fair debate and the passage of a real Patients' Bill of Rights that will truly strengthen our health care system, protect South Dakota families, and enrich our Nation for the 21st century.

Mr. GREGG. Mr. President, I will continue the discussion we have been having over the last few days about some of the concerns relative to the McCain bill in the area of liability, especially as it relates to employers ending up being sued. It is important to put it in context.

We continue to hear a lot of anecdotal stories which are compelling about people who have been maltreated by their HMOs or by their insurers. It is important to remember that there has not yet been a story related on the floor, as compelling as they are, that would not have been addressed not only by the McCain bill but by the Breaux-Frist-Jeffords bill or by the Nickles bill which was on the floor last year.

So those are not the issue. We all intend to introduce a bill that makes sure that people have adequate recourse when they are treated improperly by HMOs or by their health insurer. The problem we have with the McCain bill is that it is essentially a gross expansion of the ability to sue. It is a bill that was designed for the purpose of allowing lawsuits against employers at a rate which has never been conceived of under present law or in other bills being considered.

The bill creates all sorts of new causes of action and new opportunities for these lawsuits. As a result of the expansion and explosion of lawsuits, you are going to see employers dropping insurance and people being left without insurance. So instead of being a Patients' Bill of Rights, it is going to be a bill that creates employees who have no insurance.

It would be just the opposite result that we should be looking toward. In fact, CBO has scored the McCain bill as being a bill that will cost 1.3 million Americans their insurance, because it will be dropped by their employers. The reason is simple: The bill just was written for lawyers by lawyers and of lawyers—trial lawyers.

For example, it allows forum shopping, one of the age-old games that is played in the legal community. I used to be a lawyer and we used to forum shop when I was doing trial work. It allows forum shopping, which is something that should not be allowed and is not allowed today because ERISA controls this area, and the Federal courts are responsible. But under this bill you can go to Federal court or State court, depending on where you think you are going to get the most recovery. Some States have no compensation caps, no liability caps, and punitive damages are available in State courts; sometimes you may pick the State court and other times the Federal court, depending on the judge and the type of jury you expect to get. Forum shopping allows the employer, as I have talked about, to be sued for minor offenses that are administrative. Literally hundreds of new causes of actions are created under this bill—hundreds—where the employer can be sued in private causes of action. It allows employers to be sued for unlimited compensatory damages, and for punitive damages, which is something that cannot occur today under Federal law.

It has a new title—''special assessments,'' I think, is the term in Federal court—with a $5 million cap. Today, you can't sue for punitive damages. But that is really irrelevant to the cap because you can get around the cap by going to State court with the forum shopping opportunities. So punitive damages are there.

Punitive damages is one of the things that worries employers the most. Most employers accept the risk of punitive damages if it is for a product they produce. If I am an employer and I am making desktops, I accept the risk that I make a good desk top and I sell it. If something goes wrong with that, I accept the risk that I should be subject to liability. But what we are talking about here is making the employer liable for medical treatment that his or her employee gets because the employer presented his or her employee, as part of employment, health insurance.

The employer doesn't have any control over a doctor that acts poorly or an HMO that acts irresponsibly, but under this bill an employer can be subject to punitive liability. That is something most employers find totally unacceptable—and they should. That is why you will have employers walking away from the insurance concepts and from giving insurance if this bill passes. That is why you will have more people uninsured. It permits a lawsuit right out of the box. You do not have

to go through the administrative appeals process.

Now, the great strength of both the Frist bill and the Nickles bill is that they try to avoid lawsuits while still giving the person who has been injured redress. The way they do that is through an administrative appeals process that has independent doctors, independent reviewers, people who have nothing to do with the HMO, nothing to do with the employer, reviewing the situation when you think you have been maltreated or poorly treated by your HMO or your doctor, and they are totally independent and you get a fair and honest evaluation. That is called the external appeals process. That is an important reform and an important right for patients—a huge right and an important right for patients.

But what the McCain bill does is say you don't have to go through that stuff. You can go directly to court and bypass the external appeals process. This is a huge loophole for the purpose of creating more lawsuits. Any good lawyer is going to be able to skip the external appeals process and go directly to court and sue not only the HMO and the doctor—potentially, but also sue the employer. Under this bill, the lawyer would be committing malpractice if they didn't sue the employer. So that is another area where you have this huge expansion of lawsuits. Not only that, but you undermine what is true reform. True reform is destroyed by that proposal.

Another area where the plaintiff's trial lawyer language and fingerprints are all over this bill is that there basically is no time limit for when you can bring the action. If, after the 180-day appeals process has expired, you decide you have a cause of injury, you can claim a cause of injury and you toll the statute of limitations. You could be 10 years out under this bill and still energize an action against the HMO, the insurance company, and the employer. It is basically open-ended. It is lawsuits to infinity.

In addition, of course, it allows for simultaneous lawsuits. Not only do you have forum shopping, you can sue in all the forums, all the time, altogether. You might have some employer who is running a small restaurant, with maybe 30, 40 employees, or who has a small startup business, with maybe 20 or 30 employees, or a few gas stations that he operates, or a repair station with 20, 30, 50 employees; they can suddenly find themselves defending a case on literally hundreds of different causes of action in two different forums within one State, in the Federal court and the State court. This could be so multiplied that they would have to hire 16 law firms to defend themselves. And the cost is extraordinary.

The average cost of defending a malpractice issue is $77,000. That is more than the profits of many small businesses in America today. And they all can be drawn into these lawsuits. It won't be the insurance companies they will have to defend—they will, too, but the employer will also have to defend under this bill. So you can have consecutive and simultaneous claims both in State and Federal court. Plus you can have multiple and duplicative class action lawsuits.

Class action lawsuits are not allowed under present law. I do not think they are allowed under the Nickles bill. I am pretty sure they are not allowed under the Frist-Breaux bill, and they are not allowed in present law under ERISA. Under this bill one can have multiple class action suits under ERISA and under RICO for the same violation.

That is why, because of all these different opportunities to sue, I have called it the ''Lawyers Who Want to be Millionaires Act.'' That is why this bill generates such a huge loss of insurance to people. Of course, our goal should be to cause people to be insured, not to become uninsured, but the result of this bill is that the people become uninsured instead of being insured to the tune of at least 1.3 million people, according to CBO's estimate. That is extraordinarily low, by my estimate, but that is still a huge number.

Some want to increase the number of uninsured because they see that as the vehicle of putting more pressure on the Federal Government to step in and insure everyone through some nationalized system. But I think we have seen from the experiences of our neighbors in Canada and our friends in England that a nationalized system is not the solution. It produces a huge penalty, and it means that health care deteriorates, it is rationed, and that research and movement into new types of treatments are significantly limited and severely impaired.

This bill which creates all these new uninsured, creates all these new lawsuits, and which puts the employer at risk, is off in the wrong direction. We have proposals which do address the needs of patients. They have been proposed by Senators JEFFORDS, FRIST, and BREAUX. They have been proposed by Senator NICKLES. They are good proposals, and they address the needs of Americans who interface with their HMOs or their other insurers and do not get fair treatment. We are very strongly supportive of those, but we cannot support a bill which, in the name of patients' rights, actually puts more people out on the street and makes more people uninsured, so actually reduces rates. I believe my time has expired.

The PRESIDING OFFICER (Mr. CARPER). The Senator from New Hampshire has 6½ minutes remaining.

Mr. GREGG. I reserve that time.

The PRESIDING OFFICER. The Senator reserves his time. Who yields time?

The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, it is my understanding that amendments are now in order and the Republican side will have the first opportunity. I call up amendment No.——

Mr. GREGG. If the Senator will yield, I yield back the remainder of my time.

The PRESIDING OFFICER. By yielding back the remainder of time, the Senate can now proceed to amendments. The Senator from Arkansas is recognized.

AMENDMENT NO. 807

Mr. HUTCHINSON. Mr. President, I call up amendment No. 807, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Arkansas [Mr. HUTCHINSON] for himself and Mr. BOND, proposes an amendment numbered 807.

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

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

The amendment is as follows:

(Purpose: To amend the Internal Revenue Code of 1986 to provide a deduction for 100 percent of health insurance costs of self-employed individuals)

At the end, add the following:

SEC. ___. DEDUCTION FOR 100 PERCENT OF HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to 100 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.''.

(b) CLARIFICATION OF LIMITATIONS ON OTHER COVERAGE.—The first sentence of section 162(l)(2)(B) of the Internal Revenue Code of 1986 is amended to read as follows: ''Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any subsidized health plan maintained by any employer (other than an employer described in section 401(c)(4)) of the taxpayer or the spouse of the taxpayer.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

Mr. HUTCHINSON. Mr. President, earlier this morning as I left the Chamber after the vote to proceed to the Patients' Bill of Rights, I was approached by a reporter who said: Senator HUTCHINSON, what do you have to say about all of these terrible stories, these horror stories that are being presented on the floor of the Senate?

My response was: They are true; they are right. We are all horrified by some of the abuses that have occurred and the need for patient protection.

I went on to say: Whether it is the Nickles bill from last year on which many worked so hard, whether it is the Frist-Jeffords bill this year, or whether it is the Kennedy-McCain bill, all of them have agreed upon basic patient protections; that every one of these stories that have been graphically portrayed in the Senate will have been addressed by these pieces of legislation.

Whether it is access to the closest emergency room, whether it is direct access to an OB/GYN, or any of the basic protections, all of these bills address those concerns.

The biggest point of contention, I went on to comment, is on whether or not there is going to be an open-ended right to sue that will cost millions of Americans health insurance coverage. Are we going to have a bill that is so prone to lawsuits that those lawsuits will increase the cost of premiums and, as a result, employers are either going to drop their insurance or increase the copays and, as a result, we are going to see millions more lose their health insurance? That is the debate.

We are talking about people in need. We need not just focus upon those terrible stories where an insurance company may have overruled a medical decision of a doctor. We need to address that, but there is a consensus on that. What we need to remember is we must not in this legislation do such harm to our system that we actually have a cure that is worse than the malady.

We have to keep in mind the whole issue of access, and the amendment that Senator BOND and I offer today addresses specifically how we can decrease the number of uninsured in this country instead of exacerbating a situation that is growing worse year by year.

The Kennedy-McCain bill before us, I am afraid, will, without question, increase premiums, CBO says, by 4.2 percent. That surely is a conservative estimate. But even with the 4.2 percent, we will see 300,000 new uninsured for every percentage point of increase in health care premiums. We are going to see well over a million, 1.3 million, lose their health care benefits. I think it will be far more than that.

This is of deep concern to me. Forty-three million Americans are currently uninsured, and in my home State of Arkansas, there are almost a half million people who do not have health insurance. Twenty-two percent of the State population is uninsured.

We must not, I believe, in our zeal to have new patient protections open the door to increases in premiums that are going to result in hundreds of thousands of people losing their health insurance.

Roughly half of employers, 46 percent, reported ''they likely would get out of the business of providing health care coverage if exposed to increased liability.'' And that is what we are confronted with in the Kennedy-McCain bill: increased liability.

Similarly, 48 percent said expanded liability would hinder care, and 80 percent said it would increase consumer costs.

I know that as the American people become more familiar with the Kennedy-McCain bill and what its liability provisions are, they are going to be less and less enamored by the Kennedy-McCain version of the Patients' Bill of Rights.

We are going to pass, I believe with all my heart, a Patients' Bill of Rights. It is my hope we will pass one that will not add to the ranks of the uninsured.

According to the Urban Institute, medical malpractice claims take an average of 60 months to file, 25 months to resolve, and 5 years to receive payment.

With increased liability, we are not talking about increased health care for patients, we are talking about increased dollars for trial lawyers.

The Kennedy-McCain bill allows unlimited economic damages, unlimited noneconomic damages, unlimited punitive damages, both in State court and Federal court, taking two bites out of the apple. This whole issue of access is what concerns me.

Our amendment will provide an immediate 100-percent deductibility for the self-employed. The Senate has taken a position on this in the past. This bill that Senator BOND has courageously taken the lead on for years had 52 cosponsors in the Senate, so we know where the Senate stands on this issue. It is one of equity, it is one of fairness, it is one of decreasing the number of uninsured in this country.

As current law stands, self-employed individuals are only allowed to deduct 60 percent of their health insurance costs this year, 70 percent next year, and only in the year 2003 will the self-insured be allowed to deduct 100 percent of health insurance costs.

Corporations are allowed 100-percent deduction for their health insurance costs right now. Employees receive 100-percent exclusion for their health insurance paid by their employers right now. However, to the self-employed individual, we have said: We know it is unfair, we know there is a disparity, we know there is an inequity. You wait. You have waited years, wait 2 more years. In 2003 we will finally give you equal treatment.

There is no excuse as we deal with this Patients' Bill of Rights legislation, not to make that 100-percent deductibility immediate. Under this amendment, beginning January 1 of next year, there is a 100-percent deductibility allowed.

This is an appropriate step to take. Self-employed individuals under this amendment are allowed to deduct 100 percent of the costs of health insurance for themselves and their families beginning next year. This is one small step, and a very important and significant step, in turning back the direction of this legislation, which is to increase the number of uninsured.

It also corrects the disparity under current law that prohibits a self-employed individual from deducting his or her health care costs if he or she is simply eligible to participate in another health insurance plan, whether offered through a second job or by a spouse's employer. The Hutchinson-Bond amendment addresses this by disallowing the deduction only if the self-employed individual actually participates in another health insurance plan.

The question might be asked, and should be asked, Who are the self-employed? I received an e-mail from one of our small self-employed businesses in Arkansas. I will read but the pertinent aspect:

Patrick Burnett, PB& J Creative Communications, Little Rock, Arkansas.

Senator HUTCHINSON: The main issues plaguing those of us who decide to work independently are unaffordable and nontax deductible health insurance. I have no insurance right now because I can't afford it.

The bill before the Senate, unless we address some of these issues, will only make that situation worse. Who are these people? Of the 12.5 million self-employed individuals in this country, 3.1 percent are uninsured. These self-employed, almost one out of four, cannot afford to buy insurance. Almost one out of four of the self-employed in this country could write exactly the e-mail I received in which he said, ''I can't afford to buy insurance.'' One-hundred-percent deductibility helps relieve that.

Who are these people? Nearly 70 percent of these individuals earn less than $50,000 annually. Some might say: Self-employed equates to affluent, high income. Why should we provide 100-percent deductibility for those who can afford it?

The fact is, one out of four self-employed are not insured because they cannot afford it, because 70 percent of these individuals earn less than $50,000 annually. When you count the number of family members a self-employed family has, 21.6 million Americans benefit from the Hutchinson-Bond amendment, including—and I emphasize this to my colleague—including 6.4 million children, of whom 1 million are currently not insured at all.

If we want to talk about caring about people, if we want to display emotional, heart-rending pictures in the Senate that tear at the very heart of all who care about those who are hurting and vulnerable in our society, think about those 1 million children today in the homes of the self-employed who are uninsured because—at least in part—because we have not given them treatment equal to that of the large corporations. We have not given them the 100-percent deductibility.

The purpose of this amendment is simple. Increasing the deductibility of health insurance for the self-employed is an important step toward equalizing the Tax Code treatment of health insurance and increasing its affordability.

What difference will it make? The tax savings will be substantial. If a self-employed individual trying to buy health insurance finds out the premiums are $6,000 per year—not unlikely; it could well be higher than that; perhaps they have insurance and they are paying that $6,000 per year—current law allows the current deduction, 60 percent for the self-employed.

If they are in the 27-percent tax bracket, they currently have tax savings at that 27-percent tax bracket of

$972. Under the Hutchinson-Bond amendment, under the 100-percent deduction that we allow, that $3,600 they can deduct currently increases to $6,000 and the $972 in savings increases to $1,620. That means an additional savings from this amendment for that self-employed individual of $648. That is very significant, very meaningful. It may well be the difference for literally millions and whether they have the ability to purchase that insurance or whether they stay in the ranks of the uninsured or join the ranks of the uninsured.

The Joint Committee on Taxation estimates this amendment reduces revenues by $214 million in fiscal year 2002, $642 million in fiscal year 2003, for a total of $856 over 10 years, and that minimal revenue loss is easily accommodated under the budget resolution.

I am very pleased the first amendment on this Patients' Bill of Rights is one that will deal with the issue of access and is going to reduce the number of uninsured and try, in so doing, to improve this bill.

I am pleased to be joined in cosponsoring this amendment with a man who has led this fight for years and deserves enormous credit for the progress that has been made on this issue.

I ask unanimous consent to add Senator COLLINS and Senator ALLEN as cosponsors of the amendment.

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

Mr. KENNEDY. I inquire of the Senators, would they be interested in entering into a time agreement for this amendment?

Mr. HUTCHINSON. This is at the very heart of this bill on access, and I think we need a lot of time to talk about this.

Mr. KENNEDY. I thank the Senator.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. BOND. Mr. President, I commend my colleague and neighbor from Arkansas for offering this amendment which will fulfill the promise we have been making to the self-employed in America for a long time.

Small business owners, farmers, and others have suffered. Their families have been denied health insurance because the Tax Code has unfairly discriminated against those who are self-employed.

They say if you work for a large organization, if it is a taxable organization, it deducts all of the health insurance premiums paid by that organization. The recipient, the employee, does not have to report that health insurance as income. Therefore, there is an incentive to provide health care coverage.

I have been involved in debate on health care coverage in this body almost since I came here. We have talked about how we can make sure that every American is covered. What the Senator from Arkansas is doing today in offering this amendment is saying now is the time, we are going to provide 100-percent deductibility for those who are self-employed.

Over the years—and I will talk about it later—we have gradually moved up the deductibility. But when I go home and I talk to a group of farmers or small business owners who have come together to ask what the U.S. Government is doing for them or to them, I say: Well, if you can just hold off until the end of 2003 to get sick, we will allow you to have 100-percent deductibility. They say: Well, I want to ensure that neither I nor my family suffers an illness that requires us to get health care. And what the Senator from Arkansas is doing today is saying if we are going to debate a significant bill on health care that focuses on the patients, let us make sure we cover those who need to be covered.

Access to health care is one of the greatest challenges we face.

Yesterday I discussed a number of serious problems I have with the McCain-Kennedy bill. Today as we start the long and arduous process of actually working on the bill, as we should have in committee—we are going to have to mark up the bill in the Chamber—we all hold in our hearts the high goal, the high hope that we will pass patient protection legislation that works, that gets health care coverage, that provides the patients the protection from health care organizations, HMOs or insurance companies, that want to put their bottom line profits ahead of the well-being of patients.

In its zeal, however, to provide patient protections, the McCain-Kennedy bill adds significantly to the cost of health care. The end result? More than 170 million Americans will pay more for health care. The lucky ones will pay more. The unlucky ones will actually lose their insurance.

The CBO tells us that McCain-Kennedy increases costs on average by 4.2 percent. When you use the general rule of thumb that a 1-percentage-point increase in premiums means a loss of insurance for 300,000 people, this means the McCain-Kennedy bill will cost 1.25 million Americans their health care coverage. But we can be a little more specific.

Yesterday I pointed out that we had had phone calls, faxes, letters from small businesses in Missouri telling us what they would do if they were subjected to the potential liabilities of the McCain-Kennedy bill. Yesterday we had 1,042 Missouri citizens who would stand to lose their coverage. Today I want to read a letter from a woman with a small convenience store in a rural part of Missouri. She says:

> About 2 years ago we started carrying a group health insurance plan for our employees. We currently have 6 employees and 4 dependents on this plan. We pay 100 percent of the employees costs and make payroll deductions for the dependents. None of our employees had any major illnesses or hospital stays in the previous year, but we had a 22 percent increase in our premiums anyway. This year one of our employees was diagnosed with breast cancer. She's had surgery and has completed chemotherapy. She now has to go through radiation therapy for 6 weeks and then reconstruction surgery. She told me that had she not had insurance she would have died because there was no way she could have afforded this treatment and surgery. She is 42 years old. I am very concerned about ever-increasing costs of health care, but I am personally afraid not to carry it. If expanded liability were to pass, we would definitely have to drop our group coverage because we could not financially put ourselves at risk if workers were allowed to sue their employers as well as HMOs, if they felt like they had been denied some coverage.

So today, Mr. President, I give you an update on the numbers. It is now 1,287 people who will lose their health care coverage from the expanded liability of the McCain-Kennedy bill.

I would point out that the woman who wrote me that letter is self-employed. She only gets to deduct a portion of her health care coverage. This amendment offered by the Senator from Arkansas would increase to 100 percent the deductibility of her health care coverage. So it obviously would enhance her ability to continue to pay for herself and her family. But with the expanded liability of the McCain-Kennedy bill, there would be another 10 people denied health care coverage in Missouri.

Apparently the proponents of this piece of legislation before us think that is worth it—enriching trial lawyers is important enough that they place a higher priority on them than on coverage for almost 1.3 million Americans. Is this a Patients' Bill of Rights or a lawyers' bill of rights?

If we are going to do something, however, that threatens to reduce coverage, should we not at least do something that makes sense at the same time to try to increase coverage and access to health insurance? Apparently some on the other side would say no. With this bill, they say we are going to take coverage away from more than 1 million Americans but we are not going to do a single thing to help people who are not covered get the coverage they deserve.

This first amendment offered by the Senator from Arkansas tries to correct this callous approach. I am sure there will be a variety of attempts to increase access to coverage during this debate. This route focuses on the 21.6 million Americans who are self-employed or in families headed by a self-employed individual.

On January 22 of this year I introduced S. 29, the Self-Employed Health Insurance Fairness Act of 2001. I am pleased that the Senator from Illinois, Mr. DURBIN, is the lead cosponsor out of the 52 cosponsors who have joined this bill so far. Obviously, this is important to many Members of this body.

During the time I have served as chairman of the Senate Committee on Small Business—and now as its ranking member—one of my top priorities has been to ensure full deductibility of health insurance for the self-employed, and to provide it now.

Today, while the self-employed can deduct 60 percent of their health insurance costs, they are still not on a level playing field with large businesses which can deduct 100 percent. While the self-employed are slated to have full deductibility in 2003, these small business owners and their families should not have to wait any longer to get sick.

With only partial deductibility, it comes as no surprise that a quarter of the self-employed still do not have health insurance. In fact, 4.8 million Americans live in families headed by a self-employed individual, and those families include more than a million children who lack adequate health insurance coverage due at least in part to our failure to provide full deductibility for their health insurance costs.

Coverage of these self-employed individuals and their children through the self-employed health insurance deduction will enable the private sector to address the health care needs of these individuals rather than an expensive and intrusive Government program.

Full deductibility has been on the must-do list of the national small business groups for too long. I know the farm groups and the Farm Bureau and other groups have long argued for this.

Last year when I convened the National Women's Small Business Summit in Kansas City, having full deductibility of health insurance for the self-employed was one of their top goals. I assured them at the time that we would bring this to the attention of our colleagues in this body, and I do so again today.

In the 107th Congress we have a tremendous opportunity to see this goal achieved in a bipartisan manner to the benefit of all the country's self-employed individuals. We have had bipartisan support for this proposition in the past, and I expect we will do so today.

For some of you who may not remember or may not have been here or probably have just forgotten, this battle has been going on in this body for a long time.

In 1995, I offered an amendment to the Balanced Budget Act which would have increased the health insurance deduction to the self-employed to 50 percent. I thought this was a great start. Unfortunately, President Clinton vetoed it.

In 1996, I worked with Senator Kassebaum to include in the Health Insurance Portability and Accountability Act an increase in the self-employed health insurance deduction incrementally to 80 percent over 10 years.

In 1997, provisions of my Home-Based Business Fairness Act were included in the Taxpayer Relief Act of 1997 to finally increase the deduction to 100 percent, with full deductibility occurring in 2007. The Taxpayer Relief Act also accelerated the phase-in over then existing laws.

In 1998, as part of the omnibus appropriations bill, I worked to see that the phase-in of 100-percent deductibility was accelerated from 2007 to 2003. We also succeeded in substantially increasing the deduction in the intervening years. Under that measure, the deduction was raised to 60 percent for 1999, 2000, and 2001, to 70 percent for 2002, and to 100 percent in 2003. These were increases of 10 to 20 percent.

In 1999, I worked to include in the Taxpayer Refund and Relief Act 100-percent deductibility in 2000. Unfortunately, former President Clinton vetoed that bill. Had he not done so, the self-employed in America would be enjoying full deductibility of health insurance costs today.

In 2000, I worked to provide immediate full deductibility in the minimum wage tax package, the Patients' Bill of Rights legislation, and the year-end small business tax package. There is no surprise to say that the veto threats from the Clinton administration derailed those bills, and, once again, the self-employed were denied full deductibility.

This year, the Finance Committee, on a bipartisan basis, was good enough to provide immediate full deductibility in the package that was brought to the Senate floor and which passed the full Senate. Thank you, leaders of the Finance Committee, Senator GRASSLEY and Senator BAUCUS. Unfortunately, I must tell you that the provision was removed in the conference and did not pass into law with the rest of the President's tax cut package.

The bottom line, immediate full deductibility for the self-employed has overwhelming bipartisan support. It was passed by the Senate Finance Committee and the full Senate multiple times in the past.

As my colleague from Arkansas has pointed out, according to the Joint Committee on Taxation, the amendment is expected to cost $214 million in 2002 and $641 million in 2003.

As a result, the 5- and 10-year costs of the amendment is really only the first 2 years when we get to 100-percent deductibility, and that total cost is $855 million. That is within the budget parameters that we adopted and under which we operate.

In summary, let me say that after waiting for too long we now have another chance to see that self-employed Americans get health insurance by passing this important provision. Our chance to pass it is on a bill that desperately needs to deal with the problem of insurance coverage and insurance access.

As we look to protect patients, we must be expanding—not limiting—access to care. We will have further amendments that deal with some of the problems that could substantially limit access to care, could drive out small businesses—such as the small businesses that have already told me that, without change in the liability provisions of the McCain-Kennedy bill, they will have to cut off health care to 1,287 Missouri citizens.

This is just the beginning, good friends. Wait until you start hearing from small businesses in your State that I believe will tell you they will not be able to continue to provide health care coverage for their employees if they are going to be subjected to liability whenever there is a problem with their health insurance coverage.

We believe more than 1 million Americans will lose their coverage as a result of the increased costs and the expanded liability of the McCain-Kennedy bill.

This amendment offered by my good friend and colleague from Arkansas is our chance to mitigate that approach by trying to help more Americans get coverage.

I urge my colleagues to support the Hutchinson-Bond amendment. I believe it is a most important step for us to take as we begin debate on this bill and work to see that more and not less Americans get the health insurance coverage we want to see all of them have.

Mr. HOLLINGS. Mr. President, will the distinguished Senator yield?

Mr. BOND. I am finished and happy to yield.

The PRESIDING OFFICER. The Senator from South Carolina is recognized.

Mr. HOLLINGS. Is this the tax deductibility amendment that the Senator from Missouri and I cosponsored previously?

Mr. BOND. Mr. President, the Senator from South Carolina has been a very active sponsor. I mentioned Senator DURBIN. During my period in the Senate, I have had great support from the Senator from South Carolina and others on both sides of the aisle.

Mr. HOLLINGS. If the distinguished Senator pleases, I hate to demur at this particular point. But I don't think this particular bill is appropriate on a matter of procedure. So I didn't want to be associated with the amendment on this particular bill. This is not a tax bill, obviously. I wish to withdraw my name as a cosponsor because I have to vote against the amendment.

Mr. BOND. Mr. President, we have not included the distinguished Senator from South Carolina as a cosponsor of the bill. We know his heart is with us. We are sorry his vote is not with us.

I think you will find before this bill is over with that there will be many issues in the jurisdiction of the Finance Committee, and what we should be talking about on this bill is making sure that we protect patients, we protect Americans who must have health care coverage. This bill goes in the wrong direction. We will have an opportunity for all Senators to express themselves on whether they believe the self-employed and their families deserve to have 100-percent deductibility. I hope we will have the same bipartisan support, maybe with one exception that we have had in the past because the self-employed, the farmers, the truck drivers, the daycare operators, the mom-and-pop operations, the 21.2

million Americans who own small businesses who are taxed under individual rates will have full benefits.

Again, the principle is very important. I don't think the American people are going to care much about procedure when this bill really turns into a bill with significant Finance Committee implications. We ought to take a look at what is going to make a difference to the self-employed, and the Hutchinson-Bond amendment will help us get coverage to many who are now not covered.

I thank the Chair.

Mr. GRASSLEY. Mr. President, I want to discuss my vote on the Hutchinson-Bond amendment. I commend Senators HUTCHINSON and BOND for raising the issue of accelerating full deductibility for the self-employed. I support, and have always supported, this important effort and wish to see it realized. I am confident that with the leadership of Senators HUTCHINSON and BOND it will become reality.

However, as the recent experience with the $1.35 trillion tax relief bill has shown, it is critical that tax legislation be first considered by the Finance Committee as part of a tax bill.

I have sought and have received agreement from the chairman of the Finance Committee that this measure and similar health tax related matters will be subject to a markup in the Finance Committee in the near future. I look forward to pursuing this issue at that time.

Mrs. CARNAHAN. Mr. President, I am a cosponsor of the bill by Senator BOND that is identical to this amendment. This proposal will provide a vital acceleration of the phase in of full tax deductibility for the health insurance costs of the self-employed. This is a much-needed change to provide relief and level the playing field for small businesses, farmers, and independent contractors.

I voted for this provision when it was included as part of the Senate's $1.35 trillion tax cut bill and was disappointed that it was not included in the Conference Report.

Although I strongly support Senator BOND's legislation, I regret that I cannot support this amendment to the Patients' Bill of Rights. First, the tax cuts in the amendment are not offset and therefore would increase the national debt. Now that the $1.35 trillion tax cut has been adopted, we need to exercise restraint when considering additional tax cuts. Furthermore, I do not believe the amendment is an appropriate addition to the Patients' Bill of Rights.

We need to pass a Patients' Bill of Rights to improve patient care and hold HMOs accountable for their health care decisions. Reducing the number of Americans that lack health coverage is a vitally important subject, but one that should be addressed separately from the Patients' Bill of Rights.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, may I first express my appreciation to the distinguished Senator from Missouri for his leadership, not only on the issue of 100-percent deductibility for the self-employed but for his strong advocacy for small business. He has been one of the great champions for small business in this country, and he continues to be as the cosponsor of the amendment. I am pleased to be associated with him on this important effort.

If I might say in response to the concerns of my good friend, the distinguished Senator from South Carolina, about the Finance Committee's jurisdiction, in fact, no Senate committee ever reviewed S. 1052 before we proceeded to it on the floor of the Senate.

While it is true that there have been other Patients' Bill of Rights legislation debated in the past, the fact is that this bill contains several provisions within the jurisdiction of the Finance Committee, including customs user fees, Medicare payment shifts, Social Security transfers—all of which come under the jurisdiction of the Finance Committee, which has never marked up this bill.

In fact, this amendment is most appropriate for this bill because the concern of many on this side of the aisle—and I think many on the other side of the aisle—has been that the Kennedy-McCain version of the Patients' Bill of Rights, because of the liability provisions and some of the other concerns in it, but particularly the liability provisions—the wide open right to sue provisions, the ability to circumvent the internal and external appeals process and go straight to court, and the impact that liability will have upon increasing premiums, increasing costs of health care, and increasing, in fact, the number of uninsured—that dealing with an access amendment is the most appropriate way we could start the amendment process on the Patients' Bill of Rights.

This is the most germane, most appropriate amendment with which we could begin. There are going to be many very important amendments and a lot of important issues addressed, but what could be more important than ensuring that there are going to be literally millions more people who will be able to get insurance because we are giving 100-percent deductibility a year sooner than they would get under current law?

So the Senate has spoken, saying this is a matter of fairness. We have voted in the past in favor of 100-percent deductibility. There is no need for us to phase that in, particularly in light of a bill that promises to increase the number of uninsured.

I want us to put a human face on those people. We talk about a 1-percent increase in premiums. That is 300,000 more uninsured; 4.2 percent. That is 1.3 million more people who lose their insurance. If you think about the number—1.3 million—it becomes very impersonal, but every one is a human being. And those are people who currently have health insurance, currently are covered, currently have the assurance and the confidence each day that when they get up, if something happens—if an illness strikes—they are covered, protected in this employer-based health insurance system. And they are not going to have it when we pass the Kennedy-McCain bill. We need to keep that in mind. We need to keep the focus upon those uninsured.

I would like to share with my colleagues an important statement of administration policy which was just issued today. I have just been handed this. This is a June 21 ''Statement of Administration Policy'' regarding the Kennedy-McCain Patients' Bill of Rights. All who have followed this issue know the President wants to sign a good Patients' Bill of Rights. He signed a bill in Texas. He campaigned in support of a Patients' Bill of Rights. He outlined his principles. He is on record as not only supporting this, but enthusiastically believing we need to do it. But he has expressed deep concerns about this Kennedy-McCain bill. The ''Statement of Administration Policy'' reads as follows:

The President strongly supports passage of a patients' bill of rights this year and has been working with members of both parties since the first week of the Administration to forge a compromise. Congress has been divided on this issue for far too long at the expense of patients and their families. The President strongly urges Congress to pass a strong patients' bill of rights this year that provides meaningful protections for patients, not a windfall for trial lawyers or a threat to Americans' ability to obtain and afford quality health care. On February 7, 2001, the President transmitted to Congress his principles for a bipartisan patients' bill of rights and urged Congress to move quickly on this important issue.

The President's principles called for passage of a patients' bill of rights that ensures all Americans enjoy strong patient protections, including: access to emergency room and specialty care; direct access to obstetricians, gynecologists, and pediatricians; access to needed prescription drugs and approved clinical trials; access to health plan information; a prohibition of ''gag clauses''; consumer choice provisions; and continuity of care protections. The President also recognizes, however, that many States have passed strong patient protection laws already, some of which have been in force for over a decade. To the extent possible, a Federal patients' bill of rights should give deference to these effective State laws.

The President's principles emphasized the importance of providing patients who have been denied medical care with the right to a fair, prompt, and independent medical review, which will ensure that disputes are resolved quickly and inexpensively and that patients receive the quality care they deserve.

The President stated that only after this independent review decision is rendered should we resort to the costlier, time-consuming remedy of litigation in Federal courts to ensure that health plans are held liable for wrongful decisions.

The President's principles also reminded Congress of the necessity of avoiding unnecessary and frivolous lawsuits, which will only serve to drive up costs and leave more individuals without insurance coverage. S. 1052—

That is the Kennedy-McCain bill.

will significantly increase health insurance premiums and the number of uninsured. According to the Congressional Budget Office, health insurance premiums under S. 1052 as originally drafted would increase by over 4%. If the effects of litigation risk on the practice of medicine and of the reduced ability of health plans to negotiate lower rates were included, CBO's estimated cost impact could be much higher, by 4–5% or more. This is in addition to the estimated 10–12% premium increases employers are already facing in 2001. Further, leading economists have predicted that employers drop coverage for approximately 500,000 individuals when health care premiums increase by 1%. According to these estimates, S. 1052 could cause at least 4–6 million Americans to lose health coverage provided by their employers.

The President is encouraged by efforts in the Senate, Like those of Senators Frist, Breaux, and Jeffords, to develop a common sense compromise that forges a middle ground on this issue and meets the President's principles.

While the President strongly supports a comprehensive and enforceable patients' bill of rights and has been working with members of both parties to enact legislation this year, he believes that S. 1052 would encourage costly and unnecessary litigation that would seriously jeopardize the ability of many Americans to afford health care coverage.

The President objects to the liability provisions of S. 1052. The President will veto the bill unless significant changes are made to address his major concerns. In particular, the serious flaws in S. 1052 include:

S. 1052 circumvents the independent medical review process in favor of litigation. The President believes that patients should be given care first—litigation should be the last resort. Patients should exhaust the medical review process first, allowing doctors, not trial lawyers, to make decisions about medical care.

S. 1052 jeopardizes health care coverage for workers and their families by failing to avoid costly litigation. S. 1052 overturns more than 25 years of Federal law that provides uniformity and certainty for employers who voluntarily offer health care benefits for millions of Americans across the country. The liability provisions of S. 1052 would, for the first time, expose employers and unions to at least 50 different, inconsistent State-law standards. The result will inevitably be that employers and unions will be forced to pay for different benefits from State to State, even within a particular State, based on varying precedents set in State courts and leading to inconsistent standards of care of patients. Further, S. 1052 imposes no limitations on State court damages, and it is not clear whether existing State-law caps would apply to the broad, new causes of action in State courts that S. 1052 creates.

S. 1052 also would allow causes of action in Federal court for a violation of any duty under the plan, creating open-ended and unpredictable lawsuits against employers for administrative errors. These new Federal claims do not have any limitations on the amount of noneconomic damages, creating virtually unrestrained damage awards that are limited only by an excessive $5 million cap on punitive damages.

Moreover, S. 1052 would subject employers and unions to frequent litigation in State and Federal court under a vague ''direct participation'' standard, which would require employers and unions to defend themselves in court in virtually every case against allegations that they ''directly participated'' in a denial of benefits decision. Because such determinations are inherently fact-specific, any such allegation will force a costly and time-consuming court process and result in varying State interpretations of ''direct participation,'' forcing employers to adhere to different standards in every State.

S. 1052 fails to provide a fair and comprehensive remedy to all patients. The President believes the new Federal law should establish a comprehensive set of rights and remedies for patients. S. 1052 instead encourages costly litigation by providing no effective limitations on frivolous class action suits and allows trial lawyers to go on fishing expeditions to seek remedies under other Federal statutes.

S. 1052 subjects physicians and all health care professionals to great liability risk. S. 1052 would expand liability for physicians and all health care professionals in State courts well beyond traditional medical malpractice by permitting new, undefined causes of action in State courts for denials of medical benefits. This expanded litigation against physicians and all health professionals will create an opportunity to circumvent State medical malpractice caps that may not apply to these new causes of action.

Extraneous User Fee Provision. The Administration objects to inclusion in S. 1052 of an extraneous revenue-raising provision (section 502), which extends for multiple years Customs charges on transportation, passengers, and merchandise arriving in the country.

PAY-AS-YOU-GO-SCORING

S. 1052 would affect direct spending; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's preliminary scoring estimate of the bill is under development.

Just before I yield the floor to our distinguished deputy minority leader, I will re-cite the President's Statement of Administration Policy in which the President says he will veto the bill unless significant changes are made to address his major concerns.

The amendment before us, providing 100-percent deductibility, is one step in addressing the concerns of our President, by increasing the availability and affordability of health insurance to those who have faced an inequitable Tax Code in the past.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I compliment my friend and colleague from Arkansas for this amendment. I ask unanimous consent to be listed as a cosponsor.

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

Mr. NICKLES. Mr. President, I also thank my colleague, Senator BOND from Missouri. He and I and the Senator from Arkansas have been fighting for this provision for years, and we are going to get it done.

This provision is basic tax equity. Why in the world wouldn't we allow self-employed individuals to deduct 100 percent of their health care premiums if we allow corporations to do so?

I used to be self-employed. I used to run a corporation. Corporations get to deduct 100 percent. Every corporation in the country, if they want to provide health care for their employees, gets to deduct 100 percent of the expense of that health care. They get to deduct it. A self-employed person this year gets to deduct 60 percent. That is not fair. That is not right. It needs to be changed. It can be changed in this bill.

You might ask, why are we changing this bill? There are a lot of reasons. Unfortunately, the bill we have before us, the so-called McCain-Kennedy bill, will increase the number of uninsured in the millions. Some have estimated 1 million, some 2, 3, 4 million. I think it is a higher figure, but millions of people will lose their insurance if we don't improve the bill.

Last year when Congress passed a Patients' Bill of Rights, we called it the Patients' Bill of Rights Plus. Not only did we have patient protections, but we also put in some very positive provisions to help people buy health care. So we would increase access, and we would increase the number of people who have insurance. This amendment was one part of that—a small part but a vital part, an important part.

Some of the people who are going to be hit the hardest under this bill are self-employed individuals, people who own their own business, people who are very small employers from a variety of different businesses. Many of these are new businesses, not the old, established ones that have been around for decades. These are new businesses that were just created. And many of them are asking what kind of compensation package do we have for our employees. They are adding health care or they hope to add health care. Then when they find out they only get to deduct 60 percent of the cost, they realize that is not fair—not when General Motors gets to deduct 100 percent, not when every corporation in America gets to deduct 100 percent. So many times their compensation package for their employees will not include health care.

They might say: We will pay your salary and we hope that you will buy health care. It might be a hope. It might be a wish, but it is not a reality because the Tax Code discriminates against self-employed individuals.

We can change that. The amendment of the Senator from Arkansas would change that. This Congress has passed this amendment. We passed it last year when we passed the Patients' Bill of Rights Plus. We passed it last year when we passed the minimum wage bill. We added this provision as well.

We are going to give everybody a chance to pass it in this bill. I compliment my friend and colleague. If we have a bill that increases the number of uninsured and directly hits a lot of people who are self-employed, let's do something to help the self-employed. If we want to help the self-employed individual, this is one amendment that can do so.

Not only that, it is basic equity. Why in the world would we have a policy where we allow corporations to deduct 100 percent and the self-employed 60 percent, next year 70 percent. It is not right. It is not fair.

Somebody asked, what does this amendment really boil down to? It boils down to the difference in deducting 60 percent versus 100 percent. For an individual who has health care costs of about $6,000, it means deducting $1,600 instead of about $1,000, a difference of $600 savings in taxes for self-employed individuals.

This amendment is a serious amendment. This amendment is an amendment that should be adopted. I hope this amendment will be adopted overwhelmingly.

Other people have said we shouldn't be doing taxes on this bill. This is not a Finance Committee bill. This bill never went through the Finance Committee. That is correct, but it is also correct that the bill never went through the labor committee. This bill never went through the Judiciary Committee. It has a whole new tort section that creates new sections of legal action against employers and medical health care providers, HMOs, and so on, all new legal actions, tort cases, but it didn't go through the Judiciary Committee. This bill never went through the Labor Committee, and it didn't go through the Finance Committee.

This bill also has sections in it that deal with the Finance Committee. I happen to be a member of that committee. I was kind of surprised to find out that there is language in here extending custom user fees for 8 years. What does that have to do with the Patients' Bill of Rights? At least the amendment of the Senator from Arkansas says we want to help people buy health care. We want to help those people who are targeted by this bill. Self-employed people who may not be able to afford insurance because of this bill, let's help them a little bit.

The amendment of the Senator from Arkansas is pretty relevant. I don't know what custom fees have to do with a Patients' Bill of Rights. I don't know what doing some jiggling with Social Security trust funds and Medicare payments—there is a little tinkering going on with those provisions. I am not sure why they are in here. Maybe it is because CBO estimates that there will be billions of dollars less in the Social Security and Medicare trust funds as a result of this bill. Maybe those trust funds have some problems because there is not as much money going into it.

You might ask, why is there less money going into the trust funds. Because CBO says if you greatly increase people's premiums, they are going to get less payment in wages. This is not my estimate. It is CBO's estimate. They estimated $56 billion less in wages over the next 10 years as a result of this bill; a reduction in Social Security payments of about $7 billion less going into the trust fund as a result of this legislation.

Maybe that is what this is. I haven't quite figured out what the purpose is. Maybe I will ask the authors of the legislation who I don't believe are members of the Finance Committee, but I am sure there is a method in their madness. I will not cast any aspersions, but I do know it deals with the Finance Committee. I do know it deals with taxes. I do know we have a tax increase in extending custom user fees. I don't know how relevant those are to patients, but I do know the Hutchinson amendment is very relevant because he is trying to help self-employed people be able to afford insurance.

This bill will greatly increase the cost of insurance for the self-employed and all employers and all employees. I say ''all employees'' because a lot of employers are going to be passing the additional cost on to their employees.

I have heard some people say: It is only 50 cents. It is only a dollar. It is only a Big Mac. That is being pretty loose with the expenses and costs. Maybe people aren't figuring the cost of health care nationwide is about $7,000 per family. That is the total cost. Employers maybe pay all of it in some cases; maybe they pay half of it in other cases. If they are paying all of it, that means the employee is getting less in wages because the employer is expending that amount.

Maybe it is some kind of copay. More and more employers and employees have cost sharing. Or maybe the employer is picking up 70 or 80 percent, and the employee picks up the balance. Those are all very legitimate ways of paying for health care; the point being, this bill is going to greatly increase health care costs on both the employer and the employee. If they are paying 20 or 30 percent of the health care costs, they are going to be paying more. They may have a higher deductible. They may have a higher copay.

The total cost of the bill will go up. How much will it go up? CBO says 4.2 percent; 4.2 percent on $7,000 is about $300 per family. It is interesting, that is the size of the tax cut for a lot of Americans. Well, we gave Americans a tax cut they will be receiving in July and August and September of this year. That is great. We are going to take it away with this bill.

I think that estimate of 4.2 percent is grossly underestimated. I notice the administration does, too. They said if the effects of litigation risk on the practice of medicine and the reduced ability of health plans to negotiate lower rates were included, CBO's estimated cost impact would be much higher, by 4 or 5 percent more. So instead of increasing the cost of health care by 4 percent, it is probably 8 or 9 percent. Clearly, when you add 8 or 9 percent on health care costs that are already rising at 12 percent in some cases, in most cases, 20 percent, you are looking at astronomical price increases for your health care costs. A lot of people won't be able to afford it. They will drop their health care as a result. Or they will say, employees, you pick up a greater share. Or they will say, employees, we can't provide this with the extended liability we now have on us and, therefore, we will give you the money. We hope you will purchase health care on the individual market.

It might be more expensive for them to do it in the individual market. Some would do it and many would not. So it is this threat of liability that would greatly increase health care costs and greatly increase the number of uninsured—not to mention the fact that it would increase defensive medicine costs because plans would have to go through an appeals process. Employers might say: Wait a minute, it is cheaper to pay for the coverage even though it is not a contractual benefit, and we will do it because it is cheaper than to go through the appeals process. Maybe you will have some situations where people will say: Let's pay for it because we don't want a threat of liability.

So everything is covered whether it is in the contract or not. You would have a lot of defensive medicine and a lot of people, because of the threat or the scare of liability, who would say: Let's just pay for the coverage.

So health care costs will be rising, and rising dramatically—I believe, like the administration, much more so than 4 percent, probably a lot closer to 8 or 10 percent. The net result will be a disaster—a special disaster on the small businessperson. I was a small businessperson. I used to have a janitor service. We didn't provide health care for our employees. It was a business I started in college. If I would have maintained it longer, I probably would have. But I would not—if somebody said, ''Oh, Mr. Janitorial Service, you could be liable for anything you have ever gotten or ever will have under a bill that the Congress just passed,'' I would say, ''Hey, I don't have to provide this health care'' and, no, I don't think I would.

A lot of people would not be doing it if they knew they could be subject to unlimited punitive damages in State court and unlimited noneconomic damages in State or Federal court. That is in this bill. I have heard some people say that the McCain-Edwards bill has a $5 million cap on damages. It has a $5 million on punitive damages in Federal Court. It doesn't have any cap, any damage limit whatsoever on noneconomic damages, which is pain and suffering. That is where the big jury awards are. We already have jury awards in the millions of dollars. Some want to do class action suits in the billions. This bill encourages class action suits.

Boy, there are trial lawyers just licking their chops just thinking they are going to have a chance to get after that. Who are they going to go after? The big bad HMOs? The people who are going to really get hit are the small, self-employed individuals who want to provide health care to employees and they can't afford it. Those big bad HMOs, are they really going to be hit? Whatever they get hit for, they will pass it on. They won't pay a dime.

Maybe their profits will be a little less, but they are going to pass it on in the form of higher rates, and employees and employers are both going to pay for it.

The reason I say ''employees'' is employers can't pay for it out of nothing, so therefore it comes out of the employee as lost wages, or as the wage increases they might have received, or higher copays.

So employees of America, this is not a bill that is going to be expanding your protection; this is going to be cutting your wages. This is going to be taking money away from employees' paychecks because they won't get the increases they hoped to get because employers will be saddled with exorbitant increases in health care costs.

We can help alleviate that by making some changes in this bill. It is very much my intention to pass a positive Patients' Bill of Rights. This bill we have before us is not that. This bill is a disaster for employers and employees across the country. This bill is a recipe for litigation. This is a trial lawyer's right to bill, not a Patients' Bill of Rights. It is a trial lawyer's right to bill, and the net result is you are going to have a lot of litigation, a lot less health care, and decisions being made in the courtroom instead of by doctors.

We don't have to go this route. We can pass something like we passed last year. We can pass something, as Dr. FRIST proposed, that has a real appeals process—an internal and external review process that is binding. Under this bill, you don't even have to go through the review process; you can bypass it. You need not apply. Don't bother. In 181 days, you can sue for all they have. You don't have to mess with the appeals and have doctors make the decisions. Let's just go to court where you can get big awards.

This bill would be a mistake. Let's not pass this bill. We are going to work over the next number of days to improve this bill. I think the amendment of the Senator from Arkansas is a small step in the right direction. It will make health care more affordable and accessible for self-employed individuals. I congratulate him and compliment him and I am happy to cosponsor his effort. I hope our entire Senate will join in this effort to pass this.

I have consulted with Members in the House of Representatives and they are going to have provisions that are in the Tax Code to encourage individuals to pay for health care, and the Senate should do likewise. Some might say, wait a minute; this is a tax measure. Let's wait for the House. If it has tax measures in it now, let's go ahead and make a good tax measure, not just an increase. Let's do something to help self-employed individuals, as my colleague from Arkansas has advocated.

I urge my colleagues to vote in favor of this amendment. It is a positive amendment and a step in the right direction to improving a bill that, in my opinion, is fatally flawed. We hope to have many improvements by the time this debate is concluded.

I yield the floor.

The PRESIDING OFFICER (Mrs. CLINTON). The Senator from Arkansas is recognized.

Mr. HUTCHINSON. Madam President, I thank the Senator from Oklahoma for his fine statement and, even more, I express my gratitude for the leadership he has demonstrated over the last 2 or 3 years on the issue of the patients' rights legislation. It was a privilege to serve on the conference committee on the Patients' Bill of Rights. I saw the Senator from Oklahoma work day and night as he chaired that conference committee. He worked arduously in trying to forge a compromise that was acceptable to the various interests and factions to ensure that millions and millions of Americans who do not currently have protections under managed care organizations and insurance plans would receive that. I know many of us regret that we didn't achieve that ultimate goal. It is not because of any lack of effort on the part of the distinguished Senator from Oklahoma.

Madam President, previously in my remarks, I quoted from the statement of the administration policy regarding S. 1052, the Kennedy-McCain legislation, and I ask unanimous consent to have that statement of administration policy printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

STATEMENT OF ADMINISTRATION POLICY

S. 1052—BIPARTISAN PATIENT PROTECTION ACT

The President strongly supports passage of a patients' bill of rights this year and has been working with members of both parties since the first week of the Administration to forge a compromise. Congress has been divided on this issue for far too long at the expense of patients and their families. The President strongly urges Congress to pass a strong patients' bill of rights this year that provides meaningful protections for patients, not a windfall for trial lawyers or a threat to Americans' ability to obtain and afford quality health care. On February 7, 2001, the President transmitted to Congress his principles for a bipartisan patients' bill of rights and urged Congress to move quickly on this important issue.

The President's principles called for passage of a patients' bill of rights that ensures all Americans enjoy strong patient protections, including: access to emergency room and specialty care; direct access to obstetricians, gynecologists, and pediatricians; access to needed prescription drugs and approved clinical trials; access to health plan information; a prohibition of ''gag clauses''; consumer choice provisions; and continuity of care protections. The President also recognizes, however, that many States have passed strong patient protection laws already, some of which have been in force for over a decade. To the extent possible, a Federal patients' bill of rights should give deference to these effective State laws.

The President's principles emphasized the importance of providing patients who have been denied medical care with the right to a fair, prompt, and independent medical review, which will ensure that disputes are resolved quickly and inexpensively and that patients receive the quality care they deserve.

The President stated that only after this independent review decision is rendered should we resort to the costlier, time-consuming remedy of litigation in Federal courts to ensure that health plans are held liable for wrongful decisions.

The President's principles also reminded Congress of the necessity of avoiding unnecessary and frivolous lawsuits, which will only serve to drive up costs and leave more individuals without insurance coverage. S. 1052 will significantly increase health insurance premiums and the number of uninsured. According to the Congressional Budget Office, health insurance premiums under S. 1052 as originally drafted would increase by over 4%. If the effects of litigation risk on the practice of medicine and of the reduced ability of health plans to negotiate lower rates were included, CBO's estimated cost impact could be much higher, by 4–5% or more. This is in addition to the estimated 10–12% premium increases employers are already facing in 2001. Further, leading economists have predicted that employers drop coverage for approximately 500,000 individuals when health care premiums increase by 1%. According to these estimates, S. 1052 could cause at least 4–6 million Americans to lose health coverage provided by their employers.

The President is encouraged by efforts in the Senate, like those of Senators Frist, Breaux, and Jeffords, to develop a common sense compromise that forges a middle ground on this issue and meets the President's principles.

While the President strongly supports a comprehensive and enforceable patients' bill of rights and has been working with members of both parties to enact legislation this year, he believes that S. 1052 would encourage costly and unnecessary litigation that would seriously jeopardize the ability of many American to afford health care coverage.

The President objects to the liability provisions of S. 1052. The President will veto the bill unless significant changes are made to address his major concerns. In particular, the serious flaws in S. 1052 include:

S. 1052 circumvents the independent medical review process in favor of litigation. The President believes that patients should be given care first—litigation should be the last resort. Patients should exhaust the medical review process first, allowing doctors, not trial lawyers, to make decisions about medical care.

S. 1052 jeopardizes health care coverage for workers and their families by failing to avoid costly litigation. S. 1052 overturns more than 25 years of Federal law that provides uniformity and certainty for employers who voluntarily offer health care benefits for millions of Americans across the country. The liability provisions of S. 1052 would, for the first time, expose employers and unions to at least 50 different, inconsistent State-law standards. The result will inevitably be that employers and unions will be forced to pay for different benefits from State to State, even within a particular State, based on varying precedents set in State courts and leading to inconsistent standards of care for patients. Further, S. 1052 imposes no limitations on State court damages, and it is not clear whether existing State-law caps would apply to the broad, new causes of action in State courts that S. 1052 creates.

S. 1052 also would allow causes of action in Federal court for violation of any duty under the plan, creating open-ended and unpredictable lawsuits against employers for administrative errors. These new Federal claims do not have any limitations on the amount of

noneconomic damages, creating virtually unrestrained damage awards that are limited only by an excessive $5 million cap on punitive damages.

Moreover, S. 1052 would subject employers and unions to frequent litigation in State and Federal court under a vague ''direct participation'' standard, which would require employers and unions to defend themselves in court in virtually every case against allegations that they ''directly participated'' in a denial of benefits decision. Because such determinations are inherently fact-specific, any such allegation will force a costly and time-consuming court process and result in varying State interpretations of ''direct participation,'' forcing employers to adhere to different standards in every State.

S. 1052 fails to provide a fair and comprehensive remedy to all patients. The President believes the new Federal law should establish a comprehensive set of rights and remedies for patients. S. 1052 instead encourages costly litigation by providing no effective limitations on frivolous class action suits and allows trial lawyers to go on fishing expeditions to seek remedies under other Federal statutes.

S. 1052 subjects physicians and all health care professionals to greater liability risk. S. 1052 would expand liability for physicians and all health care professionals in State courts well beyond traditional medical malpractice by permitting new, undefined causes of action in State courts for denials of medical benefits. This expanded litigation against physicians and all health professionals will create an opportunity to circumvent State medical malpractice caps that may not apply to these new causes of action.

Extraneous User Fee Provision. The Administration objects to inclusion in S. 1052 of an extraneous revenue-raising provision (section 502), which extends for multiple years Customs charges on transportation, passengers, and merchandise arriving in the country.

Pay-As-You-Go Scoring. S. 1052 would affect direct spending; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's preliminary scoring estimate of the bill is under development.

Mr. HUTCHINSON. As the Senator from Oklahoma very rightly said, this amendment provides 100-percent deductibility for the self-employed beginning in January of next year, and accelerating that 100-percent deductibility, which the Senate has been on record in support of, is very germane and relevant to this bill.

I think at the heart of this bill is the question of access. At the heart of this bill is, are we doing more damage than we are good? In our efforts to provide patient protection, are we increasing by millions the number who have no patient protections because they have no health insurance? That is, to me, a core fundamental question in this debate. I believe this amendment that I have offered with Senator BOND is a significant step—though far from all that is needed—in improving access. It is something we should do and indeed we must do.

Sometimes, as we deal with the issue of liability, we forget exactly what kind of impact that liability will have. The President, in his statement of administration policy, really homed in on the impact of a wide-open lawsuit provision such as he believes and I believe exists in the Kennedy-McCain bill, what impact it would have on the uninsured. I think he cites very accurate numbers as to the millions of people who could well lose their health insurance were the Kennedy-McCain bill to pass as it currently exists.

One survey found that roughly half of employers reported that they would likely get out of the business of providing health care coverage if exposed to increased liability. Some people say these employers aren't going to do that. How can they do that? This is essential to offer that benefit. You have to offer that to employees if you are going to be competitive.

Well, many small businesses in particular and, for that matter, large corporations who are self-insuring today and are providing good health benefits to employees or their associates, when faced with the prospect of going to Federal court or State court on a host of actions, costly actions, are going to question seriously, understandably, whether they can operate in that kind of environment. Similarly, this study found that 48 percent said that expanded liability would hinder care management, and 80 percent said it would increase consumer costs.

The point is that even those employers who are able to continue to offer health insurance are going to find their costs going up and those costs—they are not going to be able to absorb all of those costs, and they are going to be passed on to employees and consumers. That is going to have a detrimental impact upon, I believe, the health care system in this country.

Sometimes cartoons can simplify a very complex issue down to something that is quite understandable to the average American or to the average Senator. Today, in our statewide newspaper in the State of Arkansas, the Arkansas Democratic Gazette, this cartoon appeared. It is a Vic Harville cartoon. It sums up the concern a lot of us have about the liability provisions in the Kennedy-McCain bill: ''Who will benefit the most from a Patients' Bill of Rights?'' There is a gleeful, happy attorney with a nameplate: Will Cheat 'Em Attorney At Law.

There are going to be a lot of smiling attorneys, I am afraid, with the Kennedy-McCain bill, as it is currently framed. I have a number of concerns with the liability impact. The McCain-Edwards-Kennedy bill has been called the Trial Lawyers' Bill Of Opportunities. We all want a Patients' Bill of Rights. The President, in the Statement of Administration Policy, outlines specifically the patient protections he believes are essential that we provide millions of Americans. I think we would have a 100–0 vote on those patient protections.

That is not good enough. Instead of finding a consensus bill that will provide patient protections for millions who do not have those kinds of protections today, we have a bill that has a liability provision, a right to sue not at the end of the road where there is an insurance company that has abused their clients, but at any point circumventing the internal-external appeal, the ability to go right into court after 180 days and tie up not only the court system, but spend literally hundreds of millions of dollars in the defense of those suits, whether they are meritorious or not.

This chart expresses some of my concerns with liability. It bypasses external review and brings lawsuits at any time. It allows forum shopping between State courts. So while there is agreement—I certainly believe a right to sue should be included at some point. When an employee believes the insurance company has not treated them properly or has overridden a proper medical decision by that doctor, that individual ought to have a right of appeal. They should have an internal appeal that is accelerated, expedited.

If at that point they are not satisfied, they should be able to go outside the insurance company, have an expert independent review to look at the issue and make a determination. If at that point the insurance company says, we are going to ignore it, we are still not going to comply with the decision of the external reviewer, at that point I think it is certainly appropriate there be a remedy.

The McCain-Edwards-Kennedy bill allows lawsuits in Federal and State courts relating to the same injury; it allows forum shopping; it allows frivolous suits against employers for merely offering health insurance to their employees; that is, an employer is willing to take the risk of providing health insurance, is willing to invest the cost, some 60 percent, some 75 percent, some paying entirely for those premiums. What do they get for their willingness to provide that benefit? They get the possibility of frivolous lawsuits.

Frivolous? Yes, because they need not go through the internal-external appeals process. If they are willing to wait 180 days after they discover the injury, they can go into court and leverage those frivolous suits for some kind of negotiated agreement. Those settlements will benefit trial lawyers. This is a bill of opportunities for trial lawyers. They collect large contingency fees on unlimited noneconomic and punitive damages. There is no limit; the sky is the limit. Whatever a good trial lawyer can convince a jury should be the damages and the sky is the limit on that.

It abuses the class action lawsuits because there is no limit on class action lawsuits in the McCain-Edwards-Kennedy bill. All of these are great concerns to me.

Americans will pay for trial lawyers' opportunities. It is not a Patients' Bill of Rights so much as it is a lawyer's right to sue. At least 1.2 million Americans will lose their health insurance. We have heard that figure 1.2, 1.3. That figure is based upon very conservative estimates by the Congressional Budget

Office. Their estimate is that the McCain-Edwards-Kennedy bill will increase premiums by 4.2 percent.

The President in his Statement of Administration Policy said he believes they are overly conservative. I believe they are overly conservative. The impact is going to be far greater.

At least 1.2 million Americans will lose their health insurance at a time the number of uninsured has been increasing. The 43 million number goes up, and that is a huge number of Americans who are uninsured.

Perhaps that is what some want. Maybe some want to increase the uninsured with a separate agenda to come back with radical changes in a health care system that I believe is the envy of the world. The evidence is people from all over the world come here to get the best quality health care. Millions of Americans will lose their health insurance.

The average American family will pay at least $300 more in annual premiums. The Senate, in its wisdom, collectively and on a bipartisan basis, just passed a tax relief bill, only the third time since World War II in the sixties under President Kennedy, the eighties under President Reagan, and now under President George W. Bush we passed tax relief for the American people. We are going to give a rebate check. This $300 increase in the annual premium will quickly eat that up. It will consume that little bit of tax rebate we were able to give in the tax package this year.

Americans will pay $200 billion more in extra premium costs over 10 years. Over half of America's employers will increase health plan deductibles and copays. It is not only that we are going to have 1.2 million or more lose health coverage altogether, but those who are able to stay insured are going to find their copays will increase; they are going to find their premiums will increase; that those are going to be passed on; their deductibles are going to be higher; and then the result of this legislation will be thousands of new lawsuits clogging our already overcrowded courts.

This is often the case. If we have an unlimited, unbridled right to sue, the result will be that creative trial lawyers will find a way to get a case into court.

Our goal should not be to go to court. Our goal should be to ensure patients are protected, forgetting quality health care. We do not have to have a circumvention of the appeals process, the review process to assure that.

The gaping flaw in the Kennedy-McCain bill is that it allows thousands of new lawsuits to be filed in State court and Federal court without an exhaustion of the appeals process. Unlimited liability could bankrupt small businesses or force them to drop health coverage altogether.

Those are, in fact, some of my deep concerns about this legislation, and those concerns should drive us to amendments such as the one Senator BOND and I have proposed. The Hutchinson-Bond amendment provides 100-percent deductibility beginning next year, not in 2003, and will save small employers, self-employed individuals millions of dollars. There is no justification for us continuing to delay what we have recognized in this body on a bipartisan basis is an issue of equity.

The Wall Street Journal sometime back in one of their editorials wrote:

> In the 18th century, doctors believed they could cure patients by bleeding them with cuts or leeches. Modern equipment is politicians who want to improve American health care by unleashing the trial lawyers.

I note that not because anybody would be surprised that the Wall Street Journal editorial page would have this, but the analogy is not far off. My concern is we would pass a Patients' Bill of Rights. Ask the American people that broad question, Do you favor a Patients' Bill of Rights? and you will get an overwhelming yes. Probably three-quarters of Americans would say yes.

Who could be against rights? Who could be against patients? But it's different when asked, If you knew your employer would have to raise your copay, your premium, your deductible, are you still for that Patients' Bill of Rights? if you knew your employer might not be able to continue to provide health insurance coverage, are you still for that Patients' Bill of Rights?

My concern is we would pass a bill they say ''cures'' the problem of patients in health care plans with their rights not being protected, and the reality is we have made the malady worse. The problem we have created in exacerbating the problem of the uninsured is worse than the problem we are trying to address.

I believe the biggest hoax perpetrated in the course of the debate over the last couple of years on a Patients' Bill of Rights is that a bill such as the Kennedy-McCain bill covers all Americans. To those who have argued most States have enacted patient protection laws and we should provide proper deference to those State patient bills of rights, those States and situations are different. We have argued our proper responsibility is to address the ERISA plans, the self-insured plans that States cannot touch. States cannot provide protections for those. People in those plans are left unprotected unless we do something. The response on the other side has been, you are leaving millions out, you are not protecting them.

The great hoax has been to say that the Kennedy-McCain bill covers all Americans. It doesn't cover all Americans. It surely does not cover the 43 million Americans who do not have insurance today. They don't get a thing out of the Patients' Bill of Rights except less chance they will be able to receive health insurance.

I quoted the Wall Street Journal, and one might expect their sentiments on this subject. But listeners may be interested to know that last month the Washington Post wrote on this subject:

> Our instinct has been and remains that increasing access to the courts should be a last resort, that Congress should first try in this bill to create a credible and mainly medical appellate system short of the courts for adjudicating the denial of care. To the extent it can be avoided, it seems to us not in the national interest to have the practice of medicine governed by the fear of lawsuits. It will add to the cost of care, though how much is in question. It is not clear to us that it will add comparably to the quality. The higher the costs, the larger the number of uninsured.

From the Washington Post to the Wall Street Journal, they are right:

> The liability provisions in the Kennedy-McCain bill will result in thousands of new lawsuits, higher costs on premiums, higher costs on copay and deductibles for consumers, and millions more people in the ranks of the uninsured.

The Washington Post is right, we should have a remedy that is mainly a medical appellate system, short of the courts, for adjudicating denial of care. It is in the national interest to avoid having the practice of medicine governed by the fear of lawsuit.

They go on to say it will add to the cost. They are absolutely right.

Imagine—under the Kennedy-McCain bill one is allowed after 180 days, at the 181st day, to go straight to court. You are not required to appeal internally whatever the question is you are contesting—the decision of the insurance company to not provide coverage. Perhaps the insurance company says the contract is clear and that is not covered, or perhaps the insurance company does say it is not medically justified. As a patient and as an insuree, you object to that. You question that, but you don't bother to appeal it. And you wait. You don't use the internal appeals process, which most managed care companies have already established and which by law we would, under the Patients' Bill of Rights, establish. They never bother to go through the external appeals court, even though under the proposed bills that would be expedited. You would get quick care, a quick decision on the external appeals. They don't do that. Instead, they wait. And they wait.

After 180 days, a very creative, very enterprising lawyer talks to that patient and says: Haven't you just discovered that you were wronged? Without any requirement under this legislation to go through the appeals process, that individual, with his creative, enterprising lawyer, can go straight to court.

One would think if they were wronged, they would have a remedy, even after 6 months, a year, or 10 years, because there is no limit when that individual can file the lawsuit after disregarding the appeals process. One would think perhaps after that long length of time they could have a remedy.

As I have said before, studies indicate medical malpractice claims take an average of 16 months to file. Even after

the 6 months of waiting, on the 181st day the lawsuit is processed, you have another long period of time—on average, 16 months—to have the lawsuit filed. On average, it requires 25 months to resolve the lawsuit. That is another 2 years. And then after there is a decision made of a lawsuit, it requires on average another 5 years to receive payment. That is what we are doing in the Kennedy-McCain bill. In the open-ended lawsuit provision, we are in the end going to reward the process and the lawyers.

The tort system returns less than 50 cents on the dollar to the very people it is designed to help and less than 25 cents on the dollar for actual economic loss. Even if one figures 50 cents on the dollar, months, years, you file it, years more to get to court, decisions rendered, years more to collect the payment—what, I ask my colleagues, what does that have to do with quality health care? What does that have to do with ensuring that a patient is getting the best possible health care provision under their insurance policy? I suggest it has very little, if anything. The right to sue should exist. But it should only exist after the appeals process has been exhausted.

When we talk about this being an opportunity for trial lawyers, it is exactly that. It is the trial lawyers who are the big winners.

I offer this amendment today to address this access issue. There will be other amendments that will address more clearly the liability concerns I have expressed. Because the liability alone, we know, and the CBO says, it is the second leading component increasing costs in the Kennedy-McCain legislation. This is the big contributor to increased premium costs, the big contributor to loss of insurance by hundreds of thousands of Americans.

The amendment I have offered providing 100-percent deductibility helps address this access issue and the concern about the uninsured.

I reiterate, because I think it is very important as we look at the amendment and consider how important it is, who are the self-employed? Who are the people to whom we are trying to provide relief? We know there are a lot of them. According to the Employee Benefit Research Institute, there are 12.5 million self-employed individuals in this country and 3.1 million of those self-employed individuals are uninsured. That means they don't have a spouse who is employed somewhere with an insurance plan. It means they aren't working part-time. They are simply uninsured. They are unprotected.

That is almost one out of four in this pool of self-employed individuals. Nearly 70 percent of these individuals earn less than $50,000 annually. I think that is an important point to make because many think of self-employed and equate self-employed with business people, and they are usually. They think of those business people as being affluent, wealthy individuals. According to the Congressional Research Service, based on the 1998 current population survey, 70 percent of these self-employed individuals are hardly high income. They make less than $50,000 a year. So think about those who can't afford the insurance. Think about people who make less than $35,000 a year not receiving equal treatment for what they can deduct on their health care premiums and one out of four of them cannot afford to buy to really get the picture.

To understand the importance of this amendment, you have to look not just at the 3.1 million who are uninsured but you have to look at their family members. When you count the number of family members with self-employed family heads, we are now talking about 21.6 million Americans who would benefit from the Hutchinson-Bond amendment, including 6.4 million children. Now, of those 6.4 million children who are going to benefit because you get 100 percent deductibility, currently 1 million are uninsured.

So I ask my colleagues to think about 1 million children who are without insurance today whose parents would perhaps be able to purchase that insurance under the 100 percent deductibility provision. So I think it is critically important that be adopted.

Madam President, I have one correction to make in my remarks. I referred earlier to a cartoon that appeared in a Statewide newspaper. It was from the Don Rey Media, not the Democratic Gazette. I give a plug for the Gazette, but, in fact, the cartoon was in the Don Rey Media, and it did very well portray what faces us today. If you are paying $6,000 a year in premiums, and you are able to deduct 60 percent of your premiums, that is $3,600, and you will have a savings of $972. If this amendment that is pending before the Senate right now passes, instead of $972, 100 percent deductibility will turn that into $1,620 and that will be an additional savings of $648. At least for the self-employed, that will offset the additional costs that the Kennedy-McCain bill will have upon premiums. So it is worth supporting from the standpoint that it has been a battle fought for years. It has been something recognized for a long time; that we have unfairness; we have a disparity, an inequity in the Tax Code.

Senator BOND, to his credit, and Senator NICKLES worked and worked to clip away at that disparity, and we got 60 percent of the way there. There is no reason, there is no excuse for us not to immediately go to the 100 percent deductibility and in so doing save millions of dollars for those who are out there trying to keep this economy going. I know that there has been broad support for this concept in the past. I believe there will be broad support as this amendment is debated. I talked to a number of my colleagues on the floor about the importance of this amendment.

I believe that access is going to be the center of debate as we go through the Kennedy-McCain bill. If we cannot address the access issue, if we cannot address a wide-open lawsuit issue and put some real restraints in what is currently an unbridled prospect for thousands of new lawsuits, then we will have done a disservice and we really have been disingenuous with the American people. We will have passed a bill saying it is a Patients' Bill of Rights without a real understanding by the American people of what the impact is going to be on their day-to-day lives. Nothing illustrates that more than the kind of push polls that have been done in which the questions have been posed in terms of raising premiums, raising the cost of health insurance, the possibility of losing health insurance and how that affects attitude towards a Patients' Bill of Rights.

So access to emergency rooms, I will agree on that. The President has supported that. The McCain-Kennedy bill has emergency room access provisions. The Nickles bill last year had emergency room access provisions. The Frist legislation covers that concern.

Many of the stories that have been portrayed in this Chamber have dealt with the horrors of those who were denied immediate access to an emergency room. We have heard examples about tragedies that have occurred because of that. These tragedies would be addressed in any one of the patients' bill of rights. That is not the core of the debate before us. Access to pediatricians, access to OB/GYNs—the President listed those commonly agreed upon patient protection provisions.

That is not what is at issue. That is not what is at debate in this Chamber. What is at debate is not access to ERs, access to pediatricians or OB/GYNs. The debate is access to health insurance.

I am determined, and I know my colleagues are as well, that we not lose focus of what an ill-conceived patients' bill of rights is, which is the Kennedy-McCain bill as it is currently constructed, and what it would do to access to health insurance. We are going to keep the focus upon not only the 43 million who do not have it now but the millions more who would lose their health insurance were this bill to pass in its current form.

My colleague from Oklahoma pointed out some of the provisions in this Kennedy-McCain bill that address issues that come before the Finance Committee. The Senator from South Carolina expressed that, while being a previous cosponsor of the 100 percent deductibility, he could not support this amendment because of the jurisdictional issue. Perhaps there are other Senators who share that concern. So I want to remind my colleagues on both sides of the aisle, those who are members of the HELP Committee, as I am, and those who are members of the Finance Committee, that there are a number of provisions within the jurisdiction of the Finance Committee that

are already in the bill. The provisions were never debated before the Finance Committee, but they are in the bill. It is kind of disingenuous when you have something that is going to benefit taxpayers, going to provide full deductibility for the self-employed, to say we don't want that in the bill when there are already a horde of provisions in the bill that come under the jurisdiction of the Finance Committee.

I am sure at some point there is going to be an explanation as to why custom user fees is in this Patients' Bill of Rights, why the custom user fees, Medicare payment shifts, and Social Security transfers are included. We talk a lot about the sanctity of the Social Security trust fund. There are some issues regarding Social Security. All of those come under the jurisdiction of the Finance Committee and were never debated by the committee. There were no witnesses, no hearings, no people to come in and explain why they are going to be in this hugely important bill, but they are there.

And so for those who may be concerned that we have a provision that would normally go to the Finance Committee, I say, well, let's take a look at all of these. At least this one is going to increase access, not decrease it; at least this one is going to ensure that more people are going to buy more health insurance and those million people who are currently in households in which the head of the household is self-employed that is not eligible for the 100 percent deductibility is going to be addressed.

Now, the bill reduces revenues. I have alluded to that. And some may question about having those kinds of provisions in the bill. In fact, the McCain-Kennedy bill reduces the Social Security tax revenues by nearly $7 billion over 10 years. So it is going to have a pretty significant impact upon revenues—$7 billion in Social Security. That is the estimated impact of passing this bill. If you pass this bill, that is the impact it will have upon payments into the Social Security System. It ought to concern us if it is going to have that kind of impact upon employment in this country.

So we have a bill that we have to work on. We are going to have a lot of amendments in the days to come, and we have a good one to start with, one that will provide that 100 percent deductibility and increase accessibility.

I see my colleague from the State of Kentucky has come to the floor, and I know he has expressed interest in this amendment. He has been a long-time supporter of small business and of providing 100 percent deductibility as quickly as is possible for these who have been treated unfairly in our Tax Code. He has expressed interest not only in supporting it but speaking in behalf of the amendment. I yield for the Senator from Kentucky.

The PRESIDING OFFICER. The Senator from Kentucky is recognized.

Mr. BUNNING. Madam President, first of all, my good friend from Arkansas has been a champion of full deductibility for health care for the uninsured and the self-employed for a long time. I also supported that in the House of Representatives on the Ways and Means Committee, and since I have arrived here in the Senate.

Even more important than just the deductibility for the self-employed, I would like to talk generally on the Patients' Bill of Rights and the two competing bills we have before us today.

Rarely is there a piece of legislation that so directly affects the American people's health and well-being as the debate we are having right now.

It's important right at the start to point out that every Senator here agrees about one thing—patients come first.

We all have the same goals here—making sure that patients get the care they need without interference from their insurers and without driving up costs.

But the competing bills before us take two different approaches.

In writing a Patients' Bill of Rights, we're trying to strike a balance, and the Kennedy-McCain bill fails that test.

As we debate this health care bill, it's important to keep some perspective and to remember how we got to this point because recent congressional health care debates set the stage for the legislation before us today.

Over the past decade, Congress has wrestled with health care insurance legislation a number of times.

In the late 1980s, there was the Medicare catastrophic bill that we passed and then the next year we repealed it.

There was the Clinton health care bill that failed. Then we worked on the Kassebaum portability bill.

Now the latest version of the fight comes on the Patients' Bill of Rights.

Some of my colleagues on the other side of the aisle now say they're interested in ''improving'' the private employer-provided health care system that we currently enjoy in this country.

But I have to admit that I am more than a little bit skeptical about that. Many of my friends who now claim to want to improve our current system were just a few years ago trying to get rid of it altogether with the Clinton bill.

And many of them still openly admit that their ultimate goal is single-payor, government-run health care—a Washington-mandated, one-size-fits-all health care system.

Now many of us have the same fear that the Kennedy-McCain bill is just the first step down the regulatory path to socialized medicine.

We still remember the nightmare of the Clinton health care bill.

Many of us thought that was a trojan horse that was set up on purpose to fail in order to help make it easier for many of my Democrat friends to reach their final goal—to step in with a government-run, single payor health care program.

The words surrounding the debate about that bill sounded good, just like some of the rhetoric we hear today about Kennedy-McCain.

The Clinton health bill was going to be the best thing since sliced bread. It was going to provide all Americans access to health care at an affordable cost.

But it was a bad bill. It was drafted behind closed doors by a secret task force. There were no hearings. No input from the public, until a federal court ordered it.

In fact, the reason that they were hiding it for so long was that it was just another old-fashioned liberal social program in disguise.

Now we are hearing the claims that the Kennedy-McCain bill is going to do all of these great things for patients—guaranteed treatments, clinical trials for cancer patients, access to specialists.

But the bill before us today hasn't ever been before a Senate committee for a hearing, and it's been two years since the Senate last debated it.

In fact, the latest version of the Kennedy-McCain bill was only introduced last Thursday night. Now we're being told that we have to pass it immediately and that the Democrats think it's so good that it doesn't even need to be amended.

I think I have heard this song before.

Thanks to the good judgment of Congress in 1994, we were able to defeat a national health insurance proposal.

But today I am afraid that many of my friends who support socialized medicine are still trying to reach their goal, just by different means.

So I think we need to take a long hard look at this bill so that every Senator understands exactly what's in it.

From what I have seen so far, it is not very good.

There are a number of problems with the bill.

First we know Kennedy-McCain is going to raise costs. The neutral experts at the Congressional Budget Office tell us its going to increase costs by 4.2 percent above inflation.

Health care experts tell us that for every 1 percent increase in costs, 300,000 Americans will lose their health coverage.

That means that if Kennedy-McCain passes, over 1.2 million Americans are going to lose their health insurance.

I just do no understand why those who support this bill, who usually argue that we need to cover more of the uninsured and hold the line on costs, now are pushing so hard for a bill that does just the opposite.

Another troubling part of the Kennedy-McCain bill is its reliance on lawsuits as a means to promote better health care.

It is just common sense: lawsuits don't lead to better medical care. Getting the lawyers involved isn't going to drive down costs, or deliver care faster.

I can understand in outrageous situations that the threat of a lawsuit

might be needed as a last report. But in Kennedy-McCain, they are the first option.

In fact, the most troubling part about Kennedy-McCain is that it could in fact lead to lawsuits by employees against employers over health coverage. That is the last thing we need and could eventually lead to the end of our current employer-based health insurance system.

I know that sounds drastic, but it is just common sense.

If any employee can sue their employer because they are unhappy with their health coverage, the employer is going to do one of two things: drop the coverage and simply give the employee cash to buy their own insurance—or worse just drop the benefit altogether.

Recent news reports tell us what happens to health care when lawsuits flourish. For instance, in Mississippi, where there has recently been a dramatic increase in forum shopping by plaintiffs' lawyers, 44 insurers have left the state.

Recent studies by the General Accounting Office show that the average medical malpractice claim takes 33 months to resolve. Most patients can't wait that long. I don't see how making it easier for them to sue is going to help anyone except the lawyers.

Usually here in Congress we try to make laws simpler, and to cut down on lawsuits, not to encourage more. Making it easier to sue might sound good to those who are angry about their health care, but it's only a knee-jerk, feel-good reaction that isn't going to help anybody get medical care any faster.

Finally, if Kennedy-McCain is so good, why doesn't it apply to everyone? Millions of Americans aren't covered by it. Medicare and Medicaid recipients, and all of those who get coverage from their unions through collective bargaining agreements, they are not covered.

While I admit that I don't want Kennedy-McCain to pass, I have to admit that I am surprised that my friends who support the bill, who tell us what a good effort it is, don't want it to apply to every single American.

Instead of the Kennedy-McCain bill, I hope my colleagues take a good long, hard look at the Breaux-Frist proposal. The heart of Breaux-Frist is a new impartial medical review to make sure that patients get the care they need quickly, without getting bogged down in courts and lawsuits. Patients are guaranteed access to independent medical review to ensure that doctors, not HMOs, are making medical decisions. Breaux-Frist gives States flexibility. While providing new Federal rights. The legislation stays out of the way of States that have already made progress in protecting patients. It creates a floor, not a ceiling, when it comes to protecting patients' rights.

Breaux-Frist also guarantees access to care through comprehensive patient protections. It guarantees emergency room coverage under the prudent layperson standard, and direct access to OB–GYNs for women and pediatricians for children. Best of all, Breaux-Frist ensures that employers are not going to be held liable for health decisions. And Breaux-Frist covers everyone—all 170 million Americans who get their coverage through private health plans.

For health plans that fail to comply with these independent reviews, patients will be able, as a last resort, to sue in Federal court. It provides a clear-cut, sensible process that will help patients get care and hold HMOs accountable.

Most importantly, we know that the President will sign Breaux-Frist into law. He won't sign Kennedy-McCain. If the supporters of Kennedy-McCain really want to pass a bill that becomes law, they will help us to amend it and improve it. If they do not, we will just continue to talk in Congress without getting anything done.

I would like to conclude by telling my colleagues about what will happen if we end up passing Kennedy-McCain. Seven years ago, in Kentucky, we passed a version of the Clinton health bill. It promised better care to patients through increased regulation and lawsuits. But guess what happened. Health care in Kentucky went downhill. For starters, all of the private insurers left the State. We used to have 60. After the Clinton-Lite bill passed, we had two. The number of uninsured Kentuckians rose. Costs increased. Medical care became more expensive and harder to get. Ever since then we have been trying to fix our health care laws, and we have managed to get back to five different insurers who will now offer coverage in Kentucky.

Employer-provided coverage in Kentucky nearly collapsed. Passing McCain-Kennedy could be the first step down this road for the Nation, and I can tell my friends it is a path we don't want to take.

Republicans want a bill. Democrats want a bill. If we work together, I think we can get one. But Kennedy-McCain is not the answer. It has to be changed or nothing else is going to change. And the patients will lose.

Madam President, I yield back my time.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I see my friend from Arizona is in the Chamber.

Does the Senator wish to seek recognition?

Mr. MCCAIN. For about a minute.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. MCCAIN. Madam President, I understand the amendment that is being proposed. It contains provisions, as I understand it, that were dropped in conference on the tax bill we passed not long ago. I think the Senator from Texas would confirm that. Is that right?

Mr. GRAMM. I do not know. I was trying to find out.

Mr. MCCAIN. It was, I believe, not accepted in conference. Obviously, we would like to do everything we can to encourage employers and employees to be able to obtain health care plans.

What I am concerned about is the possibility that this would open up other tax provisions that might be added to the bill. Also, there is the blue slip problem that would apply because it is a revenue issue that does not originate in the other body. Again, I think the Senator from Texas would recognize that is a problem that we face in this amendment.

So I wonder if the proponents of the amendment would agree to a unanimous consent request, which I will state now and explain as follows: That the time between now and 5:30 be equally divided between Senator HUTCHINSON and Senator KENNEDY, or their designees, for debate on the pending amendment; that no second-degree amendments be in order to the amendment; and that at 5:30 the amendment be agreed to, and that there be no further revenue or blue slip material amendments in order to this bill; further, that when S. 1052 is read a third time, it be laid aside and the Senate immediately turn to the consideration of Calendar No. 69, H.R. 10; that all after the enacting clause be stricken, and the text of S. 1052 be substituted in lieu thereof; the bill be read a third time, and the Senate proceed to vote on final passage of the bill; that the Senate insist on its amendment, request a conference with the House, and the Chair be authorized to appoint conferees.

What I mean by this unanimous consent request is that in order to avoid the so-called ''blue slip'' problem, that this amendment would be adopted, but when the bill is laid aside for the first time, we would take up a House revenue bill which is pending here in the Senate on the calendar, and add that provision to the bill, thereby avoiding the problem of it being negated.

I note the Senator from Oklahoma is in the Chamber as well. I would be glad to discuss this unanimous consent request with my colleagues to see if they would give it some consideration, so we could discuss getting it done.

Mr. GREGG. Reserving the right to object.

Mr. GRAMM. Reserving the right to object.

The PRESIDING OFFICER. Is the Senator propounding a unanimous consent request?

Mr. MCCAIN. I ask unanimous consent.

The PRESIDING OFFICER. Is there objection?

Mr. GRAMM. Madam President, reserving the right to object, let me first say that obviously Members can only answer for themselves.

I would have no objection to trying to deal with a potential blue slip problem through unanimous consent. The House bill will almost certainly contain a provision related to access to

health care, and so the two bills would be conformable in that way. Nor do I have any concern about taking up a House measure which would be a further guarantee against the blue slip problem. If we put in a quorum call and worked this out or had debate while we worked it out, all that could be worked out.

Where I think we might run into problems is that there are two problems in terms of access to health care. One is the self-employed who have to pay both parts of their health care coverage. The other is very low income people who don't get health insurance through their jobs. You then have a very small—and I know the Senator is aware—you have a very small revenue component in medical savings accounts. I would not want to limit our ability to at least debate the other two parts of the problem. But within the constraints of those problems, I think there might be room to debate it. I don't want to preclude our ability to offer, for example, a medical savings account amendment because I think that is very important as part of this access.

I understand this amendment. I very strongly support it. I want to be sure we have a chance, if we fix it for the self-employed, that we fix it for very low income people who don't get health insurance through their jobs. I can assure the Senator that for my part—and I am sure on behalf of every Republican—we are not trying to create a technical ''gotcha'' problem here. We can work together to fix that problem, if that would make this amendment more acceptable.

The PRESIDING OFFICER (Mr. NELSON of Florida). The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I believe the bill already has a blue slip problem. There is already a tax increase in the bill, section 502, that extends customs user fees from the year 2003 to the year 2011. That is blue slip material. It is already there.

Mr. MCCAIN. I don't agree. I don't agree. We will be glad to debate that and have a parliamentary decision on it.

Mr. NICKLES. I am informing my colleague, there are revenue measures in the bill right now. I don't think whether there is an additional amendment or not would have any additional impact on blue slip. I am perfectly willing, as the Senator from Texas said, to set up a way of taking up a House-passed bill and substituting the entire text of whatever we pass to avoid that. I am happy to cooperate in doing that at some point. I will be happy to work with my friend from Arizona to do that.

Mr. MCCAIN. I thank the Senators.

I guess the Senator from New Hampshire had also a reservation.

Mr. GREGG. The point I was concerned about was, there are parts of this unanimous consent with which I could agree, but the two points the Senator from Texas and the Senator from Oklahoma have made are equally of concern to me. Maybe there is a way to work this out, but in its present form I have a serious reservation about it.

The PRESIDING OFFICER. Is there objection?

Mr. GRAMM. Mr. President, I would object. I would like to also ask that our staffs sit down together to see if we can work these problems out. I reiterate, we are not trying to create a technical problem here. We are worried about people losing their health insurance. We want to be sure we are doing other things to promote it. If the Senator is willing to work with us, we will try to work out the problem he has raised to everybody's satisfaction, and then perhaps later today or tomorrow we could do a unanimous consent request on a bipartisan basis to which we could agree.

The PRESIDING OFFICER. Objection is heard.

The Senator from Arizona retains the floor.

Mr. MCCAIN. Mr. President, I thank my friends from Texas as well as from Oklahoma and New Hampshire. We would like to sit down and see if we can work this out. Whether the Senator from Texas intends there to be a problem or not, there is a problem on passage of this amendment. So I appreciate the intentions of all involved here, but the fact is, there will be a technical problem because of raising revenue. I would like to work that out, and we will sit down and begin conversations about it.

Mr. GREGG. If the Senator will yield on that point.

Mr. MCCAIN. I am glad to yield.

Mr. GREGG. I do believe that problem can be worked out. Actually, the language for working it out is in this unanimous consent request. It is just that the unanimous consent request goes significantly further than that. That is where I think we have to sit down and see if we can't reach some accommodation.

Mr. MCCAIN. I understand. I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, may I proceed for 30 seconds?

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

Mr. KENNEDY. Mr. President, in response to the Senator from Oklahoma, we have been assured, from the Budget Committee, the Finance Committee, and the Ways and Means Committee, that there is no blue slip problem. Anyone can raise this and challenge those authorities, and maybe they will. At least we want to give assurances to the membership that we did anticipate this issue. We have received those assurances from the leaders. I believe we received them in a bipartisan way as well.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, we have been on this amendment now for 2 hours. The debate has been good. We are arriving at a point where we might be able to offer a unanimous consent agreement as to when we would terminate this debate.

I say to everyone: We do not intend to arbitrarily cut off debate on any amendments. But we should also understand that it is up to the people who oppose the Patients' Bill of Rights to offer the amendments they believe will improve the bill. We have today; that includes the evening hours. We have part of the day tomorrow. As had been announced by the two leaders some time ago, there will be no activity in the Senate in the way of votes on Monday. There could be some debate taking place. We have Tuesday, Wednesday, and Thursday to finish the bill, if we are going to go to the Fourth of July recess as has been planned. That is to begin on Friday.

Again, Senator DASCHLE, the majority leader, has said if we do not finish this Thursday night, we are going to work Friday, Saturday, Sunday, Monday, Tuesday, take Wednesday off, which is the Fourth of July, and come back on Thursday and begin the bill again. We are going to finish.

Mr. GREGG. Will the Senator yield?

Mr. REID. I am happy to yield.

Mr. GREGG. I believe there is a unanimous consent to which this side is agreeable which has been circulated from your side, and we are willing to proceed with that at this time.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I ask unanimous consent that the time on the pending amendment prior to a vote in relation to the amendment at 5:30 be divided as follows: Senator KENNEDY or his designee to control 30 minutes of debate; Senator HUTCHINSON or his designee to control the remaining time, including the last 15 minutes prior to the vote; that at 5:30 the Senate vote in relation to the Hutchinson amendment; that upon completion of the vote at 5:30, Senator MCCAIN be recognized to offer a sense-of-the-Senate amendment regarding clinical trials; the amendment be debated this evening; and then when the Senate resumes consideration of the bill tomorrow at 9:30, the time prior to 11 a.m. be divided between Senator MCCAIN and Senator GREGG or their designees; and then a vote in relation to the McCain amendment occur at 11 a.m.; and then following the disposition of the McCain amendment, Senator GREGG or his designee be recognized to offer an amendment; that no second-degree amendments be in order to either the Hutchinson or McCain amendments.

The PRESIDING OFFICER. Is there objection?

Mr. NICKLES. Reserving the right to object.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. It is not my intention to object. I haven't seen the McCain

amendment. Would it be possible for us to get a copy of that amendment?

Mr. KENNEDY. Yes. While the Senator was asking, we never received the Hutchinson amendment until it was offered either. As we proceed, what we would like to try to do, for the benefit of the Members, is to at least have the two or three amendments on either side so that the Members are familiar with the material and would have knowledge as to what those amendments are. I think that might save a good deal of time in terms of the explanation of the amendments and the disposition of them. We will make every effort to make those available. And we hope—if I may have the Senator's attention—that that would be reciprocal and we might have the amendment you also intend to offer tomorrow.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Illinois is recognized.

Mr. DURBIN. I seek recognition under Senator KENNEDY's time.

Mr. KENNEDY. I yield 10 minutes to the Senator.

Mr. DURBIN. Mr. President, I stand in opposition to the amendment offered by Senators HUTCHINSON and BOND. At the outset, this is an issue I have worked on as long as I have been in Congress—extending the tax deductibility of health insurance premiums for self-employed people in this country.

What we face in this country today is a terrible situation where those in small business and family farms cannot deduct their health insurance premiums as those who work for major corporations can. At a time when more and more people are losing health insurance, this is certainly a policy change that needs to take place.

Yet I rise today in opposition to this amendment. Let me tell you why I do. Only a month ago on this floor of the Senate, I offered an amendment to the tax bill which would have provided the self-employed with a full 100-percent tax deduction. That was a month ago when we were considering a tax bill where we were providing benefits to individuals and families.

What happened to my amendment? Well, my amendment was accepted by my Republican colleagues. They put it in the bill in the Senate, and they killed it in the conference. That is right. They said they accepted it on the floor, and when it went to conference committee on the tax bill, they yanked it out and eliminated it. It is the same provision being offered today on the Republican side as part of this bill that was eliminated by the Republican majority in the conference committee on this tax bill. The tax bill had $1.3 trillion in benefits it could provide over a 10-year period of time, and the Republican majority could not find $2 billion to provide the very tax deduction they are asking for today.

It raises an important question. If this issue was important enough for us to include it in the tax bill, why did they eliminate it when they went to conference committee? Second, why is it being offered today?

The second question, I think, bears some exposition here. That is obvious. This is a Patients' Bill of Rights. This is a bill which the health insurance industry opposes. They oppose it because it will eat into their profits and instead is going to empower families and businesses and individuals across America, when it comes to their health insurance, to finally stand up and say that doctors should make medical decisions, not insurance companies.

On the Republican side, they are offering killer amendments in an effort to scuttle and stop this bill. They know that if they can put a tax amendment on this bill, it is over. So they come in and say they want to offer tax deductibility for the self-employed people when it comes to health insurance premiums—the very position they eliminated when they had a chance to pass it a few weeks ago on the tax bill.

It wasn't good enough for the tax bill, but it is the very first thing they want to offer when it comes to the Patients' Bill of Rights. Excuse me if I question whether or not their strategy reflects their sincerity. If they were sincere about helping self-employed people, they would have included it in a $1.3 trillion tax bill and not put it in the Patients' Bill of Rights in an effort to kill this important legislation.

We have waited 5 years for this bill. We have worked out a bipartisan compromise with Senator JOHN MCCAIN, Senator JOHN EDWARDS of North Carolina and, of course, Senator KENNEDY from Massachusetts, who has been a leader on this issue.

The other side, the opponents, are desperate to kill this bill. They understand that every health professional organization in America that has taken a position has supported the bipartisan legislation we have on the floor. They are desperate to find a strategy and a tactic to stop the bill, nevertheless.

The health insurance industry wants the bill to die, and now they want to kill it with kindness—the kindness of a tax break for the self-employed. Where was that kindness a month ago when the conference committee met on the tax bill? It wasn't there. You could not put it in the bill that really counted. You want to put it on this bill to put an end to the debate.

We are not going to fall for that. Those who have supported this provision throughout our careers are not going to let you kill the Patients' Bill of Rights by putting on a provision which you rejected in your own tax bill just a few weeks ago. I urge my colleagues to join me in continuing to fight for the deductibility of health insurance premiums for the self-employed, but don't do it at the expense of this important legislation that gives individuals and families and businesses across America the protection they deserve when it comes to their health insurance.

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

Mr. DURBIN. Yes.

Mr. REID. I came to Washington with the Senator from Illinois. I can't remember a session of Congress where he didn't promote this issue. The Senator's fingerprints are all over this legislation. The Senator has certainly portrayed what is happening with this bill. They are taking the Senator's amendment and putting their name on it and trying to kill this bill. I am anxious to see what the next one is going to be. It will be someone else's amendment that they have killed in the past to try to kill this Patients' Bill of Rights.

The Senator from Illinois has said it so well. Here is legislation that has been yours for almost 20 years. It was put in a tax bill, and now I read in the paper it is not $1.3 trillion, it is $1.8 trillion—and for a speck of that, they eliminated the Senator's provision. I don't know if they planned that, to come back and do it here, or if it is something they picked up recently. But I know the Senator from Illinois will be forced to vote against his own amendment. I have always joined him in his efforts to pass the legislation. I will join the Senator from Illinois because we cannot fall for, in my words, this cheap trick.

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

Mr. DURBIN. I am happy to yield.

Mr. KENNEDY. How much time does he have left?

The PRESIDING OFFICER. The Senator has 3 minutes 40 seconds remaining.

Mr. KENNEDY. Does the Senator not find this somewhat disingenuous that the administration had made the recommendation on the Durbin amendment for the business community, for the self-employed, and these Republicans dropped it, put it aside; they didn't make it a priority for their tax break? The administration came up with $60 billion to try to help the uncovered with insurance, and they dropped that. And now two of the principal reasons they give from this side are that they are not taking care of business and they are not taking care of the uninsured. I mean, if this was such a big priority on their side, why didn't they fight for it when they had the opportunity? Does that not lead one to believe that rather than being serious about getting these achievements and providing some relief, they basically want to sink this bill?

Mr. DURBIN. The Senator from Massachusetts is correct. The Republicans and those supporting their positions cannot come to this floor and argue, I think, with a straight face that American families don't need protection when it comes to their own health insurance. They are not standing here and arguing that, really, health insurance clerks should make decisions, not doctors.

So they have come in with a new strategy. A month ago, this idea of providing the deductibility of health insurance premiums for the self-employed was good enough to adopt on the Senate floor and kill in conference on their tax bill. Now they are coming back and saying that really is the highest priority. We have to go back to that old argument, to that old position. Well, I think people can see through it.

You had your chance, you had your tax bill. This was the bill that was supposed to help families across America. We know what happened. Forty percent of all the benefits in that tax bill went to people making over $300,000 a year. Instead of finding even $2 billion out of $1.8 trillion to help those small businesses and family farmers, no, the highest priority was the wealthiest 1 percent of America. Well, that was your decision. That was your tax bill. I voted against it. I will vote against it again if you come back with it.

Instead, let's vote for something and say that after 5 years we are going to pass a bipartisan bill that for the first time will hold health insurance companies accountable for their actions like every other business in America. I know that is a dagger in the heart of the health insurance industry. They want to continue to be a special privileged class that never has to answer when they make decisions which deny basic medical treatment to families and individuals. Those days are numbered.

I urge my colleagues in the Senate to reject this amendment for what it is. This is an effort to derail an important piece of legislation. Let us stick with and support the Patients' Bill of Rights. Let us not fall for this ploy.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas is recognized.

Mr. HUTCHINSON. Boy, I have to smile. I am sincere about this, and I resent it being portrayed as, I believe, a ''cheap trick.'' It was called a ploy, an effort to derail. It is none of that. It is a sincere concern about those who are self-employed and who do not get equal treatment. It is a sincere concern that this legislation does not empower anybody but trial lawyers, and that the big issue in this whole debate is access.

I am sincerely trying to address an issue about which I have been concerned, and I know the Senator from Illinois has, but it is no effort to derail. If I had been on the conference committee, I assure the Senator from Illinois I would have fought as hard as I could have with every fiber of my being to ensure this very important provision was included in the tax bill. Unfortunately, I was not on the tax conference committee, and so my alternative was to come to this Chamber and try to do the right thing. I assure the Senator from Illinois that is what I am trying to do.

I also remind him that every Patients' Bill of Rights that has ever passed the House of Representatives has included tax incentives for health care. Every Patients' Bill of Rights that has ever passed the Senate has included tax incentives for health care. The bill the House of Representatives is likely to pass within the next few weeks will undoubtedly, will with a certainty contain tax access provisions, as it should.

If the Senate does not adopt its own tax incentives and access provisions, we will be at a distinct disadvantage as we go into the House conference on this legislation.

If the Senator wants to face the American people and explain that he opposed this on the basis of a blue slip problem, please, I am sure, they are going to appreciate that explanation. This is something that has had broad support in the past. It is without question something we should do. We have an opportunity to do it, and we should.

I yield to the distinguished Senator from Maine who has been such an advocate for small business in this country and has fought hard for full deductibility for the self-employed.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I commend my friend and colleague from Arkansas for offering this important amendment. It will allow self-employed Americans to deduct the full amount of their health insurance premiums.

As we proceed with consideration of legislation to protect patients' rights, legislation I believe every Member of this body, in one form or another, wants to see passed, we should also be considering ways to expand access to health insurance coverage for millions more Americans by making health insurance more affordable.

We know that at a time of almost unprecedented prosperity in this country, we have 43 million Americans who lack health insurance. Just think of the impact of an economic downturn and escalating increases in health insurance costs. It will only expand the number of uninsured or underinsured Americans. That is why I support the amendment that has been offered by the Senator from Arkansas.

As President Clinton's own Advisory Commission on Consumer Protection and Quality noted in its report: ''Costs matter—health coverage is the best consumer protection.''

Simply put, the biggest single obstacle to expanded health care coverage in the United States is costs. While American employers everywhere are facing huge hikes in their health insurance premiums, these rising costs are particularly problematic for small businesses, and they are most problematic for self-employed individuals who have to purchase health insurance on their own without a subsidy from an employer and without the benefit of a group health plan rate.

Since most Americans get their health insurance through the workplace, it is a common assumption that people without health insurance are unemployed, but the fact is that most uninsured Americans are members of families with at least one full-time worker. Eighty-five percent of Americans who do not have health insurance live in a family with a full-time worker. Most of these uninsured workers are self-employed or they work for very small businesses that simply cannot afford to provide health insurance as much as they would like.

Our amendment will help make health insurance more affordable for these Americans by allowing those who are self-employed to deduct 100 percent of the cost of their health insurance premiums. Since some 35 million Americans are in families headed by self-employed individuals, this will be of enormous help to them. Five million of those 35 million are uninsured.

Establishing parity in the tax treatment of health insurance costs between self-employed individuals and those working for large businesses is also a matter of equity. I have never thought it was fair that a corporation can deduct 100 percent of its share of the health insurance premiums that it pays for its employees, but a person who works for himself or herself can only deduct a portion of that cost.

This is a matter of equity, but it would also help to reduce the number of uninsured but working Americans. Our amendment will help make health insurance more affordable for the 82,000 people in my home State of Maine who are self-employed. They include our lobstermen, fishermen, farmers, hairdressers, electricians, plumbers, and the owners of many of the small shops that dot communities throughout our State.

We are a State of self-reliant people. We are a State where there is a large number of self-employed, and they deserve to deduct the cost of their health insurance premium just as a large corporation can write off that cost.

This is a particularly important amendment when we are looking at a bill that by every estimate is going to drive up the cost of health insurance. This is just a modest effort to provide some assistance to help offset the escalation in health insurance rates that this bill, unfortunately, will produce. This is a reasonable amendment. It deserves bipartisan support.

Finally, I am a bit puzzled by some of the statements that have been made by those on the other side of the aisle. During consideration of the budget resolution earlier this year, I offered an amendment to make sure we set aside funds in the budget resolution to provide for 100-percent deductibility for health insurance for the self-employed and also to help our small businesses that are struggling with the cost of health insurance by giving them a tax credit.

That amendment was opposed by my colleagues on the other side of the aisle. Had it been accepted—it was narrowly defeated by only one vote—we

would have had a better chance of holding those important provisions in the tax bill when we went to conference, but it was opposed by my friends from the other side of the aisle.

I find it ironic to hear today the argument that we should have done it earlier, we should have done it on a different bill when, in fact, our attempts to do so were defeated during the course of the budget resolution.

This is an excellent amendment. I am puzzled why there would be any opposition to it. Surely we ought to be able to agree that self-employed individuals, those hard-working men and women across America, should be able to deduct the full cost of their health insurance. It is the right policy, it is the fair policy, and it would help expand access to needed health insurance for millions of American families. I hope there will be a strong bipartisan vote for this very important amendment.

Again, I commend my friend from Arkansas for his leadership in bringing forth this very important amendment on this bill.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, I thank the distinguished Senator from Maine for her excellent statement, for her cosponsorship of this amendment, for her leadership in advocacy for small business in this country.

I now yield to the Senator from New Hampshire for such time as he might need.

Mr. SMITH of New Hampshire. Mr. President, I support my colleagues' amendment wholeheartedly and I ask unanimous consent my name be added as an original cosponsor.

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

Mr. SMITH of New Hampshire. I compliment my colleague from Maine for the eloquent statement she made regarding those independent business people who do not have the fallback or the luxury of the assets of the giant corporation. There are thousands in Maine and thousands in our neighboring State of New Hampshire. It is hard to see them without the ability to have the 100-percent deduction. It is a struggle to provide those benefits. They do provide them. In spite of the fact they don't have the deductibility, they still provide insurance. It is a tremendous burden.

I hope our colleagues will see how important this amendment is.

I rise today to make a few general comments about health care in America and about this legislation specifically as we move forward in this debate. We have gone full circle on the health care debate. We started in the early 1990s with an attempt to nationalize all health care in America, which would have been a disaster. We then swung over to HMOs, and now we are back somewhere in the middle. This bill is now moving back toward the national trend.

We have a vision for America. This debate is about what vision is accepted. Is the vision you accept one of government control of health care? One of government control of who your doctor is? One of government control of who has access to health care and who does not?

Talk to some of our friends to the north in Canada and ask them how that triple or quadruple-tiered system works there.

The other vision is what I believe our country stands for. That is a vision of America of limited government, an America of individual freedom and choice and personal responsibility. These are the principles that helped make America the greatest Nation in history. When we talk about these principles in other areas—whether it be regarding business or any area regarding individual responsibility where government does not take a peek at your private life—one cannot isolate health care. We have to say health care is very much a part of the whole concept of America of individual freedom, personal responsibility, and choice.

Access to affordable, quality health care is an issue, a health issue that we as a government and society should promote and encourage. It is a shame the Senator from Arkansas has to have an amendment like this. It should be part of the Tax Code to begin with.

We achieve this access to affordable health care using the strengths of our system, not accenting weaknesses. The strength of our system is free market, quality care, consumer choice. All Members agree we need health care reform. The question is, What health care reform? The question is, How do we reach this goal?

I ask my colleagues, is increased regulation more government control over your life? If it is a problem with the HMOs over what doctor to see or over a health procedure to be used, which is a legitimate concern, how would you like the Federal Government making those decisions? How would you like to deal with the bureaucracy of the Federal Government, as constituents have to deal with, calling each day asking to please help them get the Social Security that, after the Government declared them dead 2 months ago, they have not received for 2 months?

Is that who you want to control your access to health care? Is that who you want to go through for a decision on your medical condition, or to see a doctor? Do you want the lawyers in America to run the health care system? That is what is happening in this bill. The trial lawyers will run it.

There are no comments made about the trial lawyers on this side of the aisle. We know the reason: The American people do not want a government-run health care system. We want reforms. We want access to our doctors. We want doctors and patients to make the decisions. That is what we want. We don't want anybody in between. There should not be anybody in between. To have the Federal Government in there is a serious error.

The question should be, Should patients have recourse if they are harmed by a decision made by their HMO? Of course they should. Better yet, let's have a procedure set up so there is nobody getting in the way to begin with, so that the doctor and the patient make the decision about which medical procedure should be used.

I urge both sides to put aside the gamesmanship and partisan rhetoric and work toward real patient protection. We all know this is about politics. We know the political argument: Bash the HMOs, bash the Republicans. The Republicans don't want consumers to have choice. Or the other side: The Federal Government will run the health care system.

That is not the issue. We all should work together to help people who need access to health care. Consumers don't want drastic increases in premiums. I haven't found any yet who want premiums increased. I have not found anybody yet who wants a maze of legal wrangling to achieve benefits they are already owed. Do you want to have to go through ten levels of government bureaucracy to get something owed you? I have not found anybody yet who wants to do that. If they are out there, they have not written to me.

The President is concerned about patient protection. He worked on it hard as a Governor of Texas and showed a willingness to work in a bipartisan way to improve the insurance system. He extended his hand in this way. I hope the other side will take advantage of it. This is an extraordinary opportunity to achieve reform. It will make a real difference for the people of this country. This is what this debate should be about. I am afraid it is not what it is about.

Sure, we can pass a bill right now that bashes the HMO industry, hikes premiums, and delays benefits to patients. Let's look at them one by one.

Bash the HMO: Does that make you feel good? Maybe. Does it help you get better benefits, better access to your doctors? I don't think so.

Hiked premiums: Anyone want to raise the premiums higher, make it more difficult to receive the health care you are now trying to get? Do you want to delay your benefits to the patients? I don't know anybody who wants that. I don't think anyone wants premium hikes or delays, but such a bill would be vetoed and the status quo preserved. If we have a bill that bashes HMOs and raises premiums, President Bush will veto it, as well he should. Why pass it?

President Bush made it clear he will veto this bill in its current form. Why not work here, roll up our sleeves, do what we are paid to do by the taxpayers in this country, and work together to get a bill that will be signed by the President. Why wait for him to veto?

If my colleagues are dissatisfied with the status quo, do not want it to continue, and are concerned about constituents who are patients, they need to understand we need to make improvements in this bill. The Senator from Arkansas has made a very good improvement in this bill. We should not even be talking about it. It should be unanimously approved. Instead, it is debated hotly and unfairly on the Senate floor.

I don't think the current system is perfect. It is the best system in the world, though. For all the criticisms, does anybody want to go to Pakistan to have heart surgery, or North Korea? It is the best system in the world, with all its blemishes. As Winston Churchill used to say about democracy: It is not perfect, but it is the best thing out there. Remember that when we get to the bashing of the health care system in the country. We have the best doctors, the best nurses, the best hospitals in the world, the best pharmaceutical companies that get bashed on the floor day in and day out.

They have made tremendous progress in such diseases as cancer and AIDS and all kinds of disease that impacts us as a people.

We have seen how expensive and inefficient health care programs run by the Federal Government can be. I address my colleagues in the spirit of bipartisanship. I think some of my colleagues can admit that on the Environment and Public Works Committee, which I used to chair, I reached out on a lot of issues, specifically brownfields and Everglades, and we had bipartisan bills, two of them, both big issues that passed overwhelmingly, 99–0 on one, and 85 on the other. It can be done, but it should not be done out here. People on the respective committees ought to roll up their sleeves and accept reality and quit trying to score political points.

You ought to say if President Bush is going to veto this bill, that here are the reasons he is going to veto it. Let's sit down and see if we can address those reasons. If you can't, then fine. We will move forward.

But stop trying to score political points by trying to paint the picture that somehow all of us on this side are somehow opposed to having consumers get good health care. It is not true. It is a cheap shot, frankly, to do it.

We shouldn't let the heavy hand of Government further aggravate the problems that plague our private health care system. We should reform it. We can increase choices for the employers and the individuals and foster innovation with market-driven ideas and competition.

I have tried for a year and a half to get the attention of colleagues on my side of the aisle on a prescription drug plan that reduces premiums and provides more coverage. But I can't get any attention to it—I guess because I am not the guy who is supposed to be bringing it up. I do not know. But I encourage people to take a look at it because it works.

If we are talking about reducing premiums, then here is a way to reduce premiums on just those prescription drugs. We ought to discourage frivolous lawsuits while ensuring that patients who are truly harmed have a recourse. That is what we should be doing. If this legislation passes, it will make lawyers wealthy. They are going to do real well.

We ought to emphasize what works, get rid of what doesn't, and stop bashing what is good in our health care system, as if it is the worst in the world rather than the best.

We ought to cut down on the health insurance fraud. Barry Mawn, head of the FBI in New York, has called health and medical insurance fraud America's No. 1 white-collar crime costing billions of dollars.

We should eliminate the fraud and put those dollars to the consumers—to the people who really could use some help. How much new technology could we put into place? How many new medical breakthroughs could we make, if we could take those billions of dollars that we waste in fraud and put it into cancer research, or AIDS research, or multiple sclerosis, or muscular dystrophy, or any other disease? That would be a good step. We could do that, too, on the floor of the Senate today, if we wanted to do it.

We ought to offer a clear and compelling vision of how patient empowerment in truly free markets can give Americans a better health a system.

I ask you: Would we have the breakthroughs that we have in some of the miracle drugs we have on the market today if the Federal Government had been responsible for doing it? I ask anyone to answer that question, other than to say no.

Mr. DURBIN. Mr. President, will the Senator yield on that question?

Mr. SMITH of New Hampshire. Yes. Of course.

Mr. DURBIN. Is the Senator aware of the National Institutes of Health's basic research and medical——

Mr. SMITH of New Hampshire. I think the Senator knows I am aware of that.

Mr. DURBIN. Research that leads to these drugs and this medical equipment funded by American taxpayers?

Mr. SMITH of New Hampshire. Yes. I am very much aware of it. In terms of licensing medicines and doing the research, you know where it is happening. It is happening in the private sector. We can't shut it down.

I want health care for Americans, and my constituents want real choice and control over their own decisions. We should not reform something or change something in the name of reform that causes the Federal Government to get in the way of the doctor providing services to the patient.

My friend from Missouri pointed out earlier that thousands, if not millions, of Americans could lose their insurance under this bill as it is currently drafted. Is that really what the intent is—to have millions of Americans lose their insurance? I hope not.

Over the next few days we could discuss amendments to this bill that will make those badly needed improvements, such as the Senator from Arkansas has just done. I urge my colleagues to cross the partisan divide, enact responsible and reasonable health care, stop the attacks on each other, roll up your sleeves and do something good for the American people. We can do it.

I think if we do that we would get the thanks of the American people, rather than this partisan rhetoric that gets nowhere.

I yield the floor.

The PRESIDING OFFICER (Mr. NELSON of Nebraska). Who yields time? The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, might I inquire as to the time remaining on each side?

The PRESIDING OFFICER. The Senator from Arkansas has 144½ minutes remaining.

Mr. HUTCHINSON. I yield to the Senator from Texas such time as he might require.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. GRAMM. Mr. President, I thank our dear colleague from Arkansas. I thank him for his leadership on this very important amendment.

I hope all of my colleagues, no matter where they stand on this important issue, will vote for this amendment.

I was asked earlier today: Why should this amendment be the first amendment? This amendment is the first amendment because this is an amendment that is aimed at helping expand coverage in America so more Americans have access to health care.

It is one thing to talk about patients' rights. But what good are these rights if you do not have health insurance? What good are all these rights we are guaranteeing if you do not have access to the system?

This first amendment basically says that for the mom-and-pop little businesses where people have to buy their own health insurance because they work for themselves—they are self-employed—they ought to get the same tax treatment that General Motors gets.

Why is this important in this bill? This is important in this bill because the Congressional Budget Office estimates that, at an absolute minimum, 1.2 million people will lose their health insurance because of the cost of this bill.

It seems to me that it is perfectly logical that our first amendment ought to be trying to do something about that problem to assure people have the most basic freedom, which is freedom to get into the health care market with health insurance. I thank my colleague.

Mr. DURBIN. Mr. President, will the Senator from Texas yield for a question?

Mr. GRAMM. I am not going to yield. I am going to speak. When I am finished, I might be willing to yield.

I wish to begin by thanking our colleague from Arkansas for his leadership on this issue.

I want to cover a lot of issues today. I would like to begin with the issue of finishing the bill. Let me say that I believe we have the capacity in the Senate to reach a compromise.

I believe we can write a Patients' Bill of Rights that will not cause millions of people to lose their health insurance. I believe we can write a Patients' Bill of Rights that will keep the sanctity of contracts. I think we can write a Patients' Bill of Rights that doesn't trample States that already have good, viable, working programs. I think we can write a Patients' Bill of Rights that will do for people who are under employer-sponsored plans what States such as Texas and other States have done for people who have their health insurance purchased directly through private health insurance.

I don't know whether we will do that or not, but I believe we have the capacity to do it. One of the issues that has been raised here is the implicit threat that we are going to have to finish this bill by certain dates or that we are going to call off the Fourth of July, or we are going to call off Christmas, or whatever these threats may be.

I would like to say this: I don't have any interest in preventing us from making decisions on substantive issues. But as people hear what I have to say on this bill, they are going to hear that I feel very strongly about this bill. I believe the future of health care in America, the quality of care in America, and the freedom we have to choose our own doctors and our own hospitals—all of those things—are threatened by this bill, if we do it wrong.

I am willing to work with the majority leader and with the majority, but we are not going to be stampeded. We may very well be here over the Fourth of July, and we may be here over the Christmas holidays. But being here is one thing and being stampeded is another. And that is not going to happen.

Let me start sort of at the beginning. Why are we so concerned on this side of the aisle—and I hope some people on the other side of the aisle—about people losing their health insurance? Part of the reason we are concerned is that national polls show, in overwhelming numbers, that small businesspeople say if they can be sued—and they can be sued under the bill that is before us—they are going to drop their health insurance.

We do not have a law that requires your employer to provide health insurance. That is a decision the employer makes based on negotiating with the employee and what the employer believes is in his best interest.

The great majority of employers try to provide health insurance because, they care about their employees. They want to keep good employees. But there is no law that says your employer, large or small, has to provide health insurance. They can cancel it.

In national poll after national poll, we know that businesses, in overwhelming numbers—especially small businesses—say that if you expand this liability, and if they can be sued, or if the contract can be rewritten, causing costs to explode, they are going to cancel their insurance policies. What that means is, millions of people who have health insurance today will not have health insurance.

Why are we so concerned about it? Let me talk about a little history because I think it is important for people who are coming in, in the middle of this debate to understand how we got here. I want to begin with 1989.

In 1989, we had 33 million Americans who did not have private health insurance. When President Clinton was elected, he sent to Congress a bill, which I have at my desk, the Clinton health care bill. The argument of that bill was very simple, and that was that the problem America faced, with about 34 million people who did not have private health insurance was so overwhelming that we had to take extraordinary action. And that extraordinary action was contained in this bill which came to the Congress in 1993.

What the bill said was: Covering these 34 million-plus people was more important than patients' rights, so that what we ought to do was make every person join an HMO that would be established as a Government monopoly in each part of the country, and it would be run by a panel of local leaders and local citizens and local health care providers, and that panel would set a policy for that region, and there would be national coordination.

In this context, there was not talk of a patients' rights such as we are debating today. The bill before us today requires that even an employer who has two employees has to provide an option, what is called a point-of-service option, to people who may not want to go to an HMO. That is provided in this bill.

I want to remind my colleagues that in 1993 President Clinton, and those who supported him, were so concerned about 34 million people not having health insurance that they gave no point-of-service option. In fact, their bill, that was in this Senate Chamber in 1993 and 1994, said that if a physician in this health care purchasing collective provided medical care that the Federal Government and these local commissions believed was inappropriate, that physician could be fined $10,000. And if the physician took a payment from the person receiving the health care, for care they thought they needed and their doctor thought they needed, the physician could be sent to prison for 5 years.

We talk about liability in this bill. This bill has, for all practical purposes, unlimited ability to sue in State and Federal court. The only limit in the bill—which I do not think the media has ever gotten right in anything written—is a limit on contract disputes in Federal courts on punitive damages of $5 million.

I am not aware of punitive damages being granted on any kind of regular basis in a contract dispute anywhere in any State in the Union. This bill has unlimited liability in the name of patients' rights.

I remind my colleagues, and the American people, that in 1993 and in 1994, many of the same people who are for this bill had severe limits on the ability to sue, had caps on lawyers' fees, because they were worried about 34 million people not having health insurance.

We are now 7 years later. What has happened in the ensuing 7 years? What has happened is that now 42.6 million people do not have private health insurance. Yet today we have before us a bill that, even by the Congressional Budget Office estimates, will drive up the cost of health care by over 4 percent and will cost 1.2 million people private health insurance.

So why am I concerned about people not having health insurance? I am concerned really for two reasons. No. 1, the number of people keeps growing. This bill, if it is adopted, will make the problem far worse. No. 2, if many of the people for this bill 7 years ago were willing to argue the Government ought to take over the health care system, and deny health care freedom to everybody because 34 million people did not have health insurance—when 42.6 million do not have it now, and we are looking at at least 44 million or so not having it after this bill passes—does anybody doubt that some of these same people are going to be back here next year, or the next year, saying: My God, we have a crisis in the number of people who do not have health insurance?

Maybe we ought to get back out the old Clinton health care bill and have the Government take over and run the health care system. I do not believe that this is an idle concern.

I ask my colleagues, and anybody trying to follow this debate, to look at this chart because, to me, this chart is startling and frightening.

What this chart does is, it shows the right people have to make health care decisions. This chart basically takes the seven richest and most developed countries in the world, and it asks the question: What percentage of the population get their health care from Government-run programs? And what percentage of the population get their health care through programs they control and they purchased and they negotiated?

These seven developed countries are Canada, Italy, Japan, the United Kingdom, France, Germany, and the United States. As you can see by looking at this chart, by far the freest country in the world, in terms of the right of a free people to choose their own health care, is the United States of America.

Sixty-seven percent of health care in America is controlled by private citizens; 33 percent of health care in America is controlled by Government.

The point I want to make is the following: What is the second freest country in the world in terms of people having the ability to choose their own health care? The next freest developed country in the world is Germany, where Government controls 92 percent of the health care purchased.

So I think, when you look at every other developed country in the world, that one of the things you have to be concerned about is America, by far and away, has the freest health care system in the world, where people make decisions for themselves, and the next freest country in the world has Government running 92 percent of their health care.

With the exploding cost of health insurance through the proliferation of lawsuits and frivolous litigation and through rising health care costs costing people their health insurance, there is every reason in the world to be concerned about it because we have a lot of freedom to lose. And we, quite frankly, are unique among all the developed countries in the world in that we have a private health care system. Of all the other developed countries in the world, Canada, Italy, Japan, and the United Kingdom have a 100-percent government system. In the United Kingdom, you can go outside the system and you have to pay for health care twice. In France, government dominates 99 percent; in Germany, 92 percent; in the United States, 67 percent of health care decisions are private.

I am worried about this bill and its cost, the litigation and the trampling on States that already have workable programs, because I don't want to live in a country where government controls 92 or 99 or 100 percent of health care.

As I said when we debated the Clinton health care bill 7 years ago, when my momma is sick, I want her to talk to a doctor and not some government bureaucrat. I still want that.

Now let me talk about this bill and the problems it has. Let me make it clear to begin with that I believe these problems can be fixed if we work in good will. I will pick out several problems with this bill, and I want to go through them in detail because I don't want there to be any doubt about what I am talking about.

What I think we have in this bill is a tremendous amount of what I call ''bait and switch'' provisions. What do I mean by that? I mean that where the bill says one thing in one place, where it appears that a policy is set, and yet when you look further, you find that in fact that policy is not set and the bill does exactly what it claims it does not do.

I will give you three examples. I have blown it up because I want to be sure everybody is just looking at the language of the bill. The first has to do with something that is very hotly debated in America, where, as the public listens to both sides of the debate, they get the idea that both sides are on their side. I want to start with the issue of whether or not you can sue an employer.

What is the role of the employer here? The role of the employer has to do with buying health insurance. Sometimes the employer buys it. Sometimes the employer enters into a partnership with the employee and they buy it together. But the question is, Should you be able to sue an employer whose role in the process is buying health insurance?

Many of our colleagues here who support the bill that is before us, the McCain-Kennedy-Edwards bill, say it is like Texas. This bill is like Texas. Let me read to you what Texas law says on this issue. Texas law says:

> This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees.

In other words, the Texas law, which proponents of this bill say that they think is wonderful and they want at the Federal level, has an outright total exemption of employers under the Texas law. Under no circumstance can you sue the employer.

Why did Texas do this? Texas did this because they did not want employers, especially small employers, to cancel health insurance. What does the bill before us do? If you listen to the proponents, it is just like the Texas bill. And if you listen to them, you can't sue employers. Let's just go through the language.

This is the language on page 144: ''Exclusion of employers and other plan sponsors.'' Boy, that sounds good. And then it says: ''Causes of action against employers and plan sponsors precluded.'' Great. Great. They have precluded causes of action against employers and plan sponsors. Read on.

> Subject to subparagraph (B)—

That ought to make you suspicious right there—

> paragraph (1)(A) does not authorize a cause of action against an employer or other plan sponsor maintaining the plan (or against an employee of such an employer or sponsor acting within the scope of employment).

Hallelujah. Just like the Texas plan. There is only one problem. It does not stop there. It goes on to the next paragraph. You get to this paragraph (B), on which I said you had better watch out because there is already a caveat. What does paragraph (B) say? Paragraph (B) says:

> Certain causes of action permitted—Notwithstanding subparagraph (A), a cause of action may arise against an employer or other plan sponsor. . . .

And then it goes on for several pages talking about when you can and can't sue an employer.

Compare that with what is done in Texas. In Texas you can't sue the employer. Here we have a classic case of bait and switch. The bait is, they say you can't sue the employer. And then they say, notwithstanding that you can't sue the employer, you can sue the employer. This bill is full of these bait-and-switch provisions.

Let me give another example. I want to make it clear this is not just an outlier where I just found one little provision of the bill that looks very suspicious. The next one has to do with exhaustion of external review.

What is the question here? The question is, Have you ever seen anybody get healed in a courthouse? I have seen people healed in hospitals, doctors' offices, clinics. I have even seen people healed in tent revivals. But I have never, ever seen anybody healed in a courthouse. I have never seen a lawyer heal anybody. I am sure they have. They may have become a doctor and done it.

But what is this issue about? This issue is the following: We have set up in both bills—everybody agrees, or they say they agree—that you ought to have an external appeal where you say, No, I think I need this service; and then your doctor looks at it and says yes or no; and then if you don't agree, you get to go before a doctor panel that is made up of doctors who are independent of the HMO, and then they make a decision; and if you are still dissatisfied, then you can go to the courthouse.

But everybody claims that they want to have you go through this appeals process at the hospital before you go to try to get cured at the courthouse. And we have all kinds of provisions that say, if you are really sick, this external review process has to occur, in some cases, immediately.

Now the proponents of this bill say you have to go through external review. That is what they say. And sure enough, if you look at their bill on page 150, it sure looks as if they say it.

They say ''Requirement of Exhaustion''—sounds like exhaustion. You have to go through the process. ''In General''—notice right away you get the key:

> In General.—Except as provided in this paragraph, a cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102 and 103 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

In other words, they are saying here on page 150 that you have to go through internal and external review; no ifs, ands, or buts about it. Right? Well, no, it is not right. It is right on page 150. But then on page 151, they say:

> In General.—The requirements of subparagraph (A)—

That is this exhaustion paragraph—

> shall not apply in any case . . .

And then they go on and set up a circumstance whereby you do not have to go through external review. Now, I

raised this a week ago and they changed it, but they still didn't fix it.

Here is the point. I understand part of what we do here is score points in debating, but how do you defend a bill that, on page 150, says you have to go through external review before you go to the courthouse; and then on page 151 it says the requirements of subparagraph (A) shall not apply, and then it goes into the circumstance whereby you can go to court and make various claims?

Now, it doesn't end there. Here is another one. Boy, this is as fundamental as you can be in health care. The question is a simple question. I have a standard option Blue Cross/Blue Shield policy, and 40 million people have the same policy I have. I could have gotten a better policy. I could have gotten the upscale Blue Cross/Blue Shield, but I and my family are pretty healthy, and I looked at the cost of the Blue Cross/Blue Shield premium policy, and I looked at the standard option policy, and I looked at the low option policy, and I decided standard option is what I want. That is what I paid for, and Blue Cross/Blue Shield gave me a contract. Now, that contract is binding today.

But there is a question here. Is the contract binding in the bill that is before us? If you have listened to our colleagues who are for this bill, they say it is binding. Contracts are binding in court—binding under law. When you sign a contract, the contract is binding. Sure enough, if you look at their bill on page 35, it sure looks like contracts are binding. It says: ''No Coverage For Excluded Benefits.''

In other words, if your contract says we only pay for 60 days in the hospital for mental illness, then if you are in the hospital the 61st day, you have to pay for it. I have all kinds of provisions like that in my Blue Cross/Blue Shield standard option plan.

Then under this wonderful headline, you read:

No Coverage For Excluded Benefits.—Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan, or health insurance issuer offering health insurance coverage, provide coverage for items or services for which benefits are specifically excluded or expressly limited under the plan or coverage in the plain language of the plan document.

That sounds about as clear as it can be. If your plan says you only get 60 days for mental illness in the hospital, or if your plan says we don't cover heart and lung transplants, then this language is as clear as the morning sun that they are not covered. But read on. After having said:

Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan, or health insurance issuer offering health insurance coverage, provide coverage for items or services for which benefits are specifically excluded or expressly limited . . .

It then goes on to say:

. . . except to the extent that the application or interpretation of the exclusion or limitation involves a determination described in paragraph (2).

Where is paragraph (2)? Paragraph (2), as it turns out, is 2 pages back. In fact, I want to be sure the Presiding Officer, among others, hears this. Let me do it one more time. On page 35 of this bill, it says in language as clear as the morning sun: ''No coverage for excluded benefits.'' In other words, your contract excludes more than 60 days in the hospital for mental illness, or it says it doesn't cover heart and lung transplants. It is excluded. It goes down here and says:

Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan, or health insurance issuer offering health insurance coverage, provide coverage for items or services for which benefits are specifically excluded or expressly limited under the plan or coverage in plain language of the plan document . . .

Then it has the big word, ''except''.

. . . except to the extent that the application or interpretation of the exclusion or limitation involves a determination described in paragraph (2).

Where is paragraph (2)? As it turns out, paragraph (2) is on page 33. Paragraph (2), on page 33, has ''Medically Reviewable Decisions.'' So you can't require them to provide services beyond those enumerated in the contract, except where you have got a medically reviewable decision.

The second part of paragraph (2) is ''Denials Based On Medical Necessity and Appropriateness.'' In other words, what this bill does, in the clearest possible way, is a bait and switch. The bait and switch is on line 14 of page 35, where it tells you contracts are binding. And then you get to the ''except.'' When you go to look at the exception, it is anything that is medically reviewable and anything that the panel decides is medically necessary.

Now, why does that matter? Don't we really want people to be in the hospital longer than 60 days if they need to be? Or if they need a heart or long transplant, don't we want them to have it? Here is the point. When I negotiated my standard option Blue Cross/Blue Shield, I got the policy that I thought best suited me based on my family's needs and my ability to pay.

Now, if you are going to come back and say that Blue Cross/Blue Shield has to provide me services even if they are excluded in the contract and if a medical reviewer decides that I need them, what is that going to do to the cost of the standard option Blue Cross/Blue Shield policy?

The cost of health insurance is going to explode in America because contracts do not mean anything, and when contracts do not mean anything we all have to pay higher prices, and some people lose their health insurance. I am not going to lose my health insurance. I am a Senator. My wife is successful and works. I am not going to have to give up my health insurance. So when my policy goes up $1,000 or $2,000, I am not going to lose my health insurance. But how many people working in America are going to lose their health insurance? What happens to cost when contracts are not binding, when medical reviewers can say: I know your contract said that you have only 60 days for mental care, but this patient needs more. And so they have to provide it. That is wonderful for that patient, but what it means is we all have to pay higher prices, and some people lose their health insurance.

I do not want to stretch the analogy too far. This is not the Clinton health care bill that is before us. I personally believe we can work these things out and fix them, but there is one element where this bill is like the Kennedy health care bill we debated 7 years ago.

The Kennedy health care bill was immensely popular. There were 77 cosponsors. It looked about as certain as Christmas was going to come or we were going to be off for the Fourth of July recess that the Clinton health care bill was going to become law. Guess what happened. We debated it about 2 weeks and people discovered what was in it, and they decided they did not want it.

This bill is full of provisions that were written by clever lawyers that appear to do things they do not do. We could go a long way toward working out a compromise by simply saying: Do we mean contracts to be binding or not? If we do, take all that language out and say contracts are binding. If we mean you ought to be able to sue employers, say you can sue employers. If you do not think you ought to sue them, say you should not be able to sue them, but do not try to have it both ways.

I want to talk now about preempting States. I have never been one who believed States were perfect. People have this habit of thinking because I am from Texas and Texas was involved in the Civil War on what some people call a States rights issue—there were a lot of other issues involved, several of which we were just flat wrong on. There were some elements of States rights, but, look, just because I am from Texas and from the South does not mean I believe States are right on everything and the Federal Government is wrong on everything. I pick and choose based on what I think works best.

There is something in this bill that is terribly unworkable and egotistical. This bill says it does not matter if Arkansas, Nevada, Nebraska, and Texas have written programs for a Patients' Bill of Rights, and most States have. It does not matter how well their system is working. It does not matter how happy they are with it. In fact, proponents of this bill constantly say look how great the program is working in Texas. It is just great. Then they say their bill is the same. I think I have demonstrated it is not the same. Even if it was, they then would say: Wait a minute. We think it is great, but we want our program to override it. This

is my point: Do we really believe we know what is better for Texas than they know for themselves?

What I want to do is, if States have adopted their own program and it is working well for them, their legislature, and their Governor, look at our program and look at theirs and say: Ours is working well; we like our provision to guarantee people, for example, on the right to sue employers; we like our provision that says you cannot sue them instead of your provision that says you cannot but you can.

What I want to do somewhere during this debate is say if the States are happy, if they have adopted a plan—it does not have to be exactly the same as the Federal Government as long as it is a comprehensive program and they are satisfied with it—why can't Texas say to the Federal Government, why can't Nebraska say to the Federal Government: We really appreciate you looking out after us, but we have already done it ourselves. We want to do our plan. Our plan is different in three of the 10 different areas, but it is a comprehensive plan and we want to have our own plan.

Why can't Nebraska do that? Why can't Texas do it? Why does there have to be one size fits all? I do not think there has to be, but if you look at this bill, they claim in this bill that States can operate their own program, but the only way they can operate their own program is for the legislature to go back and adopt this bill as State law. So is that their program? I do not think so.

This is forcing States to do it our way when, quite frankly, in my State—I cannot speak for Nebraska or Arkansas—but in my State, I know in my State our plan is better than the bill that is before us. I want States to have the right to opt to do it themselves, to opt out. That is very important.

There are a lot of other issues in here, and I am afraid there has been so much focus on liability, so much focus on lawsuits and, boy, there is reason to be concerned about them, that people forget all these other issues.

I want to pick out one more. I have spoken a long time, but this is an important bill. I want to talk about something that just does not look too bad on the surface, but when you get right down to it, it is bad.

There is a provision in this bill which has been in every Patients' Bill of Rights that has been considered in Congress, and that is a provision that is a prudent layperson standard. If I believe I am sick and I might die or I might be permanently hurt, I have the right to go to the hospital, and they have to treat me and my HMO has to pay for it.

Needless to say, since these bills started passing in the States, what do you think has happened with the willingness of hospitals to negotiate in advance with HMOs about paying for emergency care? Do you think they have negotiated more or less?

This headline is from an article from the American Medical Association, Medical News, ''Patients Bypassing Primary Doctors for Emergency Care.''

The article says:

> With the growth of prudent layperson laws and other pressures, health plans are backing off from strict limits on visits to emergency departments.

It goes on to explain it is six times as expensive to provide health care in the emergency room as it is in the doctors office, outpatient clinic, or hospital, and that we are having an explosion of the use of emergency rooms.

In this bill, not only do we have the prudent layperson standard which no one opposes, but we have a brand new provision which has been pushed by emergency room physicians who have lobbied for this provision, and in a bill that is supposed to be about patients, we have a great big special interest provision.

The provision basically says that if I, as a prudent layperson, go to the emergency room, I have to be treated. These hospitals have stopped negotiating in advance with HMOs because they know they will get paid whatever they charge.

But this bill goes one step further. It is living proof of how everything ultimately gets infected with special interests. In addition to treating the patient for the emergency room problem, this bill has a provision that allows the emergency room to give poststabilization care. Then it has a trigger that says, if, within an hour, the HMO does not get back to the emergency room to give the direction as to whether the person having now been treated for the emergency problem should go to the doctor's office, go to the hospital, go to outpatient care, or go back into their HMO, then the emergency room poststabilization care can be provided.

Why in the world would we want to put poststabilization care into the emergency room when costs are skyrocketing and it is six times as expensive in the emergency room as it is anywhere else? Why would such a provision be in a bill? It is in the bill because emergency room doctors wanted it in the bill.

When we debated the Clinton health care bill, one of the big arguments was they were going to get medical care out of the emergency room. So they got all kinds of restrictions where the health care purchasing collectives are going to decide what is really emergency room care. That was then.

Now we have a requirement that says an HMO or a health plan has to pay not just for emergency care but poststabilization care potentially in the emergency room. That provision ought to come out. That makes no sense. That is not in the public interest.

To sum up, we want an opportunity, and we will insist on an opportunity to debate every one of these issues. It may be we decide we want to put more health care in the emergency room and drive up health insurance costs and let the chips fall where they may and let millions of people lose health insurance. But we are going to vote on it. It may be that we decide we want to be able to force people to provide health care that is specifically excluded, enumerated, in their contract that is not covered. But we are going to debate it and we are going to vote on it. It may be we decide we want to sue employers—I cannot imagine why we would want to do that, and this bill does it—and we may decide we want to do it, but we are going to vote on it.

Everybody who says they think the Texas plan is so great, we will give them a chance to vote on the Texas plan of exempting employers and doing it in a lot of different ways.

I believe if we asked the American people if they were for a Patient's Bill of Rights, they would say yes. In fact, they have them in most States in the Union in an overwhelming number. If we asked, in my State, would they rather stay under the Texas plan or come under the national plan, I think the great majority of our people would say: We are doing great; leave us alone.

If people knew what was in this bill, I think they would not be for it. There was a reason the Founding Fathers established the Senate under the rules they did. Some may remember when the Constitution was written, Jefferson was in France. He was Minister to France. When he came back, he went to Mount Vernon. The Constitution had been written. He came home from France and went to Mount Vernon and he met with Washington. He asked Washington: What is the Senate for?

The purpose of the House was clear. But why two bodies? Washington used the example of pouring tea into the cup and pouring it into the saucer to cool and pouring it back in the cup and drinking. He said there will be the heat of passion that will catch up the House of Representatives, and under their structure, elected every 2 years, that passion will react to the public passion. But the Senate will be the saucer in which the cold logic of reason will prevail.

One of the reasons we are not going to be stampeded is that I am absolutely convinced, when examined in the cold light of day, when people look at the logic of this bill, they are going to decide this bill needs to be improved. The good news is it can be improved. The good news is we could write a bill for which 90 Members of the Senate could vote. But we are not going to write such a bill until we get every part of it out in the open, until people understand it, until we know these provisions mean exactly what they say. And we are going to have to make fundamental decisions. There will be a lot of heartburn.

Some people are going to want to sue employers, but they will want people to think they are exempting employers. We are not going to have it both

ways. Members have to decide. There will be some who want to say in Texas, Nebraska—we will let you have your own program; on the other hand, they want to vote for a bill that makes you go under the government program. You cannot do it both ways. We will have a vote. Members have to make that fundamental decision.

That is what this debate is about.

Mr. DURBIN. Will the Senator yield?

Mr. GRAMM. I am happy to yield.

Mr. DURBIN. I thank the Senator for his statement.

The Senator is speaking on behalf of the Hutchinson-Bond amendment which allows deductibility of health insurance premiums for self-employed people. I ask the Senator if the CONGRESSIONAL RECORD is correct, the RECORD of May 23, 2001, in which it announces the Senator from Texas, Mr. PHIL GRAMM, is one of the conferees on the tax bill that was recently considered and passed, the conference committee which removed the same provision we are now debating from the bill? In other words, the amendment the Senator has spoken on, you were on the conference that removed that protection from the tax bill. For the record, was the Senator one of those conferees who removed that?

Mr. GRAMM. Let me reclaim my time and say not only, for the record, was I one of the people who put the provision into the bill, I was a conferee. I was for the House provision that lowered the marginal rate to 33 percent. One might ask why I voted for a bill that lowered it only to 35 percent? I was for numerous provisions that did not get into the final bill. How did that happen? How that happened was we had $1.35 trillion. The House had a bill, $1.6 trillion. I wanted $1.6 trillion. The Senator from Illinois voted against it. As a result, we had to make decisions about how to live within the budget we had.

Now, I am for this provision. I can show the Senator on record a dozen times I voted for it.

The point is, are we for it or are we against it? I will State right now, unless God pauses my hand, I will vote for it. If I am a conferee, I will vote to keep it in this bill.

I don't know how the Senator will vote on this amendment. How is the Senator going to vote?

Mr. DURBIN. I thank the Senator for asking that question because my amendment that was offered to the tax bill, adopted in the Senate, and then the conference committee the Senator from Texas sat on, removed my amendment, the same one being offered today on the bill.

When the bill was $1.3 trillion in tax relief, as a member of the conference, you couldn't find $2 billion to help the people we are talking about today. Instead, you are offering a Patients' Bill of Rights.

I think that raises an interesting question.

Mr. GRAMM. How is the Senator going to vote on this amendment?

Mr. DURBIN. I will vote on the Patients' Bill of Rights. And we know this amendment should not be in it because it is a tax provision.

Mr. GRAMM. Mr. President, I am a little bit confused listening to the Senator. He sound as if he is for the provision. It is kind of bait and switch. He seems to be chiding me in that I was not the dictator of the conference and I couldn't do everything exactly as I wanted. Thank God, we are going to have another chance at 5:30 to make this right. I am going to vote on the right side. I want everybody to know I am for this amendment. We need this amendment because the bill before us is one that costs, at a minimum, 1.2 million people their health insurance. Shouldn't we be trying to help more people get health insurance?

One final point, and then I will stop.

We use this cost figure of 4.2 percent that the bill before us is going to impose on everybody who owns health insurance. Where does that number come from? The plain truth is, that number is made up by the Congressional Budget Office. Here is what they assumed.

They assumed that 60 percent of the cost of health care going up will be borne by the employer; that they will just pay it, absorb it, and will not respond to it. Then 40 percent will be borne by the employees, who will end up getting lower wages. In fact, in this bill receipts to Social Security fall off because wages fall off by $55 billion.

The plain truth is the Congressional Budget Office, in adding up the cost of this bill, basically assumed that no employer will cancel health insurance because of this rising cost.

When you ask the Congressional Budget Office, When you were doing this estimate, did you happen to see this language where actually things that are excluded in the contract could be covered and the insurance company could be forced to pay for it, did you note that? guess what. They didn't see it.

When you ask them, On the question of excluding employers, you probably saw the big headline that said they couldn't be sued, but did you read on and see, ''Notwithstanding subparagraph A, a cause of action may arise against an employer''? guess what? Nowhere in their estimate did they show that they caught the bait and switch.

Here is my point. We are talking about a 4.2-percent increase in costs. We are taking a national figure—not from the Congressional Budget Office—that 300,000 people per 1 percent are losing their health insurance. But all of that is assuming that businesses—especially small businesses—don't just cancel their health insurance because they are worried about being sued.

One of the things I am fearful of—and it never does you much good around here to say I told you so, and, quite frankly, I don't like to do it—but I am afraid that 3 or 4 years from now millions of people will have lost their health insurance because of this bill if we don't fix it.

One of the ways to start fixing it is this amendment by the Senator from Arkansas. If you are for it, if you think self-employed people ought to be able to buy their insurance with pretax dollars just as General Motors does, then you are going to vote for this amendment. If you do not think so, you are going to vote against it. I think so. And I am for it.

I thank the Chair for the Chair's tolerance.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I rise in opposition to the amendment.

I asked the Senator from Texas if he was on the conference because it raises an interesting point. The amendment which has been filed on the floor today would allow individuals to deduct the cost of their health insurance if they are self-employed—small businesses and family farmers—100-percent deductibility. It is something that is not only right and fair, but it is something that is already available if you work for a corporation.

It is a position I have supported throughout my congressional career in the House and in the Senate. It is a provision I feel so strongly about that I offered it as an amendment to the tax bill a month ago at a time when we had $1.3 trillion to give away in tax breaks. I said, For goodness' sake, let's do something about health insurance for the self-employed, for small businesses, and for farmers. It was adopted on the floor of the Senate. It then went into this misty world of a conference committee, of which the Senator from Texas was a nominal conferee. I don't know if he was at this meeting when it got into the room and was controlled by the Republicans. This same provision was removed from the tax bill.

The Senator from Texas said there just wasn't enough money to go around. The tax bill gave 40 percent of its benefits to people making over $300,000 a year. They are arguing today that they didn't have enough money to help a small businessman trying to pay for insurance for himself and his spouse and for his employees. They did not have enough money to take care of every family farmer struggling to pay their health insurance.

It raises a question of credibility, for you see what happened was this: This amendment before us today has been filed in the Senate. This is the amendment which was filed on the tax bill. It is identical. What did the Republican majority do with this amendment on the tax bill? They filed it as well. That was the end of that amendment.

Now they come to us today and say this is what health care is really all about. A month ago they weren't for it. A month ago, when they were in control of the situation with $1.3 trillion, they couldn't find $2 billion to take care of this problem. But today they have religion. Today they bring us the amendment. Why this conversion? Why this newfound faith in this issue?

Let's get down to the bottom line. What is this debate really about?

This Patients' Bill of Rights has been buried in a committee by the health insurance industry. They do not want it to come to the floor. They don't want it to pass. They do not want to say that doctors and nurses and hospitals make medical decisions. The health insurance industry wants to continue to make the decisions. And it was buried in committee until 2 weeks ago when control of the Senate Chamber changed.

When TOM DASCHLE became majority leader, he announced that the first item on the agenda for the Democrats was to bring this bill out of committee, put it on the floor, debate it, and vote on it. That wasn't even on the Republican agenda. Now it is before us, and they are trying to find everything under God's heaven to stop this bill. So they have come up with this.

They want to put a tax provision in this bill—a provision which they canned in conference just a month ago. Now they want to revive it and stick it on this bill, hoping it will bog down with budgetary objections and bog down in the Finance Committee and in the Ways and Means Committee which has jurisdiction. They want to stop this bill. They cannot stand the thought that these health insurance companies might lose. They are arguing that it really isn't about the rights of individuals under health insurance, it is really about deductibility of health insurance premiums on our taxes. Well, it isn't.

That is an important issue. It is one I have believed in for as long as I have been in Congress.

This debate is equally if not more important. It is a question about whether or not your doctor can make medical decisions for you and your family or whether his or her decision will be overridden by an insurance company clerk with a high school education 1,000 miles away.

That is the real world, my friends. That is what is happening across America. I can give you chapter and verse in Illinois. Every one of my colleagues can join me.

The second issue is one that really strikes at the heart of it. The Republicans can't stand the thought and the possibility that health insurance companies will be held accountable for their misconduct. We are held accountable. Individuals, families, businesses, and corporations in America can be brought into court if they are guilty of wrongdoing. But there is one privileged class in America. There is one special royalty in America—that business, HMOs and health insurance.

When they deny you coverage under your health insurance policy, when they do not let you in the hospital and they are wrong, and you come away permanently disabled, or someone in your family dies, they cannot be hauled into court and held accountable.

This bipartisan bill which we support would bring them to court and hold them accountable, as every other business in America is held accountable. And the Republicans can't stand it. So they have come with this amendment to the floor. They want to divert our attention from things they forgot about a month ago. They know better.

We ought to defeat this amendment and pass this legislation.

Mr. REID. Mr. President, how much time is left under Senator KENNEDY's designation?

The PRESIDING OFFICER. Fifteen minutes.

Mr. REID. Mr. President, I ask unanimous consent that the vote in the morning be scheduled at 10:30 a.m. rather than 11 a.m. pursuant to the previous unanimous consent agreement.

Mr. President, I further ask unanimous consent—Senator HUTCHINSON has the last 15 minutes of the debate—that Senator MCCAIN have 7 minutes prior to his 15 minutes prior to the 5:30 vote.

The PRESIDING OFFICER. Is that time to come from Senator MCCAIN's time or Senator KENNEDY's time?

Mr. REID. The time controlled by Senator DASCHLE.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Who yields time?

The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, I think it is unfortunate if we allow the debate—legitimate debate on legitimate issues—on this bill to degenerate into finger pointing and partisan accusations that one party or another does not favor patients' rights, does not care about people, that there is some insidious plot to bury a Patients' Bill of Rights.

The reality is, over the last 2 years there have been over 20 votes in this Senate Chamber on versions of the Patients' Bill of Rights. There has been plenty of debate and scores of votes.

So to say that somehow this Patients' Bill of Rights legislation has been hidden, buried in a committee and not been allowed to have free and open debate on it and to be amended and debated in this Senate Chamber is simply to mislead the American people and to mislead the Senate.

We have debated this. I have spent a year myself on the conference committee trying diligently to reach a consensus, at least a compromise, so we could have a Patients' Bill of Rights that would serve the American people.

I think it is very unfortunate when we start judging motivations and judging individuals as to what they want to do. I know the Presiding Officer has his own concerns about portions of the Kennedy-McCain bill. Those are legitimate concerns. People may agree or disagree on various aspects, but to point the finger and say that there is some kind of partisan plot to bury a bill or to be the ally of any particular industry—I will speak for one Senator; and I think I speak for a lot on my side of the aisle—I want a Patients' Bill of Rights. I want a good one. I want one that will provide protections for those who do not have those protections today. I want to have respect for States that have already acted upon it, but I believe we have a responsibility to act on the Federal level.

I hope we have a bill, but I do not want to pass a bill that, in the words of the Senator from Texas, plays a bait-and-switch game, where it says it is doing one thing and then has an exception, where it says here is the rule and then comes back with an exception to the rule that consumes the rule itself. So let's have an honest debate. Let's avoid judging one another's motivations. At least I hope that will characterize more of the remaining debate.

My colleagues seem to equate accountability with getting to court, that the only way an insurance company can be held accountable is if you have the right to sue them, and sue them immediately. There are those of us who think—and I am one of them—lawsuits are not necessarily the best way to resolve a dispute. That is why an internal appeal is an appropriate step, an external appeal is a right process, and that only at the point that those appeals are exhausted should there be a right to go to court to redress a wrong. I think if we have that kind of restrained appeals process, we will minimize the amount of lawsuits that are necessary.

This is a legitimate debate, but we need not say that anyone is using cheap tricks, ploys, or that there is some kind of insidious effort to derail the Patients' Bill of Rights.

One of the critical issues in this bill is how much we are going to increase costs and how many people are going to lose their insurance. How many small businesses are going to say: I can't afford to do it anymore? Exactly how many people are going to join the ranks of the uninsured? What kind of impact is it going to have? Those are real questions.

So there can be no amendment more relevant than the amendment that is before us; and that is one that, most assuredly, by all who assess its impact, will decrease the number of the uninsured, will take those who are currently in the ranks of the self-employed who cannot afford to buy insurance and enable them to do it.

This is very relevant. This whole blue slip statement, in my opinion, is a red herring. You are either for it or not. You are either for giving 100-percent deductibility or you are not. You say we should have done it in the tax bill. I would have liked us to have done a lot more things in that tax bill.

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

Mr. HUTCHINSON. No. I am giving a statement right now. I ask the Senator, is this for a UC?

Mr. KENNEDY. No, just for a question.

Mr. HUTCHINSON. I am glad to yield.

Mr. KENNEDY. I listened to the Senator talk about the increased costs and how that would translate——

Mr. HUTCHINSON. Mr. President, I yield on the Senator's time.

Mr. KENNEDY. I yield myself 1½ minutes.

You say with the increased costs there is an increasing number of people who will lose their health insurance.

Last year there was a 9-percent increase in premiums. I would like to ask the Senator: Where was the decrease in the number of the uninsured? To the contrary, the figures show there are more people who are uninsured. So I have difficulty in accepting that.

This year the HMOs have already said the premiums are going up 10 percent, even without this. So under that assumption, that would mean 5 million more people who will be uninsured. There were 4 million last year; 5 million now.

I do not see where the facts are to support your position.

Mr. HUTCHINSON. Reclaiming my time, I say to Senator KENNEDY, you are not arguing with me; you are arguing with objective studies that indicate that with every 1 percent——

Mr. KENNEDY. Not CBO.

Mr. HUTCHINSON. Every 1-percent increase in insurance premium costs equates to about 300,000 people losing their insurance.

Mr. KENNEDY. If I could have 15 seconds of my own time, that is not what CBO or OMB have said. In fact, in specifically studying the costs of this, they have indicated, where you are going to have these kinds of protections, you might have greater numbers of people covered, rather than less.

Now, you may be able to find some economist someplace who can cook some numbers, but according to OMB and CBO—which we use around here—they do not support the Senator's statement.

Mr. HUTCHINSON. Mr. President, reclaiming my time.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. It is the Lewin study that came out with those statistics. I think it has been borne out over time that, in fact, as premiums go up, the rates of the uninsured go up. While you may find a slight blip of it going down over the past year, if you look back over the course of the last 5 years, the last 10 years, the number of uninsured have dramatically increased in this country as premiums have increased.

I think it defies logic—I do not believe it is going to sell with the American people—that increased costs are not going to result in more people being in the ranks of the uninsured. That, to me, not only is borne out by studies, but is borne out by practical experience. As costs go up, more people are unable to afford insurance. And it is the Congressional Budget Office that has said the Kennedy-McCain bill will, at the least, increase premiums by an additional 4.2 percent, in addition to premium increases that are occurring naturally with medical care inflation.

So I will leave that to my colleagues to make their own conclusions as to whether higher prices on premiums, higher prices on insurance, will not, in fact, result in more people going into the ranks of the uninsured.

Mr. President, I ask unanimous consent to add Senator CONRAD BURNS as a cosponsor of the amendment.

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

Mr. REID. Will the Senator yield for a unanimous consent request?

Mr. HUTCHINSON. I am glad to yield.

Mr. REID. Since we entered the agreement, I have had a number of requests on this side. We have 13½ minutes left on this side prior to the debate that will begin with your final remarks.

So I ask unanimous consent that the 13½ minutes, rather than the 7 minutes, prior to your 15 minutes, be the time that the Democrats will use to close their phase of this debate.

Mr. HUTCHINSON. I have no objection.

The PRESIDING OFFICER. The Senator from Massachusetts has 13 minutes 13 seconds.

Mr. REID. But he was given 1½ minutes. So 15 minutes, minus 1½ minutes, is 13½ minutes. But anyway, whatever, we would give Senator KENNEDY that final time. We would go 2 minutes to Senator KENNEDY, 2 to Senator DURBIN, and 2½ minutes, or whatever is remaining, for Senator EDWARDS.

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

Mr. REID. Thank you, Mr. President. I thank Senator HUTCHINSON.

Mr. HUTCHINSON. Mr. President, I know on our side we have a number of other Senators who want to speak on this amendment. I will be glad to yield to them as they come to the floor. I believe Senator VOINOVICH will be in the Chamber in a few moments.

But let me just pick up on a few points that Mr. GRAMM, the Senator from Texas, made during his speech. I think what we need, during the course of the debate on this bill, is the kind of careful analysis that Professor GRAMM brings to this issue. I think as Members of the Senate actually read this bill, as the American people hear the contents of the bill and hear the kind of passionate expression and concern for a Patients' Bill of Rights in general, it will give way to concern about the impact that the bill itself would have.

So the Senator from Texas called it bait and switch. It could also be called the exceptions swallow the rule.

Let me review some of those examples where the exception swallows the rule. On page 35 of the bill, paragraph (C), ''No coverage for excluded benefits.'' The point in that very plain statement is that the contract is to be sacred. It is to be honored. The contract means what it says. That statement, though, doesn't mean what it says, ''no coverage for excluded benefits.'' If you turn to page 36, at the top of the page, it says, ''except to the extent that the application or interpretation of the exclusion or limitation involves a determination described in paragraph (2).'' So this is one of the examples in the area of excluded benefits.

Paragraph (2) on page 33 includes anything that is a medically reviewable decision. So, in fact, the exception does swallow up the rule. Anything that is a medically reviewable decision—in other words, when you go to the independent review panel, they have virtually carte blanche in overturning the very provisions of the contract. If you don't have a binding contract, how in the world can you make projections, how in the world can anybody provide health care plans with any assurance of what costs are going to be?

Another example is on page 144 in this rather lengthy Patients' Bill of Rights legislation. On line 16, it says: ''Exclusion of employers and other plan sponsors. Causes of action against employers and plan sponsors precluded.'' That sounds good. That is a concern a lot of us who have questions about this legislation have raised. Are you going to be able to sue your employer? Are employees going to have a means by which they can sue their employer? What impact is that going to have on an employer's willingness and ability to provide health insurance? The statement sounds good: ''Causes of action against employers and plan sponsors precluded.''

But if you turn over to the next page, you find in section (B) and (C), ''Certain causes of action permitted.'' Then it goes on and talks about direct participation, another example of exceptions swallowing the rule. You can't sue your employer, except there are some suits that are permitted.

Then another example of the exception swallowing the rule is on page 122. On line 19 of page 122, it says: ''Preemption; State flexibility. Continued applicability of State law with respect to health insurance issuers.''

That sounds good. At least it sounds good to me. I know a lot of States have done very good work in the area of patient protections. So the clear statement is: State law with respect to health insurance issuers will be continued and will be applicable. That sounds very good until you find that the rule is, once again, swallowed up by the exception. That was page 122.

Turn to page 123. On line 4 it says: ''Except to the extent that such standard or requirement prevents the application of a requirement of this title.''

In other words, it is going to be the Federal patient prescriptions that are going to supersede any State laws, and to the extent they are not in compliance with and follow very prescriptively the Federal standard, they then

will be null and void. They will be superseded by Federal.

''Application of substantially equivalent State laws''—that is a standard that undermines what the States have already done in this area. So we find, once again, that the exception swallows up the rule.

The same thing is true on the appeals process. The rule claims all appeals must be exhausted. It is very clear the way it states that. Those procedures that are put in place on internal/external must be honored. You must exhaust those. But then you find exceptions that allow going straight to court for dollars even if the appeal has not been filed, if the injury first appears after the time has elapsed for filing an appeal. Go straight to court for dollars if immediate irreparable harm prior to completion of appeals process, if you allege that, allow the 180 days to run and go straight to court without having used the appeals process. You really don't have an exhaustion of appeals.

I find example after example of where there is a bait-and-switch occurring. There is a rule that is being swallowed up by the exception to the rule.

Another point the distinguished Senator from Texas made—a point that needs to be thoroughly debated on the Kennedy-McCain bill—is the area of scope. I read that wonderful title where it says State laws will apply and then, unfortunately, there is the clear exception that really swallows up that rule.

The Kennedy-McCain bill would allow the Federal Government to overturn patient protection laws in every State. The States have done, quite frankly, a lot. Here is all of our 50 States, various areas of patient protections, emergency medical care. You can see Arkansas has that, Arizona, State after State. Very few States have not acted upon emergency medical care. They may do it in a different way than we would do it. Are they less concerned than we are? Are we the only ones who can establish the precise standard for emergency medical care?

These patient protections have been enacted by State legislatures all over the country. Access to OB/GYNs, once again, you can see overwhelmingly the States have already acted. They have already provided patient protections. Continuity of care, gag provisions, almost every State in the Union, with the exception of Mississippi, have acted upon the gag provisions. Formulary exceptions, clinical trials, a number of States have decided they are not going to mandate clinical trials. They have legitimate reasons why that should or should not be included in a State action on a Patients' Bill of Rights.

On the internal appeals, virtually every State in the Nation, all 50 of them, now have an internal appeals process that has been mandated in State patient protections. Forty-one States have an external appeals requirement. Why should we have the right to go beyond what is clearly our responsibility on the ERISA plans, the federally unprotected plans right now, but to go beyond that and go back to all of the States that have, through their own legislatures, enacted patient protection laws and overrule them? I think that is an error.

In the State of Arkansas, the following protection laws would be superseded by this Patients' Bill of Rights: the emergency room provision, the point-of-service provision, the access to OB/GYNs, continuity of care, the gag prohibition, drug formulary exceptions, patient information, all of those would be preempted by this Federal legislation. That is why the National Association of Insurance Commissioners have written us as a Congress expressing their opposition to what we are about to do if we enact this McCain-Kennedy bill as currently drafted.

They wrote to us:

> States have faced the challenges and have produced laws that balance the two-part objectives of protecting consumer rights and preserving the availability and affordability of coverage. For the federal government to unilaterally impose its one-size-fits-all standards on the states could be devastating to state insurance markets.

That is a very legitimate concern they have expressed. And the President, in his statement from the administration on their position on this bill, expressed similar concern about not showing proper deference to what States have already done.

Under Kennedy-McCain, at least 297 patient protection laws that are already on the books would be potentially erased leaving millions of patients unprotected as the States have enacted them. Forty-four ER laws, 20 point-of-service laws, 37 OB/GYN laws, 48 gag clause laws, 26 drug formulary laws, 12 clinical trial laws, 47 prompt payment laws, 30 financial incentive laws, all of these potentially would be erased by the one sweeping action in the Kennedy-McCain bill.

Kennedy-McCain would further force States with minimal or no managed care penetration to adopt Federal standards, or else HCFA would come into those States and take over the regulation of health insurance. Managed care penetration in a number of States is minimal. Alaska is 0 percent. In Wyoming, my good friend from Wyoming, Senator ENZI, has been concerned about this kind of blanket takeover, when there is only 1.2 percent penetration in Wyoming. In Arkansas, it is 11.8 percent. In Idaho, it is 6.3 percent.

The point is that these States vary. They are widely different in the impact of managed care. For us to have a one-size-fits-all approach, I think, is ill-conceived and is something that we need to reconsider. Of the six States which haven't enacted emergency room legislation, five of these have less than 10-percent managed care penetration. So there is a reason why they have not acted upon them. I think we should show proper respect for the wisdom of some of these State legislatures for having real reasons for not acting on some of these patient protections.

At least 11 States have rejected clinical trial mandates, California being one of them, with Florida, Indiana, Massachusetts. At least five States have rejected access to specialist mandates. At least eight States have rejected drug formulary exception mandates, including Florida, Hawaii, Illinois, Massachusetts, Minnesota, North Dakota, Utah, and West Virginia. Kennedy-McCain would force these States to adopt these provisions even if they rejected them in their State legislatures for good reason. I hope my colleagues will think about what we are doing in this preemption of State laws in this very important area.

The amendment that I have offered is a small step in expanding access. My concern about Kennedy-McCain is that it is going to shrink access to insurance, that we are going to have an awful lot of people, families and children, who are not going to be able to access health care insurance because of the impact of this legislation on premium costs. I have offered this amendment that would provide 100-percent deductibility for the self-employed. I think apart from raising extraneous issues that are really germane to the value of this amendment and to what it will do, this amendment has support. Support has been indicated in the past in this body. This is an opportunity for us to do it. And to say it should have been in the tax bill—every time the House of Representatives produced a Patients' Bill of Rights—they passed one that had access provisions, to expand access, and they are going to do that again when this passes in a few weeks, or sooner, and I hope they will. We can be as certain as you can be that it will have tax provisions in it.

It is a red herring to say we are not going to pass this—because we believe it is equitable, it is going to right a wrong—because of a blue-slip potential. I think that is going to be hard to explain to people.

One of my constituents in Arkansas wrote me and my colleague in Arkansas. I think this really expresses why this amendment is important. It says:

> I am a small business owner in Springdale, AR.
>
> Our company has always made an effort to provide, at no expense to our employees, full family health insurance coverage.

Again, they have made the effort to provide it at no expense to employees. So they are paying 100 percent of the health insurance premiums for their employees for full family health insurance coverage—and not just for the employee, but the family receives the benefits. That is something we ought to encourage, something that is good. He goes on:

> A couple of months ago, we were forced to begin sharing some of the cost of the health plan with the employees because of 40 percent plus increases.

Those who would argue that somehow there is no relationship between

increased insurance premiums and availability of insurance to people in this country, that somehow increasing premiums is not going to increase the number of uninsured—we have seen a lot of examples on the floor. We have heard stories and anecdotes told. Here is a prime case in my State:

. . . we were forced to begin sharing some of the cost of the health plan with the employees because of 40 percent plus increases. The monthly cost climbed to over $4,000 a month for our relatively young group. I fear passing [Kennedy-McCain] because it will not only cause greater increases, but subject our company to possible legal actions because of our offering health insurance. We could be at the mercy of whoever decides to pay a claim or not—and open the door for the company to be liable.

I think this bill has a lot of danger in it.

I take that concern very seriously. I think this person who took time to e-mail us from Springdale, AR, is typical of a lot of small businesses that are struggling, that have a few employees, that are trying to pay insurance for those employees and are facing a very large increase in premiums. We are going to exacerbate that, I believe, if we have this bill with all of its liability provisions included in it. This is one small thing we can do to make it a little easier for the self-employed—give them 100-percent deductibility, and give it to them now, not wait until 2003.

I ask unanimous consent to have this e-mail printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SPRINGDALE, AZ.

DEAR ARKANSAS SENATORS LINCOLN AND HUTCHINSON: I am a small business owner in Springdale, AZ. Our company employs 8 very fine people.

Our company has always made an effort to provide, at no expense to our employees, full family health insurance coverage.

A couple of months ago we were forced to begin sharing some of the cost of the health plan with the employees because of 40% plus increases. The monthly cost climbed to over $4,000.00 a month for our relatively young group. I fear passing the S–238 bill will not only cause greater increases but subject our company to possible legal actions because of our offering health insurance. We could be at the mercy of whoever decides to pay a claim or not—and open the door for the company to be liable.

I think this bill has a lot of danger in it. I urge both of our Arkansas Senators to do all in your power to defeat this bill. I urge you to vote against ''cloture'' thus limiting the truth to be brought out on the floor.

On behalf of myself, my partner and our employees, thank you in advance for lodging this request.

JOHN W. HAYES,

P.S. Your voting records are the proof of your loyalty to the people of the Great State of Arkansas.

Mr. HUTCHINSON. Then I received this letter from a different kind of employer. This is McKee Foods Corporation, a large company that is not headquartered in Arkansas. It is in Tennessee, I think, but they are a large employer in Arkansas, in Gentry, AR. I think they employ about 1,400. It is not an insignificant employer.

They write:

Dear Senator HUTCHINSON: The Senate will soon consider a proposal that will give Americans the right to use their insurance provider in state and federal court for coverage decisions. As a business owner, this prospect has me worried. McKee Foods has voluntarily sponsored its own health plan for more than 30 years. All of our employees and their families have the option to take part in our group coverage, including the 1,420 employees who work at our Gentry, Ark., manufacturing facility. In 2000, McKee Foods and its employees spent $25 million to provide health care benefits for all 6,100 of our employees and their families. The company directly paid for more than 75 percent of this amount.

Over the last two years our group insurance benefit costs are up about 26 percent and our prescription drug benefit cost has nearly doubled. The company has absorbed most of the cost increases, but employee premiums have also risen by 10 percent.

That is what the employees are paying and we are going to make that worse if we open this to unbridled lawsuits.

It's important to note that none of the proposals presently under consideration have protections in place to protect the health care purchaser, whether individual or company, from the increased cost of coverage due to insurer liability. A health care bill containing additional costs will simply compound the problem of rising costs.

Our health plan, which is governed by ERISA, is self-insured, self-funded, and self-administered. Maintaining an ERISA plan allows McKee Foods to provide uniform health care benefits to our employees in all contiguous 48 states. We've reviewed the various proposals put forth by both the Senate and the House of Representatives and have come to conclusion that McKee Foods can be sued for voluntary providing health care benefits. Each of the major bills under consideration contains language that defines the liability trigger as ''direct participation'' or ''discretionary authority'' over the decision. This standard directly implicates ERISA's fiduciary responsibility duty. For employers who offer a health plan governed by ERISA, liability is real.

I believe that legislation containing liability for companies will certainly lead to more uninsured Americans. I also believe that many employers want to offer health care benefits because this type of benefit helps us attract and retain high quality employees. Please remember that the voluntary employer-based health care system in our country provides coverage for more than 172 million Americans.

I'm asking you to support a health care bill that sets up a strong system for binding external review instead of lawsuits. Let's get patients the medical treatment they need, when they need it. Reaching a conclusion later in a court only benefits the attorneys.

Then he asks for opposition to this bill.

Are they greedy? Are they an uncaring company; they do not care about their employees and their welfare? I suggest that 30 years have put the lie to any such allegation. This company for 30 years has paid 75 percent of the premiums for their employees and their families, and they write not out of a spirit of greed or lost profits. I suspect it will not affect their profit line. What this legislation will affect is their ability to provide affordable health insurance for their employees.

So many times we do the right thing in the wrong way when we pass legislation in the Senate. We have the greatest motivations. Patients' Bill of Rights—we hear these heartrending stories. They are real and there is a need for legislation, but then trial lawyers get into it, the clever attorneys who can write a rule and write an exception bigger than the rule, and the goal of providing legitimate patients protection suddenly is lost and its impact raises insurance premiums, causing employers to question whether they can even afford to offer that benefit to their employees.

I hope as we continue to debate we will address these issues and we will also adopt this amendment which will help provide greater access.

I did not realize Senator VOINOVICH has been patiently waiting. I could not see behind this chart. I extend my apology for going over the time. I thank Senator VOINOVICH, the distinguished Senator from Ohio, for his strong commitment to better health care in this country, for patient protections, and for also ensuring access is there and that it is affordable. I appreciate his support of this amendment.

I yield such time as he might require.

The PRESIDING OFFICER (Mr. DAYTON). The Senator from Ohio.

Mr. VOINOVICH. Mr. President, I thank the Senator from Arkansas. He does have my support for his amendment. It is well taken, and it will go a long way to help provide more health care for the citizens of our country.

The quality of health care in the United States has long been the envy of the world. If I happen to fall ill when I am home in Cleveland, I know that I can go to any of the hospitals in the community and receive quality care unparalleled around the globe.

However, I also think that more can be done to improve the overall status of health care in America. In fact, I believe Congress must do more to expand health care coverage for more individuals, keep health care costs down and maintain the rights of each individual patient to make decisions affecting their own health.

Five years ago, Congress realized that one arena in which the Federal Government has an obligation is protection for those Americans covered under self-insured ERISA plans because the Federal Government has the sole authority to do so.

There are 56 million Americans who are in health care plans that are self-insured, which are regulated under Federal law. The Federal Government, unfortunately, has been slow in creating consumer protection standards for these 56 million Americans, and I agree with my colleagues that patient protections should be established for these ERISA plans.

In 1999 and 2000, this body passed patient protections legislation that filled the hole in ERISA protections. These absolute and comprehensive patient protections, included:

Access to emergency care;
A point-of-service option;
A continuity of care provision;
Access to prescription drugs that are not covered in plan formularies;
Access to specialist;
A prohibition of gag rules;
Access to clinical trials;
Provider nondiscrimination;
A strong internal and external review process;
A genetic nondiscrimination provision; and
Provisions that would increase access to health insurance, such as increasing the availability of medical savings accounts, full deduction of health insurance for the self-employed and long term care insurance.

I am encouraged that the McCain-Kennedy bill, in spirit, has the same core patient protections that the Senate passed in 1999 and again in 2000. However, while the McCain-Kennedy bill contains these provisions, I cannot support the McCain-Kennedy bill as currently written for two significant reasons.

First, the bill represents an inappropriate preemption of state law. Ohio and the vast majority of other states have already enacted strong patient protection laws that provide their citizens with quality health care.

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

The proponents of this legislation believe we need to pass a bill that will wipe clean the hard work the States have done.

I could not disagree more.

A Federal Patient's Bill of Rights should not preempt the work that has already been done by the States. State regulation of the insurance industry has been very effective for more than 50 years. There are more than 117 million Americans who are covered under fully insured plans, governmental plans and individual policies, which are all regulated under State law.

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

Mr. President, do you know to whom the Federal Government will turn to enforce the law? The Health Care Financing Administration.

The fact is, HCFA already has its hands full. Administering and regulating Medicare, Medicaid and the SCHIP program has already overburdened this administration. Think about it. HCFA already has under its purview over 70 million Americans through these Federal programs. Now my colleagues want to place the health care of an additional 170 million Americans on HCFA's shoulders.

Under the McCain-Kennedy bill, States will now have to report to HCFA on the status of the health care plans in their States. It has been pointed out to me numerous times that the regulations that only govern Medicare are three times what the Federal Tax Code is.

Imagine the regulatory nightmare that will occur when Congress hands over regulation of the private insurance market to the Federal Government. The simple fact of the matter is that HCFA cannot handle the burden this bill would bestow.

However, even if HCFA had the ability to enforce uniform consumer protection standards across the country, it would still not be the right decision. Different regions have different problems against which they need to guard.

A ''one-size-fits-all'' approach from Washington will not work any better for health regulation than for other centralized approaches to problems, such as education. All wisdom does not reside in Washington—local people understand their own local needs, and they elect representatives to serve those needs.

On the Federal level, if we in Congress want to mandate certain health care changes with respect to Federal coverage, then it is well within our ability to do so. And in certain instances, it may be necessary to do so.

But why should Congress intrude on the States and mandate sweeping, across-the-board changes on how they regulate the health care industry in their States? We should let the States decide what is best for their citizens, but there seems to be a feeling here in this town that the States just will not do the right thing.

If you observe what the States have accomplished, you will see that the States have been and will continue to be at the forefront of the nation's efforts to improve the quality and efficiency of our health care system.

In fact, the States have been on the vanguard of health care services, and because of this, many ERISA plans have followed suit voluntarily.

It should be pointed out that the majority of ERISA plans have already taken upon themselves to provide quality patient protections, taking notice from what their States have done. They have mirrored in their insurance plans what the States have already done. However, by seizing and usurping the great works the States have accomplished, the Federal Government is once again stating a one-size-fits-all approach.

It will not work. The majority of States, including Ohio, have moved aggressively, certainly more quickly than the Federal Government, to reduce health care inflation, expand access for the working poor, enhance consumer protections, and bring greater accountability to the system. In fact, if the States waited for the Federal Government to step up to the plate to provide patient protections, 117 million Americans would not have the patient protections they currently enjoy. The simple truth is, the States have been in front of the Federal Government in providing sound protections for their citizens.

The following facts prove it: 50 States have mandated strong patient information provisions; 50 States already have internal appeals processes, and 41 States have included external processes; 48 States already enforce consumer protections regarding gag clauses on doctor-patient communications; 47 States have regulations regarding prompt payment; 42 States have already enacted a comprehensive Patients' Bill of Rights; and 44 States have already enforced consumer protections for access to emergency care services.

As a former Governor of Ohio, I have been on the front lines in the fight to give working men and women in Ohio real health care choices. As Governor, I signed into law five legislative measures and pushed through several administrative improvements to protect families who relied on State-regulated plans for their health care coverage. Now I am in the Senate to try to give those Ohioans who are covered by the Federal ERISA law those same benefits.

I believe the legislation the Senate approved in 1999 and 2000 went a long way to ensuring that Ohioans covered under ERISA are given the health care protections they deserve. The bills passed in this body are nearly identical to those protections passed in Ohio for State-regulated plans, many of which I fought for as Governor. The bills passed by the Senate in 1999 and 2000 extend emergency care coverage under the prudent layperson standard. Ohio enacted that protection in 1997. The Senate passed bills included a ban on gag clauses. Ohio enacted that protection in 1997. The Senate passed bills included strong internal and independent external appeals. Ohio enacted those provisions in 1999. The Senate passed bills allowed a woman to designate an OB/GYN as her primary care provider. Ohio enacted a standing referral provision in 1997, and then direct access in 1999.

The Senate passed bills provide patients the right to accurate, easy-to-understand information about their health plan. Ohio's law requires that all beneficiaries have an I.D. card and access to health care information on a 24-hour, 7-day-a-week basis via a toll-free number. The Senate passed bills ensure that patients may go out of a network if the plan does not have an appropriate provider within its network. That is already Ohio law.

Additionally, Ohio already has enacted a prompt payment provision and a prescription drug formulary exception. Ohio has already put into place a

mandatory 48-hour maternity hospital stay benefit for new mothers. We were the first State to eliminate the drive-through baby, 24-hour situation we had several years ago. Prior to the State's action, in a number of instances, women were being discharged sometimes within hours of giving birth. Now all women in Ohio know that when they give birth, they will have the peace of mind that they and their baby will have access to medical care, if only for observation, for at least 48 hours.

In Ohio, we also allowed for the creation of insurance pools for companies who wanted to be able to provide insurance for their employees but could not afford to do it by themselves. Now, Ohio has one of the most successful examples of an insurance pool in the entire country—the Council of Smaller Enterprises, COSE. COSE provides health insurance to more than 200,000 people and represents more than 16,000 small businesses in Ohio. Without the ability to pool together, many of these businesses would not be able to offer their employees health insurance, and therefore, many more Ohioans would be uninsured.

The second reason that I cannot support McCain-Kennedy as it is currently written is because the bill will encourage frivolous lawsuits, leading employers to question whether or not providing health insurance is worth the cost. A great deal has been said about the options available to a patient who has somehow been wronged by a particular health care plan.

Proponents of the McCain-Kennedy legislation have indicated that the only way patients can ensure that they will be able to obtain relief from being denied benefits is if they maintain the ability to sue their health plans.

They further contend that if they can sue their health plans, it should follow that they can sue their employers. They base this on the belief that employers maintain a fiduciary responsibility to monitor health plan quality, making it impossible to completely delegate responsibility for the health benefit plan's decisions.

I believe such a provision would open a virtual Pandora's box of potential lawsuits and would force any employer who provides health insurance to cover every health claim or risk being sued over those that are not.

Proponents of the McCain-Kennedy legislation believe they have carved out employers, stating only those employers that ''directly participate'' in medically reviewable decisions can be held liable.

However, for all these claims of employer carve-outs, the fact remains, employers can still be sued. Lawsuits can still be brought against the employer for a number of reasons. For instance, the phrase ''actual exercise of control'' broadens the avenue for a lawsuit to come against an employer, although the employer had no ''direct participation'' in a medically reviewable decision. If, during negotiations with a health plan, an employer agrees to the definition of a certain contractual phrase used by the plan for a decisionmaking process, this could be a cause of action for a lawsuit.

Additionally, although proponents of McCain-Kennedy believe they have properly excluded employers, the phrase ''conduct constituting failure'' to perform plan terms and conditions provides a clean sheet for any personal injury lawyer to claw at any alleged failure of an employer. This could be as minor as a simple administrative error in notifying individuals about the availability of continued health coverage after they leave employment.

And as a practical matter, do my colleagues think a personal injury lawyer will not attempt to test the defense of the ''no direct participation'' standard? If I were a savvy personal injury lawyer and saw before my eyes unlimited punitive damages and a new Federal cause of action with a cap of $5 million, I certainly would test the defense laid out in the McCain-Kennedy bill. Unfortunately, this is what it has come down to: the ability of personal injury lawyers to dictate health care in America.

Whom will this ultimately hurt? It will hurt those individuals and families at the margins who are working hard to take responsibility for themselves. I am thinking about the families to whom that employer protection is provided. The fact is, health insurance is a benefit that employers have provided. It is a voluntary benefit they provide because they care about their workers. Approximately two-thirds of insured Americans under 65 receive their health insurance through employer-sponsored plans.

I point out for senior citizens who are retired, half of their Medicare Supplemental for Part B is paid for under the employer plan—half of it. We want employers to stay in this business. It is important to the country.

According to a Gallup poll conducted last September, the vast majority of Americans, 70 percent, are satisfied with their health insurance provided by their employer. If the McCain-Kennedy bill passes with its current liability provision, I cannot honestly see employers continuing this benefit. As a matter of fact, employers have already told me they will drop their health care insurance.

These liability provisions, the unlimited punitive damages in state courts on top of the $5 million damages that can be awarded in Federal court, will hang like a cloud over employers. Even if a lawsuit was never filed, a prudent employer would place in his budget the possibility of this occurrence.

Therefore, the costs associated with retaining legal counsel, as well as the insurance premium paid against the possibility of a large award would be budgeted annually, which of course, would be passed along in higher premiums to the employees.

Employers, if they decide to continue providing coverage, will then place on employees a higher participation of the financial burden for health insurance.

And what if one state jury finds an employer liable and grants a multi-million dollar award? Well, I can tell you what will happen. Employer-based insurance will tumble like a house of cards. Employers will see the writing on the wall and say, Good-bye! Although I care a great deal about each and every one of you, my employees, I cannot afford to be subjugated to this kind of liability. Here's my contribution of what I pay for your health insurance: good luck finding the same coverage at a fraction what you had previously paid.

The proponents of McCain-Kennedy say that the State of Texas has enacted a similar bill that has not caused the collapse of employer based insurance in Texas. What my colleagues are not saying is that Texas specifically carved-out all employer liability.

The provision in Texas law reads as follows, and I quote, ''This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees.''

That is what any Federal law ought to state.

It really is amazing to me that the United States Senate is contemplating opening up employers to lawsuits. Through these actions, we are sending a mixed signal to the American people.

Out of one side of our mouth, we say there are too many uninsured people in the United States. And, in fact, I think there are.

However, out of the other side of our mouth, we say that the United States Senate may allow legislation to move forward that will increase health care premiums by at least 4.2 percent. This is on top of the hyper health care inflation that the country's employers are currently facing—between 18 to 22 percent increases in the State of Ohio over the past year alone.

Indeed, it is estimated that if the McCain-Kennedy bill went into effect as is, over 1.4 million Americans will lose their health coverage—nearly 30,000 in my state of Ohio. (Based on CBO numbers).

What's more, according to a study conducted by the U.S. Chamber of Commerce, 57 percent of small employers said they would likely drop health benefits for their employees if the McCain-Kennedy liability provision was the law of the land.

In addition, at least 1,000 larger employers across the nation-including many Fortune 500 companies-have expressed opposition to the McCain-Kennedy liability provision.

The implementation of a liability standard would not only have a devastating impact on many families in America, but I don't believe it will have the intended purpose of providing restitution to patients.

Most Americans don't realize that 70 percent of all health care liability claims filed in our courts are resolved with absolutely no payment to the patient. Zero dollars.

In cases where a payment is made to a patient who sues, the patient receives, on average, only 43 percent of the damage award. Forty-three percent! The other 57 percent goes right into the pockets of the personal injury lawyers and their expert witnesses.

In addition, achieving a final resolution to these claims is not a speedy process. The average medical malpractice case takes over 2 years, 25 months, to resolve. In many instances, that is long after the patient has suffered permanent damage, or even death.

What we need to do is focus our attention on getting patients treated quickly and accurately and not concentrating on getting them a pay-out that may never come.

I would like to have an opportunity to support a bill that truly utilizes the internal and independent external review process. Towards that goal, I believe we should revisit the legislation that the Senate passed in 2000.

In the Senate-passed bill for which I voted last year, if the group health plan makes a determination to deny coverage and notifies the enrollee and health care professional, the enrollee or the doctor would be able to request an internal review of the coverage decision. That review must be completed within 30 days for a routine determination, or 72 hours for an expedited determination.

If an enrollee is denied after an internal review, he or she can request an independent, external review. An independent medical expert, utilizing valid, relevant scientific and clinical evidence, including peer reviewed medical literature, would then make an objective determination based on the medical exigencies of the case, within 30 days. The decision of the external reviewer would be binding on the plan.

If the external reviewer rules in favor of the enrollee, the plan must notify the enrollee of their decision to cover the benefit with ordinary care. If the plan refuses to follow the decision of the expert reviewer, the enrollee could then sue in Federal court for unlimited economic damages and capped non-economic damages.

If the court ruled for the enrollee, then the court: one, would require the plan to cover the service; two, assess a $10,000 penalty for failing to comply with the agreed upon time frame; three, additionally assess a penalty of $10,000, payable to the enrollee, for failure to comply with the decision of the medical reviewer; four, award attorneys' fees; and five, provide non-economic damages of up to $350,000.

I think we should offer patients an opportunity to obtain timely coverage of legitimate health services before permanent damage is done to them. Unfortunately, the McCain-Kennedy bill offers patients faint hope that, well into the future, after the damage is already done, they may recover less than half of a damage award.

Our main goal in this debate must be to provide quality health consumer protections while maintaining the ability for America's families to obtain their insurance through their employers. We should not enact massive changes to our health care system which will irreparably harm the ability of millions of Americans to obtain affordable, quality health care.

I hope that my colleagues and I can work to pass a real Patients' Bill of Rights: one that will not impede on the progress the states have made, and one that provides health care to patients, not money to personal injury lawyers.

Regrettably, I do not believe that the McCain-Kennedy bill will accomplish these goals.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, I thank the Senator from Ohio for his work in the State of Ohio and for his work in the U.S. Senate.

I yield to my cosponsor, Mr. BOND, the Senator from Missouri.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. BOND. Mr. President, I thank my lead sponsor of this amendment.

I say to my good friend from Ohio, and a fellow former Governor, that I recognize the work he did as Governor to assure access to the working men and women of Ohio. I think his comments and his views are very important in this debate. We appreciate the good judgment he brought based on his experience.

I want to take just a couple of minutes before we get into the closing to respond to a couple of points that have been made on the other side.

Some who are proponents of this bill and who are opponents of this amendment have offered two arguments.

First, they say if we—meaning Republicans—somehow wanted employee-supported deductibility for the self-employed, it would have been included in the final tax package that was passed a month ago.

Second, they contend that this issue is unrelated to patients' rights and that we are trying to kill the patients' protection bill.

Let me deal with those two points.

First, regarding the tax bill, it is regrettable and, in my view, very regrettable that the conference committee did not include this provision in the final package. This provision reflected an amendment that I offered and an amendment that the Senator from Illinois, Mr. DURBIN, offered. We both offered amendments.

As I mentioned in my earlier statements on this measure, I had provided over the last 6 or 7 years a continuing string of amendments to achieve 100-percent deductibility. Senator DURBIN in recent years has joined.

When the bill went to the conference committee, there were a lot of interests that had to be accommodated. The Senate had a much lower figure than the House had originally. They had to accommodate as many interests as possible. The House of Representatives had a very important voice in what the final package included.

As a matter of fact, Democrats on the conference had a voice. I wasn't at the conference. I have talked to some Members who were there. They tell me that the Democrats did not raise objection to excluding the full deductibility. This was a conference committee of Republicans and Democrats from both the Senate and the House.

I regret that they did not get the job done. Is that an argument that we should not do it now? Obviously not.

When you ask the American people—the men and women, the farm families, the families of people who own a restaurant, a mom-and-pop grocery store, or who operate a daycare center—do they really care whether full deductibility is in a tax package or whether it is in the Patients' Bill of Rights, I can tell you that overwhelmingly they are going to say we just need the full deductibility for our health insurance costs. They want to see the job done. They are not much impressed with the argument that it didn't stay in an earlier bill we passed. They want us to pass it. We want to see it passed. That is what Senator HUTCHINSON and I are doing. To blame us for the failure of a conference to include it I believe is a bit of a stretch.

Second, they are saying that this amendment is being used to kill the patients' protection bill. If we wanted to kill a bill completely, why would we put something on that is so important to the people in our States and the people in America? I think that is laughable. It would be laughable, if it weren't such a serious, unwarranted charge.

Every patient protection bill that has passed either the House or the Senate in the last few years has included tax incentives for health care of some kind or another.

The House patient protection bill that we expect to see passed in the next 2 or 3 weeks will almost certainly include tax provisions as well. As a matter of fact, I notice that in the statement of administration policy they are objecting to a user fee provision. They call it an extraneous user fee provision that is already included in S. 1052, extending for multiple years customs charges on transportation, passengers, and merchandise. It has a little tax measure in there already. This is a tax reduction or tax deductibility.

Contrary to what our colleagues who are supporting the measure and opposing this amendment say, if there are no tax provisions in this bill when it finally comes out, it will be an absolute first. I will buy somebody a soda if they pass a bill that has no tax provisions in it.

Including tax provisions in the bill does not hinder its passage. Frankly, I think it makes it better because this amendment is not about killing the bill. I want to vote for a bill that helps all Americans have good health care coverage. That means getting rid of the bait-and-switch provisions in this bill. That means taking out the provisions that force employers to drop their plans because of employer liability. That means taking out the provisions that rewrite the contracts that HMOs, insurers, write with those they wish to cover.

I just want to mention very briefly an article by Mort Kondracke in today's Roll Call. In it he says:

A debilitating civil war is under way in the American health care industry and Congress will make it worse by passing the Kennedy-McCain patients' rights bill and inviting trial lawyers to enter the fray.

Kennedy-McCain is the medical profession's effort to counterattack its enemy, the insurance industry, using expensive lawsuits as a weapon. But innocent ''civilians,'' i.e. patients, will pay the ultimate price.

He goes on to say:

Doctors surely should have more say in medical decisions than insurance clerks. . . .

He says: The Breaux-Frist bill does it.

He says:

Instead of increasing the ranks of the uninsured, Congress and Bush should be helping lower-income workers afford health insurance.

That is what we are trying to do.

He concludes by saying:

. . . Congress should observe the famous rule: First do no harm. Kennedy-McCain violates that maxim.

I urge my colleagues to support the Hutchinson-Bond amendment.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. I thank my colleague from Missouri for his excellent statement.

I yield such time as we have remaining to the Senator from Nevada.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, may I inquire as to the amount of time left on our side?

The PRESIDING OFFICER. Twenty-four minutes thirty seconds, of which fifteen is reserved for the Senator from Arkansas.

Mr. ENSIGN. Mr. President, I want to start by talking on this amendment, and then I want to conclude my remarks by speaking on the underlying bill in general.

Deductibility for the self-employed is absolutely critical to anybody who has ever been in business on their own. My brother-in-law is a tile contractor in Las Vegas, NV. When he first started his business, he was in his late twenties. I remember talking to him about having health insurance.

He said: I'm young. I'm healthy. I'm not going to get sick.

He said: Besides, I really can't afford it. When I am looking at my monthly expenses, I look around, and it just doesn't pencil out for me.

That is the kind of person we want to be covered under health insurance.

The way health insurance works is if we spread the risk out, especially amongst the younger, healthier people, it costs all of us less money. So what we want to do is have people, like my brother-in-law, to buy health insurance. If we give the self-employed—which he is—full deductibility, it will make financial sense for more of them to purchase health insurance.

It does not matter what vehicle—whether it is a tax plan or whether it is the Patients' Bill of Rights—we use to provide this deductibility. We have been talking about it for years, and we ought to finally make this policy a reality.

Let me shift now and talk about the Patients' Bill of Rights. If you listen to the media, it almost sounds like the Democrats and Senator MCCAIN are for a Patients' Bill of Rights and the Republicans are against one. That is not so. Almost everybody in this Chamber is for a Patients' Bill of Rights. As a matter of fact, the two major competing bills are 90 percent the same. Another 5 percent of each bill I think we agree, conceptually, on the language; and then on the other 5 percent there is true disagreement.

Let me go through these divisions just briefly. The 90 percent where there is agreement has to do with things that we have heard about for the last several years that most of the States have already enacted. They have to do with emergency room access, no gag clauses for doctors, and allowing OB/GYNs and pediatricians to be considered primary care doctors. There is a whole list of things that both bills address and to which everybody agrees.

The place where we have conceptual agreement—and I want to applaud Senator MCCAIN for his willingness to work with us to try to come up with some language that will work for both sides—deals with, how are we actually going to protect employers from getting sued? Everybody I have heard from agrees that the employer should not be sued for this very simple fact: If you allow employers to be sued, they will look at this risk and say that they cannot afford it. Consequently, they will give their employees a voucher, calculating, for example, that it would cost $5,000 to $6,000 per employee per year for health coverage, and the employee will go out and buy their own health insurance.

However, a lot of employees who are young and healthy will say: I'm healthy. I'm young. I would rather have this $6,000 to do something else with.

As a result, those people will not have health insurance. And because those people are no longer in the overall insurance pool, everybody else's insurance rates will go up. Consequently, when those insurance rates go up, more people become uninsured because they can no longer afford coverage.

One of the biggest problems we have in this country is the number of uninsured. This is the reason why it is so critical that we come together on this language to protect the employers.

As I have learned—I was only in the House of Representatives for 4 years; and I have only been in the Senate for 6 months—the devil truly is in the details. When we are looking at the legal language, lawyers from one side can say the employers are protected, and the lawyers for the employer groups can say absolutely under the McCain-Kennedy bill they are not protected. A good lawyer, I think, can take the language in the McCain-Kennedy bill and absolutely get lawsuits against employers.

That is why it is important for us, if we agree on the concept—which we seem to do—to come together with tight language that does not allow employers to be sued, especially if they are not involved in actually denying health care that they did not pay for in the first place.

The other thing that I think is conceptual language that we agree on is that the appeals process is important for us to go through first. All of us agree this whole thing is about getting health care to the patient. Do we really want just access to a courtroom? Or do we want access to the emergency room and to the hospital and to health care providers?

The appeals process is set up with a short time frame to guarantee that people will get the health care they have paid for in a timely fashion. That is really what this whole debate should be about—getting people the health care they deserve.

We all know the movie, ''As Good As It Gets,'' where everybody cheered when the HMOs—I cannot use the language the way they described the HMOs—were described in not so favorable terms when they denied health care to the child that had asthma. That is a perfect example of what we are trying to fix with a Patients' Bill of Rights—greater access to quality health care.

The appeals process will help us get children like that the health care they need. That is really a lot of what this debate is supposed to be about.

On the 5 percent where we truly have disagreement is where we are going to have to sit down and compromise. This has to do with whether a person goes to State court or goes to Federal court with their health care liability suit. Neither side is going to get, I think, everything they want in this. We are going to have to come down to some kind of compromise.

The second area of major disagreement deals with the liability provisions. Basically, it has to do with whether we are going to cap punitive damages and noneconomic damages. Are we going to put some reasonable limits on some of the liability provisions so we do not end up with these outrageous lawsuits?

The two sides are going to have to come together and realize that a compromise is going to be the only way we can get a bill passed through the Senate, passed through the House, and signed into law by the President. Otherwise, we are just making political hay. Otherwise, all this exercise is about is: Can we use this in the 2002 elections?

If that is what we are about, then I don't believe we should be here as United States Senators. We should be here to do the right thing for the American people. We were sent here by our individual States to stand up and do what is right. If people want to make political hay, then they can do that on a purely individual level. If they truly want to get a good Patients' Bill of Rights passed, then we have to sit down behind the scenes where the cameras aren't, where the news media isn't, and say: Let's compromise on some of these things that we disagree on and come up with language that protects employers, makes sure the appeals process is exhausted, and then shake hands on the parts we agree to.

If we can do those procedures, I truly believe this Senate will pass a very good Patients' Bill of Rights which will help the type of kid that was in ''As Good As It Gets'' get the kind of health care he or she deserves.

I thank the sponsor of the amendment for helping out the self-employed. I think it is an important amendment that I will be voting for and encourage all of the rest of the Senators to do the same. I look forward to working with the authors of the Patients' Bill of Rights, Senators EDWARDS, KENNEDY, and MCCAIN. Hopefully, we can come up with some compromise on the rest of this language.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, I commend the Senator from Nevada for his excellent statement, that spirit of cooperation that will ensure we really can get a good Patients' Bill of Rights passed and enacted into law this year.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Mr. President, on the first day of debate on the floor of the Senate on the Bipartisan Patient Protection Act, supported by a majority of the Senate, a majority of the House of Representatives, and virtually every health care group in America, what was the response of the President of the United States? A written veto threat on patient protection legislation. In fact, this written veto threat could very easily have been written by the big HMOs. It duplicates what we have been hearing from the big HMOs from the very outset of the fight for patients and doctors to give them real and meaningful rights.

It reminds me a great deal of what was said to the New York Times by a consultant for the big HMOs. When brought to his attention that they were spending millions of dollars to fight against patients and against doctors, millions of dollars on lobbyists, broadcast television ads and public relations, this was his response:

We'll spend whatever it takes.

The HMOs of America are prepared to do whatever is necessary and to spend whatever it takes to make sure that the patients of this country and the families of this country never get the protection they deserve.

We have a message for the big HMOs of this country. We are prepared to fight as long and as hard as is necessary to ensure that finally the big HMOs no longer have their privileged status, that the families and patients of America are protected. That is what this debate is about.

We welcome the participation of the President. We would love to have his involvement in standing with patients and doctors instead of standing with the big HMOs.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, throughout this debate we have heard the same tired old refrain. It is the same refrain we hear whenever we confront a powerful vested interest on behalf of the American people: Costs will go through the roof; people will lose their jobs or their health insurance; gloom and doom will envelop the Nation.

We heard it on the minimum wage. We heard it on the family and medical leave bill. We heard it on the Kennedy-Kassebaum insurance reform bill. Every time the special interests launched a massive disinformation campaign, and every time they were wrong.

Six hundred organizations of doctors, nurses, patients, from the American Medical Association to the American Nurses Association to the American Cancer Society, support our bill—virtually the entire medical and patient community. Do the opponents really expect the American people to believe that doctors, nurses, and patients would support legislation that would cause people to lose their insurance? Do they?

We heard an eloquent statement this morning from Senator ZELL MILLER. All these claims were made in Georgia and all of them proved to be false. I hope we can move beyond these false charges and get back to the business of protecting patients.

On this amendment, I support providing full deductibility for the self-employed. This can pass the Senate any time. It has passed the Senate before. But on this bill, it is a poison pill. It kills the bill. Anyone who votes for this amendment is voting against patient protections. I urge its rejection.

During the course of the afternoon, we heard those on the other side talking about the importance of the premium. It was pointed out that the increase over 5 years will be 4.2 percent, a little less than under the bill of the President, which is 2.9, a point difference.

Look what the CEO of United Health Group received last year: $54 million in annual compensation and $357 million in stock options. That particular payment amounts to $4.31 a month. Ours is $1.19 a month. If you want to do something, there are 7 million employees here. This one individual raises the cost of the premium by $4.13. Ours, in order to protect and grant greater patient protections, is $1.19.

Let's get serious about these facts. Let's get serious about the figures. Let's not just read the HMO script sheets. Let's debate the real issues and protect American patients.

The PRESIDING OFFICER. Under the previous order, the Senator from Arizona is recognized.

Mr. MCCAIN. Mr. President, according to an article in Business Week on February 19, 2001:

So far, though, Texans have filed only about 15 suits under the new law, and few are predicting a barrage of cases, according to the State Attorney General John Cornyn, a Republican. Similarly, experts say that at most only a couple of suits have been filed in the other six states with such laws. The reason: Appeals procedures settle most cases before they get to the lawsuit stage. Except for Maine, all states with right-to-sue laws require patients to complete an external review before going to court.

That is exactly what this legislation calls for.

We heard from a number of people, not about the pending amendment, which is unfortunate, but with a lot of very strong allegations.

Senator ZELL MILLER is a former and rather successful Governor of the State of Georgia where the law was passed. According to a media report:

Miller took the Senate floor and quoted from the president's ''principles'' for patients rights, released in February.

''Only employers who retain responsibility for and make final medical decisions should be subject to suit,'' Miller read from the White House letter to Congress which became a favorite quotation during the day.

Miller also said that a Georgia patients' protection law passed two years ago should answer any concerns about a flood of lawsuits.

''When the Georgia Legislature debated this law, there were critics, critics who made the same arguments we're hearing in Washington today,'' Miller said.

''In Georgia, they paid for ads saying the law would drive up premiums and cause more people to lose coverage,'' he said. ''The critics paid for ads claiming employers would be held liable for HMO mistakes.

Sound familiar, Mr. President?

They paid for ads predicting—

I love this alliteration—

a flurry of frivolous lawsuits.

Oh, there was hissing and moaning. But you know what? None of those dire predictions has come true.''

Miller said that the law is ''working well'' and that no patient has filed a lawsuit yet.

That comes from the former Governor of the State of Georgia who strongly supports this legislation.

Mr. President, I have tried very hard—how much time remains?

The PRESIDING OFFICER. Five minutes 5 seconds.

Mr. MCCAIN. Mr. President, I have tried very hard to negotiate a unanimous consent agreement concerning this pending amendment. I think it is a good amendment. Yes, it was passed before and it was dropped in conference by the Republican leadership as they negotiated the tax bill out. That is a fact. But it is still a good amendment and it is still a good thing to have deductibility for people who have to pay for health care insurance. I think it is a good one.

So in my negotiations with the opponents of this bill, I asked that we go ahead and accept this, and maybe even two others, as long as it stayed under the window of money that is available under this legislation, which is called for in order to pay for the cost of this legislation. Unfortunately, we were unable to get an agreement. I am very disappointed because I think we could have included this. But we had to do it in a constitutional fashion. In other words, I called for an agreement that we would accept the amendment, and perhaps even two others, and then we would, under unanimous consent, call up a revenue bill that would be pending at the desk from the other body so as to satisfy the blue slip concerns.

Look, if this amendment is passed and it goes to the House, the bill is immediately killed. That may be the intent of the opponents of our legislation; I don't know. But let the RECORD be clear that I want this amendment accepted, and I want us to accept even others that could reduce the cost of health care to American citizens. But we have to do it in a constitutional fashion because we all know that a revenue-raising amendment can only originate in the other body. So I will repeat my unanimous consent request as follows:

I ask unanimous consent that at 5:30 today the amendment be agreed to and that there be no further revenue or blue slip material amendments in order to this bill; further, that when S. 1052 is read a third time, it be laid aside and the Senate immediately turn to the consideration of Calendar No. 69, H.R. 10; that all after the enacting clause be stricken and the text of S. 1052 be substituted in lieu thereof, the bill be read the third time, and the Senate proceed to vote on final passage of the bill; and that the Senate request a conference with the House and the Chair be authorized to appoint conferees.

The PRESIDING OFFICER. Is there objection?

Mr. GREGG. Reserving the right to object——

Mr. MCCAIN. I ask unanimous consent that my time not be used by this reservation.

Mr. GREGG. Then I will simply object. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. MCCAIN. Obviously, that is objected to.

I ask unanimous consent that at 5:30 today the amendment be agreed to and that there be no further revenue or blue slip material amendments in order to this bill, except for three revenue amendments to be offered by each leader or his designee and that each be considered under the regular order with no points of order being waived; further, that when S. 1052 is read the third time, it be laid aside and the Senate immediately turn to the consideration of Calendar No. 69, H.R. 10; that all after the enacting clause be stricken and the text of S. 1052 be substituted in lieu thereof, the bill be read a third time, and the Senate proceed to vote on final passage of the bill; that the Senate request a conference with the House, and the Chair be authorized to appoint conferees.

Mr. GREGG. Reserving the right to object, I will take 30 seconds off our time to make my reservation.

Regarding the unanimous consent request, as he knows, we said we are willing to talk about this. Due to the timing, we are not going to be able to resolve it. I would be willing to suggest that we take out the first part of that unanimous consent request and go with the language which at least cleans this amendment up relative to blue slip language, so that the unanimous consent would instead read as follows: That when S. 1052 is read the third time, it be laid aside and the Senate immediately proceed to the consideration of Calendar No. 69, H.R. 10, and that all after the enacting clause be stricken, and the text of S. 1052, as amended, be substituted in lieu thereof, and the bill then be read the third time, and the Senate proceed to a vote on final passage of the bill.

The practical effect of that would be that at least as to this amendment, until we can clear the other issues, we would have avoided the blue slip matter. Would the Senator accept that as an amendment to the request?

Mr. MCCAIN. Mr. President, of course not, because we——

Mr. GREGG. This is not on my time anymore.

Mr. MCCAIN. We would not know how many bills—I think three revenue bills is reasonable. This is not a revenue bill, Mr. President. This is not a tax bill. This is a Patients' Bill of Rights bill. I think it is perfectly reasonable to say that three, as long as they fit under the window, would be appropriate. I went from one to three.

I kept asking the Senator from New Hampshire if we could reach agreement on numbers of amendments. No. We have a lot of amendments. Well, that is not what the bill is all about. I am willing to agree to three. I think that is reasonable. So, obviously, I cannot agree to something which is basically open ended.

Mr. GREGG. Reserving the right to object, off my time, I say that we are willing to talk about the number and, unfortunately, in the timeframe to get to the vote we were not able to reach a conclusion because there are a lot of Members who have issues that at least marginally affect this question.

I do think if blue slip is an issue, we can correct it right here with the language I have proposed. I can understand that the Senator will not accept that. I cannot accept his amendment in its present context. So I object.

The PRESIDING OFFICER. Objection is heard.

Mr. MCCAIN. I thank the Senator. I hope we can reach agreement. In the meantime, so this doesn't become just a tax bill, I hope we can agree on three and they would fit under the window of the revenue that is generated according to this legislation, and, by the way, the Frist-Breaux proposal has no way of raising the money in their legislation for that. So I hope we can work this out because I think it is a worthwhile amendment that would be very helpful to low-income Americans.

Mr. President, I ask unanimous consent that all first-degree amendments be filed by 2 p.m. this Monday.

Mr. GREGG. Reserving the right to object, again, that would be very difficult to do at this time. Obviously, there are a large number of Members who have first-degree amendments. It is fairly late in the week, and some are actually on the move, as I understand it. We would have to object to that.

The PRESIDING OFFICER. Objection is heard.

The time of the Senator from Arizona has expired.

Mr. HUTCHINSON. I yield such time as he might require to the Senator from New Hampshire. How much time remains?

The PRESIDING OFFICER. The Senator has 13 minutes 28 seconds.

Mr. GREGG. Mr. President, I ask unanimous consent that the unanimous consent I propounded earlier be accepted. I will review it:

That when S. 1052 is read a third time, it be laid aside and the Senate immediately proceed to the consideration of Calendar No. 69, H.R. 10, and that all after the enacting clause be stricken and the text of S. 1052, as amended, if amended, be substituted in lieu thereof, and the bill then be read the third time, and the Senate proceed to a vote on final passage of the bill.

The purpose of this amendment is to make it absolutely clear that if we want to, there is no blue slip issue relative to this bill, this amendment, because there is a bill sitting at the desk that can be dealt with now by this unanimous consent, or at the end of the day, or when we get to the end of the bill.

The fact is that the blue slip issue is truly not an issue because we have a vehicle available to us. I ask unanimous consent for that request to be accepted.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Objection.

Mr. MCCAIN. Reserving the right to object.

Mr. BAUCUS. I will withdraw the objection if the Senator from Arizona wishes to speak.

Mr. MCCAIN. Reserving the right to object.

Mr. GREGG. On what time is the Senator speaking?

The PRESIDING OFFICER. The time of the Senator from New Hampshire.

Mr. MCCAIN. I will not make my reservation long in deference to the Senator from New Hampshire.

Mr. President, I will object. The point is, we need to have a finite number of amendments that we can accept, and we need to have it under the window of revenue that would be allowed according to the legislation. I hope we can work that out. But we cannot allow this simply to turn into a tax bill. We have already spent time on that. So I will object.

Mr. GREGG. Mr. President, it is clear from this last exchange that the blue slip issue is a red herring to throw a few more colors on the table. The fact is, if we want to address the blue slip issue as a Senate, we can clearly do that. This amendment should not be defeated on the basis of a technicality which is clearly correctable.

This is a good amendment. This is an amendment which gets to one of the core issues in this bill, which is the fact the bill, as proposed by Senator MCCAIN and Senator KENNEDY, is a bill that will create more uninsured individuals. I still do not understand how we can call it a Patients' Bill of Rights when this bill creates 1.3 million people who will not have insurance. To me it is not giving rights but taking away their capacity to get health insurance.

At least if this type of bill is going to pass, we ought to expand access to health insurance in other ways. What the Senator from Arkansas has proposed is a very appropriate way to do it. It is something that passed the Senate a number of times before and should be passed at this time.

I want to make a couple of points because there were a couple points made as we have come down to the line. There was a representation made that we are representing the special interests. Let me tell my colleagues, those 1.3 million people are going to lose their insurance are the people I am representing. The small employer who runs a restaurant or a gas station or a little business starting out is going to have to drop health insurance because of this bill. Those are the people I am representing.

We can make the representation on our side when you look at the drafting of this bill that it was put together with certain interests, such as trial lawyers, because it so grossly expands the opportunity for lawsuits, creating new causes of action, creating multiple forum choices, creating no punitive damage caps, creating no noneconomic damage caps, allowing people to escape the external appeals process at will.

We have not said that. It is really inappropriate for the other side to be making these types of representations.

The fact is, as has been represented on the other side that this bill costs 4.2 percent over 5 years—this bill costs 4.2 percent every year in added costs, and that point should be made because that is a lot of new money that is going to have to be borne by the employers.

Those two points needed to be cleared up. I reserve the remainder of time for the Senator from Arkansas.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, how much time remains?

The PRESIDING OFFICER. Eight minutes forty-one seconds.

Mr. HUTCHINSON. I thank the Chair, and I thank the Senator from New Hampshire for his good statement regarding the blue slip issue. He called it a red herring. It is a red herring. It is clear, if we want to adopt this, we can. If we want to enact this, we can. The whole blue slip smokescreen is a distraction from the reality.

This is something we should do. Most of us know we should do it. It is something we can do. It is not an effort to subvert or derail this bill. It is an effort to improve it. It is most definitely relevant to this legislation because this legislation will increase the uninsured. It is going to do that. I do not think there is any doubt about that.

The CBO says it is going to increase costs and, as a result of that 4.2 percent increase in cost in premiums, at least on top of the inflation that is already occurring in the health care industry, we are going to see at least 1.3 million more uninsured.

Any effort we can make in this legislation to reduce the uninsured is most relevant. This legislation will do that.

The National Association of Manufacturers is going to key vote this. I do not blame them. This is a key vote. This is an important vote. This is one that deals directly with access to health care.

I remind my colleagues as well, every bill the House of Representatives has passed dealing with a Patients' Bill of Rights has had a tax provision. This is a figleaf that is being held up on a blue slip, and I do not believe the American people will buy that.

Current law discriminates against the self-employed. Corporations are allowed 100-percent deduction. Employees receive 100-percent exclusion for health insurance paid by their employers, but self-employed individuals still are not treated equally.

We can, with a very modest expense, very low expense, move this up a year, give them 100-percent deductibility beginning January of next year. We should do so.

We heard a lot about the liability concerns in this legislation. They are very legitimate concerns. These are not special interests talking:

Chicago Tribune:

Better to put teeth in administrative review than allow malpractice lawyers to tear the entire health insurance system to shreds.

The Arizona Republic:

The cost of these reforms is uncertain, but it will be borne by businesses that provide health care coverage perhaps by their employees in the form of higher deductibles or copayments and by employees who may find themselves uninsured if their employer no longer provides coverage as a result of increasing costs.

The Washington Post:

The threat of a lawsuit should not be what governs health care in this country. To the extent Congress can avoid or contain that awful possibility, we think it should.

Those are not special interests. Those are legitimate concerns about what this bill will do to lawsuits and litigation across the board.

Who are the self-employed we want to help? There are 12.5 million self-employed, and 3.1 million of them are uninsured. We want to minimize the impact on the insured. This is one way we can do it. One out of four of those self-employed in this country are uninsured, almost one out of four. This will make insurance closer to a reality for those people. Seventy percent of these individuals earn less than $50,000. More than two-thirds of those who are self-employed are not affluent, are not rich. They are making less than $50,000 a year.

Then I want my colleagues to think as they vote on this amendment not just about the 3.1 million who are uninsured, who are self-employed, but I want them to think about their children, those who are family heads.

The Hutchinson-Bond amendment will provide the possibility of insurance not only for 6.4 million children who are going to have their situation made better, but for the 1 million children absolutely uninsured right now. That I know is a concern of every Member of this body. This is a means by which we can help that situation. I ask my colleagues to join in an overwhelming vote in support of this amendment. Do not pretend that a technicality somehow justifies a ''no'' vote. This is a sincere effort to access more people to insurance.

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

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

Mr. HUTCHINSON. I yield back any time.

Mr. REID. Mr. President, I ask unanimous consent that the Senator from Montana, the chairman of the Finance Committee, be recognized for 2 minutes, and the Senator from New Hampshire be recognized for 2 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Montana.

Mr. BAUCUS. Mr. President, I oppose the pending amendment for several reasons. One, the bill before us is a Patients' Bill of Rights; it is not a tax bill. We have already passed a tax bill. It was a big one, $1.35 trillion, just a

short while ago. There could be an opportunity later to examine tax issues, but this is not the time to do it nor do I submit this is the place to do it.

I oppose this amendment on jurisdictional grounds because the Finance Committee is the committee responsible for tax issues, and we will take up similar legislation at a later date, but this is not the time or the place for a tax provision.

Also, Senator GRASSLEY, the ranking member of the committee, agrees—I have discussed this with him—this is not the time and place to include this legislation. The place is in the Finance Committee. That is the committee of jurisdiction over tax legislation. Senator GRASSLEY, as do I, has a strong interest in addressing health care-related tax cuts, but rather in the context of the Finance Committee. He and I strongly urge the Senate to reject this amendment. This is not the time and place to offer tax amendments.

When all time expires, I will make a point of order against the pending amendment.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Mr. President, I am going to yield our time to the Senator from Missouri, but I want to make the point very clear. If my colleagues vote for the point of order against the amendment, they will be voting against people's ability to fully deduct their health insurance.

I yield to Senator BOND.

Mr. BOND. Mr. President, I thank my colleague from Arkansas, Senator HUTCHINSON, for making this the first amendment. My thanks to the Senator from New Hampshire for explaining very carefully. We can talk about the procedure we want, but very simply stated, this has been agreed to by the Finance Committee before. This is a bill that will have tax-related provisions in it. This is a bill that already does. We have heard from both the Senator from Arizona, one of the principal sponsors, and the Senator from New Hampshire, how we assure that this bill is not blue-slipped.

I urge colleagues to support this amendment regardless of the procedural basis on which it is challenged. The underlying purpose is to assure every self-employed businessperson in this Nation and their families that they will get full deductibility of health care. We want to do something good for patients. This is a first step.

I urge my colleagues to support the Hutchinson-Bond amendment and help take a positive step to begin what will be a very important and significant debate on how we protect patients. Cut through the procedure. The question before my colleagues is: Do you want to see self-employed individuals have full deductibility for health care?

Mr. BAUCUS. I make a constitutional point of order against the Hutchinson amendment on the grounds that the amendment would affect revenues on a bill that is not a House-originated revenue bill.

I urge Senators to vote aye on the point of order.

Mr. GREGG. Parliamentary inquiry.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. If I wish to support allowing people to deduct their health insurance, do I vote no on this amendment?

Mr. REID. Yes, you vote no.

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

The PRESIDING OFFICER. It takes an affirmative vote to sustain the point of order.

Is there a sufficient second on the request for the yeas and nays? There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. Under the precedents and practices of the Senate, the Chair has no power or authority to pass on such a point of order. The Chair, therefore, under the precedents of the Senate, submits the question to the Senate. Is the point of order well taken?

The yeas and nays have been ordered.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Vermont (Mr. JEFFORDS) and the Senator from Georgia (Mr. MILLER) are necessarily absent.

Mr. NICKLES. I announce that the Senator from Alabama (Mr. SESSIONS) is necessarily absent.

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

[Rollcall Vote No. 194 Leg.]

YEAS—52

Akaka	Dodd	Lieberman
Baucus	Dorgan	Lincoln
Bayh	Durbin	McCain
Biden	Edwards	Mikulski
Bingaman	Feingold	Murray
Boxer	Feinstein	Nelson (FL)
Breaux	Graham	Nelson (NE)
Byrd	Grassley	Reed
Cantwell	Harkin	Reid
Carnahan	Hollings	Rockefeller
Carper	Inouye	Sarbanes
Chafee	Johnson	Schumer
Cleland	Kennedy	Stabenow
Clinton	Kerry	Torricelli
Conrad	Kohl	Wellstone
Corzine	Landrieu	Wyden
Daschle	Leahy	
Dayton	Levin	

NAYS—45

Allard	Enzi	Murkowski
Allen	Fitzgerald	Nickles
Bennett	Frist	Roberts
Bond	Gramm	Santorum
Brownback	Gregg	Shelby
Bunning	Hagel	Smith (NH)
Burns	Hatch	Smith (OR)
Campbell	Helms	Snowe
Cochran	Hutchinson	Specter
Collins	Hutchison	Stevens
Craig	Inhofe	Thomas
Crapo	Kyl	Thompson
DeWine	Lott	Thurmond
Domenici	Lugar	Voinovich
Ensign	McConnell	Warner

NOT VOTING—3

Jeffords	Miller	Sessions

The PRESIDING OFFICER. On this vote the yeas are 52, the nays are 45. The point of order is sustained and the amendment falls.

Mr. KENNEDY. I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

Mr. LEVIN. Mr. President, I voted to sustain the Constitutional Point of Order made against the Hutchinson-Bond amendment to the Patients' Bill of Rights legislation. While I have in the past supported and continue to support full deductibility of health insurance for the self-employed, I oppose this amendment to this bill for several reasons. Firstly, the Constitution states that tax legislation must originate in the House of Representatives. Attaching this amendment to this bill would create parliamentary burdens for the Patients' Bill of Rights legislation which would be very difficult to overcome. This is precisely the reason that opponents of this bipartisan legislation are proposing to attach this amendment at this time and why Senator MCCAIN, Senator KENNEDY, and Senator EDWARDS, the authors of the bipartisan Patients' Bill of Rights oppose this amendment. Secondly, the full phase-in of premium deductibility is already scheduled to occur in 2003. Congress has already speeded up the phase-in twice since passing the 1996 Health Insurance Portability and Accountability Act. Because I strongly support the Patients' Bill of Rights, I do not want to see language added to the bill which will interfere with its becoming law.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, I think, under the previous agreement, there is going to be recognition of the Senator from Arizona. We have a very important amendment now that will be offered by the Senator from Arizona. We will only have an hour of debate time in the morning. We will come in at 9:30. There will be a half hour on each side to debate this. But this is very important.

I hope our colleagues will pay close attention to the Senator and those who address this issue tonight. We look forward to having a good debate and discussion on this measure.

The PRESIDING OFFICER. Under the previous order, the Senator from Arizona is recognized to offer an amendment.

AMENDMENT NO. 809

(Purpose: To express the sense of the Senate with respect to the opportunity to participate in approved clinical trials and access to specialty care)

Mr. MCCAIN. Madam President, on behalf of myself, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Arizona [Mr. MCCAIN] proposes an amendment numbered 809.

At the appropriate place, insert the following:

SEC. . SENSE OF SENATE WITH RESPECT TO PARTICIPATION IN CLINICAL TRIALS AND ACCESS TO SPECIALTY CARE.

(a) FINDINGS.—The Senate finds the following:

(1) Breast cancer is the most common form of cancer among women, excluding skin cancers.

(2) During 2001, 182,800 new cases of female invasive breast cancer will be diagnosed, and 40,800 women will die from the disease.

(3) In addition, 1,400 male breast cancer cases are projected to be diagnosed, and 400 men will die from the disease.

(4) Breast cancer is the second leading cause of cancer death among all women and the leading cause of cancer death among women between ages 40 and 55.

(5) This year 8,600 children are expected to be diagnosed with cancer.

(6) 1,500 children are expected to die from cancer this year.

(7) There are approximately 333,000 people diagnosed with multiple sclerosis in the United States and 200 more cases are diagnosed each week.

(8) Parkinson's disease is a progressive disorder of the central nervous system affecting 1,000,000 in the United States.

(9) An estimated 198,100 men will be diagnosed with prostate cancer this year.

(10) 31,500 men will die from prostate cancer this year. It is the second leading cause of cancer in men.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) men and women battling life-threatening, deadly diseases, including advanced breast or ovarian cancer, should have the opportunity to participate in a Federally approved or funded clinical trial recommended by their physician;

(2) an individual should have the opportunity to participate in a Federally approved or funded clinical trial recommended by their physician if—

(A) that individual—

(i) has a life-threatening or serious illness for which no standard treatment is effective;

(ii) is eligible to participate in a Federally approved or funded clinical trial according to the trial protocol with respect to treatment of the illness;

(B) that individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual; and

(C) either—

(i) the referring physician is a participating health care professional and has concluded that the individual's participation in the trial would be appropriate, based upon the individual meeting the conditions described in subparagraph (A); or

(ii) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in the trial would be appropriate, based upon the individual meeting the conditions described in subparagraph (A);

(3) a child with a life-threatening illness, including cancer, should be allowed to participate in a Federally approved or funded clinical trial if that participation meets the requirement of paragraph 2;

(4) a child with a rare cancer should be allowed to go to a cancer center capable of providing high quality care for that disease; and

(5) a health maintenance organization's decision that an in-network physician without the necessary expertise can provide care for a seriously ill patient, including a woman battling cancer, should be appealable to an independent, impartial body, and that this same right should be available to all Americans in need of access to high quality specialty care.

The PRESIDING OFFICER (Mr. CORZINE). The Senator from Arizona.

Mr. MCCAIN. Mr. President, this amendment is not a complicated one. In fact, it is very simple and straightforward. It simply reiterates the Senate's strong support for providing strong patient protections to Americans who are battling deadly and life-threatening illnesses.

The reason I offer this sense-of-the-Senate amendment is that there has been a great deal of discussion about the difference, according to the Congressional Budget Office, between the cost of the so-called Breaux-Frist proposal and the pending legislation.

At the outset, so there is no misunderstanding, this sense of the Senate does not in any way tell the HMOs what they should cover and what they should not cover. That is not the point. The point is that when these are covered, there are obviously increased costs, but the reasons for covering them are compelling. The reason I just had the resolution read is the really compelling statistics: 182,800 women this year will be diagnosed with invasive breast cancer; 40,800 women will die from the disease; 1,500 children are expected to die from cancer this year; an estimated 198,100 American men will be diagnosed with prostate cancer; 31,500 men will die from prostate cancer this year.

What I am trying to say is that we think there are additional costs associated with coverage for a disease that affects literally millions of Americans.

The CBO, the Congressional Budget Office, scored the Frist-Breaux proposal as increasing premiums by 2.9 percent. They scored our proposal as being a 4.2-percent increase in premium cost. This is the estimated ultimate effect of the Bipartisan Patients' Bill of Rights on premiums for employer-sponsored health insurance in percent.

I point out that the Congressional Budget Office costs out in lawsuits and damages an increase in premiums under the Breaux-Frist bill of .4 percent; our bill, .8 percent. So there is a .4 percent difference in their estimate—and we argue with that estimate—in costs associated with the provisions for litigation or remedies, lawsuits and damages, in this bill. I want to emphasize, .4 percent.

The overall difference, according to CBO, is 1.3 percent, the difference between 2.9 and 4.2. But the difference associated with lawsuits and damages is .4 percent.

Where do the other differences, according to CBO, occur? Well, timely access to specialists. They believe it would increase premiums by .1 percent and ours .3 percent. On charges for individuals participating in approved clinical trials, they say it would increase costs by .5 percent and ours by .8 percent. The right to hold health plans accountable—that is, the review of health care plans—the Breaux-Frist bill increases cost by .8 percent and ours by 1.2 percent, which is a difference of .4 percent—adding up to an overall additional cost in premiums, the Breaux-Frist proposal of 2.9 percent, and ours, the pending legislation, of 4.2 percent.

My point is, as we have already seen, the majority of the debate has been centered around the allegation that there will be an explosion of litigation and lawsuits. That is not according to our view nor that of the former Governor, Senator ZELL MILLER, who spoke this morning of his experience as Governor of the State of Georgia, nor is it true in the CBO estimates.

I happen to personally believe that clinical trials are important and should be part of health maintenance organization coverage, but that is up to the HMO. I happen to believe that treatment for breast cancer should be part of an HMO's coverage, but I also believe that that is up to the health maintenance organization.

What I am trying to do here is put the Senate on record of being in favor of trying to address these illnesses which affect so many Americans, and it is our view, as a body, that these causes of death—breast cancer is the second leading cause of cancer death among all women and the leading cause of cancer death among women between ages 40 and 55—that there are protections that all Americans should receive under HMOs.

I stress again, we are not in any way mandating that those should be covered. We are entitled, as a body, to express our opinion and our sense. That is why it is a sense-of-the-Senate resolution and not any mandate that would be in the form of another amendment.

This does not encourage excessive new mandates for health plans. It simply says that if the plan provides certain benefits, such as cancer care, then that plan cannot stop a qualified patient from participating in an approved or funded clinical trial.

So I hope my colleagues will agree on this amendment.

I have a letter from the American Cancer Society in support of increased access to clinical trials, prompt and direct access to medical specialists, and strong, independent, and timely external grievance and appeals procedures.

I ask unanimous consent that the letter be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

AMERICAN CANCER SOCIETY,
Washington, DC, June 13, 2001.
Hon. JOHN MCCAIN,
U.S. Senate,
Washington, DC.

DEAR SENATOR MCCAIN: On behalf of the American Cancer Society and its 28 million supporters, I am writing to respectfully request that you allow debate on the Patients' Bill of Rights to move forward and that you support S. 283/S. 872, the ''Bipartisan Patient Protection Act of 2001.'' As the largest voluntary health organization dedicated to improving cancer care, the Society has set the enactment of a patients' bill of rights that provides strong, comprehensive protections to all patients in managed care plans as one of its top legislative priorities for this session of Congress.

While the Society does not have a position on health plan liability, we have identified several other provisions that are critical to

cancer patients. Specifically, we advocate patient protection legislation that provides all insured patients with:

Increased access to clinical trials—assuring that cancer patients who need access to the often lift-saving treatments provided in both federally and privately-funded or approved high-quality, peer-reviewed clinical trials have the same coverage for routine patient care costs (e.g., physician visits, blood work, etc.) as patients receiving standard care.

Prompt and direct access to medical specialists. Patients facing serious or life threatening illnesses, such as cancer, need continuity of care, the option of designating their specialist as their primary care provider, and the ability to have a standing referral to their specialist for ongoing care.

Strong, independent, and timely external grievance and appeals procedures.

As of today, the ''Bipartisan Patient Protection Act of 2001'' (S. 283/S. 872) is the only bill under consideration by the Senate that fully meets these criteria.

We are particularly pleased that S. 283/S. 872 includes a strong clinical trials provision that provides access for cancer patients and others with serious and life threatening diseases to both federally and privately-sponsored high-quality, peer-reviewed trials. Clinical trials are a critical treatment option for current cancer patients and are also essential in our nation's efforts to win the War Against Cancer. Without clinical trials, new or improved treatments would languish in the laboratory, never reaching the patients who need them. Unfortunately, only three percent of cancer patients currently enroll in clinical trials. Part of the problem is that many health insurers refuse coverage for a patient's routine care costs if the patient enrolls in a clinical trial—effectively denying access to possibly life-saving treatment.

S. 283/S. 872 would remove this financial barrier by requiring health insurance plans to cover the same routine patient care costs that they would cover if the patient were receiving standard therapy. It is important to note that the legislation would not require the health plans to cover new costs—they would not be required to cover the research-related costs or even the cost of the actual drug.

The Society also strongly supports the clinical trials provision because it offers patients access to a broad range of clinical trials—including new drug trials approved by the Food & Drug Administration (FDA)—helping to ensure that no one is left behind as we march forward in our fight against cancer. The recently FDA-approved oral anti-cancer drug Gleevec is a prime example of the important role privately-funded trials play in our War Against Cancer. This revolutionary new drug, developed by the pharmaceutical industry, has offered hope to many patients suffering from chronic myelogenous leukemia (CML). Just as the Society believes that health insurance plans should cover the same routine patient care costs that they would cover if the patient were receiving standard therapy, we also believe that this requirement should be the same regardless of who is funding the trial. Patients continue to pay premiums for this care and should not be forced to go through burdensome administrative hurdles solely because their best treatment option is being developed by the private instead of the public sector. As a result, the Society feels very strongly that any clinical trials provision adopted by Congress must include the innovative treatments being developed in FDA-approved trials.

While we appreciate the efforts of Senators Frist and Breaux to include a clinical trials provision in their alternative bill, S. 889, the provision falls far short of the protections needed by cancer patients. Specifically, the Frist-Breaux proposal would exclude many new drug trials that are approved by the FDA—trials that are essential to providing quality cancer care. S. 889 would also create a negotiated rulemaking procedure to develop a new definition of routine patient care costs instead of relying on the existing Medicare definition already in use. It is important to note that this definition has already been vetted through a federal rulemaking procedure. Further, managed care plans who participate in Medicare + Choice are already following the Medicare definition. Duplicating this effort would be a waste of scarce federal resources and subject patients to a needless waiting game that could be the difference between life and death for some cancer patients.

The diagnosis of cancer is devastating—patients must not only confront an array of medical decisions, they must cope with the financial and emotional burdens as well. We strongly believe that cancer patients in managed care plans must be assured of access to clinical trials this year and hope to continue to work with you to achieve our mutual goals.

Cancer patients have been waiting for enactment of a strong, comprehensive Patients' Bill of Rights for several years. For many current and future cancer patients, enactment of this legislation is a life-or-death issue. Please do your part and support S. 283/S. 872, the ''Bipartisan Patient Protection Act of 2001.'' If you or your staff have any additional questions, please contact Megan Gordon, Manager of Federal Government Relations (202–661–5716).

Sincerely,

DANIEL E. SMITH,
National Vice President,
Federal and State Government Relations.

Mr. MCCAIN. I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. I thank my colleague from Arizona for the sense-of-the-Senate resolution. I think it is important to bring this up early in the debate.

The Senator from Arizona, in his resolution, spells out the grim statistics about the fatal diseases which Americans and their families fight every single day. He notes the fact regarding breast cancer, the most common form of cancer among women, excluding skin cancer, that during the year 2001, 182,800 new cases of female invasive breast cancer will be diagnosed and 40,800 women will die from the disease. Fourteen hundred male breast cancer cases are projected to be diagnosed, 400 to die from the disease. Breast cancer is the second leading cause of cancer death among all women. The leading cause, of course, is lung cancer. This year, 8,600 children are expected to be diagnosed with cancer; 500 will die from that disease. Three hundred thirty-three thousand people in our country are diagnosed with multiple sclerosis; 200 more cases each week. Parkinson's disease is a progressive disorder of the central nervous system affecting a million in the United States, and the numbers are growing. An estimated 198,000 men will be diagnosed with prostate cancer this year; 31,500 will die from this disease. It is the second leading cause of cancer among men.

The reason these statistics are important and the sense-of-the-Senate resolution is so important is that Senator MCCAIN, as well as this bipartisan legislation, addresses the hope that we have to deal with this scourge of disease and all the pain and sorrow and suffering it brings to so many people.

What we are talking about are clinical trials. Clinical trials are an attempt by the medical profession to find new therapies and new approaches that may be promising and may create breakthroughs for people who have lost hope.

HMOs, the health insurance companies, many times deny access to these clinical trials.

Think about that for a moment: You visit your doctor and he says there is a suspicion that there may be a serious problem. You come back for a final diagnosis and you learn it is, in fact, a very serious disease; in fact, it is so serious that there is no known cure. But there is a clinical trial on the way at a hospital or a university that is trying a new approach, something that may have a significant impact on your disease. You ask how much it costs. Of course, it could be very expensive. Can you pay for it personally? Some people can, but most can't. So you call your health insurance company and say to the health insurance company: I have this bad diagnosis, but I have a chance. There is a clinical trial.

Sadly, too many health insurance companies say: No, we are not going to cover it. We can't afford it.

Clinical trials represent the gold standard of care for cancer patients across the United States. Yet only 3 percent of the eligible adults are enrolled in clinical trials for the treatment of cancer.

The General Accounting Office has found that patient participation in clinical trials is often dependent on this approval by the insurance company. They found that, increasingly, HMOs and health insurance companies are saying no to these clinical trials.

Yesterday, I had a very interesting visit in my office, unplanned, when a young lady from Chicago came in and asked at the last minute to see me. She was in town to testify at a committee on which I don't serve. Her name is Liz Cohen. She was here with her husband Richard. Liz is a cancer survivor. She was testifying before a subcommittee about clinical trials and medical research. Liz was diagnosed with lymphoma about 6 years ago. Luckily for her, she told me that she was willing to put up a fight with the insurance company to make sure she got into the clinical trial. She said—and I certainly agree with her—that many people are not so fortunate. How could anybody afford the thousands of dollars it would cost to go through one of those clinical trials? We talked about one of the new miracle drugs for cancer that has just come on the market. It is known as Gleevac. The pharmaceutical industry developed this revolutionary drug for chronic myelogenous leukemia and it has now been approved by the FDA in

a record 2-month period of time. That may have been one of the fastest approvals ever.

The trials for this groundbreaking new treatment were privately funded, but approved by the FDA. Why is that important in this debate? Many people on the Republican side of the aisle tell you there is very little difference between the Breaux-Frist bill and the one being offered on our side, the Kennedy-Edwards-McCain bill.

Listen to the situation that faced Liz Cohen, where this breakthrough drug came about as a result of a clinical trial approved by the FDA. Under the McCain-Edwards bill, the one I support, the bipartisan bill, this type of clinical trial approved by the FDA would be covered. The Frist bill would not cover the trial for patients with this form of leukemia because they don't require coverage for FDA approved trials. They make a distinction which, frankly, from the point of view of a patient makes no difference whatsoever. If you are talking about a clinical trial and a breakthrough drug, how important is it for you to know whether it is FDA approved or not? If it is approved, why would your health insurance company not cover it?

It seems unfair for Congress to limit treatment options based on who is funding the clinical trial. That is exactly what the bills do. The bill offered on the Republican side by Senator FRIST and Senator BREAUX is a bill that would have denied her the access to that clinical trial. Our bill would have given her that access.

There are other major problems with the Frist bill, not the least of which is the fact that it imposes a lengthy rulemaking process in terms of this whole clinical trial issue. It is estimated that they would not be able to decide the rules relative to these clinical trials before fiscal year 2004, maybe as late as 2007. Can you think about that for a moment—that we would wait 5, 6, or 7 years for rulemaking under the Frist bill on clinical trials? Would you like to try to explain that in a doctor's office to someone desperate for a breakthrough so that they can live?

That is what is at stake here. The clock is not just running on rulemaking; the clock is running on life or death. That is the difference between the bills.

The Frist bill also provides the HMO with an opportunity to refuse to cover unanticipated patient care costs as a result of a clinical trial. So even if you get access to a clinical trial and pay with your own money, you have to hope you won't suffer side effects, or you might be on your own paying for the bills out of your own pocket.

Clinical trials are sometimes the only hope that a family has. The Frist and Breaux bill, sadly, would extinguish that hope. In an effort to protect the insurance company's bottom line, their bill would rob cancer patients sometimes of their last chance.

I hope when we look at clinical trials, there will be honest information given on the Senate floor. The Mayo Clinic and the Memorial Sloan-Kettering Cancer Center have done studies. They have concluded that the cost of a clinical trial is usually comparable to the cost of other treatment. But the clinical trials are important because they try to push the envelope and find new approaches, new therapies, new drugs, things that could be used for everybody's good benefit later on. They give an example. They went to the Mayo Clinic, to the National Cancer Institute, and found that after one year the cost for a cancer chemotherapy trial was $24,645. For those under standard care, it was $23,964. The difference is not significant. For a person desperate to find a cure, the difference makes the importance of this debate come through very clearly.

Another study at Memorial Sloan-Kettering Cancer Center found that clinical trial patients spend less time in the hospital, lower costs for radiation therapy, fewer drugs and supplies, and fewer operating room procedures. Overall costs for clinical trial patients were 20 percent less than those patients in standard care.

Why do the insurance companies say no? It is not a matter of cost. It is a question about how far they will go if you leave them alone. The reason for this Patients' Bill of Rights is to make sure that families across America have these rights and guarantees and protections.

What we are seeking to do with the amendment offered by the Senator from Arizona is to put the Senate on record, to stand up for clinical trials, stand up for the bipartisan bill that guarantees access to these important life-or-death clinical trials. I am happy to stand in support of the Senator's amendment. I hope all of my colleagues, regardless of their party affiliation, will understand that the diseases that affect Americans don't know any party label. They affect everybody—Republican, Democrat, or Independent. I hope all my colleagues will join in supporting this amendment. I thank the Senator for bringing it to the floor.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. MCCAIN. Mr. President, I thank my friend from Illinois for the eloquent statement. I want to make a brief comment about the last vote.

I believe we made a good-faith effort in order to see that we could circumscribe the number of tax amendments that would be on this bill. I thought it was a good-faith effort. Obviously, that offer was not accepted. I want to continue to work to see if we can work that out.

In a larger sense, we had some pretty strong rhetoric on the floor after our first day of debate on this issue. But time after time, I hear the statement made by my colleagues on both sides of this legislation that we want a Patients' Bill of Rights. There is acknowledgement that we are in agreement on 90 percent of this issue. Well, then, let's really get serious about negotiating. Let's sit down together.

I know I speak for the supporters of this legislation when I say there is nothing that we feel is not negotiable. We cannot betray principle, but it is interesting that we go over the President's principles and we find that we are not in any disagreement with the message that was sent over from the White House as far as the President's principles are concerned. If we are in agreement on the principles, then it seems to me there should be no reason why we can't reason together—whether it be on employer liability, or whether it be on the external appeals process, or whether it be in other areas that divide us.

So I hope that we will take this opportunity after the vote tomorrow to contemplate it over the weekend, recognizing that the majority leader has stated that we will be on this bill until its conclusion, and take the opportunity to engage in serious negotiations because I don't think that we are that far apart on this issue.

It is not our desire in any way, shape, or form to incur a veto. I was somewhat disappointed at the President's message today concerning the threat of veto because given the reasons listed, frankly, we believe that we are in compliance.

So I hope that we can, tomorrow, and in the week ahead, have some meaningful negotiations and discussions so that we can reach an outcome that meets the goal that all of us state over and over again on the floor of the Senate, that we want an HMO Patients' Bill of Rights.

I believe we can achieve it, and I hope today's debate—5 hours on an amendment that has to do with revenue—will not be the practice we continue here. Otherwise, it will be a long time before we complete consideration of this legislation. I, like 99 of my colleagues, do have plans for the Fourth of July. So I hope we can, not only because of the virtues and merits of the issues, but also for less noble reasons, try to get this issue resolved.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I too, join my colleagues in commending the Senator from Arizona for bringing this to our attention. It brings focus to two very important protections of this legislation. It is appropriate we bring focus to these two protections. Many of the other protections are essential as well, but I think these two are of special importance and concern because the clinical trials part of this legislation is the key, the basis of translating the breakthrough drugs to American families. If we do not have the clinical trials, that is not going to happen, and we are in the century of life science.

Specialty care is of enormous importance. We may have challenges in our health care system, but we have well-trained, highly skilled professionals.

Specialization has brought a quality of instruction, comprehension, and experience to so many of our medical professionals that their knowledge in areas of specialization every single day makes extraordinary differences to families. The Senator from Arizona has brought special focus to both of these areas.

I want to mention a few points about why I think this amendment is needed and why I support it. I will explain the reason why this amendment is important.

Two of the biggest loopholes in the bill sponsored by our opponents are in the sections providing access to clinical trials and specialty care. Under their bill, the patients do not have access to critical FDA-approved clinical trials. Access to trials is potentially delayed for years because of a cumbersome administrative process.

Their proposal for access to speciality care is not a right because it lets the HMO decide whether the child needs specialty care, but the decision is not appealable.

Do my colleagues understand that? If you have a situation where a child has cancer, as my own son did—we went to our general pediatrician, and he was able to tell us very quickly about the importance of going to a pediatric oncologist.

He visited an oncologist and received recommendations and supervision. There are about 2,000 of these cases each year. He was admitted into a clinical trial in which 22 children at that time had actually survived. But that particular clinical trial was breathtaking in its success. There are still a number of fatalities, but it changed from about a 10 or 15 percent chance of survival to only a 10 or 15 percent chance of mortality. I have seen the importance of this in a very important way.

A ''yes'' vote on this amendment will effectively take this issue off the table and put the Senate on record as saying that women and children with cancer, and any American with a dreadful disease, should have the opportunity to see a specialist qualified to treat the disease. They should have the opportunity to participate in a potentially lifesaving clinical trial.

Earlier today, I was talking about the importance of specialty care when serious and complex illnesses strike. It is critical to get the best specialty care that is needed. Denial of access to needed specialists is also one of the most common abuses in the current system.

According to a survey at the University of California School of Public Health, 35,000 patients every day are denied specialty referrals. One of those patients was little Sarah Pedersen of San Mateo, CA.

Sarah was born with a brain tumor. When she was 3, it became clear she needed aggressive treatment to save her life, including brain biopsies and chemotherapy. Her neurosurgeon knew that Sarah needed to be seen by a doctor specializing in brain tumors in children, and there was no qualified doctor in her family's health plan. When Sarah's mother, Brenda, a nurse, asked to go outside the network, her HMO said no. The HMO said: We are not giving you second best, we are giving you what is on the list.

After months of fighting with the HMO, it finally agreed to let Sarah see someone qualified to treat her condition. Her chemotherapy began. Everyone knows chemotherapy causes severe nausea and vomiting. The HMO denied Sarah's $54 prescription for antinausea medication because it was too expensive. Finally, Sarah's family was able to switch insurance companies and get proper care for their child.

There you have it, two parents facing one of the worst nightmares a family can have: a child with cancer. Instead of being able to focus on dealing with that terrible stress and working to give their child the comfort and assistance they can, they have to spend their energy fighting with an insurance company simply to get the child access to an appropriate specialist.

Sarah was lucky in the sense that the HMO's delays did not kill her, but what a burden for her family to face and what a travesty of common decency. Passage of our legislation will assure that every family with a child who has cancer can get the specialty care they need without the dangerous delays.

Women with cancer face special burdens. They must cope with a dreaded and often deadly disease. They need prompt specialty care. Often their best hope for a cure or precious extra months or years of life is participation in a clinical trial, but too often both are lacking.

When a woman with advanced breast or cervical cancer reaches a qualified specialist, the best—and sometimes the only—therapeutic choice is participation in a clinical trial. But too often, women with cancer and their physicians must fight HMOs to take advantage of this opportunity. Diane Bergin, a wife and mother of three children, suffered from ovarian cancer. Participation in clinical trials has prolonged her life, gave her hope, and offered the prospect of better care for future women suffering from this terrible disease. She was allowed to participate in clinical trials—but she had to fight every step of the way—and she knows that other women were not so fortunate. Here is what she said, ''No one facing a serious illness should be denied access to care because that treatment is being provided through a clinical trial. Sometimes, it is the only hope we have. And the benefit to me, whether short or long-term, will surely help those women who come after me seeking a cure, a chance to prolong their life for just a little while, just so that they can attend a graduation, or a wedding, or the birth of a grandchild.''

Traditionally, the insurance companies have paid the routine doctor and hospital costs associated with clinical trials.

According to the CBO, 90 percent of the cost of such trials is paid by the insurance companies. But managed care is reversing that policy, with devastating effects on patients and researchers alike.

Diane Bergen was a patient at the Lombardi Cancer Center in Washington. Karen Steckley, a nurse, is director of clinical operations at the center. She has eight full-time master level nurses on her staff who spend virtually all of their time, not in patient care, but in arguing with managed care companies. These companies do not want to pay for clinical trials, even when it is clearly the best treatment available for a patient. Often Ms. Steckley's team is able to get patients into trials. But sometimes they fail and patients suffer or die needlessly as a result.

Our legislation will end this abuse. That is one reason it has been endorsed by virtually every organization in the country representing cancer patients.

We have heard moving testimony on the subject. In one of the many forums we held on access to specialists for cancer patients, we heard from Dr. Mirtha Casimir, a distinguished Texas oncologist. Dr. Casimir talked about the heartbreaking stories of cancer patients whose HMOs delay and deny access to specialty care—often until it is too late. When Dr. Casimir gets a patient whose cancer has progressed substantially from the initial diagnosis to the time they are allowed to seek needed specialty care, she often flips to the front of the chart. Nine times out of ten, the insurer is an HMO. Every centimeter a cancer grows can mean the difference between a good chance at life and the likelihood of death. Every centimeter represents potentially devastating and avoidable pain, suffering, and death for a patient and a family.

Dr. Casimir's message was clear: Pass the Patients' Bill of Rights so more cancer patients will not die needlessly. That is exactly what the McCain amendment will accomplish, something which the underlying amendment on clinical trials fails to do.

Congress took action last year in the area of the Medicare and Medicare Plus by establishing the protocol for shared costs between the industry and clinical trials. All of that was worked out. The basic agreement is completely consistent with the Institute of Medicine's recommendation. It is working and working well. Yet under their proposal, they have to go through the whole administrative process once again to try to determine the costs. The best estimates would take 5 to 6 years. That kind of delay is not acceptable.

The opponent's bill also excludes FDA trials which, as we have mentioned previously, are a source of enormous importance. So many of these trials involve pharmaceutical companies on the cutting edge of breakthrough drugs, drugs that offer enormous opportunities. A patient cannot

even gain entrance into the clinical trial unless the doctor makes the determination that there is a reasonable chance of success. Still, under the Frist-Breaux proposal, the clinical trials provision does not give the clear guarantees that are in the McCain amendment.

I ask unanimous consent that two letters be printed in the RECORD at the conclusion of my remarks, one from the American Cancer Society and another from the Cancer Leadership Council.

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

(See Exhibit No. 1.)

Mr. KENNEDY. From the Cancer Leadership Council:

On behalf of cancer patient advocates, health care professionals and research organizations, the undersigned organizations thank you for your vital leadership in introducing a Patients' Bill of Rights that provides comprehensive coverage for routine patient care costs in clinical trials. Notably, your legislation covers ALL high quality clinical trials, not just those sponsored by government funding agencies. As cancer drug development is increasingly undertaken by the pharmaceutical and biotechnology industries, it is essential that their trials be accessible to cancer patients, and your legislation will achieve this result. In addition, your bill provides a workable definition of ''routine patient care costs'' that will enable implementation to proceed expeditiously.

That is what the McCain amendment is all about.

The American Cancer Society talks about increased access and about assuring that the cancer patients who need access get access to clinical trials. Access must be available to trials that involve lifesaving treatments provided in both federally and privately funded trials. Approved high-quality peer reviews are an essential component of this process. Clinical trials should have the same coverage for routine patient care costs as patients receiving standard care.

This is an enormously important protection for the American people. We should embrace it, endorse it, and ensure this kind of patient protection is included in any successful Patients' Bill of Rights legislation.

EXHIBIT NO. 1

AMERICAN CANCER SOCIETY,
Washington, DC, June 13, 2001.

Hon. EDWARD M. KENNEDY,
U.S. Senate,
Washington, DC.

DEAR SENATOR KENNEDY: On behalf of the American Cancer Society and its 28 million supporters, I am writing to respectfully request that you allow debate on the Patients' Bill of Rights to move forward and that you support S. 283/S. 872, the ''Bipartisan Patient Protection Act of 2001.'' As the largest voluntary health organization dedicated to improving cancer care, the Society has set the enactment of a patients' bill of rights that provides strong, comprehensive protections to all patients in managed care plans as one of its top legislative priorities for this session of Congress.

While the Society does not have a position on health plan liability, we have identified several other provisions that are critical to cancer patients. Specifically, we advocate patient protection legislation that provides all insured patients with:

Increased access to clinical trials—assuring that cancer patients who need access to the often life-saving treatments provided in both federally and privately-funded or approved high-quality, peer-reviewed clinical trails have the same coverage for routine patient care costs (e.g., physician visits, blood work, etc.) as patients receiving standard care.

Prompt and direct access to medical specialists. Patients facing serious or life threatening illnesses, such as cancer, need continuity of care, the option of designating their specialist as their primary care provider, and the ability to have a standing referral to their specialist for ongoing care.

Strong, independent, and timely external grievance and appeals procedures.

As of today, the ''Bipartisan Patient Protection Act of 2001'' (S. 283/S. 872) is the only bill under consideration by the Senate that fully meets these criteria.

We are particularly pleased that S. 283/S. 872 includes a strong clinical trials provision that provides access for cancer patients and others with serious and life threatening diseases to both federally and privately-sponsored high-quality, peer-reviewed trials. Clinical trials are a critical treatment option for current cancer patients and are also essential in our nation's efforts to win the War Against Cancer. Without clinical trials, new or improved treatments would languish in the laboratory, never reaching the patients who need them. Unfortunately, only three percent of cancer patients currently enroll in clinical trials. Part of the problem is that many health insurers refuse coverage for a patient's routine care costs if the patient enrolls in a clinical trial—effectively denying access to possibly life-saving treatment.

S. 283/S. 872 would remove this financial barrier by requiring health insurance plans to cover the same routine patients care costs that they would cover if the patient were receiving standard therapy. It is important to note that the legislation would not require the health plans to cover new costs—they would not be required to cover research-related costs or even the cost of the actual drug.

The Society also strongly supports the clinical trials provision because it offers patients access to a broad range of clinical trials—including new drug trials approved by the Food and Drug Administration (FDA)—helping to ensure that no one is left behind as we march forward in our fight against cancer. The recently FDA-approved oral anti-cancer drug Gleevec is a prime example of the important role privately-funded trials play in our War Against Cancer. This revolutionary new drug, developed by the pharmaceutical industry, has offered hope to many patients suffering from chronic myelogenous leukemia (CML). Just as the Society believes that health insurance plans should cover the same routine patient care costs that they would cover if the patient were receiving standard therapy, we also believe that this requirement should be the same regardless of who is funding the trial. Patients continue to pay premiums for this care and should not be forced to go through burdensome administrative hurdles solely because their best treatment option is being developed by the private instead of the public sector. As a result, the Society feels very strongly that any clinical trials provision adopted by Congress must include the innovative treatments being developed in FDA-approved trials.

While we appreciate the efforts of Senators FRIST and BREAUX to include a clinical trials provision in their alternative bill, S. 889, the provision falls far short of the protections needed by cancer patients. Specifically, the Frist-Breaux proposal would exclude many new drug trials that are approved by the FDA—trials that are essential to providing quality cancer care. S. 889 would also create a negotiated rulemaking procedure to develop a new definition of routine patient care instead of relying on the existing Medicare definition already in use. It is important to note that this definition has already been vetted through a federal rulemaking procedure. Further, managed care plans who participate in MedicareChoice are already following the Medicare definition. Duplicating this effort would be a waste of scarce federal resources and subject patients to a needless waiting game that could be the difference between life and death for some cancer patients.

The diagnosis of cancer is devastating—patients must not only confront an array of medical decisions, they must cope with the financial and emotional burdens as well. We strongly believe that cancer patients in managed care plans must be assured of access to clinical trials this year and hope to continue to work with you to achieve our mutual goals.

Cancer patients have been waiting for enactment of a strong, comprehensive Patients' Bill of Rights for several years. For many current and future cancer patients, enactment of this legislation is a life-or-death issue. Please do your part and support S. 283/S. 872, the ''Bipartisan Patient Protection Act of 2001.'' If you or your staff have any additional questions, please contact Megan Gordon, Manager of Federal Government Relations (202–661–5716).

Sincerely,

DANIEL E. SMITH,
National Vice President,
Federal and State Government Relations.

CANCER LEADERSHIP COUNCIL,
Washington, DC, June 13, 2001.

Hon. JOHN MCCAIN,
Senate Russell Office Building,
Washington, DC.
Hon. EDWARD KENNEDY,
Senate Russell Office Building,
Washington, DC.
Hon. JOHN EDWARDS,
Senate Dirksen Office Building,
Washington, DC.

DEAR SENATORS MCCAIN, KENNEDY and EDWARDS: On behalf of cancer patient advocates, health care professionals and research organizations, the undersigned organizations thank you for your vital leadership in introducing a Patients' Bill of Rights that provides comprehensive coverage for routine patient care costs in clinical trials. Notably, your legislation covers all high quality clinical trials, not just those sponsored by government funding agencies. As cancer drug development is increasingly undertaken by the pharmaceutical and biotechnology industries, it is essential that their trials be accessible to cancer patients, and your legislation will achieve this result. In addition, your bill provides a workable definition of ''routine patient care costs'' that will enable implementation to proceed expeditiously.

One of the primary objectives of advocacy by the cancer community over the past decade has been assured coverage of routine patient care costs in clinical trials. Last year, the Medicare program acted pursuant to executive memorandum to extend coverage to all trials conducted under the auspices of either government funding agencies like the National Institutes of Health (NIH) or the regulatory oversight of the Food and Drug

Administration (FDA). If such a policy is appropriate for the Medicare program, surely it should be a guaranteed right for patients under private health plans.

Recent reports in the scientific and popular press have highlighted the impressive advances in development of cancer drugs that are both more effective and less toxic than traditional treatments. People with cancer should have early access to these investigational drugs, as well as investigational devices, in the context of high quality clinical trials. Without a comprehensive coverage provision, patients will continue to be at the mercy of health plans' inconsistent approach to this issue. For this reason, we strongly support the clinical trials provisions contained in S. 283 and look forward to their eventual enactment.

THE CANCER LEADERSHIP COUNCIL.

MEMBERS

Alliance for Lung Cancer Advocacy, Support, and Education.
American Cancer Society.
American Society of Clinical Oncology.
American Society for Therapeutic Radiology & Oncology, Inc.
Association of American Cancer Institutes.
Cancer Care, Inc.
Cancer Research Foundation of America.
The Children's Cause, Inc.
Coalition of National Cancer Cooperative Groups, Inc.
Colorectal Cancer Network.
Cure for Lymphoma Foundation.
Kidney Cancer Association.
International Myeloma Foundation.
The Leukemia & Lymphoma Society.
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National Coalition for Cancer Survivorship.
National Patient Advocate Foundation.
National Prostate Cancer Coalition.
North American Brain Tumor Coalition.
Ovarian Cancer National Alliance.
Pancreatic Cancer Action Network.
Susan G. Komen Breast Cancer Foundation.
US TOO! International, Inc.
The Wellness Community.
Y–ME National Breast Cancer Organizations.

Mr. KENNEDY. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. FRIST. Mr. President, I rise in response to the amendment of the Senator from Arizona on clinical trials. I will spend the next few minutes reflecting on what clinical trials are and how many clinical trials are out there, the tremendous benefit and the power of clinical trials to translate basic science, basic knowledge to the patient, to the clinical application to that patient, and then that transfer or discovery and creation and investment in research at the basic level, that transition through clinical trials in order to have practical application in terms of curing cancer or heart disease or lung disease or kidney disease or Parkinson's disease, a neurological disease. It can't be done without the transition through clinical trials.

I have participated in a number of clinical trials as a scientist and as a surgeon. I have participated in clinical trials as an investigator of artificial hearts. I have participated in clinical trials in heart valves that have been inserted to see whether or not those heart valves would work, whether they would last. I have participated in clinical trials in prescription drugs and in immunosuppressive drugs, drugs given to transplant patients to fight infections and to suppress the immune system so a transplanted heart could survive short term, midterm, and long term.

In this role as a physician and as a scientist and as a clinician, what is called a clinical investigator, I have seen the good things and the great benefits of trials, but I have also seen the inevitable failures. That is why you do an experiment, that is why you do experiments on humans. That is what a clinical trial is. You don't really know whether that basic science or early clinical discovery can be applied practically in a safe and effective way, so you do the clinical trial.

I say that because it is clear that there is a real lack of understanding of the rich value, coupled with the potential adverse effects that are inherent in this process, of basic science to clinical science to application.

Clinical trials are just that. They are trials. They are investigations. They are experiments.

I want to spend a little bit of time talking about that both the good and the bad. I also want to give some sort of feel for this for my colleagues, because as I talked to my colleagues and we heard this amendment was going to come up (We had the chance to look at the amendment about 20 minutes ago for the first time), my colleagues would come up to me and ask: How many clinical trials are there today? Are we talking about 100 clinical trials? Are we talking about 200 clinical trials, or 300 clinical trials, or 100 clinical trials, or 1,000 clinical trials, or 10,000 clinical trials, or 100,000 clinical trials?

Right now, as I talk about those numbers, I wonder what my colleagues are thinking. Is it 5,000, or is it 10,000? Because clinical trials cost something. Everybody listening to me in this Chamber today and everybody around the country is going to have to bear the burden of that cost. Again, there is tremendous benefit, but it has an increased cost. We should know at least how many trials there are. How else can you know what the cost, or the incremental cost, is going to be? We know that the incremental cost is ultimately going to come from an increase in premiums. How much will the 170 million people out there who get their health care from their employer have to pay?

I ask my colleagues, is it 1,000 trials, or is it 5,000, or is it 10,000? I will come back to that as people are trying to figure out how many trials there are.

What is the nature of these trials? There is a pill and a placebo given to an individual to take for a period of time. That pill could do any number of things. It could, hopefully, stop heart disease. Hopefully, it could slow down a malignant cancer. Hopefully, it could reverse what might otherwise be intractable deterioration of the kidneys. But you don't know. Otherwise, it wouldn't be a clinical trial. You just do not know how that experiment will turn out. You hear the good things. You hear the positive things. You hear the hope, and you know the innovation will capture the dreams. Members will show pictures and talk about individuals. It is all there. But ultimately we have to translate that down into policy.

It is done one way in the Kennedy-McCain-Edwards bill. It is done differently in the Frist-Breaux-Jeffords bill. It has been done differently in bills that have passed in the Senate and in the last Congress. We discussed and debated for hours on the floor different approaches, different costs, and, yes, different benefits, because it is unlimited; there is no stopping in terms of what the scope could potentially be.

But this bill is about balance. It should be about balance. It should be about balance—introducing new patient protections, new patient rights, but doing it in a way that you don't drive up the cost unnecessarily so high that the working poor have to drop their insurance because they cannot afford it.

Intuitively and practically speaking, we know that the more you load onto a bill in terms of real costs—and all these things in health care are expensive today—that the increased costs are passed on to the person paying the premium. At some point, if that person is just scraping by, that person is going to say: I just can't afford health insurance anymore. I can't afford to pay for the 25,000 clinical trials for people all across the country because I don't have the money. I have to take care of my children and put food on the table.

That is why we have to again and again keep coming back to balance in this particular bill.

I have been blessed in the last 20 years to be a scientist and an active clinical investigator, and to be someone who is both trained to participate and watch these thoughts, the creativity, and the innovation come alive.

I was blessed in my own clinical practice to be in the field of heart and lung transplantation. When I first started doing heart transplants, we thought heart-lung transplants would never be done successfully. Five years later, we were doing heart-lung transplants. At that time, lung transplants had never been done successfully. Then we were doing lung transplants. And we started transplanting little babies at 5 and 6 days of age.

Again, a lot of investigational drugs were being used to immunosuppress the patients. In fact, most of the drugs

were investigational in clinical trials at the time because it was a new field.

There was a 6-day-old child I was able to transplant who had a 100-percent mortality and would die, but because of the great innovation and the breakthrough in drugs I was able to give that child its heart that I transplanted, that little 6-day-old baby, whose heart was about the size of my thumbnail, would be alive 6 months later, a year later, or 5 years later, or 7 years later, or 10 years later, or 12 years later.

That is the blessing I have seen. I have seen the clinical trials, and I have seen the benefits of clinical trials. There have been dramatic advancements.

This Senate has contributed tremendously to that process I just described—to the innovation, to the advances in science, to the clinical applications, and taking basic science and getting it to the field as quickly as possible. How? By supporting basic research.

Yes, I am proud that, under Republican leadership, we are doubling the National Institutes of Health funding. We started about 3 years ago. Connie Mack sat right behind me and said day in and day out that we were going to double NIH funding.

As I sat where the President is sitting right now and listened, I thought it would be tremendous to be able to double the funding. I was not sure it could be done in this day and time, but indeed we are about three-quarters of the way through the process of doubling basic science research.

The NIH also funds clinical trials and basic science. This body has contributed tremendously to investing in clinical trials and basic science research. We have done a pretty good job in creating and fostering an environment of innovation where breakthroughs occur—not as I described when I started doing heart transplants. We were doing heart-lung transplants. We started doing single lung transplants and then pediatric heart-lung transplants. That was during the period of years that I was able to participate. Now we are seeing clinical breakthroughs because of investment in clinical trials. That is how important they are.

I was thinking about this acceleration and explosion of innovation. It requires those clinical trials as we walk through that process of understanding disease.

The human genome project: 15 years ago we didn't know 3 billion bits of information. What we now know we didn't know 12 years ago. Those 3 billion bits of information ultimately are going to be organized in such a way, through improved understanding of clinical research and eventually clinical trials, that we will be able to take that new information and translate it in breakthrough ways for cures—yes, cures of diseases that 12 or 15 years ago we would have said were impossible—we would never see that cure.

Let me start on some of the issues. The first point I need to make is that clinical trials, by definition, are experiments. We try to minimize the adverse reactions. But there are adverse reactions. People can be hurt by those experiments. We minimize that.

I want to talk a little bit about the patient protections because that is very important as we go forward. Right now, our patient projections are inadequate. We are holding hearings on a regular basis in the Public Health Subcommittee. I will mention several shortly.

Mr. President, the point I wish to begin with is this whole point that clinical trials are clinical investigations. They are experimentation on humans. Therefore, you have the positive, which is huge, which I have described, but you do have the adverse reactions. I say that because when we say we are either going to invest in or encourage clinical trials, we basically will, I believe, encourage people to participate in clinical trials. I think that is a good thing. I think it is a critical thing if we are going to really handle this explosion in knowledge.

In addition, as public servants, we in this body need to be prepared to make sure that each of those patients or individuals who comes into clinical trials comes in with the full trust that their safety is first and foremost. Based on hearings Senator KENNEDY and I have had in the Public Health Subcommittee, it seems clear that today we are failing miserably in terms of what is called human subject protections in clinical trials. I say that because, again, we are on a Patients' Bill of Rights and we all want to focus on the patients and helping the patients as much as possible.

In doing that, we at least need to be aware of the positive and the negative, and the potential of doing harm unless we have a system that is sufficiently developed, with sufficient safeguards, to make sure it can handle this increase in the numbers of people participating as we go forward.

It was about a year ago, a year and a half ago, that I had the opportunity to meet the family of Jesse Gelsinger, who died in a clinical trial in 1999. I mention that because the Public Health Subcommittee addressed this issue of oversight structures that we have in our Government. Whether it is the National Institutes of Health or the FDA, there are certain oversight mechanisms we have built in to assure that human subjects are protected. It became clear in those hearings that there had been at that time—we have had some improvement, but not nearly enough—a systemic breakdown of oversight. That ranged from the clinical investigators conducting the clinical trials all the way to the institutional review boards. It included the Federal agencies that are responsible for ensuring the safety of patients.

We have made real progress. Individual researchers, research institutions, and Federal agencies have all come together and have worked to address the specific problem that had to do with gene therapy. Again, you heard me just a few minutes ago speaking of my excitement in relation to the 3 billion bits of information in one of the most successful Government investments ever. We probably spent $12, $13 billion over a 10-year period for the human genome project. It came in under-budget, in a shorter period of time. That is rare for Government.

But as public oversight officials, you see one of the downsides: The fact that basic science, as it was, rushed to the clinical arena, resulted in death.

Again, people do not generally hear that we have to be careful. We have to address the good and the bad and the difficult. There is much to be done. I continue to hear stories about problems in our system for protecting human research subjects.

Secondly, I want to mention this whole idea of access to clinical trials. I appreciate the amendment the Senator from Arizona has offered because it does bring attention to the importance of these clinical trials. The language that is used, the findings, the recommendations that are made in the sense-of-the-Senate amendment, I think, are very positive in terms of what is set out as fact and what the underlying bill tries to do. It is a sense of the Senate that we will be voting on tomorrow.

I mentioned before in my remarks the various bills that are now before the Senate. Right now we are debating the McCain-Kennedy-Edwards bill on clinical trials. This is a provision that is different from the provision that is in my bill, the Frist-Breaux-Jeffords bill. It is different from the amendment that was adopted in this Senate Chamber last year.

The bill we debated in this Chamber, and passed with a majority vote, required private sector, self-insured, employer-sponsored health benefit plans to provide coverage for routine patient costs associated with one type of clinical trial, and that is cancer.

We have progressed since that debate a year and a half ago. At that point in time, my question was—and Senator DODD and I had an exchange back and forth—how much do these cancer trials cost? This is cancer. Cancer is the one that is the most studied of all the clinical trials.

We will talk about how many clinical trials there are out there. There are thousands of cancer clinical trials. They have been studied and studied because it is pretty easy to study them, for the most part.

You have a patient who has cancer. It can be in the early, mid, or late stages of cancer. You have an intervention. You compare two interventions. Sometimes it is just a pill, some type of medicine, versus a placebo. You see actually which of those works. And you go ahead. You have a clinical trial that is double blinded; which is, you do not know which medicine the patient is getting. You have to have enough patients and statistically analyze those

patients in such a way that you determine what the medicine you are testing actually does versus not doing anything. That is what a clinical trial is. People say: No. We thought everybody gets the experimental medicine. No, that is not the way it is; otherwise, you are not going to know incrementally what the impact is. You have to give one the intervention, the other not the intervention in these clinical trials.

Most clinical trials are double blinded; maybe 95 percent of them. They should be, because otherwise you inject bias into it, so there is a 50-percent chance you are not getting the intervention you think you might be getting. Again, that is appropriate. I am not being critical. That is the only way to find out what the incremental difference is as you go forward.

For cancer clinical trials, the data is a little bit mixed, but there is pretty good evidence that if the cancer clinical trials are conducted well, and they are in appropriate centers—centers of excellence that do a lot of cancer studies—you can actually save some money in terms of having somebody in a protocol versus treating them outside of protocol, having them in a clinical trial. There is some data—mixed data—from some very good institutions that demonstrates that, again, for cancer. There is some anecdotal data for noncancer, for some heart disease, but again it is very mixed.

Some might say: In my study it costs a lot more to test artificial hearts for heart disease and kidney disease. If you start looking more in the device arena, there have not been very many studies of how much the costs of those trials are going to be. Somebody might have a cardiomyopathy, a big dilated heart, and you might give one set of patients drugs to try to reduce the size of that heart. That is pretty inexpensive. You do not have to go into the hospital to do that. And the other arm—to compare the two—is you would make an incision down the sternum, and you would open up the manubrium and the sternum, open up the paracardial sac, take the heart, put an artificial heart around it, close everything up, and the patient would be in the hospital for maybe 2 weeks, maybe 3 weeks. That hospitalization would be very expensive, and you are comparing it to somebody giving pills to someone on the outside.

The question is, What are the routine costs? Because that is what we are talking about reimbursing. Then it gets pretty hard because in relation to what are the routine costs, do the routine costs include the hospitalization? You might say, yes, an artificial heart can be paid for by the company studying it. The clinical trial could be reimbursed by the National Institutes of Health. But what about the hospitalization in that arm? Or is it just the testing when you put in the artificial heart, is that the routine cost? Nobody can answer the question. Why? Because nobody really thought about it because the studies had been for the pills, studying cancers, and hadn't been for cardiomyopathy and the human heart, major surgery.

I use that as sort of the extreme example with the understanding that you have big technology, expensive, hundreds of thousands of dollars out here, and you have some inexpensive therapy in the other arm. And you are asking a managed care company or insurance company to pay for the routine cost of both of those and the thousands of other trials that are in the middle.

No. 1, you don't know or nobody in this body has been able to tell me how many clinical trials are out there. People will scurry around tomorrow. But today, in asking how many of these clinical trials are out there, nobody in this body can tell me how much the average clinical trial is going to cost. Yet we want to make a commitment that we will cover essentially all clinical trials in the United States of America, however many there may be, however much they may cost, and the HMOs are going to pay for it, the bad HMOs. Again and again we have heard how bad those HMOs are, and therefore, they pay for it.

It doesn't work that way. What happens, whatever those costs are, which nobody can answer—nobody can answer—we will come to what the CBO says. The CBO can't give us an accurate answer. We give it maybe to the HMO because rhetorically we can sock it to them. What is the HMO going to do? Just raise your premiums, employer-sponsored premiums.

One hundred seventy million people are getting health insurance through these insurance plans, and what we are saying in this bill is that if you are going to be in the insurance business, there is a Federal law that we are going to pass where all trials, in essence, all trials—we don't know how many or how much they are going to cost—are going to be paid for. Health insurance premiums go up, and what happens to the working poor who are barely scraping by, again, to pay their health insurance? Everybody, employer after employer, employee after employee, comes in and says: We can barely make these insurance premiums, whether it is $200 a month or $300 a month or, for a family, $4 to $5,000 a year, or $6,000 a year. We just simply can't tolerate increased costs. We are going to drop that insurance.

I say that because the cost issue was brought up on the floor earlier tonight, the Frist-Breaux-Jeffords approach versus the Kennedy-McCain-Edwards approach. There is a difference in cost and that difference in cost is about 60 percent. What is defined in my bill—I will talk a little bit about that—is about 60 percent, according to the Congressional Budget Office, of what is in their bill. I didn't believe it when I saw it because I know nobody can answer this question, how many trials there are today, because there is no database of all these trials. You certainly can't figure out the cost.

So through conversations, talking to people who participate with the Congressional Budget Office, basically saying, how do you come up with these numbers, the answer that was received again reinforces the fact that we don't really know what the costs are. We do know that the cost under the Frist-Breaux-Jeffords is only 60 percent of the cost estimated using the same sort of guesses as the Kennedy bill.

Knowing what I know, having participated in clinical trials from artificial hearts—personally, I put the artificial hearts in; I have gotten the consent; they are in clinical trials approved by our Government—to immunosuppressive agents or drugs that I have given to patients to keep them alive in clinical trials, gotten the consent to do that. I can tell you we don't know what the costs are. Therefore, yes, maybe 60 percent on paper, that is what you hear about. In truth, we don't know.

We don't know. As we look ahead, not knowing by definition, we are going to basically say those costs are going to be paid for by people through their insurance policies. When you get an insurance policy, you expect that insurance policy in part to be for your benefit, and that is why I think having access to clinical trials is important because clinical trials can be very beneficial to patients. I mentioned the adverse effects, but clinical trials can be very beneficial to individual patients. For that patient who gets that artificial heart, it becomes very beneficial.

I mentioned the bill that passed on the floor of the Senate. Let me note very quickly, because I just talked about the cost of the two bills, what is the difference between the Frist-Breaux-Jeffords bill and the Kennedy-McCain-Edwards bill. The Frist-Breaux-Jeffords bill, part of the Bipartisan Patient Bill of Rights Act, S. 889, is not the bill on the floor right now. I wish it was on the floor, but it is not right now. It applies to all private plans and insurance issuers offering coverage in the group and individual markets. So it applies to people broadly. It expands coverage not to just where we were last year. We have expanded coverage not to just cancer, but it is expanded to all diseases. You don't limit it to one disease group.

I do that because I think that it is important to reach out and give more equal access to people who have kidney disease or heart disease or lung disease or emphysema or neurological disease or some type of mental illness. You need to have access broadly.

We expand it to clinical trials and we include the clinical trials of the National Institutes of Health, the veterans hospitals I work in, and we include the Department of Defense. I will talk a little bit more about others. It is true that we stopped short in our bill of including the FDA. (Although, as I will mention later, previous versions of the Kennedy bill did not include the FDA.) I will mention a little bit about

why we stopped short of including the FDA, but it is because nobody can tell me how many FDA trials there are. FDA looks at the devices, the artificial hearts, the valves, the lasers, the expensive technology. That is the device part of it, of the Food and Drug Administration, the device part of what the FDA examines. Therefore, we cover all of the others, but we do stop short of the FDA. The cost difference between the clinical trials provisions of the Kennedy bill and our bill is principally just that.

Several Members on the other side commented on the fact that in our bill we have what is called a negotiated rulemaking process in order to determine what routine costs are. The other side said: We don't need that. We can just take what Medicare has looked at. Medicare, about a year ago, September—I have to go back and look—did come out with guidelines for Medicare for coverage of seniors and for individuals with disabilities, did come out with guidelines and coverage. But in reading through that, it doesn't answer to my satisfaction what a routine patient cost truly is.

Thus, I think that, since we don't really know and the implications are so huge, since people all across the country are going to be paying for this new benefit, that we ought to bring the very smartest people around the table. We ought to propose rules based on the discussion of people who are in clinical trials. We ought to get input from other people around the country. All that is part of the negotiated rulemaking process that I think is the best way to define routine medical cost.

If we are going to say: HMOs, indirectly all the beneficiaries, all the patients out there, all the 170 million people who are getting care from their insurance company, are going to be paying for it, we need to be able to look them in the eye and say, this is how we define routine cost. We have studied it and talked through it. We have applied it not just to seniors. We have applied it not just to the Medicare population, but we have designed a definition that applies to all Americans—to children, to babies, to adolescents, to adults. That is the negotiated rulemaking process. Earlier, the comment was made that it would take 6 years to do that. That is just not true. In fact, in the amendment that passed on the floor last year we set time guidelines in there and we said January 10, 2001, was when it was supposed to convene and a final report was going to be issued 6 months later on June 30, 2001. That just shows it can be done in 6 months—to do it right and responsibly and define what routine medical costs are.

Since you are making people pay for it, that makes sense to me. It comes back to the idea of having balance in this bill.

I don't think you are going to hear people on our side of the aisle or Senator BREAUX or Senator JEFFORDS promise everything to everybody because it has a cost. It has to cost. We talk about the field of liability, why don't you have unlimited lawsuits running through the system, and allow lawsuits to go to court early on because the court system is good. The answer is, do you want balance? Yes, you want to be able to go to courts, but not first. You want to exhaust internal and external appeals and have an independent physician make the decision before you go to court.

Why? Because you want to protect the patient, but you don't want to subject the system to the incentives that are going to drive health care costs sky high, make premiums go through the roof, skyrocket, with no limit. By definition, liability has no limit to it whatsoever, and the working poor are the first to be punished.

So that is our bill, the Frist-Breaux-Jeffords bill. It basically covers all clinical trials. We go through the list and stop short of the FDA trials. The McCain-Edwards-Kennedy bill on the floor has all private sector plans offering coverage in the individual markets—sounds pretty familiar, sounds the same—to provide coverage for routine patient costs associated with all clinical trials. They do NIH, we do NIH—National Institutes of Health—about $20 billion a year. It is a tremendous national resource. About 70 percent of that money, so people will understand, is not spent out here in Washington. About 70 percent of the grants go to universities and academic health centers all across America, and capture again the creativity and the sharp minds of academics, clinicians, doctors and nurses.

They include Department of Defense clinical trials. Frist-Breaux-Jeffords includes all the clinical trials for the Department of Defense. The Veterans' Administration—I mentioned that one of the privileges I had as a practicing physician was every week I would be able to operate on and take care of and treat our veterans. Actually, even during my residency and chief residency, every week after I finished my training, cardiothoracic training, every week I had the opportunity of spending a day taking care of veterans and administering care to them and participating in the great research programs in thoracic surgery that is made possible through this body's investment in our veterans affairs.

They include clinical trials through the VA. Frist-Breaux-Jeffords includes all clinical trials through the Veterans Affairs. The difference is between FDA, and I will come back to that. The definition of routine costs that they use is the routine cost definition developed by the Clinton administration for cancer clinical trials. If there is one thing—the reason I am taking time to do this is because it sounds so simple—cancer clinical trials. I have gone through this process, that cancer clinical trials are very different than clinical trials for hypertension or high blood pressure or for ischemic cardiomyopathy or laser therapy or removing obstruction from the windpipe itself. These clinical trials are different. Therefore, I am a little uncomfortable taking a definition that was worked out for a certain segment of the population—that is, our seniors—that started and was based on one disease entity—cancer—and applying that broadly to all clinical trials. Why? Because we have to achieve balance and do what is responsible if we are going to make 170 million Americans—and we are by definition—pay more once we pass a Patients' Bill of Rights.

The 170 million people are going to pay more whether it is our bill or their bill. They are going to pay a whole lot more under the Kennedy bill than under the Frist-Breaux-Jeffords bill.

The fourth point I want to make is, who is paying? I implied it a few minutes ago when I said it is easy to say these bad HMOs out there are going to be paying for these costs. Each of the patient protections we go through—we are starting with clinical trials, and I am glad because both sides feel very positively and the amendment by the Senator from Arizona is, I believe, very positive because it speaks to the positive aspect of these clinical trials. But it allows me to show how complex each one of these patient protections is and the potential, even though CBO gives us a figure there, for that being blown out of the water as we go next year, or 2 years later, or 3 years later.

Much of what we have tried to do—Senators BREAUX, JEFFORDS and myself—in crafting our bill is to give patient protection, give the access to clinical trials, but do it in a way that is responsible—responsible to the 170 million people who are going to be paying the bill, responsible so that we don't have a million people—which is what will happen under the Kennedy bill—a million people are going to lose their health insurance or would lose it if that bill were to pass as written. Thankfully, the President made it very clear today that he, as the leader of the free world, the leader of this country, is not going to allow the Kennedy bill to pass. He is not going to allow 1.2 million people to go to the ranks of the uninsured when you can pass an alternative bill that gives patient protections that will not drive 1.2 million people to the ranks of the uninsured and will not involve frivolous lawsuits. This says, yes, it makes sense to go through an appeals process and have an external review, an independent physician making a decision before going over to the trial lawyer.

The trial lawyers have an incentive. You know, we keep coming back to the trial lawyers, in part, because it kind of blows away the potential for these runaway lawsuits, and the potential is in their bill, and it is a little in ours, but not so much because we tried to restrain it and give it balance, recognizing that we have to have balance as we go forward.

If we are going to ask 170 million people to pay more under passage of a Patients' Bill of Rights, we need to be able to tell them why they are paying more. I think the argument for clinical trials is so positive, they will understand that there is some downside. Some people die because of clinical trials, and there are adverse effects; but the overwhelming benefit for clinical trials means we need to make them more available to people, and that is why in the Frist-Breaux-Jeffords bill, clinical trials are one of the 12 main basic patient protections we want out there in our bill of rights.

The 170 million people are going to be paying for this added benefit, so we want to make sure it is good and the human protection is there, and that safety is put first and foremost. We are failing in that category, as I have said—not miserably, but we are failing. I will demonstrate how I can say that with such assurance. In addition, taxpayers, for much of this research, clinical research, are already paying. I say that because with the $20 billion that the National Institutes of Health is getting, the NIH will turn around and subsidize many of these clinical trials, in terms of the clinical trials themselves as we go forward. So the 170 million people out there working, who are working with insurance that we want to keep—make sure they keep their insurance—are already investing in these clinical trials by supporting Department of Defense with their taxpayer dollars, by supporting the Veterans Affairs with their taxpayers' dollars, and by supporting the National Institutes of Health with their taxpayers' dollars.

Clinical trials are vital, critical, and make all the innovation and clinical applications a reality when they start with basic science.

Do all the clinical trials work? Some do. I do not know if I can say most do. In other words, are there positive results from clinical trials?

The assumption is clinical trials always have a breakthrough drug. Again, what my colleagues do not understand—and I want to state it more publicly instead of sitting in the Cloakroom explaining it—is that a high percentage of clinical trials do not work. That is good because they have to figure out whether or not the breakthrough drug works. It may have worked in a mouse, and it may have worked in an animal model, or it may have worked in a test tube, but they have to see whether it works in a human being.

That is what a clinical trial is: an experiment with a human being. Not all of them work after it worked in a test tube or a mouse.

It is important that my colleagues understand that. Clinical trials are necessary. There is a reason for them: to figure out what does and does not work. What does not work can be harmful, and it comes back to the fact they have to have adequate consent, what is called informed consent, for those participants who come into clinical trials to make sure they understand that in every one of these clinical trials there is a risk of harm and there is a potential for gain.

Yes, in our bill, and I believe in their bill and in this amendment, there is this concept of talking about clinical trials where there is potential for gain. That is a little hard to define. We all write it into the bill, and, obviously, we would not do a clinical trial if we did not think there was some potential for gain, but, again, there is some risk or they would not be doing a clinical trial.

A clinical trial is an investigation. A clinical trial is human experimentation. It is all the same. ''Clinical trial'' sounds very positive. ''Investigation'' sounds—well, I am not quite sure. ''You mean experimenting in humans?'' That is what it is. It just depends on which words one uses.

I want to move to one other point which many of my colleagues, in talking with them, had not thought about. I am thinking about it because we have a bill with patient protections. In the underlying Kennedy bill, there are 18 or so patient protections. There are a few less in my bill. Prompt payment is in the Kennedy bill as a patient protection. Prompt payment is good for the doctor, for a doctor's bill of rights; you have to pay a doctor—I have forgotten; I need to go back and look—in x number of days, and that is a patient protection, I guess. It is not clear to me.

I understand why many of the doctors like their bill because they have prompt payment as a patient protection, which means you should pay your doctor on time. You should pay your doctor on time. I am not sure you need a Federal law passed in what is billed as a Patients' Bill of Rights. That is in the Kennedy bill as one of the patient protections.

This patient protection on clinical trials is one in which I believe strongly. We have given a price to it which is significantly higher in their bill than my bill, and I have already argued that price to me is inaccurate. I will not really know how true that is until 5 years from now, but I do not want to be sitting at my desk 5 years from now looking back to today and saying: You mean to tell me we bought into this fact that we could cover clinical trials when we did not know how many there are and we did not know how much they cost? We made 170 million taxpayers pay for it, and some of them lost their insurance? Why weren't we smarter than that?

I want it to be a part of the RECORD as we walk through the complexity of what clinical trials are all about. We can make promises, and the promises sound good, but is it truly responsible to make these huge promises at huge costs when there is a very real potential that we are hurting, not thousands, but millions of people? The answer to me is no. I do not want that to happen.

My colleagues are going to hear me say again and again this is where we were last year and this is where Senator KENNEDY's bill is, and I think we can be in a more balanced position by being in the middle rather than either extreme. That is what we tried to achieve, and clinical trials are a good example.

Why am I so convinced that the underestimate in their bill is real and not so much in our bill? It is because we have patient protections. We have internal appeals and external appeals if there is some sort of disagreement on what the HMO or insurance company has decided. In their bill, one can opt out; they do not have to go through internal and external appeals. One can go to the courtroom before exhausting the appeals process. Hopefully, we can debate that tomorrow or next week.

One can go to the court system, Federal court, State court, or shop from one State court to another State court. One can pick a State. If the insurance company covers Tennessee, Alabama, and Georgia, you can go down to Alabama. I do not know what their caps are, but I hear about these exorbitant lawsuits. The trial lawyer gets 30, 40 percent, whatever it is. Whatever a patient settles for goes in the trial lawyer's pocket, not to the patient. If you settle for $2.5 million, $1 million goes to the trial lawyer and only $1.5 million goes to the patient. I do not understand that. I hope we will come back to that.

My point is, we have patient protections, and we cannot look at them in isolation from what happens with liability. I just built the case or just told my colleagues that not everything goes perfectly all the time when you have human experimentation, clinical trials, clinical investigations.

By definition not everything is going to work. There is going to be damage. When they are studying Parkinson's disease, there is going to be sometimes a worsening of the disease in the experiment. There sometimes is going to be death, not intended death, but in clinical trials people are going to die. I just mentioned one patient, and there are hundreds of patients who die in clinical trials.

We have a trial lawyer out here, and because we passed this bill, we cannot separate what we are doing over here. What we are saying is: HMO, you are responsible for paying for these clinical trials now; you have not in the past, and you have a lawyer out here with unlimited lawsuits; who are you going to go after? Who has the deepest pocket? Is it the doctor who maybe made a mistake, or is it the HMO, the big bad HMO that has assets of $½ billion or $400 million?

If you are the trial lawyer and you are going to walk away with 40 percent, 30 percent, 20 percent or 10 percent—10 percent of $1 billion is a lot. Who are you going to go after? Maybe the doctor, but you will be able to go after the HMO.

Adverse events, by definition, in clinical trials are going to occur. Trial lawyers are part of this overall system. There is no cap. They have an incentive to sue. They are going to get the HMO because we are making the HMO pay for the trial.

Was that even part of the reasoning? Did CBO put all that together in terms of saying clinical trials are going to cost this much in their bill and in my bill this much?

I have talked with a lot of people involved in these estimates, and I have talked with a lot of people in this body, and not one person had thought about that.

If there is an adverse reaction in a clinical trial, if a person participated, there is a risk of losing your arm or of dying. All the consents say death, or any serious life-threatening condition. That is what the Kennedy bill used as their baseline for trials. Ninety-five percent say there is risk of death. A large majority say there is a risk of death in the consent form you sign.

Is that protection in a court of law? There is no protection in a court of law. In the hearings Senator KENNEDY and I have held on human subjects, protections are inadequate today given the type of research we are doing. They were OK 15 years ago. There are all sorts of reasons, including inadequacy of explanation of the clinical trial in consent forms, or conflict of interest in certain cases. There is what is called the common rule that is supposed to apply to all Federally sponsored or regulated research, but that does not apply equally to everybody. These are all very specific issues and technical issues, but if we will force 170 million ratepayers to pay for all clinical trials, we need to know the implications. We will probably never talk about it. This is just one little item from the 179-page bill.

These estimates of how much clinical trials cost may be approximately right. I don't think they are. I know they were not calculated on a peer-reviewed study. Maybe a little bit on cancer, but it did not include the range of diseases that the FDA approves, or safety and efficacy regarding the devices out there, all the high technology out there. That is different from Veterans Affairs or the Department of Defense, which is mainly breast cancer and breast disease. It is very different from the National Institutes of Health.

When people say: Why not FDA? Was it arbitrary? No, it is because that is the most balanced. You cover the clinical trials for all diseases out there. Thousands of clinical trials are being covered. We will stop short of FDA because we do not know what we are covering in terms of numbers or how much it costs for each trial.

It's interesting that the earlier versions of the Kennedy bill did not cover the FDA. I am not sure why or why this was changed. It may be that it makes us feel good to say we are covering everybody, in all trials. It is irresponsible to say we will cover something that will increase liability and that we will introduce the liability equation on HMOs as part of the bill without knowing the impact.

If there is one death and a trial lawyer goes to that person's family, or say they lost an arm with an injection of a medicine to treat cancer and the veins shut down and they lost an arm, that is a tragedy. That trial was paid for by the big bad insurance company. The trial lawyer says: Let's go after the doctor for malpractice; why not go after the HMO? When you are a trial lawyer, it will be tempting on go after the HMO.

Then we hear people say: How can you cap it? If you lose an arm, is that worth $1 million? Is it worth $5 million? Is it worth $10 million? Is it worth $100 million? Is it worth $1 billion? There is no answer. It is rhetorical. No amount of money can satisfy the loss of an arm.

If you allow that sort of lawsuit, $20 million or $30 million, but you allow it and incentivize a lawyer to have it and you create adverse reactions, that is just one little clinical trial. What about the other 1,000, 5,000, 10,000 clinical trials?

I don't want to drive that point home too much that I think we made. However, it is important for my colleagues to understand and at least to think about and recognize the complexity in the bill. We cannot rush through this bill. I am here and the Presiding Officer is kind enough to be here tonight. The majority leader said we will finish this bill in 6 or 7 days. This is probably 1 page out of 179 pages.

On clinical trials, taking the flip side, not covering all clinical trials but stopping just short of covering all clinical trials, why are you doing that? The answer is that clinical trials have such value to society that I believe we have an obligation to make the clinical trials available, coupled with the obligation to make sure there are adequate human subject protections.

The GAO, at the request of Senator JEFFORDS, who is the cosponsor of the Frist-Breaux-Jeffords bill, conducted a review of patient access to clinical trials sponsored by the National Institutes of Health, for which I, obviously, have tremendous respect. Senator JEFFORDS asked the GAO the following questions.

No. 1, to examine how the health insurers' coverage policy and practices affect patient participation in clinical trials.

This is before we passed the bill.

No. 2, to examine researchers' experience in enrolling patients for trials sponsored by the National Cancer Institute.

No. 3, whether NIH has evidence of recent difficulties in enrolling patients in clinical trials. Determine if there are enough patients. We have a huge amount of basic science information and, if you cannot get patients into the trials, you are not going to be able to have a clinical application, you will not get to a practical application. You need sufficient patients in the clinical trials.

The GAO report found, even though many policies exclude coverage for clinical trials, nearly all insurers interviewed allow for exceptions, following case-by-case reviews by the insurer's medical personnel. For approved coverage, insurers generally agree to pay the standard nonexperimental cost associated with the trial. However, since there is little agreement on what constitutes ''standard care,'' payments vary from insurer to insurer.

That, says the GAO, agrees with the idea of what is standard care. There is a lot of disagreement. I argue that is why we go to a standard rulemaking process.

The same report—and that is why I believe clinical trials should be part of the Patient's Bill of Rights—concluded that generally health insurance policies exclude coverage of clinical trials, but most do allow exceptions to be made after a case-by-case review. Denials generally are based on the grounds that health insurers consider clinical trials to be investigational and experimental care, and, as such, are excluded from coverage. Again, that is why we need to include clinical trials in our Patient's Bill of Rights.

Typically, insurers prefer to review requests for clinical trial coverage individually because of the perception that trial costs and quality vary greatly. The most common consideration during case-by-case reviews was the scientific merit of the trial and the anticipated cost, although none of the insurers had data on the cost of covering clinical trials—again, it just shows we do not have the data, even insurance companies that have been putting money into the clinical trials.

I will go back.

These perceived trials could be somewhat more costly than standard treatment. The GAO report continues.

There is little agreement on the definition of standard care which causes payment for service to vary widely. Insurers stated that it is often difficult to distinguish expenses that constitute standard care from strictly research related services.

Again, that is a good reason to have negotiated rulemaking—to determine what routine care or standard care is.

This is from the GAO report.

The GAO did not find evidence of widespread limitations on patient access to clinical trials. Most health insurers said they allow for coverage of trials in some circumstances. Most cancer centers reported no shortage of payments for trials and the NIH did not document significant trial enrollment problems. Information on the extent to which insurers cover clinical trials is not clear-cut.

To me, looking at that report—again, Senator JEFFORDS was chairman of the Health, Education, Labor, and Pensions Committee—it basically comes to the conclusion that there is not a shortage of patients for clinical trials

now but that we don't have data as to the costs or participation. The insurance companies don't have it. We don't have a good or adequate definition of standard or routine care. All that means is that we need to know more before promising everything to everybody.

Since we don't have the answers, why don't we address the issue in a balanced way and in a step-wise way? Why? Because unknowns could expose us to exploding costs of premiums, which would drive people to the ranks of the uninsured. What I would like to do is go in a deliberate, thoughtful, and balanced way.

I mentioned earlier the numbers of clinical trials. We don't know how many trials there are.

Let me quote Susan Okie who was actually a classmate of mine in medical school and who writes for the Washington Post. On May 16, 2001, she wrote an article for the Post entitled ''U.S. Oversight Urged for Human Research''. It says:

No figures are available on how many studies on humans are conducted annually in this country.

Again, I just want to make the point that nobody knows how many studies there are.

She continues:

However, data on biomedical research show explosive growth in the last two decades. Federal spending for health research increased from $6.9 billion to $13.4 billion between 1986 and 1995, and industry spending tripled from $6.2 billion to $18.6 billion during the same period. Between 40,000 and 50,000 U.S. researchers are thought to participate in conducting clinical studies in humans.

I went to the FDA. Since the Congressional Budget Office does not know, since none of my colleagues knows, since in the hearings people did not know, I asked, What about the FDA? The FDA does not track the number of clinical trials being conducted as a part of their protocol. Yet the extension of the Kennedy bill is going to cover these trials. The FDA doesn't even track the number of clinical trials. They do track the number of investigational new drugs and investigational device exemptions.

There are roughly 11,800 trials by the Center for Drug Evaluation. There are about 2,800 trials by the Center for Biologic Evaluation and Research. And there are about 1,000 trials by the Center for Devices and Radiological Health. That is the FDA.

The Kennedy-McCain-Edwards bill says they will pay for the increment in the number of trials, but they do not know how much those trials are going to cost. At least that data has not been present, and it has not been presented in the hearings. When I have looked for it, I have not been able to find the incremental cost.

If you go back to the Congressional Budget Office, it says that is the difference between the CBO estimate and yours. That is working backwards, because the Congressional Budget Office does not know.

In the NIH, for the record, in terms of clinical trials, there are about 4,200 clinical trials, what are called extramural and intramural—outside of the institution and inside of the institution.

The Department of Defense: I have not been able to determine how many clinical trials we are going to cover.

The Veterans' Administration: About 162 clinical trials and 729 extramural VA-funded clinical trials.

The FDA was supposed to create a database of clinical trials last year. It is up and running, but it is not complete, to the best of my knowledge. I will try to look into that to see if we can find out how many they have on that particular database.

Let me close with one last point that I implied earlier and talked about a little bit earlier. It has to do with protection of human subjects.

Our goal should be to protect individuals who voluntarily participate in research and clinical trials. This is very important for my colleagues to understand. Right now, there are inadequate safety protections, if we look in the global sense at these thousands of clinical trials.

I mentioned the death of Jesse Gelsinger in gene therapy in a clinical trial in 1999. Following that, the Subcommittee on Public Health held two hearings. We found a systemic breakdown of oversight, ranging from investigators to institutional review boards in the Federal agencies specifically responsible for ensuring the safety of patients.

Since we came to this conclusion that we are inadequately protecting human subjects, we must act. As we go into this field of further subsidizing clinical trials, I am very hopeful that on both sides of the aisle we can work together and put forth the appropriate protections.

The underlying amendment put forth by Senator MCCAIN is a sense of the Senate that we will be voting on tomorrow morning. From my reading of it, it appears to be a very positive amendment that endorses the importance of clinical trials. On the last page it says: A health maintenance organization's decision that an in-network physician without the necessary expertise can provide care for a seriously ill patient, including someone battling cancer, should be appealable to an independent, impartial body, and the right should be available to all Americans in need of access to high-quality specialty care.

Again, it goes to the internal and external appeals. That is something that would be taken care of in the underlying bill—both the Frist-Breaux-Jeffords bill as well as the Kennedy-McCain-Edwards bill.

As I understand, it, the debate will continue tomorrow morning. I believe there are 30 minutes for each side, and then we will vote at that point in time.

Mr. President, I yield the floor. I appreciate your patience and the patience of my colleagues for allowing me to address this issue.

THE NEXT ROUND OF NATO ENLARGEMENT

Mr. BIDEN. Mr. President, I rise today to congratulate President Bush for his unequivocal support for the next round of enlargement of the North Atlantic Treaty Organization, which he voiced during his recent trip to Europe.

Several months ago I made clear my opposition to a so-called ''zero option'' of not admitting any new country to membership at next year's NATO Summit in Prague. Largely at the administration's urging, the alliance last week formally laid the ''zero option'' to rest. At least one country will be invited to membership in Prague.

In addition, in several venues I have declared that no country outside of NATO has any veto right over which country or countries the alliance will invite to membership.

Most particularly this statement applies to the three Baltic states—Lithuania, Latvia, and Estonia—and Russia's evident opposition to their joining NATO.

It would be totally unacceptable to grant Russia any such veto. Let us not forget the history of the last 61 years.

In 1940, Moscow rigged bogus ''invitations'' from the three independent Baltic states to be incorporated by the Soviet Union. I am proud as an American that this country for more than 50 years never recognized this illegal annexation.

Following annexation, and during the ensuing 5 years, the Soviets murdered thousands of Baltic citizens and deported thousands more to deepest Siberia. Guerilla warfare against the occupiers erupted in the forests of all three countries, with the last anti-Soviet partisan in Lithuania not surrendering until the 1960s.

Despite their heroic struggle, the Baltic peoples had to endure the iron repression of Soviet communism for half a century. Now, in the wake of the collapse of the Soviet Union, all three Baltic countries are full-fledged democracies that are developing their civil societies and free-market economies.

After Lithuania, Latvia, and Estonia suffered the 51 years of Soviet-inflicted brutalities, it would be morally grotesque to deny them the fundamental right to choose their own system of security that is accorded to every other European country. This would be the ultimate ''double whammy,'' in essence saying, ''since you suffered so much, you may not ensure your safety in the future!''

No, Mr. President, we must never repeat, even by inference, the infamous Molotov-Ribbentrop Pact of 1939, which carved up northeastern Europe between Stalin and Hitler: There must be no more ''red lines'' in Europe.

Russia, with which I sincerely hope we can develop a harmonious and productive relationship, must understand