



United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE *107th* CONGRESS, SECOND SESSION

WASHINGTON, WEDNESDAY, JUNE 27, 2001

Senate

BIPARTISAN PATIENT PROTECTION ACT

Mr. CARPER. Mr. President, I rise in support of the amendment. I am pleased to be an original coauthor with Senators BAYH and MCCAIN. The Senator from Indiana is very modest in giving to others the credit, but this is really an idea that I first heard from him. Early this week, Senator Ben Nelson and Senator Bayh and myself were trying to deal with issue of medical necessity. It is a difficult issue around which there are competing interests--doctors, nurses, insurers, patients--who really find consensus hard to reach.

I thank Senator Bayh for helping us to find this middle ground on which I am encouraged that maybe we will have strong bipartisan support. I express my thanks to Senators MCCAIN and KENNEDY and EDWARDS for their leadership in getting us here this day, and to my friend, Senator Gregg from New Hampshire, for his thoughtful comments, as well as those I heard on the floor yesterday, alluded to by Senator Bayh, from Senator Nickles. As I recited, earlier today PHIL GRAMM of Texas echoed almost those same comments.

Before I return, I want to step back a little bit and go back in time. I used to be State treasurer of Delaware before I was a Congressman, before I was Governor, before I became a Senator. Senator Bayh was Governor of Indiana and was the secretary of state. We worked in those venues before we came here to work. With our State treasurer at the time, we administered benefits of State employees.

Among the things I was mindful of was health care costs.

In the 1970s and 1980s, health care costs went up enormously. It was not uncommon to see increases then of 20, 25, or even 30 percent annually in the cost of health care for State employees. These really mirrored increases that inured to other employees outside the State of Delaware.

Along about the late 1980s, a dozen or so years ago, a number of people began working seriously in this town to figure out how to introduce some competition into the provision of medicine. In a fee-for-service approach in medicine, I might see my doctor and he says, "You are not well; I will order tests A, B, C and D, and to be sure we will order E, F, G and H," and he owns the lab where the tests are administered. Then he says, "Come back and we will see how you feel next week." There really wasn't much impetus for containing costs. As a result, costs spiraled out of control.

Managed care was designed and conceived to try to stop that spiraling and introduce some market forces and competition in order to control the cost of health care. It really succeeded better than I think any of its proponents had imagined. Those costs that were going up 20, 25, even 30 percent, back in the 1980s, by the time we got to the end of the 1990s, were going up by 2, 3 percent, in some years nothing at all. As we went about controlling costs, the concerns switched to a different area, and that different area was quality of health care.

Instead of a lot of our doctors and nurses making decisions, a lot of decisions for the care to be offered or given to us was made within the HMOs running the managed care operation. In some cases, they were doctors and nurses, and in some cases they were not.

What we are trying to do in the context of the Patients' Bill of Rights legislation is restore some balance to the system. We don't want to see costs spiral out of control or employers cutting off health care for employees. By the same token, we want to make sure that more of the medical decisions that affect us if we are covered by an HMO, especially if it falls under a Federal regulation, which ERISA is--we want to make sure we are getting the kinds of protections that inure to folks who are in State HMOs.

How do we do that and not lead us back to spiraling, out-of-control costs in a way that is fair to doctors and nurses, and in a way that is fair to employers and at the same time fair to the HMOs? The issue we are trying to address is this: I am in an HMO; I don't like the decision my HMO renders with respect to my health care. I appeal that decision, and it is reviewed by an internal mechanism within the HMO. If they don't provide a decision my doctor and I like, we can appeal to an external reviewer. In some cases, certainly in my State, an external reviewer can override the HMO's decision and mandate the provision of that health care under a State-regulated plan.

What about in a case where there is a federally regulated HMO, one that falls under ERISA? What do you do in a case when the language of the plan explicitly excludes the treatment that a member of that plan desires? What do we do when the language of the plan explicitly excludes the very treatment that I or the member of a managed care plan desires?

Unintentionally, the language of the bill as drafted says to the external reviewer that

you have license to go beyond that which is explicitly excluded in treatment for a patient. That external reviewer can order additional explicitly excluded treatment for a patient. That might be great for the patient, might be appreciated by the patients' doctors and nurses. But how fair is that to the insurer who is trying to cost out a plan, to charge for that plan and have a sum certain to operate with?

What Senator Bayh has fashioned, something that he and Senator Nelson and I worked on, is a way to provide that certainty for the insurer and also to provide certainty for the consumer, the patient, and the health care providers. It is a simple change--one endorsed, at least indirectly, by Senator Nickles and today by Senator Gramm. By simply striking a couple lines in his bill and putting a period where a period ought to appear, we helped solve a problem. It doesn't solve all of the problems in this bill, but it solves one of the problems. It is clear, clean, and easy to understand.

Let me close my remarks with some comments about another one of our colleagues who, before he was in the Senate, was a Governor, Ben Nelson of Nebraska. Before he was Governor, he was insurance commissioner for his State. He has forgotten more about these insurance matters than most of us will ever know. His insights and perspectives on these issues have been enormously helpful to me in this debate. I thank him for joining with Senator Bayh and me and others in the conversations that really led to the emergence of this proposal.

Senator Nelson offered an amendment with Senator Kyl a little bit earlier today to try to define medical necessity, which is really the kind of issue we are talking about here. People have been trying to do that for years without a lot of success. While we are not going to agree to change the language in the bill with respect to that, we can say here clearly, if a health plan that falls under the

jurisdiction of ERISA explicitly excludes a particular kind of coverage, then in all fairness the external review committee in reviewing an appeal, cannot override the explicit exclusion in that health care plan. That is fair; that is reasonable; it provides certainty for the insurer, and I think it is fair

to consumers as well.

I am pleased to rise in support of it, and I hope that all of us in this Senate, Democrats and Republicans, and Independent as well, can support this amendment. Thank you very much.