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House of Representatives

The House was not in session today. Its next meeting will be held on Tuesday, July 10, 2001, at 2 p.m.

Senate

MONDAY, JULY 9, 2001

The Senate met at 12 noon and was called to order by the President pro tempore [Mr. BYRD].

PRAYER

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

Dear Father, we return to the work of this busy month ahead with the words and the music of the Independence Day celebration sounding in our souls. Now that the fireworks are over, work in us the fire of patriotism that has been the secret of truly great leaders throughout our history. We pray for the women and men of this Senate. Enlarge their hearts until they are big enough to contain the gift of Your spirit; expand their minds until they are capable of thinking Your thoughts; deepen their mutual trust so that they can work harmoniously for what is best for this Nation. You know all the legislation to be debated and voted on before the August recess. Grant the Senators a profound trust in You, a deep desire to seek Your will, and an unlimited supply of Your supernatural strength.

With renewed interdependence and deep dependence on You as fellow patriots, galvanize the Senators in the spirit of our founders expressed in their reliance on You and the pledge of their lives, fortunes, and their sacred honor for the next stage of Your strategy for America. You are our Lord and Saviour. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

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

RESERVATION OF LEADER TIME

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

MORNING BUSINESS

The PRESIDENT pro tempore. Under the previous order, there will now be a period for the transaction of morning business not to extend beyond the hour of 1 o'clock p.m. with Senators permitted to speak therein for up to 10 minutes each.

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDENT pro tempore. The Senator from Nevada is recognized.

SCHEDULE

Mr. REID. Mr. President, as the Chair announced, we are going to be in morning business until 1 p.m. At 1 p.m. the Senate will begin consideration of the supplemental appropriations bill under the previous order which calls for amendments to be offered prior to 6 p.m.

Over 40 amendments have been filed. I hope and guess that probably all of those will not be offered before 6 o'clock. But I would say to the Chair that I hope Senators will come to the floor and offer those amendments, debate them, so arrangements can be made as to whether the managers will accept the amendments or whether a time will be set in the future for votes. It is the leader's expectation we will finish this bill tomorrow. There are other appropriations bills we would like to finish this week also. In fact, the leader has every desire to finish the Interior appropriations bill and the supplemental bill this week. We will hear more from the leader at a subsequent time. But these are the two bills we must finish this week, and if we can finish them Thursday, that will be fine. I am sure, if we can't, the leader will want to go into Friday to complete the bills, or if it takes longer than that. I think they are both capable of being finished very quickly.

There are no rollcall votes today. There will be no rollcall votes until 2:15 tomorrow after the party caucuses.

BIPARTISAN PATIENTS' BILL OF RIGHTS

Mr. REID. Mr. President, before we adjourned for the recess, the Senate passed the bipartisan McCain-Kennedy-Edwards Patients' Bill of Rights and proved that protecting patients' rights is not a partisan issue. We can all be proud of the strong bipartisan compromises we reached which have the support of virtually every health care provider group in this country. This bill has achieved such overwhelming support because it represents a balanced approach to ensuring patient safety and health plan accountability

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

without significantly raising premiums or employer costs.

This landmark legislation will ensure that every privately insured American can enjoy important patient protection. For example, the bill will ensure that patients can have access to emergency room care; women can easily access OB/GYN services; children can access the specialty care they need; patients can access the prescription drugs prescribed for them; patients can participate in potential lifesaving clinical trials; patients can access necessary specialists, even if it means going out of the plan's provider network; chronically ill patients can receive the specialty care they need in an attempt to save their lives; patients with ongoing health care needs have continuity of care; and patients can hold their managed care plan accountable when plan decisions to withhold or limit care result in injury or death.

When I went home this past week people said, What does the bill do? Briefly, it is very old-fashioned in nature. It allows a doctor to render care that that doctor believes is appropriate to take care of that patient, whether it be prescribing drugs, whether it be surgery or other treatment. That is what the bill does.

Passage of this bill would not have been possible without the dedication and hard work of many people. First of all, the distinguished majority leader, Mr. DASCHLE, was involved in this legislation in its formative stage and every day we were in the Chamber. I think this showed to the American public what most of us have known for many years—that Senator DASCHLE really is a great leader. He indicated we were going to finish the bill before the Fourth of July break. Some people smiled, some snickered, and some thought it would be totally impossible. But it was done. It was done with all amendments being offered. Cloture was not filed. It was the way legislation should move. We spent some long hours in this Chamber, but as a result of his leadership we were able to do this work. This is an issue on which he has been working for 5 years; for 5 years we have waited to pass this meaningful and enforceable Patients' Bill of Rights that will protect all privately insured Americans. And I say again, Senator DASCHLE was able to forge bipartisan support for this critical legislation and ensure passage as a result of his patience.

We indeed also have to acknowledge the work done by the chairman of the Health, Education, Labor, and Pensions Committee, Senator TED KENNEDY. He was on this floor every minute of every day not only for the 2 weeks it took to pass the Patients' Bill of Rights but for 2 weeks prior to do the education bill. He has worked on this issue longer than anyone, was able to confront every contentious amendment, and managed to keep the integrity of the bill totally intact. Senator KENNEDY did great work. It shows what a fine Senator he is. Those of us who depend on him for leadership always have this bill to look to, to indicate what a great Senator he is.

Senator KENNEDY has had wide experience. One of the leaders in this bill was someone without the experience of Senator KENNEDY but who did great work: Senator EDWARDS of North Carolina. He proved his skill, his leadership, and his dedication to being a legislator by his work on this meaningful Patients' Bill of Rights. He has, since he came to the Senate, been a tireless voice for America's patients, and I and the rest of America are grateful for his contributions to the rest of this legislation.

Finally, I extend my thanks to Senator JOHN MCCAIN from the other side of the aisle. During his run for President of the United States, Senator MCCAIN promised the American people he would work to pass a Patients' Bill of Rights, and he did that. His name was first on this bill and he was involved as we proceeded through this legislation. He has been an extraordinary leader on this issue. Without his work, this bill would not have been possible.

It would not be fair to talk only about the proponents of this legislation. Senator JUDD GREGG did an outstanding job on this bill. He was here the entire 2 weeks. He had some difficult issues to work through. I think he did an excellent job of bringing the amendments that were meaningful to the floor at the right time. We were able to have complete and fair debate. I always had great appreciation of him.

I served with Senator GREGG when he became a Member of the House of Representatives. He left to become a two-term Governor of the State of New Hampshire. He came back—to the Senate.

I always had great respect for his abilities and certainly they were evident during the work he did on the Patients' Bill of Rights. Even though he was on the losing side of votes on many of the amendments that were offered, he was always a gentleman and a scholar. I think he did himself and this Senate very well with his work.

The Senate-passed Patients' Bill of Rights contains every one of the patient protections listed in President Bush's statement of principles. I hope the House of Representatives will work towards swift passage of this bill and that the President will sign into law this truly bipartisan legislation that will improve the quality of life for all Americans.

The PRESIDENT pro tempore. The Chair will state the time until 12:30 p.m. will be under the control of the Senator from Illinois, Mr. DURBIN, or his designee, and from 12:30 p.m. until 1 p.m. the time will be under the control of the Senator from Wyoming, Mr. THOMAS, or his designee.

Mr. REID. Mr. President, if the Senator from Wyoming wishes to say a few words, I am happy to yield him time under our time. How much time does the Senator want?

Mr. THOMAS. I was going to ask the question the President pro tempore has already answered. Thank you.

Mr. REID. The Senator from North Dakota has the rest of the time.

The PRESIDENT pro tempore. The Senator from North Dakota.

MEXICAN LONG-HAUL TRUCKS ON U.S. HIGHWAYS

Mr. DORGAN. Mr. President, later this week and perhaps through the summer we will have a discussion in both the Senate and the House about a very controversial issue. This administration and this Government will allow Mexican long-haul truckers to move across the border from Mexico into this country to drive their trucks on the highways and byways of this country unrestricted on the grounds that the North American Free Trade Agreement requires us to do so. However, after signing NAFTA the previous administration decided, because of serious safety concerns, not to allow the Mexican truckers to come in unrestricted on America's highways. At the moment, we allow them to cross the border and operate only in a zone within 20-miles from the Mexican border, on short-haul trucks.

The Bush administration is now going to lift that restriction. That is going to cause some very serious controversy. I want to explain today why that is an important issue.

A San Francisco Chronicle reporter named Robert Collier recently went on a 3-day trip with a long-haul trucker in Mexico. His article in the San Francisco Chronicle is quite interesting and quite revealing. I ask unanimous consent to have it printed at the conclusion of my remarks in the RECORD.

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

(See Exhibit 1.)

Mr. DORGAN. What is this issue of Mexican trucks coming into the United States? Why is it important and why will it provoke controversy? Simply, the issue is this: We inspect just 1 to 2 percent of the Mexican trucks that come into this country and operate within the 20-mile restriction. And 36 percent of those Mexican trucks are turned back into Mexico for serious safety violations.

In other words, up to now, we have told Mexican truckers: We will not allow you to drive on American roads because you don't meet American safety standards. Mr. President, 98 to 99 percent of the trucks were never inspected at all because we do not have nearly enough inspectors at the border. But of those that were inspected, 36 percent were turned back into Mexico for serious safety violations.

Mexico has a regime of safety issues dealing with truckers that is very lax. They are printed at the end of the article I previously mentioned. Let me run through a few of these. It says:

Hours-of-service limits for drivers: In the United States, we limit truckers to 10 hours of consecutive driving and then they must rest. That is all you can do in the United States, 10 hours. In Mexico, the sky is the limit. In fact, this reporter rode with one Mexican long-haul trucker for 3 days. In 3 days of driving a truck, the Mexican driver slept 7 hours—7 hours in 3 days. There is no restriction on hours with respect to Mexican drivers and truckers.

Random drug tests: In the United States, yes for all drivers; in Mexico, no.

Automatic disqualification for certain medical conditions: In the United States, yes; in Mexico, no.

Standardized logbooks: In the United States, yes, and you better fill them out. In Mexico, virtually no truckers use a logbook. The new law is not enforced.

Maximum weight limit for trucks: In the United States, 80,000 pounds; in Mexico, 135,000 pounds.

The point is, under NAFTA, it has been determined that the United States should allow Mexican long-haul truckers into this country unrestricted. I wonder if you want a Mexican trucker in your rear-view mirror on an American interstate, coming down the highway with questionable brakes, with questionable equipment, in a circumstance where over a third of all the trucks that we have inspected—and we have only inspected an infinitesimal number—over a third of them have been found to have serious safety violations.

This isn't rocket science. Of course, we should not allow unrestricted long-haul truckers to come into this country on America's roads; not until they meet all the requirements for safety that we require of our own trucking companies and our own drivers. This is not a hard question.

On the appropriations bill in the House of Representatives there was an amendment added that prohibits funding for permitting Mexican truckers to come into this country on an unrestricted basis. I have indicated I intend to offer a similar amendment in the Senate. I have offered stand-alone legislation which is more comprehensive than that, but it seems to me it is useful to offer language identical to that of the House because then it would be non-conferenceable and the restriction would become law when the appropriations bill is signed.

Senator MURRAY, the chair of the Transportation Appropriations subcommittee, talked to me and I know she is working on some language. I have not yet had an opportunity to see what that language is, but I appreciate the work she is doing. I hope when the appropriations bill leaves the Senate, we will have included similar or identical language to that in the House; language that says we will not allow Mexican long-haul trucks into this country on an unrestricted basis jeopardizing the safety of Americans who are driving on the roads—virtually all citizens who are driving on our roads. We do not want these safety questions to have to be in their minds.

This is a very important issue. It is one more evidence of a trade strategy that is inherently weak, that trades away our interests. How can we adopt a trade policy with another country that says: Oh, by the way, we will not allow anything that reflects safety issues from one side or the other to come in the way of trade?

It doesn't make any sense to me.

This is a paramount example of trading away our ability to make safety on America's roads something that is of significant concern. We have not gotten to the position of requiring safety equipment, driver's logs, and hours of service restrictions just because we want to regulate; we did it out of concern for safety. When you are driving down the road and have an 18-wheel truck behind you full of tons and tons of material, you want to make sure that truck has been inspected, that the truck has safety equipment, and that the truck is not going to come through the back of your car right up to the rearview mirror if you happen to put on your brakes in an emergency.

This is an important issue on its own. Giving up our ability to decide whether we will allow unsafe trucks to enter United States highways from Mexico is almost unforgivable. But it is part and parcel of a trade policy that has been bankrupt for a long while.

That brings me to another question about trade agreements. The administration is talking a lot now about fast-track. They want fast-track ability to do new trade agreements. I have some advice for them. I say: If you really want to fast-track something, why don't you fast-track solving some trade problems that you, along with previous administrations, have created through signing past trade agreements. Don't deal with Congress if you need fast-track legislative authority for anybody or anything; deal with fast-track trade solutions yourself.

Let me give you some examples of issues that the Administration might want to fast-track.

Today, in Canada, they are loading trucks and railroad cars full of molasses to bring into the United States. The molasses is loaded with Brazilian sugar and sent to Canada so it can be added to molasses. The molasses is a carrier that is used to circumvent our quota on sugar imports. They subvert the sugar quota by sending Brazilian sugar through Canada loaded as molasses. It is called stuffed molasses. It is fundamentally unfair trade, but we can not get anything done about it.

If you want fast track, let's fast track a solution to solving the stuffed molasses scheme.

Fast track: How about this? Do you know how many American movies we got into China last year? Ten. Ten American movies got into China—a country with an $80 billion trade surplus with the United States. This is intellectual property. It is entertainment. We got 10 movies into China because they say: That is all you can get into our country.

What about the issue of automobiles? Do you know how many automobiles we bought from Korea last year? Americans bought 450,000 cars from companies building cars in Korea. Do you know how many United States-produced cars were sold in the country of Korea last year? Twelve hundred—four hundred and fifty thousand to twelve hundred. Why? Because Korea doesn't want American cars in Korea. So they ship us their cars and then keep our cars out.

How about something more parochial that comes from the rich soil of the Red River Valley that I represent? They grow wonderful potatoes—the best potatoes in the world. One of the things you can do with potatoes is make potato flakes and ship those flakes around the world. They are used in fast food. So you try to ship potato flakes to Korea. Guess what you find. Shipping potato flakes to Korea means that Korea imposes a 300-percent tariff on potato flakes. Imagine that. Poor little potato flakes with a 300-percent tariff.

In all of the issues about tariffs, everybody talks about tariffs and reducing tariffs. Twelve years after we reached a beef agreement with Japan—a country that every year has a $50 billion to $80 billion trade surpluses with us—there still remains on every pound of T-bone steaks sent to Tokyo a 38.5-percent tariff. Can you imagine that? Every pound of American beef getting into Japan still has a 38.5-percent tariff. When they reached the beef agreement, my God, you would have thought they had just won the Olympics. They had dinners and congratulated each other—good for all of these folks who reach trade agreements. Yet, twelve years later, we still have a 38.5-percent tariff on every single pound of beef we send to Japan.

That is just a sample. Potato flakes, cars to Korea, beef to Japan, stuffed molasses from Canada, and movies to China—you name it.

I say to those who come to us saying we want fast track: look, you don't need fast track from Congress. I am sure not going to give it to you. You don't deserve it. You have constructed trade agreements that, No. 1, threaten safety in this country by saying to us in those agreements you have to let trucks that are fundamentally unsafe come in from Mexico. You constructed trade agreements that have allowed the Canadians to dump durum wheat across our border.

I have told the story repeatedly—it bears telling again—of driving up to the border in a little 12-year-old orange truck with a farmer named Earl Jenson, and all the way to the Canadian border we saw 18-wheeler after 18-wheeler hauling Canadian durum wheat south. It was such a windy day that the

grain was coming out from under the tarps of these big semis hauling Canadian durum wheat, splattering against our windshield every time we met one. I counted a lot of trucks coming from the other border.

When we got to the border with the 12-year-old 2-ton orange truck with a small amount of durum on it, we were told: You can't take that into Canada. You can't take American durum wheat into Canada. So we got turned around with the little 12-year-old orange truck, despite the fact that all of these semis all day long came down from Canada—evidence, it seems to me, of just one more thorn that exists in this trade circumstance, one more burr under the saddle for all those farmers and ranchers out there who have been taken by unfair trade agreements negotiated by our trade negotiators who should have known better, by trade negotiators who did not seem to stand up for this country's interest in the final agreement. They were more interested in getting an agreement than they were in getting a fair agreement.

Again, I say to the Trade Ambassador and others, if you want fast track, hold up a mirror and say this in the morning: Fast track for me means solving trade problems, solving the Canadian durum problem, solving the Canadian stuffed molasses problem, solving the problem of our getting cars into Korea, potato flakes into Korea, movies into China, and beef into Japan.

I can stand here and cite a couple of dozen more, if you like.

Show us you can solve problems rather than creating problems, then come back to us and talk. But don't suggest to me that we do something for you to negotiate a new agreement unless you have solved the problems of the old trade agreements—yes, GATT, NAFTA, you name it, right on down the road.

I have always, when I have spoken about trade, threatened to suggest that we require our trade negotiators to wear uniforms. In the Olympics, they wear a jersey. It says ''U.S.A.'' across the chest. So at least in some quiet moment in some negotiating meeting someplace, these trade negotiators who seem so quick to lose are willing to look down and see whom they really represent.

Will Rogers used to say, ''The United States of America has never lost a war and never won a conference.'' He surely must have been thinking about our trade negotiators, because in agreement after agreement after agreement we seem to end up on the short end.

That is especially true with a trade agreement that now puts us in a circumstance where we are told we are supposed to allow Mexican long-haul trucks to come into this country under the provisions of the trade agreement notwithstanding the safety issues. That is not fair. It is not right. To do so would not be standing up for the best interests of the American people.

We are going to have a fight about this. We are going to have controversy about it. But as I said when I started, this ought not be rocket science. We cannot and should not decide that these trade agreements either force us or allow us to sacrifice the basic safety of the American people. It doesn't matter whether it is safety on the roads, safety with respect to food inspection, you name it. We cannot and should not allow these trade agreements to force us to sacrifice safety.

We should insist just once and for a change that our trade negotiators stand up for this country's interest. There is nothing inappropriate and nothing that ought to persuade us to be ashamed of standing up for our best economic interests. Yes, we can do that in a way that enriches all of the world and in a way that helps pull others up and assist others in need.

We can do that, but we also ought to understand we have people in need in this country. American family farmers are going broke. We have all kinds of people losing their jobs in the manufacturing sector. Manufacturing is a sector in this country that is very important and has been diminishing rather than expanding.

So let's decide to do the right thing with respect to trade. I want expanded trade. I want robust trade. I do not believe we should construct walls. I do not believe that a protectionist—using the pejorative term—is someone who enhances this country's interests. But using the term ''protection,'' let me just be quick to point out there is nothing wrong with protecting our country's best interests with respect to trade agreements that will work for this country.

So we will have this discussion this week on the Transportation Appropriations bill, that will be under the able leadership of Senator MURRAY. My expectation is we will resolve this in a way that is thoughtful and in a way that expresses common sense in dealing with Mexican long-haul truckers coming into this country.

I yield the floor.

EXHIBIT 1

[From the San Francisco Chronicle, Mar. 4, 2001]

MEXICO'S TRUCKS ON HORIZON—LONG-DISTANCE HAULERS ARE HEADED INTO U.S. ONCE BUSH OPENS BORDERS

(By Robert Collier)

ALTAR DESERT, MEXICO.—[Editor's Note: This week, the Bush administration is required by NAFTA to announce that Mexican long-haul trucks will be allowed onto U.S. highways—where they have long been banned over concerns about safety—rather than stopping at the border. The Chronicle sent a team to get the inside story before the trucks start to roll.]

It was sometime way after midnight in the middle of nowhere, and a giddy Manuel Marquez was at the wheel of 20 tons of hurtling, U.S.-bound merchandise.

The lights of oncoming trucks flared into a blur as they whooshed past on the narrow, two-lane highway, mere inches from the left mirror of his truck. Also gone in a blur were Marquez's past two days, a nearly Olympic ordeal of driving with barely a few hours of sleep.

''Ayy, Mexico!'' Marquez exclaimed as he slammed on the brakes around a hilly curve, steering around another truck that had stopped in the middle of the lane, its hood up and its driver nonchalantly smoking a cigarette. ''We have so much talent to share with the Americans—and so much craziness.''

Several hours ahead in the desert darkness was the border, the end of Marquez's 1,800-mile run. At Tijuana, he would deliver his cargo, wait for another load, then head back south.

But soon, Marquez and other Mexican truckers will be able to cross the border instead of turning around. Their feats of long-distance stamina—and, critics fear, endangerment of public safety—are coming to a California freeway near you.

Later this week, the Bush administration is expected to announce that it will open America's highways to Mexican long-haul trucks, thus ending a long fight by U.S. truckers and highway safety advocates to keep them out.

Under limitations imposed by the United States since 1982, Mexican vehicles are allowed passage only within a narrow border commercial zone, where they must transfer their cargo to U.S.-based long-haul trucks and drivers.

The lifting of the ban—ordered last month by an arbitration panel of the North American Free Trade Agreement—has been at the center of one of the most high-decibel issues in the U.S.-Mexico trade relationship.

Will the end of the ban endanger American motorists by bringing thousands of potentially unsafe Mexican trucks to U.S. roads? Or will it reduce the costs of cross-border trade and end U.S. protectionism with no increase in accidents?

Two weeks ago, as the controversy grew, Marquez's employer, Transportes Castores, allowed a Chronicle reporter and photographer to join him on a typical run from Mexico City to the border.

The three-day, 1,800 mile journey offered a window into a part of Mexico that few Americans ever see—the life of Mexican truckers, a resourceful, long-suffering breed who, from all indications, do not deserve their pariah status north of the border.

But critics of the border opening would also find proof of their concerns about safety:

—American inspectors at the border are badly undermanned and will be hard-pressed to inspect more than a fraction of the incoming Mexican truckers.

California—which has a much more rigorous truck inspection program than Arizona, New Mexico or Texas, the other border states—gave full inspections to only 2 percent of the 920,000 short-haul trucks allowed to enter from Mexico last year.

Critics say the four states will be overwhelmed by the influx of Mexican long-haul trucks, which are expected to nearly double the current volume of truck traffic at the border.

—Most long-distance Mexican trucks are relatively modern, but maintenance is erratic.

Marquez's truck, for example, was a sleek, 6-month-old, Mexican-made Kenworth, equal to most trucks north of the border. But his windshield was cracked—a safety violation that would earn him a ticket in the United States but had been ignored by his company since it occurred two months ago.

A recent report by the U.S. Transportation Department said 35 percent of Mexican trucks that entered the United States last year were ordered off the road by inspectors for safety violations such as faulty brakes and lights.

—Mexico's domestic truck-safety regulation is extremely lax. Mexico has no functioning truck weigh stations, and Marquez

said federal police appear to have abandoned a program of random highway inspections that was inaugurated with much fanfare last fall.

—Almost all Mexican long-haul drivers are forced to work dangerously long hours.

Marquez was a skillful driver, with lightning reflexes honed by road conditions that would make U.S. highways seem like cruise-control paradise. But he was often steering through a thick fog of exhaustion.

In Mexico, no logbooks—required in the United States to keep track of hours and itinerary—are kept.

''We're just like American truckers, I'm sure,'' Marquez said with a grin. ''We're neither saints nor devils. But we're good drivers, that's for sure, or we'd all be dead.''

Although no reliable statistics exist for the Bay Area's trade with Mexico, it is estimated that the region's exports and imports with Mexico total $6 billion annually. About 90 percent of that amount moves by truck, in tens of thousands of round trips to and from the border.

Under the decades-old border restrictions, long-haul trucks from either side must transfer their loads to short-haul ''drayage'' truckers, who cross the border and transfer the cargo again to long-haul domestic trucks. The complicated arrangement is costly and time-consuming, making imported goods more expensive for U.S. consumers.

Industry analysts say that after the ban is lifted, most of the two nations' trade will be done by Mexican drivers, who come much cheaper than American truckers because they earn only about one-third the salary and typically drive about 20 hours per day.

Although Mexican truckers would have to obey the U.S. legal limit of 10 hours consecutive driving when in the United States, safety experts worry that northbound drivers will be so sleep-deprived by the time they cross the border that the American limit will be meaningless. Mexican drivers would not, however, be bound by U.S. labor laws, such as the minimum wage.

''Are you going to be able to stay awake?'' Marcos Munoz, vice president of Transportes Castores jokingly asked a Chronicle reporter before the trip. ''Do you want some pingas?''

The word is slang for uppers the stimulant pills that are commonly used by Mexican truckers. Marquez, however, needed only a few cups of coffee to stay awake through three straight 21-hour days at the wheel.

Talking with his passengers, chatting on the CB radio with friends, and listening to tapes of 1950s and 1960s ranchera and bolero music, he showed few outward signs of fatigue.

But the 46-year-old Marquez, who has been a trucker for 25 years, admitted that the burden occasionally is too much.

''Don't kid yourself,'' he said late the third night. ''Sometimes, you get so tired, so worn, your head just falls.''

U.S. highway safety groups predict an increase in accidents after the border is opened.

''Even now, there aren't enough safety inspectors available for all crossing points,'' said David Golden, a top official of the National Association of Independent Insurers, the main insurance-industry lobby.

''So we need to make sure that when you're going down Interstate 5 with an 80,000-pound Mexican truck in your rearview mirror and you have to jam on your brakes, that truck doesn't come through your window.''

Golden said the Bush administration should delay the opening to Mexican trucks until border facilities are upgraded.

California highway safety advocates concur, saying the California Highway Patrol—which carries out the state's truck inspections—needs to be given more inspectors and larger facilities to check incoming trucks' brakes, lights and other safety functions.

Marquez's trip started at his company's freight yard in Tlalnepantla, an industrial suburb of Mexico City. There, his truck was loaded with a typical variety of cargo—electronic components and handicrafts bound for Los Angeles, and chemicals, printing equipment and industrial parts for Tijuana.

At the compound's gateway was a shrine with statues of the Virgin Mary and Jesus. As he drove past, Marquez crossed himself, then crossed himself again before the small Virgin on his dashboard.

''Just in case, you know,'' he said. ''The devil is always on the loose on these roads.''

In fact, Mexican truckers have to brave a wide variety of dangers.

As he drove through the high plateaus of central Mexico, Marquez pointed out where he was hijacked a year ago—held up at gunpoint by robbers who pulled alongside him in another truck. His trailer full of canned tuna—easy to fence, he said—was stolen, along with all his personal belongings.

What's worse, some thieves wear uniforms.

On this trip, the truck had to pass 14 roadblocks, at which police and army soldiers searched the cargo for narcotics. Each time, Marquez stood on tiptoes to watch over their shoulders. He said, ''You have to have quick eyes, or they'll take things out of the packages.''

Twice, police inspectors asked for bribes—''something for the coffee,'' they said. Each time, he refused and got away with it.

''You're good luck for me,'' he told a Chronicle reporter. ''They ask for money but then see an American and back off. Normally, I have to pay a lot.''

Although the Mexican government has pushed hard to end the border restrictions, the Mexican trucking industry is far from united behind that position. Large trucking companies such as Transportes Castores back the border opening, while small and medium-size ones oppose it.

''We're ready for the United States, and we'll be driving to Los Angeles and San Francisco,'' said Munoz, the company's vice president.

''Our trucks are modern and can pass the U.S. inspections. Only about 10 companies here could meet the U.S. standards.''

The border opening has been roundly opposed by CANACAR, the Mexican national trucking industry association, which says it will result in U.S. firms taking over Mexico's trucking industry.

''The opening will allow giant U.S. truck firms to buy large Mexican firms and crush smaller ones,'' said Miguel Quintanilla, CANACAR's president. ''We're at a disadvantage, and those who benefit will be the multinationals.''

Quintanilla said U.S. firms will lower their current costs by replacing their American drivers with Mexicans, yet will use the huge American advantages—superior warehouse and inventory-tracking technology, superior warehouse and inventory-tracking technology, superior access to financing and huge economies of scale-to-drive Mexican companies out of business.

Already, some U.S. trucking giants such as M.S. Carriers, Yellow Corp. and Consolidated Freightways Corp. have invested heavily in Mexico.

''The opening of the border will bring about the consolidation of much of the trucking industry on both sides of the border,'' said the leading U.S. academic expert on NAFTA trucking issues, James Giermanski, a professor at Belmont Abbey College in Raleigh, N.C.

The largest U.S. firms will pair with large Mexican firms and will dominate U.S.-Mexico traffic, he said.

But Giermanski added that the increase in long-haul cross-border traffic will be slower than either critics or advocates expect, because of language difficulties, Mexico's inadequate insurance coverage and Mexico's time-consuming system of customs brokers.

''All the scare stories you've heard are just ridiculous,'' he said. ''The process will take a long time.''

In California, many truckers fear for their jobs. However, Teamsters union officials say they are trying to persuade their members that Marquez and his comrades are not the enemy.

''There will be a very vehement reaction by our members if the border is opened,'' said Chuck Mack, president of Teamsters Joint Council 7, which has 55,000 members in the Bay Area.

''But we're trying to diminish the animosity that by focusing on the overall problem—how (the opening) will help multinational corporations to exploit drivers on both sides of the border.''

Mexican drivers, however, are likely to welcome the multinationals' increased efficiency, which will enable them to earn more by wasting less time waiting for loading and paperwork.

For example, in Mexico City, Marquez had to wait more than four hours for stevedores to load his truck and for clerks to prepare the load's documents—a task that would take perhaps an hour for most U.S. trucking firms.

For drivers, time is money, Marquez's firm pays drivers a percentage of gross freight charges, minus some expenses. His three-day trip would net him about $300. His average monthly income is about $1,400—decent money in Mexico, but by no means middle class.

Most Mexican truckers are represented by a union, but it is nearly always ineffectual—what Transportes Castores executives candidly described as a ''company union.'' A few days before this trip, Transportes Castores fired 20 drivers when they protested delays in reimbursement of fuel costs.

But Marquez didn't much like talking about his problems. He preferred to discuss his only child, a 22-year-old daughter who is in her first year of undergraduate medical school in Mexico City.

Along with paternal pride was sadness.

''Don't congratulate me,'' he said. ''My wife is the one who raised her. I'm gone most of the time. You have to have a very strong marriage, because this job is hell on a wife.

''The money is OK, and I really like being out on the open road, but the loneliness . . .'' He left the thought unfinished, and turned up the volume on his cassette deck.

It was playing Pedro Infante, the famous bolero balladeer, and Marquez began to sing.

''The moon of my nights has hidden itself.

''Oh little heavenly virgin, I am your son.

''Give me your consolation,

''Today, when I'm suffering out in the world.''

Despite the melancholy tone, Marquez soon became jovial and energetic. He smiled widely and encouraged his passengers to sing along. Forgoing his normal caution, he accelerated aggressively on the curves.

His voice rose, filling the cabin, drowning out the hiss of the pavement below and the rush of the wind that was blowing him inexorably toward the border.

HOW NAFTA ENDED THE BAN ON MEXICO'S TRUCKS

The North American Free Trade Agreement, which went into effect in January 1994, stipulated that the longtime U.S. restrictions on Mexican trucks be lifted.

Under NAFTA, by December 1995, Mexican trucks would be allowed to deliver loads all

over the four U.S. border states—California, Arizona, New Mexico and Texas—and to pick up loads for their return trip to Mexico. U.S. trucking firms would get similar rights to travel in Mexico. And by January 2000, Mexican trucks would be allowed throughout the United States.

However, bowing to pressure from the Teamsters union and the insurance industry, President Clinton blocked implementation of the NAFTA provisions. The Mexican government retaliated by imposing a similar ban on U.S. trucks.

As a result, the longtime status quo continues: Trucks from either side must transfer their loads to short-haul ''drayage'' truckers, who cross the border and transfer the cargo again to long-haul domestic trucks.

The complicated arrangement is time-consuming and expensive. Mexico estimates its losses at $2 billion annually; U.S. shippers say they have incurred similar costs.

In 1998, Mexico filed a formal complaint under NAFTA, saying the U.S. ban violated the trade pact and was mere protectionism. The convoluted complaint process lasted nearly six years, until a three-person arbitration panel finally ruled Feb. 6 that the United States must lift its ban by March 8 or allow Mexico to levy punitive tariffs on U.S. exports.

COMPARING TRUCKING REGULATIONS

The planned border opening to Mexican trucks will pose a big challenge to U.S. inspectors, who will check to be sure that trucks from Mexico abide by stricter U.S. truck-safety regulations. Here are some of the differences:

Hours-of-service limits for drivers—In U.S.: yes. Ten hours' consecutive driving, up to 15 consecutive hours on duty, 8 hours' consecutive rest, maximum of 70 hours' driving in eight-day period; in Mexico: no.

Driver's age—In U.S.: 21 is minimum for interstate trucking; in Mexico: 18.

Random drug test—In U.S.: yes, for all drivers; in Mexico: no. Automatic disqualification for certain medical conditions in U.S.: yes; in Mexico: no.

Logbooks—In U.S.: yes, standardized logbooks with date graphs are required and part of inspection criteria; in Mexico: a new law requiring logbooks is not enforced, and virtually no truckers use them.

Maximum weight limit (in pounds)—In U.S.: 80,000; in Mexico: 135,000.

Roadside inspections—In U.S.: yes; in Mexico: an inspection program began last year but has been discontinued.

Out-of-service rules for safety deficiencies—In U.S.: yes; in Mexico: not currently, program to be phased in over two years.

Hazardous materials regulations—In U.S.: a strict standards, training, licensure and inspection regime; in Mexico: much laxer program with far fewer identified chemicals and substances, and fewer licensure requirements.

Vehicle safety standards—In U.S.: comprehensive standards for components such as antilock brakes, underride guards, night visibility of vehicle; in Mexico: newly enacted standards for vehicle inspections are voluntary for the first year and less rigorous than U.S. rules.

The PRESIDING OFFICER (Mrs. CARNAHAN). The time under the control of the majority has expired.

Under the previous order, the time until 1 p.m. shall be under the control of the Senator from Wyoming, Mr. THOMAS, or his designee.

The Senator from Arizona.

Mr. KYL. Madam President, I am going to talk about two different subjects this morning. The two subjects are the energy crisis, No. 1, and, No. 2, the situation in the Middle East. There is some connection between those two, and I will go into that in a moment. But I would like to treat them as separate subjects and begin with the discussion of what I still refer to as the energy crisis. My colleague from Wyoming, Senator THOMAS, will be addressing that briefly as well.

THE ENERGY CRISIS

Mr. KYL. I suspect that most of my colleagues, as myself, talked to a lot of our constituents over the Fourth of July recess who reminded us of the fact that out in America there is still a problem with an energy shortage. I know I had to gas up my vehicle, as did a lot of other Americans, when I drove up to the mountains in Arizona. I had a wonderful time. I marched in a Fourth of July parade in Show Low, AZ, really the heart of America as far as I am concerned. Folks out there are still concerned because they recognize that Washington is dithering; that we are not doing anything to solve the problem of an energy shortage in this country.

Some people may call it a crisis; other people may not; but the fact is we have had a wake-up call. The question is, Will we answer the call or are we simply going to dither around, ignore it, and play partisan politics?

My own view is that there is no better opportunity for us to show bipartisanship, to work together toward a solution to a common problem that affects all Americans, than working together to solve this energy shortage problem.

This is something on which the administration has weighed in. They have taken the issue very seriously. Very early in his term, the President asked Vice President CHENEY to convene a group of people to come up with some suggestions on what we could do—both short term and long term—to address this energy shortage problem.

The Vice President, along with a lot of others, came up with a series of recommendations which I would like to have us consider in the Senate. They are recommendations which deal with new production, with conservation—a majority of the recommendations, incidentally, deal with conservation, even though that has largely been ignored in the media—and recommendations dealing with new energy sources, something in which I am very interested—hydrogen fuel cells, and a whole lot of things.

The fact is, this is a serious effort. While the Republicans held the majority in the Senate, a bill was introduced which embodied many of these recommendations. Under the then-Republican leadership, it was going to be our program to take up that energy legislation in this Senate Chamber starting today or tomorrow. Sadly, that is not going to happen. The Democratic leadership announced some time ago that it had different priorities and that the Senate Chamber would not be the place for debate about the energy shortage the week following the Fourth of July recess.

It is my understanding that hearings have been scheduled and both the Finance Committee and the Energy Committee will be taking up different pieces of legislation. There will be hearings on the administration's plan, as well as other ideas. And that is good. But we need to deal with this problem while we have had this wake-up call and not kick it to the back burner where we will forget about it and then, in another year or two, realize we wasted a couple of years that could have been spent in finding new energy sources, putting them into play, and providing an opportunity for Americans to enjoy the kind of prosperity we can enjoy with the proper mix of good energy sources.

There are basically two issues. One deals with the cost of producing electricity and how that electricity will be produced. The other has to do with the reality that Americans are going to use a great deal of energy—petroleum products primarily, and primarily for transportation. That is not going to change in the near term, despite the fact that over the long run we will have to come up with some alternatives.

I mentioned hydrogen fuel cells as one of those possibilities. It is a little closer than I think most people would recognize. We put money into basic research at the Federal Government level. The administration has pushed for that as part of their energy plan. I hope we can move down that path.

But in the meantime, we have to be realistic about the fact that Americans are going to continue to drive their automobiles. We are going to have to continue to have gasoline. We cannot wish that problem away. The question is, Do we rely strictly on the sources of oil from the Middle East, for example, or do we recognize that it really puts us behind the 8 ball if the OPEC countries want to constrain supplies and increase prices? Or if there is jeopardy to those sources from military conflict, will we have to once again send our troops and spend a great deal of energy and money to protect those energy sources as we did during the Persian Gulf war? That is one path we can take.

There are some in this country who would have us ignore the potential for energy development in this country. I think we ought to have a plan that both recognizes the potential within the United States for oil production as well as buying what we can on the market internationally.

The other aspect of that problem is refineries. We have not built new refineries in this country for 20 to 25 years. We have actually had some shut down. As one of my Democratic colleagues said during a hearing in the Finance Committee a couple weeks ago, she is a

little disappointed about the fact that there is criticism of refineries making money. She said: What are my business folks in my State to do—be in the business to lose money? The fact is, they are in the business to make money. In the process of making money, they make petroleum products that we demand when we go to the service station.

When I filled up my vehicle last week, I wanted gasoline to be in that pump so I could drive my family where we were going. We have a lot of demand in this country. It is we who have the demand, not the oil companies. They are the ones that provide the product and the refineries that refine that product so that we can meet our demand. Yet there is a great deal of criticism about anybody who would make money in producing one of these products. That is the only way we get the products.

The free market system has served us well. We ought to be very careful about denigrating the suppliers who have made it possible for us to enjoy our standard of living.

So my view, just to summarize, is that we should consider the President's recommendations in a bipartisan spirit. We should move along quickly with the hearings that I understand have been scheduled. And we should bring to this Senate Chamber, as soon as possible, the legislation or other recommendations that will enable us to deal with this issue now, when we have had the wake-up call, and not kick it down the road a couple years to when we can see some real problems not just in the State of California but spreading throughout this country in energy cost increases, potential blackouts and brownouts, and the like. This is the time to deal with that problem.

Mr. President, to conclude, I rise today to express my concern that the Senate Democratic leadership has not yet scheduled floor time to allow the full Senate to promptly address the energy crisis that threatens all Americans. Having just returned from the July 4th recess in Arizona, I can tell you that not all Americans share the view that this should be a low legislative priority. Most of them want to deal with the problem in a bipartisan way.

Because of its effect on the national economy as well as peoples' individual pocketbooks, I am particularly troubled that the energy crisis seems to take a back seat to other issues on the new leadership's agenda. This is not the bipartisanship those leaders urged when they were in the minority.

The United States faces the most serious energy shortage since the oil embargoes of the 1970s. We all know about California's problems with rolling blackouts and soaring energy bills. The President thought it important enough to travel to California last month to address this problem firsthand. Unfortunately, energy shortages and price increases are spreading to other parts of the country.

I want to make it as clear as I can that we should quickly address the energy recommendations offered by the administration. With oil consumption expected to grow by over six million barrels per day over the next 20 years, natural gas consumption to jump 50 percent and electricity demands to rise by 45 percent, we must act aggressively to increase production in each of these areas before the entire nation suffers from the shortfall. Just to meet expected electricity demands, for example, we must begin now to build between 1,300 and 1,900 new power plants over the next 20 years.

To address this reality, we should act now on the 105 recommendations of Vice President CHENEY's energy task force. This plan makes 45 recommendations to modernize and increase conservation through tax credits and the expansion of Energy Department conservation programs. It proposes 35 ways to diversify our energy supply and expand our infrastructure by encouraging new pipelines, generating plants and refineries, and streamlining our regulatory process. And this proposal strengthens America's national security by decreasing our dependence on foreign oil through increased energy production within our borders.

Some opponents of the President and Vice President rely on ad hominem attacks, misinformation, and demagoguery to cast aspersions on the administration's proposals. They claim that, because the President and Vice President were once connected to the oil business, they somehow are disqualified from energy discussions. On the contrary—these are people who actually know something firsthand about the problems in the energy industry. They do not benefit personally from efforts to increase energy production.

Opponents of this energy strategy applaud the recent imposition of price caps to the western states. However, price caps do nothing to increase energy supplies, and could very well discourage investment in new generation power production by artificially limiting a producer's return on his or her investment. Indeed, California's two largest utilities are basically bankrupt as a result of artificial price caps on retail electricity prices. I am particularly concerned about price caps because Arizona, unlike California, has moved aggressively to permit new power plants needed to satisfy the state's growing demand for electricity. FERC's recent imposition of price caps could result in delayed construction or cancellation of these new facilities.

Opponents also say that the President's proposal will not encourage conservation. As an Arizonan, I certainly support commonsense conservation efforts that help preserve our natural resources. But these opponents must not have read the President's plan, for he devotes the bulk of his recommendations to efforts to enhance conservation. Among many provisions, the administration endorses tax credits to encourage use of more energy efficient products, such as hybrid or fuel-cell vehicles. It extends conservation programs in the Environmental Protection Agency and the Department of Energy. It increases funding for conservation technologies and orders federal agencies to reduce their energy usage by at least 10 percent. In total, the administration proposes $795 million for conservation programs as part of its overall budget allocation for the Department of Energy.

While these conservation efforts are important, we must also acknowledge that we cannot conserve our way out of an energy crisis. California has dramatically reduced its electricity use over the last two months, yet still faces the possibility of rolling blackouts. We must increase supply in the near-term or face even worse shortages than we have now.

Opponents also claim that we can meet our increased demand with renewable energy sources. We should support research into renewable energy technologies, such as hydrogen and fuel cells. Remember that, even so, non-hydro renewable energy produced only two percent of our energy supply last year and the Department of Energy reports that renewable energy will only produce, at most six percent of our energy supply by the year 2020. That isn't nearly enough to meet the growing demands of the next few decades.

Opponents also claim that the President's energy plan promotes ''dangerous'' energy use, such as nuclear energy and oil drilling. Let's address nuclear energy first. This is an energy resource that currently provides 22 percent of America's electricity needs, while producing no harmful emissions. Nuclear energy is safer than any comparable energy generation; capacity is more than 90 percent; power production is at an all-time high; and the costs are the lowest on record and continuing to fall. Nuclear energy use is neither a novel nor a risky concept; France receives 80 percent of all of its electricity from nuclear power.

There is a problem with disposal of nuclear waste, but it isn't so serious that the critics of nuclear power are concerned with finding an answer. They appear to be happy enough with current on-site storage. Obviously, other countries more ''green'' than the U.S. have resolved the waste issue. The fact is that it's not a technology problem but a political problem.

Increased oil drilling has proven as controversial, yet it shouldn't be. Drilling in the Arctic National Wildlife Refuge, for example, is a commonsense and safe proposal to increase domestic oil production. It is also very limited in scope. Oil exploration would occur in only a small portion of ANWR, in an area one-fifth the size of Washington's Dulles Airport. Technological advances have reduced any supposed risks to the environment. Drilling pads are roughly 80 percent smaller than they were a generation ago and high-tech drilling

allows for access to supplies as far as six miles away from a single, compact drilling site.

Two concerns are raised: oil spills and harm to wildlife. The threat of spills is far greater from ocean-going tankers than from the Alaska pipeline. And the caribou have prospered since drilling began on Alaska's North Slope.

This modest effort in ANWR would provide enormous benefits, producing as much as 600,000 barrels of oil a day for the next 40 years—exactly the amount we currently import from Iraq. Moreover, oil drilling utilizes a smaller portion of our environment than the alternative energy sources advocated by others. The Resource Development Council for Alaska reports that, to produce 50 megawatts of power, natural gas production uses two to five acres of land, solar energy consumes 1,000 acres, wind power uses 4,000 acres, and oil drilling—less than one-half of an acre. That is real conservation of our natural resources.

As it stands now, American consumers already depend on foreign and often hostile nations for more than half of our oil supply. In 20 years, that percentage will increase to 64 percent. Doesn't it make more sense to invest in domestic production so that we are not held hostage to the whims of OPEC and the need to militarily defend our interests in the major oil-producing regions?

In conclusion, I commend President Bush and Vice President CHENEY for producing serious and honest proposals to enact a long-term energy strategy on behalf of American consumers. A worsening energy crisis requires all of us to act swiftly on these proposals before the situation becomes more widespread.

I urge our new Democratic leaders to take this proposal seriously and find a way to bring solutions to the floor of the Senate. As these leaders know from their days in the minority, it is much easier to find a way to accommodate the minority's requests than fight them. I hope the new leadership will act in a truly bipartisan way and consider the administration's ideas. We're all in this energy shortage together. Democrats should work with Republicans for the good of all Americans.

THE MIDDLE EAST

Mr. KYL. Madam President, I would like to change gears a little bit and talk about another subject that is very distressing. Throughout this break I would turn the television on to the evening news, and invariably there would be a story about yet more violence in the Middle East. It really got me thinking about the fundamental issue that I think a lot of Americans have ignored.

We wring our hands. We wish that the parties could get together, that there could be peace in the Middle East, and that they could put their problems behind them and live in harmony.

So we ask—and I see newspeople basically asking different versions of this question—why can't they just go back to the peace process? Of course, Secretary Powell urged both parties to agree to a cease-fire, which temporarily they did, yet every single day there has been a bombing or other terrorist attack or attempt in the State of Israel.

The Israeli people have said: Peace is a two-way street. If Yasser Arafat and the PLO are not willing to enforce the multiple cease-fire agreements and the peace process that we thought we had agreed to before, then we will have to enforce the law, and that includes going after those terrorists who threaten our people. No nation can do otherwise.

I rise to comment briefly on this notion of ''returning to the peace process.'' The problem is that the 1993 Oslo accords, which were the genesis of this thing we call ''the peace process,'' we now learn were fundamentally flawed. That is now apparent to the Israeli people, despite significant differences. Talk about a robust democracy. It exists in Israel. You have very strongly held views by different citizens in Israel, and they fight it out. During their election process, they had a very robust election contest. Then they come together with a leader, and they hope to be unified as a people.

They had desperately wanted, to borrow someone else's famous phrase, to give peace a chance. As a result, they tried to make the Oslo accords of 1993 work. What they found after Camp David, just about a year ago this month, was that the PLO was unwilling at the end of the day to make the kinds of commitments that would be necessary for a lasting peace in the region. The reason for that is a fundamental difference of approach.

For the Israelis, it has been a question of buying peace with concessions, primarily of land, of territory. But the PLO and other Arab or Muslim groups in the Middle East apparently never had any intention of providing the quid pro quo of peace. Instead, too much of their effort has been focused on the illegitimacy, in their view, of the Israeli State, of the fundamental disagreement with the action that the United Nations took after World War II to literally create a homeland for the Jewish people. Because that homeland was taken from territory which the Palestinians saw as their lands, they have never been willing to concede the legitimacy of the Israeli State.

At Camp David, after historic concessions were made by Prime Minister Barak, concessions which had to do with the most basic rights of the Israeli citizens—to name their own capital and to have that capital an undivided city, Jerusalem; concessions with respect to over 90 percent of the West Bank land returned to the Palestinians; concessions made in removing its troops from Lebanon and a whole variety of other things—after all of those concessions had been made and there was an opportunity to seize the moment, Yasser Arafat, on behalf of the PLO, said no, he wanted one more thing. He wanted the right of return of all of the Palestinians, maybe 2 to 4 million people, maybe more, who he claims were dispossessed in order to create the Jewish state. All of those people had to have the right to go back to their homes.

That, of course, was the ultimate deal breaker. No Israeli leader could ever agree to that concession. That would literally have meant the end of the Jewish state as it is. As a result, those accords of a year ago, that discussion at Camp David of a year ago, concluded with no agreement. It exposed the fundamental fallacy of the Oslo accords in the first instance.

Very briefly, there were three essential premises of the Oslo accords. The first was that if the PLO was given this 30,000-manned armed force, that could be used to suppress violence rather than to promote more agitation in the Middle East. The idea was that whereas a democratic society such as Israel had a hard time dealing with these terrorists, a firm dictatorial Yasser Arafat, with an armed 30,000-manned force, could put down these terrorists and bring peace to the area. Of course, the force expanded significantly beyond that which had been agreed to and eventually it was used to promote violence, not to suppress it.

The second premise was that Israel could withdraw from the territory before a final peace accord was reached without losing its bargaining power or military deterrent. It had worked the other way around with regard to Egypt. Egypt, in good faith with President Sadat, dealt with the Israeli leaders up front. Israel ceded the land after the peace agreement was obtained. But peace was restored between Israel and Egypt as a result. That withdrawal of Israeli forces from Egyptian land prior to the peace ensuing was a true trade of land for peace. But under the Oslo accords, the situation was reversed. Israel was required to withdraw first and then negotiate. The result, of course, has been no credible peace.

The third premise is that peace could be made with the PLO. In Israel there had been a consensus all along among all of the parties, including Labor and Likud, that it was not possible to deal with the PLO because, A, the Palestinian organization was philosophically committed to Israel's destruction. It is hard to deal with people in a peace process who are absolutely committed to your destruction.

Secondly, the PLO's previous negotiations had been based on terrorism as the means of achieving their objectives. No Israeli government had been willing to negotiate with an entity committed to its destruction through violence.

This peace process changed that. The Israeli leaders, in a leap of faith, said: All right, we will deal with the PLO, despite this historic background.

The process itself became the basis for this understanding. A new assumption was basically created. If you are in the process of negotiating, then the quality of the people on the other side really didn't matter. That is why the Israelis were willing to make this leap of faith. It almost became a secular religion. In this country people talked about the peace process almost as the end in itself rather than the means to an end.

It turns out that the nature of the leadership of the negotiating parties does matter. So do the actions on the ground. The quality of the other people is fundamental to the success of the negotiations. The parties were never close, as some thought. Rather, the question really is whether peace was ever achievable given the Palestinian objectives.

That is why I say the fundamental assumptions of the peace process, of the Oslo accords, were flawed. In the end, none of the three premises turned out to be correct. They all turned out to be false. The Israeli people now understand that.

The question now is how to repair the damage that resulted from an adherence to this peace process where Israel gave up more and more and more and, in the end, got no peace. Ever since the Secretary of State and other officials before him went to the Middle East, there has been a bombing or an attempt every single day, an attempt of terrorism. There is no peace.

Hopefully, this helps to explain in brief form why it is not possible to simply return to the peace process as if there were some magic in that Oslo process. The Oslo process is dead. The reason it is dead is because it was premised on fundamental fallacies. That is why the Israeli people cannot go back to that flawed process.

We in the United States should not be critical of that decision on the part of the Israeli people. The Israeli people are not to blame for dealing now with a situation of violence and lawlessness and terror in as firm a way as they possibly can to protect their own citizens. No country could do otherwise. And for Americans to be so presumptuous as to lecture the Israelis about overreacting and urging them to return to a peace process which they now recognize was fundamentally flawed is the height of arrogance. We in the U.S. have to be much more understanding about the difficulties of achieving peace.

Fundamentally, Madam President, I think what we have to recognize is that as long as the leadership of the other side in this controversy—primarily the PLO—is not democratically based but is totalitarian, as long as there is not an involvement of all of the Palestinian people in the decisions on the other side, there will continue to be conflict.

The nature of the leadership on the other side matters, and it matters greatly. Until there is a democratically elected Palestinian Government, until the leaders are accountable to the people, whom I suspect want peace as much as anybody else in the region or in the world, then we are not likely to get the kind of peaceful resolution for which we all hope.

So what I hope right now is that the American people will be understanding of the position of the Israeli Government; that they will be supportive of this long-time ally, the nation of Israel; that they will recognize that there is no moral equivalence between acts of terror on the one hand and attempting to enforce the law on the other hand; that they will be supportive both in terms of military and economic support but also psychologically and not buy into this notion that there is repression on the part of the Israeli Government against the Palestinians which is the cause of the problem.

This whole idea of moral equivalence is wrong. If we go back to the founding of the Jewish state by the United Nations and recognize what was attempted there and the moral legitimacy of the Israeli State, then I think Americans will more carefully calibrate their criticism of the Israeli Government and understand that it is going to take a long time; that hearts have to change before there can be peace; and probably the best opportunity is for democracy to take hold in the Arab States so that the leaders are accountable to the people because in the long run, most people really want peace. They want to live together; they want to engage in commerce together; and they do not want to continue to send their sons and daughters to die for causes that are whipped up by their leadership—to die unnecessarily.

That is why I urge my colleagues in the Senate today, the administration in Washington, and the American people generally, to learn to listen carefully and to recognize that the peace process was based upon flawed assumptions, and not to urge the Israelis to act in ways that would be inimical both to their own immediate self-interests in terms of safety and the long-term interests of peace. It is a difficult subject, one that we have to confront; and we have to stand by an ally and also recognize the legitimacy of other Arab aspirations and Muslim aspirations in the Middle East, in which we have a great stake as well. As long as we fail to recognize the complexity of this situation and understand the process that was urged for so long cannot be the basis for future peace negotiations, we are not going to be able to proceed in a constructive way.

I hope the American people, as a result of these comments and others, will support the administration in its very delicate and difficult negotiations in that region and will be supportive of the Members of this body who seek to promote the kind of peace that will be not just temporary but lasting.

Mr. President, yet again Israel's restraint and unilateral acceptance of a ''cease fire'' has been met with terrorist acts perpetrated against an innocent civilian population. The recent tragic deaths of 20 Israeli teenagers and serious wounding of another 48 by a Palestinian suicide bomber were stark and deeply sad reminders that the key to peace in the Middle East does not depend on the State of Israel.

I am extremely concerned that the doctrine of moral equivalence has taken root among many in the United States and around the world with respect to perceptions of Arab-Israeli violence. While over the years Israel may have taken steps with which we do not always agree, the notion that it operates on the same moral plane as its adversaries is patently false. The suicide bombing, deliberately targeted against Israeli youth, was not the result of individuals driven to extremes by perceived Israeli intransigence in peace talks. It was, in fact, the action of organized groups committed to Israel's total destruction.

At the urging of Secretary of State Colin Powell, the Israeli Government has entered into cease fires. The attacks continue. When the Israelis identify and eliminate the specific perpetrators of these mass terrorist killings, they are called murderers. Meanwhile, the world wrings its hands and asks why the parties can't just return to return to the ''peace process.'' This is a good time to answer that question, beginning with an assessment of what went wrong with the Oslo peace process.

The effect of the violence in Israel today cannot be overstated. After the failure of the Camp David summit just a year ago, and the subsequent reignition of violence, Israel has suffered from an unrelenting assault on its people. The result has been a total reassessment in Israel of the premises of the Oslo peace process—premises which have turned out to be invalid.

Let's go back to 1993. The first of three basic premises of Oslo was that, if the PLO were given a 30,000-man armed force, it would be used to suppress, not to perpetuate, armed violence. Yitzhak Rabin was Defense Minister back in 1987 when the intifada started. The failure to stop it was a turning point for Rabin; it caused him to decide then to begin a peace process. He thought that if Israel couldn't handle the intifada, maybe Arafat could. But soon the 30,000-man force became a 40,000-man force, and anti-tank weapons, shoulder-fired weapons and other prohibited arms found their way into the Palestinian force's arsenal—weapons that are now pointed and fired at Israeli communities. All of this has occurred in violation of the Oslo Accords.

So the first premise—that the PLO would actually control the intifada with a 30,000-man force—turned out to be false.

The second premise was that Israel could withdraw from territory before a final peace accord was reached without losing its bargaining power or sacrificing physical security. In the case of

its dealings with Egypt, Israel had ceded land after the peace agreement was obtained. That withdrawal had worked as a true trade of land for peace. But, under the Oslo Accords, Israel was required to withdraw first and then negotiate. The result has been no credible peace.

This premise of Oslo had been based on the assumption that Israel was finally strong enough to be able to relinquish land while preserving its ability to deter violence. So Israel withdrew from the West Bank, except for a few military posts authorized in the Oslo agreement, and in May of 2000 also withdrew from southern Lebanon. Both actions appeared to the Arab terrorist organizations and the Palestinian Authority as a retreat from a successful campaign of violence. After the intifada, Israel withdrew from the West Bank. After the terrorism of Hezbollah, Israel withdrew from Lebanon. The PA understandably saw violence as a way to achieve its goals.

So the second premise of Oslo—that Israel could withdraw first and achieve its peace objectives later—has also proven false. Arafat and the PA interpreted the withdrawals simply as a sign of weakness thus emboldening them to incite the violence that has continued unabated since Rosh Hashana.

The third, and central, premise of Oslo was that peace could be made with the PLO. In Israel, there was a consensus until 1993 among all parties, including Labor and Likud, that it was not possible to deal with the PLO. There were two reasons for this view: first, the PLO was philosophically committed to Israel's destruction; and, second, the PLO's negotiations had been historically based on terrorism. No previous Israeli government had been willing to negotiate with an entity committed to its destruction through violence.

But in 1993, Oslo created a new assumption: If you had a process—a process of negotiating—then the quality of people on the other side did not really matter. The process became almost like a secular religion. The process was the important thing, and so actions on the ground didn't matter. This notion had roots in Western dealings with leaders in countries like North Korea, Iraq, and the Soviet Union.

It turns out, though, that the nature of leadership does matter, and so do actions on the ground. The quality of people on the other side is fundamental to the success of negotiations. It is the people, not the process, that matters.

The fact is, the parties were never as close as many believed. The issue was never the desirability of peace, or what either the United States or Israel could do to bring it about. Rather, the question was whether peace was ever achievable given Palestinian objectives. Yet when Barak and Arafat were near the end of negotiations, Arafat raised one more demand: that Israel must agree to the right of return, and admit more than a million Palestinians into Israel.

This notion is anathema to all Israelis. Even those on the left oppose the right of return because of its consequences; literally, the end of Israel as a Jewish state. Israel could not survive the return of over a million Palestinians and continue to exist as a Jewish state. Barak made unprecedented concessions at Camp David. Even Leah Rabin complained that Barak's concessions would cause her late husband to turn over in his grave. This move by Arafat was so shocking that virtually all Israelis lost confidence in the process. Barak lost all support. And a radical reassessment of realities set in.

Despite the disappointment at the failure of negotiations, the awakening of the Israeli people to the faulty premises and the reality of the failure of the Oslo Accords is a healthy development. The Bush Administration seems to have assimilated much of the Israeli attitude, and has been careful to avoid involving itself in the effort to restart the ''peace process'' at this time. For the future, it is helpful to acknowledge the falseness of the three key Oslo premises. The Oslo process had ended up doing severe damage to Israel's deterrent—its ability to match concessions with tangible peace.

The principal goal now should be to repair that damage. Amid all the Israeli concessions and gestures, it was assumed that there would be reciprocity on the part of the Palestinians. But the Arabs believed showing reciprocity would be a sign of weakness on their part. The evidence abounds. More Israelis were killed by terrorist acts after Oslo then in the decade before. The PLO did not fulfill the promises it made; for example, disarming the terrorists—in fact, releasing from prison some of the most dangerous Hamas terrorists—limiting its arms, and guaranteeing peace.

Moreover, and perhaps even more disturbing for the long run, the Palestinian authority created schools with a curriculum of brainwashing their children in hatred and violence. A shocked New York Times reporter last summer wrote of the creation of summer camps that even taught assassination. Former Prime Minister Benjamin Netanyahu paints the picture of posters throughout Palestinian communities showing a menacing Israeli soldier, armed to the teeth, towering over a pitiful looking Arab youngster who holds only one thing. Do you know what it is? A key. And every Arab child knows what it is. The Key to an Arab home in Jaffa, or Haifa, or any other Arab community of pre-1967 Palestine. So much for the view that the parties were ''just this close.'' All of this has caused a reassessment of the realities, and, as I said, that is a healthy development at this point.

One must view the situation today clear eyed and in strategic terms. It is a situation of more than just military or economic power. For Israel it is quite simply a question of morale. Israel's problem right now is not that it lacks either economic or military power, but rather that its people have been following a conceptual and intellectual approach to achieving peace which has turned out to be false. The result has been confusion, frustration, and a problem of morale that can only be dealt with by reevaluation of the conceptual and intellectual approach to achieving peace. The people were sold on a ''process,'' and now find that the presumptions underlying that process were illusions. Their disillusionment has set them adrift because they see they have lost territory and credibility that would never have been lost by military force.

The Camp David concessions are especially galling now that there is a recognition that they were based upon false premises, a quid pro quo that was never to be reciprocated by the Palestinians. It makes the last several years seem very lost indeed. So the Israelis are revising their thinking.

Those of us who have cared about the security of Israel and have watched the process over the years, viewed it with great anxiety because we worried it might have resulted in irreversible losses. And yet, with the last election, we see the Israeli people rethinking the premises of Oslo and charting a course to recover the initiative. The fact that Ariel Sharon, with all his political baggage, won so overwhelmingly suggests that the Israeli people are prepared to do what it takes to defend their state and to survive. Like England fighting back from its unpreparedness in the 30's and the United States after its military decline of the 1970's, Israel seems to have said, ''This far and no more,'' and begun to rethink its approach to achieving peace and security. Countries seem to have a way of being better than their failed leaders, and we can hope that the Israelis are on their way back with a more realistic and sober view of what will be required for their long-term security—what kind of approach will provide real, lasting peace.

It is recognized that peace is not available now, but that it can become available in the future. The key to peace is a more democratic and much less corrupt leadership. There are moderate Palestinians, but they are not politically relevant right now. The Palestinians have been cursed with leaders who have always seemed to be wrong for the times. In World War I, Palestinian leaders sided with the Turks against the British; in World War II, with the Nazis against the allies; in the Cold War, with the Soviets against the West; and in the Persian Gulf War, with Saddam against the coalition of allies.

Given his long record as an ideologue, a terrorist, a breaker of promises and fount of untruth, it should not really surprise anyone that Arafat remains what he has always been. As Charles Krauthammer recently noted

in the Weekly Standard, ''[Arafat] proved, even to much of the Israeli left, that the entire theory of preemptive concessions, magnanimous gestures, rolling appeasement was an exercise in futility.''

The key to peace is a Palestinian leadership that would appeal to the better nature of the Palestinian people, one that would reflect their aspirations for a prosperous and peaceful future—not one that exploits their misery through a policy of physically and vitriolically attacking Israel. In short, a democratic government. As my friend Douglas Feith expressed the point in an article in Commentary: ''A stable peace [is] possible . . . only if the Palestinians first evolved responsible administrative institutions and leadership that enjoyed legitimacy in the eyes of its own people, refrained from murdering its political opponents, operated within and not above the law, and practiced moderation and compromise at home and abroad.'' This would, of course, be a boon not only for the Israelis, but for the Palestinians—indeed especially for the Palestinians.

For over fifty years, the United States and Israel have been bound together in a relationship that has weathered many efforts to drive a wedge between us. With the coincident election of a new leader in each country, our two great nations have an opportunity to reassess the lessons recent history has to teach us. For my part, I am optimistic that the new American administration will place a great value on our relationship with the Israeli people; and I am optimistic that the Israelis will maintain the strength and morale that they will need to await a change in Palestinian leadership. At that point there will be much more the Israelis can do to secure their future.

The United States should not push Israel into a process or into an agreement with which the government and people of Israel are not completely comfortable, with their security ensured. It is their existence that is at stake, and we must take no actions that jeopardize their security.

My colleague from Wyoming would like to use the remainder of our time.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

ENERGY

Mr. THOMAS. Madam President, I appreciate the time. I thank my friend from Arizona for his comments on energy. Certainly, I can't think of an issue that affects more people and is more likely to become a crisis again than energy. We had some touch of it and backed off of it a little. California is doing a little better than it was. Gas prices are tending to stabilize or even come down.

The real cause of the problem is still there. I am surprised, frankly, that the Senate leadership hasn't been willing to go forward and at least give us a date as to the time in which we can undertake this question of energy and energy supply. We have gone now 8, 10 years without a policy regarding energy, not having any real direction with regard to what we are going to do. We have become 60-percent dependent on OPEC and overseas oil. We haven't developed refineries, new transmission lines, or pipelines in order to move energy from where it is to where it is needed, and still our leadership here refuses to move forward.

I think we will again be facing the same kind of situation we just had if we don't move to find a long-term resolution, and we can.

We now have a policy from the administration, one that deals with domestic production. There is access to public lands, much of it standing in Alaska or in many places that could indeed have production without damage to the environment. We can do that.

We can talk about conservation. We can talk about renewables. We have to have a policy to cause us to do some of these things.

The transportation is vitally important. In Wyoming, we have great supplies of coal, for example. In order to mine and move that energy to where the market is, you have to have some transmission. There are a number of ways to do that, and we can if we decide to and commit ourselves to do it.

Research, clean coal: Our coal in Wyoming is clean, and it can be cleaner if we have research to do that.

Diversity: We can't expect to have only one source of supply for all the energy we use. We are heavy energy users, and most of us are not willing to make many changes to that.

I am grateful for the comments of my friend, and I hope we can get the leadership here to set the agenda to move toward doing something there.

USING SNOW MACHINES IN YELLOWSTONE PARK

Mr. THOMAS. Madam President, I know it is now summer, but I will now talk about using snow machines in the Yellowstone Park in the wintertime. It is a question that has become quite political, as a matter of fact. There have been letters sent to the Department of the Interior from the Senate on both sides.

For a number of years, in Grand Teton, in Yellowstone Park, and many of the other parks, the principal access people have had in the wintertime to enjoy their park was with snow machines. It has been done for a long time, really. Frankly, there hasn't been much management of that technique, unfortunately. The park officials have not had much to do with it. They have not sought to organize how and where it is done, separate the snow machines from the cross-country skiers, which can be done so each can have their own opportunity. It has to manage numbers sometimes, for instance, if they become too large around Christmas vacation.

They can make changes, but they have not done that. They have an opportunity, and we have an opportunity to have much cleaner machines, which are less noisy and which are less polluting. The manufacturers have indicated they can and will do this. Of course, they need some assurance from EPA that having done it, they will be able to use these machines. But none of these things have happened. Instead, because of the difficulties that are, in fact, there and without management, an EIS study went on for several years.

Unfortunately, toward the end, instead of going on through with the regular system of input, the Assistant Secretary of the Interior went out and said this is what the answer is going to be. The answer was to do away with individual snow machines in the parks over a period of a couple of years. That isn't what is designed to happen when you have EIS studies and when you involve local communities and local people and then have somebody from Washington come and make the decision. But that is what did happen.

Furthermore, the regulation that was agreed to in the study was put before the public the last day of the last administration when there was no opportunity to do anything about it. So what has happened is that there has been a lawsuit filed. I have introduced a bill that would allow not to continue snow machines the way they have been but, rather, to do the management technique, manage the numbers and the sites, and also set specifications so that manufacturers can meet them and you can go forward.

What is the purpose of the park? It is to preserve the resources and to allow the owners to enjoy them. This is the way that you have access in the wintertime.

So this has become somewhat of a discussion, somewhat of a controversy. I am hopeful that they can come to an agreement—and this administration is working toward coming to an agreement—in which these changes could be made. Nobody is suggesting to continue to do it the way it has been done in the past. But there can be changes made that will indeed allow access and protect the environment and the animals and the rural environment at the same time. We can do those things.

One other word on national parks.

The Grand Teton National Park was expanded in 1950. When that was done, there were a number of lands that were brought into the park, and among them were several school sections that belonged to the State of Wyoming. They are now in the park as inholdings and therefore cannot be managed by the park but cannot be used for anything else. Therefore, we have two losers: One is the park which has these inholdings it cannot handle; second is the school sections are to finance education, and they are not bringing in revenue to the State of Wyoming.

To make a long story short, I have a bill I hope will be before the committee

soon to allow the Secretary of the Interior and the State of Wyoming to come to some agreement in finding a value for those lands by using an appraiser upon which they agree and then work out an arrangement to either trade those lands for other Federal lands outside the park, trade them for mineral royalties, or sell but come to some financial arrangement.

I hope we can get some support for something that will be useful to Grand Teton National Park as well as the State of Wyoming.

I think our time has expired. I yield the floor.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

SUPPLEMENTAL APPROPRIATIONS ACT, 2001

The PRESIDING OFFICER (Mr. KYL). Under the previous order, the Senate will now proceed to the consideration of S. 1077, which the clerk will report.

The senior assistant bill clerk read as follows:

A bill (S. 1077) making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BYRD. Mr. President, I ask unanimous consent the order for the quorum call be dispensed with.

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

Mr. BYRD. Mr. President, today, the Senate is debating S. 1077, the Supplemental Appropriations Act for Fiscal Year 2001.

On June 1, 2001, President Bush asked Congress to consider a supplemental request for $6.5 billion, primarily for the Department of Defense. The draft supplemental bill that is before us totals $6.5 billion, not one dime above the President's request—not one thin dime above the President's request. It contains no emergency funding. The President has said that he will not support such emergency spending, so the Committee has not included any emergency designations in this bill. Unrequested items in the bill are offset.

S. 1077 funds the President's request for additional defense spending for health care, for military pay and benefits, for the high costs of natural gas and other utilities, for increased military flying hours, and for other purposes. The bill includes a net increase of $5.54 billion for the Department of Defense and $291 million for defense-related programs of the Department of Energy.

While the Appropriations Committee has approved most of the President's request for the Department of Defense, I stress the importance of accountability for these and future funds. Financial accountability remains one of the weakest links in the Defense Department's budget process. Just last month, the General Accounting Office reported that, of $1.1 billion earmarked for military spare parts in the fiscal year 1999 supplemental, only about $88 million could be tracked to the purchase of spare parts. The remaining $1 billion, or 92 percent of the appropriation, was transferred to operations and maintenance accounts, where the tracking process broke down.

Perhaps a substantial portion of the money appropriated for spare parts was spent on spare parts; perhaps it was not. But, given the way the money was managed, nobody knows for sure and that, it seems to me, is an unacceptable circumstance, because one thing we do know for sure is that an adequate inventory of spare parts is a key component of readiness and the Defense Department apparently does not have an adequate inventory of spare parts. So we must do better in making sure these dollars for spare parts go for spare parts.

The supplemental funding bill before us today includes another $30 million for spare parts, this time specifically for the Army. As former President Reagan would have said, here we go again. To forestall a repeat of the problems that arose in accounting for spare parts expenditures provided in the fiscal year 1999 supplemental, the committee, at my request, approved report language requiring the Secretary of Defense to follow the money and to provide Congress with a complete accounting of all supplemental funds appropriated for spare parts. The intent of this provision is to ensure that money appropriated by Congress for the purchase of spare parts does not get shifted into any other program.

The supplemental appropriations bill, as reported by the Senate Appropriations Committee, provides $300 million for the Low Income Energy Assistance Program, an increase of $150 million above the President's request, to help our citizens cope with high energy costs. The bill also includes $161 million that was not requested for grants to local education agencies under the Education for the Disadvantaged Program in response to the most recent poverty and expenditure data. Also provided is $100 million as an initial United States contribution to a global trust fund to combat AIDS, malaria, and tuberculosis. In addition, $92 million requested by the President for the Coast Guard is included, as is $115.8 million requested for the Treasury Department for the cost of processing and mailing out the tax rebate checks.

In addition, the bill includes $84 million for the Radiation Exposure Trust Fund to provide compensation to the victims of radiation exposure. We thank Senators DOMENICI and BINGAMAN for their leadership in assisting those who were involved in the mining of uranium ore and those who were downwind from nuclear weapons tests during the Cold War.

The Senate Appropriations Committee's bill includes a number of offsets to pay for these additional items. Members should be on notice that, with passage of this bill, we are at the statutory cap for budget authority in Fiscal Year 2001. I say to colleagues on both sides of the aisle that any amendments that are offered will need to be offset. Exceeding the statutory cap could result in an across-the-board cut in all discretionary spending, both for defense programs and for non-defense programs. I urge Members to avoid the spectacle of a government-wide sequester by finding appropriate offsets for amendments.

There is another reason to insist on offsets for any additional spending. During debate on the recent tax-cut bill, I argued that the tax cuts contained in that bill could return the Federal budget to the deficit ditch. I stressed that the tax cuts were based on highly suspect ten-year surplus estimates and that if those estimates proved illusory, the tax-cut bill would result in spending the Medicare surplus. Now, before the ink is even dry on the President's signature on that tax bill, we may find ourselves headed back into the deficit ditch and headed in the direction of cutting into the Medicare surplus.

Our distinguished Chairman of the Senate Budget Committee, KENT CONRAD, has prepared an analysis of the budget picture for Fiscal Year 2001, the current fiscal year, based on recent economic projections from the President's own Director of the National Economic Council, Lawrence Lindsey. The tax-cut bill reduced the surplus by $74 billion in Fiscal Year 2001 alone. As a result, Chairman CONRAD is projecting a raid on the Medicare Trust Fund in Fiscal Year 2001 of $17 billion.

Any efforts to increase spending in this bill without offsets will only make this problem worse.

The President asserted in his Budget Blueprint that the authority of the Congress and the President to designate funding as an emergency has been abused. The Administration has indicated in its Statement of Administration Policy of June 19, 2001, that the President does not intend to designate the $473 million of emergency funding contained in the House-passed bill as emergency spending.

The administration further states that, ''emergency supplemental appropriations should be limited to extremely rare events.'' The Senate supplemental bill contains no emergency designations. Nonetheless, I do believe that it is appropriate for Congress and the President to use the emergency authority from time to time in response to natural disasters and other truly unforseen events in the nature of disasters.

As I mentioned earlier, this supplemental appropriations bill provides immediate relief through the Low-Income Home Energy Assistance Program, LIHEAP, for American families being hit hard by this energy crisis. Moreover, it includes funding to help educate our most needy students through the Education for the Disadvantaged Program. To help offset the cost of these two supplementals, a rescission of unallocated dislocated worker funds under the Workforce Investment Act was also included in the committee bill.

The States have accumulated a large, unexpended balance of dislocated worker funds due to start-up delays with the Workforce Investment Act of 1998. These funds are estimated to exceed $600 million for the program year that ended on June 30, 2001. Although the rescission of dislocated worker funds will reduce the Fiscal Year 2001 appropriation from $1.59 billion to $1.37 billion, the Labor Department projects that the carryover funds from the previous program year will more than offset the rescission. Federal funding, including carryover balances, will actually increase by $423 million in program year 2001, or 25 percent above the level for program year 2000.

Furthermore, report language was included in the supplemental appropriations bill expressing the Senate Appropriations Committee's support for the Workforce Investment Act, the dislocated worker program, and the committee's intent to carefully monitor the need for enhanced job-training services. Should it be determined that additional funds are needed, the Appropriations Committee will do all it can to ensure that sufficient funds are included in the Fiscal Year 2002 Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations bill.

Pursuant to the unanimous consent agreement, Senator STEVENS and I will be offering a managers' amendment that contains a number of amendments that have been agreed to by both sides. One of the items in the managers' amendment is an amendment of mine to provide $3 million to hire additional USDA inspectors to promote the proper treatment of livestock. Another item would provide $20 million to help farmers in the Klamath Basin in Oregon and California. The cost of these and other provisions contained in the managers' amendment is fully offset.

I have noted in the press recently some stories that greatly concern me. I believe the American people are concerned and are becoming increasingly sensitive to the treatment of animals. Reports of cruelty to animals through improper livestock production and slaughter practices have hit a nerve with the American people. The recent announcements by major food outlets, such as McDonalds, that they would only buy products from suppliers that could assure certain levels of humane animal treatment speak volumes to changes in public expectations.

The managers' amendment will provide an additional $3 million through the USDA Office of the Secretary for activities across three department mission areas to protect and promote humane treatment of animals. Of the $3 million provided, no less than $1 million is directed to enforcement of the Animal Welfare Act, under which standards for livestock production, laboratory animals, and so-called puppy mills are established. In addition, no less than $1 million is directed for activities under the Federal Meat Inspections Act, which will enhance humane treatment in the slaughter of animals in facilities under the jurisdiction of Federal inspection. Finally, an amount up to $500,000 is directed for the development and demonstration of technologies that can be used by producers, processors, and others to provide better care of animals at all stages of their lives.

Mr. President, I shall, in conclusion, ask unanimous consent—but not right at this point—that certain newspaper articles which have been written with respect to the slaughter of animals, and the inhumane slaughter of animals, be printed in the RECORD at the conclusion of my remarks.

This bill responds to the President's supplemental request for necessary defense spending, and it also provides funding for important domestic priorities. It is not one dime—not one thinly, much-worn dime—over the President's request. It is within the statutory spending limits. It is a responsible bill, and I urge Members to support it.

Before yielding the floor, let me express my thanks to the distinguished senior Senator from Alaska, Mr. STEVENS, who is the ranking member on the Appropriations Committee in the Senate. He is the former chairman of the committee with whom I had the great pleasure of serving for several years in that position. And I believe it is a blessing, indeed, for me, as I stand on this floor today to present this bill, to also be able to say that Senator STEVENS and I stood shoulder to shoulder, and we shall continue to work shoulder to shoulder, as we moved forward with this bill.

I cannot adequately express my appreciation to him and to his staff and to my own staff for the great work and the excellent cooperation that have been shown in connection with the preparation and presentation of this bill.

I yield the floor.

The PRESIDING OFFICER. Does the Senator make his unanimous consent request at this time?

Mr. BYRD. Yes, I do make that unanimous consent request.

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

[From the Washington Post, Apr. 10, 2001]

THEY DIE PIECE BY PIECE

IN OVERTAXED PLANTS, HUMANE TREATMENT OF CATTLE IS OFTEN A BATTLE LOST

(By Joby Warrick)

PASCO, WASH.—It takes 25 minutes to turn a live steer into steak at the modern slaughterhouse where Ramon Moreno works. For 20 years, his post was ''second-legger,'' a job that entails cutting hocks off carcasses as they whirl past at a rate of 309 an hour.

The cattle were supposed to be dead before they got to Moreno. But too often they weren't.

''They blink. They make noises,'' he said softly. ''The head moves, the eyes are wide and looking around.''

Still Moreno would cut. On bad days, he says, dozens of animals reached his station clearly alive and conscious. Some would survive as far as the tail cutter, the belly ripper, the hide puller. ''They die,'' said Moreno, ''piece by piece.''

Under a 23-year-old federal law, slaughtered cattle and hogs first must be ''stunned''—rendered insensible to pain—with a blow to the head or an electric shock. But at overtaxed plants, the law is sometimes broken, with cruel consequences for animals as well as workers. Enforcement records, interviews, videos and worker affidavits describe repeated violations of the Humane Slaughter Act at dozens of slaughterhouses, ranging from the smallest, custom butcheries to modern, automated establishments such as the sprawling IBP Inc. plant here where Moreno works.

''In plants all over the United States, this happens on a daily basis,'' said Lester Friedlander, a veterinarian and formerly chief government inspector at a Pennsylvania hamburger plant. ''I've seen it happen. And I've talked to other veterinarians. They feel it's out of control.''

The U.S. Department of Agriculture oversees the treatment of animals in meat plants, but enforcement of the law varies dramatically. While a few plants have been forced to halt production for a few hours because of alleged animal cruelty, such sanctions are rare.

For example, the government took no action against a Texas beef company that was cited 22 times in 1998 for violations that included chopping hooves off live cattle. In another case, agency supervisors failed to take action on multiple complaints of animal cruelty at a Florida beef plant and fired an animal health technician for reporting the problems to the Humane Society. The dismissal letter sent to the technician, Tim Walker, said his disclosure had ''irreparably damaged'' the agency's relations with the packing plant.

''I complained to everyone—I said, 'Lookit, they're skinning live cows in there,' '' Walker said. ''Always it was the same answer: 'We know it's true. But there's nothing we can do about it.' ''

In the past three years, a new meat inspection system that shifted responsibility to industry has made it harder to catch and report cruelty problems, some federal inspectors say. Under the new system, implemented in 1998, the agency no longer tracks the number of humane-slaughter violations its inspectors find each year.

Some inspectors are so frustrated they're asking outsiders for help: The inspectors' union last spring urged Washington state authorities to crack down on alleged animal abuse at the IBP plant in Pasco. In a statement, IBP said problems described by workers in its Washington state plant ''do not accurately represent the way we operate our plants. We take the issue of proper livestock handling very seriously.''

But the union complained that new government policies and faster production speeds at the plant had ''significantly hampered our ability to ensure compliance.'' Several animal welfare groups joined in the petition.

''Privatization of meat inspection has meant a quiet death to the already meager enforcement of the Humane Slaughter Act,'' said Gail Eisnitz of the Humane Farming Association, a group that advocates better treatment of farm animals. ''USDA isn't simply relinquishing its humane-slaughter oversight to the meat industry, but is—without the knowledge and consent of Congress—abandoning this function altogether.''

The USDA's Food Safety Inspection Service, which is responsible for meat inspection, says it has not relaxed its oversight, In January, the agency ordered a review of 100 slaughterhouses. An FSIS memo reminded its 7,600 inspectors they had an ''obligation to ensure compliance'' with humane-handling laws.

The review comes as pressure grows on both industry and regulators to improve conditions for the 155 million cattle, hogs, horses and sheep slaughtered each year. McDonald's and Burger King have been subject to boycotts by animal rights groups protesting mistreatment of livestock.

As a result, two years ago McDonald's began requiring suppliers to abide by the American Meat Institute's Good Management Practices for Animal Handling and Stunning. The company also began conducting annual audits of meat plants. Last week, Burger King announced it would require suppliers to follow the meat institute's standards.

''Burger King Corp. takes the issues of food safety and animal welfare very seriously, and we expect our suppliers to comply,'' the company said in a statement.

Industry groups acknowledge that sloppy killing has tangible consequences for consumers as well as company profits. Fear and pain cause animals to produce hormones that damage meat and cost companies tens of millions of dollars a year in discarded product, according to industry estimates.

Industry officials say they also recognize an ethical imperative to treat animals with compassion. Science is blurring the distinction between the mental processes of humans and lower animals—discovering, for example, that even the lowly rat may dream. Americans thus are becoming more sensitive to the suffering of food animals, even as they consume increasing numbers of them.

''Handling animals humanely,'' said American Meat Institute president J. Patrick Boyle, ''is just the right thing to do.''

Clearly, not all plants have gotten the message.

A Post computer analysis of government enforcement records found 527 violations of humane-handling regulations from 1996 to 1997, the last years for which complete records were available. The offenses range from overcrowded stockyards to incidents in which live animals were cut, skinned or scalded.

Through the Freedom of Information Act, The Post obtained enforcement documents from 28 plants that had high numbers of offenses or had drawn penalties for violating humane-handling laws. The Post also interviewed dozens of current and former federal meat inspectors and slaughterhouse workers. A reporter reviewed affidavits and secret video recordings made inside two plants.

Among the findings:

One Texas plant, Supreme Beef Packers in Ladonia, had 22 violations in six months. During one inspection, federal officials found nine live cattle dangling from an overhead chain. But managers at the plant, which announced last fall it was ceasing operations, resisted USDA warnings, saying its practices were no different than others in the industry. ''Other plants are not subject to such extensive scrutiny of their stunning activities,'' the plant complained in a 1997 letter to the USDA.

Government inspectors halted production for a day at the Calhoun Packing Co. beef plant in Palestine, Tex., after inspectors saw cattle being improperly stunned. ''They were still conscious and had good reflexes,'' B.V. Swamy, a veterinarian and senior USDA official at the plant, wrote. The shift supervisor ''allowed the cattle to be hung anyway.'' IBP, which owned the plant at the time, contested the findings but ''took steps to resolve the situation,'' including installing video equipment and increasing training, a spokesman said. IBP has since sold the plant.

At the Farmers Livestock Cooperative processing plant in Hawaii, inspectors documented 14 humane-slaughter violations in as many months. Records from 1997 and 1998 describe hogs that were walking and squealing after being stunned as many as four times. In a memo to USDA, the company said it fired the stunner and increased monitoring of the slaughter process.

At an Excel Corp. beef plant in Fort Morgan, Colo., production was halted for a day in 1998 after workers allegedly cut off the leg of a live cow whose limbs had become wedged in a piece of machinery. In imposing the sanction, U.S. inspectors cited a string of violations in the previous two years, including the cutting and skinning of live cattle. The company, responding to one such charge, contended that it was normal for animals to blink and arch their backs after being stunned, and such ''muscular reaction'' can occur up to six hours after death. ''None of these reactions indicate the animal is still alive,'' the company wrote to USDA.

Hogs, unlike cattle, are dunked in tanks of hot water after they are stunned to soften the hides for skinning. As a result, a botched slaughter condemns some hogs to being scalded and drowned. Secret videotape from an Iowa pork plant shows hogs squealing and kicking as they are being lowered into the water.

USDA documents and interviews with inspectors and plant workers attributed many of the problems to poor training, faulty or poorly maintained equipment or excessive production speeds. Those problems were identified five years ago in an industry-wide audit by Temple Grandin, an assistant professor with Colorado State University's animal sciences department and one of the nation's leading experts on slaughter practices.

In the early 1990s, Grandin developed the first objective standards for treatment of animals in slaughterhouses, which were adopted by the American Meat Institute, the industry's largest trade group. Her initial, USDA-funded survey in 1996 was one of the first attempts to grade slaughter plants.

One finding was a high failure rate among beef plants that use stunning devices known as ''captive-bolt'' guns. Of the plants surveyed, only 36 percent earned a rating of ''acceptable'' or better, meaning cattle were knocked unconscious with a single blow at least 95 percent of the time.

Grandin now conducts annual surveys as a consultant for the American Meat Institute and McDonald's Corp. She maintains that the past four years have brought dramatic improvements—mostly because of pressure from McDonald's, which sends a team of meat industry auditors into dozens of plants each year to observe slaughter practices.

Based on the data collected by McDonald's auditors, the portion of beef plants scoring ''acceptable'' or better climbed to 90 percent in 1999. Some workers and inspectors are skeptical of the McDonald's numbers, and Grandin said the industry's performance dropped slightly last year after auditors stopped giving notice of some inspections.

Grandin said high production speeds can trigger problems when people and equipment are pushed beyond their capacity. From a typical kill rate of 50 cattle an hour in the early 1900s, production speeds rose dramatically in the 1980s. They now approach 400 per hour in the newest plants.

''It's like the 'I Love Lucy' episode in the chocolate factory,'' she said. ''You can speed up a job and speed up a job, and after a while you get to a point where performance doesn't simply decline—it crashes.''

When that happens, it's not only animals that suffer. Industry trade groups acknowledge that improperly stunned animals contribute to worker injuries in an industry that already has the nation's highest rate of job-related injuries and illnesses—about 27 percent a year. At some plants, ''dead'' animals have inflicted so many broken limbs and teeth that workers wear chest pads and hockey masks.

''The live cows cause a lot of injuries,'' said Martin Fuentes, an IBP worker whose arm was kicked and shattered by a dying cow. ''The line is never stopped simply because an animal is alive.''

A ''BRUTAL'' HARVEST

At IBP's Pasco complex, the making of the American hamburger starts in a noisy, blood-spattered chamber shielded from view by a stainless steel wall. Here, live cattle emerge from a narrow chute to be dispatched in a process known as ''knocking'' or ''stunning.'' On most days the chamber is manned by a pair of Mexican immigrants who speak little English and earn about $9 an hour for killing up to 2,050 head per shift.

The tool of choice is a captive-bolt gun, which fires a retractable metal rod into the steer's forehead. An effective stunning requires a precision shot, which workers must deliver hundreds of times daily to balky, frightened animals that frequently weigh 1,000 pounds or more. Within 12 seconds of entering the chamber, the fallen steer is shackled to a moving chain to be bled and butchered by other workers in a fast-moving production line.

The hitch, IBP workers say, is that some ''stunned'' cattle wake up.

''If you put a knife into the cow, it's going to make a noise: It says, 'Moo!' '' said Moreno, the former second-legger, who began working in the stockyard last year. ''They move the head and the eyes and the leg like the cow wants to walk.''

After a blow to the head, an unconscious animal may kick or twitch by reflex. But a videotape, made secretly by IBP workers and reviewed by veterinarians for The Post, depicts cattle that clearly are alive and conscious after being stunned.

Some cattle, dangling by a leg from the plant's overhead chain, twist and arch their backs as though trying to right themselves. Close-ups show blinking reflexes, an unmistakable sign of a conscious brain, according to guidelines approved by the American Meat Institute.

The video, parts of which were aired by Seattle television station KING last spring, shows injured cattle being trampled. In one graphic scene, workers give a steer electric shocks by jamming a battery-powered prod into its mouth.

More than 20 workers signed affidavits alleging that the violations shown on tape are commonplace and that supervisors are aware of them. The sworn statements and videos were prepared with help from the Humane Farming Association. Some workers had taken part in a 1999 strike over what they said were excessive plant production speeds.

''I've seen thousands and thousands of cows go through the slaughter process alive,'' IBP veteran Fuentes, the worker who was injured while working on live cattle, said in an affidavit. ''The cows can get seven minutes down the line and still be alive. I've been in the side-puller where they're still alive. All the hide is stripped out down the neck there.''

IBP, the nation's top beef processor, denounced as an ''appalling aberration'' the problems captured on the tape. It suggested the events may have been staged by ''activists trying to raise money and promote their agenda. . . .

''Like many other people, we were very upset over the hidden camera video,'' the company said. ''We do not in any way condone some of the livestock handling that was shown.''

After the video surfaced, IBP increased worker training and installed cameras in the slaughter area. The company also questioned workers and offered a reward for information leading to identification of those responsible for the video. One worker said IBP pressured him to sign a statement denying that he had seen live cattle on the line.

''I knew that what I wrote wasn't true,'' said the worker, who did not want to be identified for fear of losing his job. ''Cows still go alive every day. When cows go alive, it's because they don't give me time to kill them.''

Independent assessments of the workers' claims have been inconclusive. Washington State officials launched a probe in May that included an unannounced plant inspection. The investigators say they were detained outside the facility for an hour while their identities were checked. They saw no acts of animal cruelty once permitted inside.

Grandin, the Colorado State professor, also inspected IBP's plant, at the company's request; that inspection was announced. Although she observed no live cattle being butchered, she concluded that the plant's older-style equipment was ''overloaded.'' Grandin reviewed parts of the workers' videotape and said there was no mistaking what she saw.

''There were fully alive beef on that rail,'' Grandin said.

INCONSISTENT ENFORCEMENT

Preventing this kind of suffering is officially a top priority for the USDA's Food Safety Inspection Service. By law, a humane-slaughter violation is among a handful of offenses that can result in an immediate halt in production—and cost a meatpacker hundreds or even thousands of dollars per idle minute.

In reality, many inspectors describe humane slaughter as a blind spot: Inspectors' regular duties rarely take them to the chambers where stunning occurs. Inconsistencies in enforcement, training and record-keeping hamper the agency's ability to identify problems.

The meat inspectors' union, in its petition last spring to Washington state's attorney general, contended that federal agents are ''often prevented from carrying out'' the mandate against animal cruelty. Among the obstacles inspectors face are ''dramatic increases in production speeds, lack of support from supervisors in plants and district offices . . . new inspection policies which significantly reduce our enforcement authority, and little to no access to the areas of the plants where animals are killed,'' stated the petition by the National Joint Council of Food Inspection Locals.

Barbara Masters, the agency's director of slaughter operations, told meat industry executives in February she didn't know if the number of violations was up or down, thought she believed most plants were complying with the law. ''We encourage the district offices to monitor trends,'' she said. ''The fact that we haven't heard anything suggests there are no trends.''

But some inspectors see little evidence the agency is interested in hearing about problems. Under the new inspection system, the USDA stopped tracking the number of violations and dropped all mentions of humane slaughter from its list of rotating tasks for inspectors.

The agency says it expects its watchdogs to enforce the law anyway. Many inspectors still do, though some occasionally wonder if it's worth the trouble.

''It always ends up in argument: Instead of re-stunning the animal, you spend 20 minutes just talking about it,'' said Colorado meat inspector Gary Dahl, sharing his private views. ''Yes, the animal will be dead in a few minutes anyway. But why not let him die with dignity?''

[From the Washington Post, Apr. 10, 2001]

BIG MAC'S BIG VOICE IN MEAT PLANTS

(By Joby Warrick)

KANSAS CITY, MO.—Never mind the bad old days, when slaughterhouses were dark places filled with blood and terror. As far as the world's No. 1 hamburger vendor is concerned, Happy Meals start with happy cows.

That was the message delivered in February by a coterie of McDonald's consultants to a group of 140 managers who oversee the slaughter of most of the cattle and pigs Americans will consume this year. From now on, McDonald's says, its suppliers will be judged not only on how cleanly they slaughter animals, but also on how well they manage the small details in the final minutes.

Starting with cheerful indoor lighting.

''Cows like indirect lighting,'' explained Temple Grandin, an animal science assistant professor at Colorado State University and McDonald's lead consultant on animal welfare. ''Bright lights are a distraction.''

And only indoor voices, please.

''We've got to get rid of the yelling and screaming coming out of people's mouths,'' Grandin scolded.

So much attention on atmosphere may seem misplaced, given that the beneficiaries are seconds away from death. But McDonald's, like much of the meat industry, is serious when it comes to convincing the public of its compassion for the cows, chickens and pigs that account for the bulk of its menu.

Bloodied in past scrapes with animal rights groups, McDonald's has been positioning itself in recent years as an ardent defender of farm animals. It announced last year it would no longer buy eggs from companies that permit the controversial practice of withholding food and water from hens to speed up egg production.

Now the company's headfirst plunge into slaughter policing is revolutionizing the way slaughterhouses do business, according to a wide range of industry experts and observers.

''In this business, you have a pre-McDonald's era and a post-McDonald's era,'' said Grandin, who has studied animal-handling practices for more than 20 years. ''The difference is measured in light-years.''

Others also have contributed to the improvement, including the American Meat Institute, which is drawing ever-larger crowds to its annual ''humane-handling'' seminars, such as the one in Kansas City. The AMI, working with Grandin, issued industry-wide guidelines in 1997 that spell out proper treatment of cows and pigs, from a calm and orderly delivery to the stockyards to a quick and painless end on the killing floor.

But the driving force for change is McDonald's, which decided in 1998 to conduct annual inspections at every plant that puts the beef into Big Macs. The chain's auditors observe how animals are treated at each stage of the process, keeping track of even minor problems such as excessive squealing or the overuse of cattle prods.

The members of McDonald's audit team say their job is made easier by scientific evidence that shows tangible economic benefits when animals are treated well. Meat from abused or frightened animals is often discolored and soft, and it spoils more quickly due to hormonal secretions in the final moments of life, industry experts say.

''Humane handling results in better finished products,'' AMI President J. Patrick Boyle said. ''It also creates a safer workplace, because there's a potential for worker injuries when animals are mishandled.''

Not everyone is convinced that slaughter practices have improved as much as McDonald's surveys suggest. Gail Eisnitz, investigator for the Humane Farming Association, notes that until the past few months, all McDonald's inspections were announced in advance.

''The industry's self-inspections are meaningless,'' Eisnitz said. ''They're designed to lull Americans into a false sense of security about what goes on inside slaughterhouses.''

But Jeff Rau, an animal scientist who attended the Kansas City seminar on behalf of the Humane Society of the United States, saw the increased attention to animal welfare as a hopeful step.

''The industry has recognized it has some work to do,'' Rau said. ''The next step is to convince consumers to be aware of what is happening to their food before it gets to the table. People should understand that their food dollars can carry some weight in persuading companies to improve.''

EULOGY OF THE DOG

(By George G. Vest)

WARRENSBURG, MO, Sept. 23, 1870.—Gentlemen of the jury. The best friend a man has in the world may turn against him and become his enemy. His son or daughter whom he has reared with loving care may prove ungrateful. Those who are nearest and dearest to us, those whom we trust with our happiness and our good name, may become traitors to their faith. The money that a man has he may lose. It flies away from him perhaps when he needs it most. A man's reputation may be sacrificed in a moment of ill-considered action. The people who are prone to fall on their knees to do us honor when success is with us may be the first to throw the stone of malice when failure settles its cloud upon our heads. The one absolutely unselfish friend that a man can have in this selfish world, the one that never deserts him, the one that never proves ungrateful or treacherous, is the dog.

Gentlemen of the jury, a man's dog stands by him in prosperity and in poverty, in health and in sickness. He will sleep on the cold ground when the wintry winds blow and the snow drives fiercely, if only he can be near his master's side. He will kiss the hand that has no food to offer, he will lick the wounds and sores that come in encounter with the roughness of the world. He guards the sleep of his pauper master as if he were a prince.

When all other friends desert, he remains. When riches take wings and reputation falls to pieces, he is as constant in his love as the sun in its journey through the heavens. If fortune drives the master forth an outcast into the world, friendless sand homeless, the faithful dog asks no higher privilege than that of accompanying him, to guard him against danger, to fight against his enemies. And when the last scene of all comes, and death takes his master in its embrace and

his body is laid in the cold ground, no matter if all other friends pursue their way, there by his graveside will the noble dog be found, his head between his paws and his eyes sad but open, in alert watchfulness, faithful and true, even unto death.

Mr. BYRD. Mr. President, after Senator STEVENS presents his statement, if he has no objection, I will present the managers' amendment. And at that time I will also ask unanimous consent that if that managers' amendment may be agreed to, that a second managers' amendment may be in order if necessary.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. STEVENS. Mr. President, I join the chairman of the Appropriations Committee in presenting this bill, S. 1077, to the Senate today. It provides necessary supplemental funds for the remainder of fiscal year 2001.

Let me start off by thanking Senator BYRD for his kind comments. It is a pleasure, once more, to present a supplemental bill to the Senate together with my great friend from West Virginia. He is chairman now. I was chairman last year. I can tell the Senate, it makes no difference as far as we are concerned. We work together. We may have slight disagreements from time to time, but we work those out before coming to this Chamber. I commend him for the way he is now proceeding—as rapidly as possible—to catch up on the schedule of the appropriations bills so we may do our best to complete them all by the end of this fiscal year.

As stated by Senator BYRD, this bill, as reported by our committee, conforms to the budget resources available for this year in both budget authority and outlays. The bill also matches the total request submitted by President Bush of $6.5 billion.

The bill does not present any emergency appropriations. All spending is within the budget caps set by Congress and within the President's request.

I commend the chairman for reporting this bill out of the committee just 1 day after the House passed the companion measure, H.R. 2216. Our committee had only 2 weeks to consider the President's request and House adjustments, and sent this bill forward with a unanimous vote in the committee. That is a great compliment to Senator BYRD as the chairman of the committee.

I am pleased to join him in recommending the bill to the Senate. I urge all Members to support the bill and to adhere to the tight spending limits that have been adhered to by the committee itself. Nearly 90 percent of the funding provided in this bill meets the ongoing needs of the Department of Defense.

I join also in commending the senior Senator from Hawaii, Mr. INOUYE, the chairman of the Defense Subcommittee, for his determination to meet the readiness, quality of life, and health care needs of the men and women who serve in our Nation's Armed Forces.

In addition to the amounts requested by the President, funds are provided in the bill for the direct care system for military medicine. Additional funds are also proposed for Army real property maintenance and spare parts advocated by General Shinseki, the Army Chief of Staff. Funds are also provided for Navy ship depot maintenance and engagement initiatives for the commander in chief of the U.S. Pacific Command.

Based on extensive hearings by the Defense Subcommittee and numerous discussions with the Secretary of Defense, these amounts are adequate to meet the military's needs through the end of this fiscal year.

This bill is no substitute for the significant increase in defense funds that have been sought by the President in his budget amendment. He has sought an additional $18.4 billion over the original request for fiscal year 2002. We are looking here only at amounts needed through September 30 of this year, 2001. Just 83 days from now, we will see the end of this fiscal year.

Amendments may be offered that would provide additional funds for this year—for 2001. I urge my colleagues to withhold such amendments. We have adequately discussed the needs with the Department, and we believe there are no additional funds that could be spent within this fiscal year of 2001.

We will have an opportunity to assess the needs of the Department through the Defense authorization and appropriations bills for 2002, the fiscal year that we will address starting on October 1 of this year. We cannot address all those needs here. We do not need to deal with the 2002 requests in a 2001 supplemental appropriations bill.

I join my colleagues in their belief that we need additional resources for our national defense. I shall do my best to support the request of the President, and all other funding that we might be able to achieve, to really deal with the Department of Defense needs.

The underfunding of the past cannot be corrected in one supplemental bill. The new Secretary and the President of the United States have asked for our patience while they set new priorities and determine the most vital needs for our Armed Forces. We have had significant changes in our military strategy, and we should accord the President of the United States and the Secretary of Defense the courtesy they have requested and wait for their report.

We need to move this bill out of the Senate today. I join Senator BYRD in committing to hold this bill to the level set by the committee and by the President for this fiscal year.

We need to get the military the money they need by getting this bill to conference and out of conference this week so that they will have these funds available for the remainder of this year. I also commit to working with my colleagues to secure the funding later this month, and in September, for fiscal year 2002 and future years.

In addition to the military requirements, there are several pressing disaster relief challenges that face our National Government. Through several conversations with the Director of the Federal Emergency Management Agency, Joe Allbaugh, I am anxious about the level of FEMA disaster relief funding available for the rest of this calendar year.

So far, no further supplemental request has been received from the Office of Management and Budget for this fiscal year. It is my hope that additional information will be available to the conferees on this bill later this week.

Challenges from tropical storm Allison, ice storms in the Southeast, and other disasters continue to stress our response capability. Especially damaging was the loss to the medical research programs in Houston, TX, during the storm Allison.

The Senator from Texas, a member of our committee, has worked tirelessly to find means to address that crisis, and I look forward to working with her on that effort to the maximum extent possible.

With no budget constraints, I could support additional funding for the Department of Defense, for FEMA, for LIHEAP, and several other priorities sought by many of our colleagues.

We were asked by the President to limit funding in this bill to such amounts as could be spent during the remainder of this fiscal year. That is a reasonable request. We were also asked to live within the moneys available under the funding caps set by the Congress. We have already voted on that this year, and we feel constrained by those limits.

We were asked to break the cycle of ''emergency'' appropriations as simply a tool to get around budget limits. We do not support those actions, and the executive branch in the past has required emergency appropriations each year. We hope we will not have to pursue that policy in the future.

This bill meets the demands of the Congress and the President of the United States for budget constraints.

We hope we can go to conference this week with the House. If the Senate passes this bill, as we hope, early tomorrow morning, that will take place.

I implore all Senators to work with us today to complete this bill so the funds can get to the Armed Forces by the end of this week.

We have been in sort of a vicious cycle in recent years whereby the Chairman of the Joint Chiefs and the Chiefs themselves have had to determine how much they could spend in the early parts of the fiscal year because of constraints placed on them due to the deviation of funds for peacekeeping and other activities. That has led every year to a supplemental. This is one of those supplementals for funds necessary to carry out the basic needs of our military during the summertime. The steaming hours of our Navy, the flying hours of our Air Force and our

Marines and Navy, the ground exercises by our Army, and the activities that take place throughout the world by our men and women in the armed services demand additional money.

This is the bill to fund those for the remainder of July and August and September. Those activities will depend upon the passage of this bill.

The sooner we can pass this bill, the better off we will be in terms of the training and the activities of our men and women in the armed services to assure their capabilities to defend this country.

I urgently support this bill. I urgently urge the Senate to pass it as soon as possible.

I request the cooperation of every Member of the Senate in trying to help us accomplish that objective no later than tomorrow morning.

Mr. CONRAD. Mr. President, I am pleased to rise today in support of S. 1077, the Supplemental Appropriations Act for Fiscal Year 2001.

The Senate bill provides $8.477 billion in new discretionary budget authority, offset by the rescission of $1.933 billion of budget authority provided in previous years, for a net increase of $6.544 billion. As a result of this additional budget authority, outlays will increase by $1.291 billion in 2001. The Senate bill meets its revised section 302(a) and 302(b) allocations for budget authority and is well under—by more than $1 billion—those allocations for outlays.

I commend Chairman BYRD and Senator STEVENS for their bipartisan effort under unusual circumstances in bringing this important measure to the floor within its allocation and without resorting to unnecessary emergency designations. This bill provides important resources to our uniformed personnel, including funding statutory increases in pay and health care. In addition, it provides assistance to low-income families for heating and education.

I urge adoption of the bill.

I ask for unanimous consent that a table displaying the Budget Committee scoring of this bill printed in the RECORD.

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

S. 1077, SUPPLEMENTAL APPROPRIATIONS ACT, 2001

[Spending comparsions—Senate-reported bill (in millions of dollars)]

	Discretionary	Mandatory	Total
Senate-reported bill:			
Budget Authority	6,544	936	7,480
Outlays	1,291	936	2,227
Amounts available within Senate 302(a) allocation:			
Budget Authority	6,545	936	7,481
Outlays	2,487	936	3,423
House-passed bill:			
Budget Authority	6,545	936	7,481
Outlays	1,341	936	2,277
President's request:			
Budget Authority	6,543	936	7,479
Outlays	1,232	936	2,168
SENATE-REPORTED BILL COMPARED TO			
Amounts available within Senate 302(a) allocation:			
Budget Authority	(1)	0	(1)
Outlays	(1,196)	0	(1,196)
House-passed bill:			
Budget Authority	(1)	0	(1)
Outlays	(50)	0	(50)
President's request:			
Budget Authority	1	0	1
Outlays	59	0	59

Notes: Details may not add to totals due to rounding. Prepared by SBC Majority Staff, June 26, 2001.

Mr. CONRAD. I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. COCHRAN). Without objection, it is so ordered.

AMENDMENT NO. 861

Mr. BYRD. Mr. President, I shall send to the desk a managers' amendment supported by Senator STEVENS and myself. It consists of a package of amendments. These amendments have been cleared on both sides, and I know of no controversy concerning them.

The first is an amendment by Senators HUTCHISON and INHOFE for storm damage repair at military facilities in Texas and Oklahoma.

The next amendment is offered by Senators TORRICELLI and CORZINE to convey surplus firefighting equipment in New Jersey.

The next is an amendment by myself to make technical corrections in the energy and water chapter in title I.

Next is an amendment for storm damage repair at military facilities in Texas and Oklahoma offered by Senators HUTCHISON and INHOFE.

Next is an amendment by Senator STEVENS to increase the authorization for the Bassett Army Hospital.

Next is an amendment to provide $3 million for the U.S. Department of Agriculture for humane treatment of animals. That is my amendment. It is fully offset by a later amendment.

Next is an amendment offered by Senators GRASSLEY, ROBERTS, and STEVENS to expedite rulemaking for crop insurance.

Next is an amendment by Senators FEINSTEIN and BOXER and SMITH of Oregon and WYDEN to provide $20 million for the Klamath Basin. Funding is offset in a later amendment.

This will be followed by an amendment by myself in the agriculture chapter to provide an offset for the $3 million for humane treatment of animals.

Next is an amendment to increase a rescission in the committee bill for the oil and gas guarantee program by $4.8 million.

Next is an amendment to strike section 2101 of the committee bill dealing with the Oceans Commission.

Next is an amendment to clarify the use of D.C. local funds to prevent the demolition by neglect of historic properties, followed by an amendment to redirect the expenditure of $250,000 within the Western Area Power Administration, followed by an amendment by Senator BURNS to provide a transfer of $3 million for the Bureau of Land Management energy permitting activities.

Next is an amendment by Senator HARKIN to clarify the timing of the dislocated worker rescission in the committee bill.

This will be followed by a technical change to a heading in the bill.

Next is an amendment offered by Senator DOMENICI to make a technical date correction in the Perkins Vocational Education Act.

Next is an amendment by myself and Senator STEVENS to authorize the expenditure of $20 million previously appropriated, subject to authorization, to the Corporation for Public Broadcasting for digital conversion by local stations.

Next is an amendment to allow the Architect of the Capitol to make payments to Treasury for water and sewer services provided by the District of Columbia.

These will be followed by amendments by Senators MURRAY and STEVENS to, one, appropriate $16,800,000 to repair damage caused in Seattle by the Nisqually earthquake; two, appropriate $2 million for a joint U.S.-Canada commission dealing with connection of the Alaska Railroad to the North American system; and, three, make certain technical corrections. The funding is offset by rescissions.

Next is an amendment by Senator INOUYE to transfer $1 million from the Morris K. Udall Foundation to the Native Nations Institute.

And finally an amendment to name a building in the State of Virginia for a late House colleague, Norm Sisisky, on behalf of Senator WARNER.

I ask unanimous consent that the amendments be considered en bloc and that the reading of the amendments be dispensed with.

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

Mr. BYRD. Mr. President, I ask unanimous consent that the managers' amendment be agreed to and that it be considered as original text for the purpose of further amendment.

Mr. STEVENS. Reserving the right to object, Mr. President, it is my understanding that the chairman of the committee will offer another unanimous consent request for a second managers' amendment.

Mr. BYRD. Yes. I make that request in conjunction with the request pending.

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

Mr. BYRD. Mr. President, I move to reconsider the vote by which the amendment was agreed to.

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

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The clerk will report the amendment by number for the information of the Senate.

The bill clerk read as follows:

The Senator from West Virginia [Mr. BYRD], for himself and Mr. STEVENS, proposes an amendment numbered 861.

The PRESIDING OFFICER. The amendment has been agreed to.

The amendment (No. 861) was agreed to:

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

The PRESIDING OFFICER. The Senator from Alaska.

Mr. STEVENS. The Senator's unanimous consent request included the request for a second managers' amendment; am I correct?

The PRESIDING OFFICER. That request has been granted.

Mr. STEVENS. I thank the Chair.

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

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. BYRD. Mr. President, this would be a very good time for all of our colleagues to offer their amendments if they have amendments. Senator STEVENS and I are prepared to listen to Senators propose their amendments, and we are prepared to respond to their proposals. Much time could be saved if Senators will come to the floor and offer those amendments at the very earliest. Of course, if Senators don't have amendments, that will suit the two of us just as well.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. BYRD. 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. BYRD. Mr. President, seeing no other Senator who seeks recognition at this time, I shall speak on another matter notwithstanding the fact that the Pastore rule has not run its course.

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

CRUELTY TO ANIMALS

Mr. BYRD. Mr. President, a few months ago, a lady by the name of Sara McBurnett accidentally tapped a sports utility vehicle from behind on a busy highway in California. The angry owner of the bumped vehicle, Mr. Andrew Burnett, stormed back to Ms. McBurnett's car and began yelling at her; and then reached through her open car window with both hands, grabbed her little white dog and hurled it onto the busy roadway. The lady sat helplessly watching in horror as her frightened little pet ran for its life, dodging speeding traffic to no avail. The traffic was too heavy and the traffic was too swift.

Imagine her utter horror. Recently, Mr. Burnett was found guilty of animal cruelty by a jury in a California court, so my faith in the wisdom of juries was restored. Ever since I first heard about this monstrous, brutal, barbaric act, I have wondered what would drive any sane person to do such a thing. There are some people who have blamed this senseless and brutal incident on road rage. But it was not just road rage, it was bestial cruelty. It was and is an outrage. It was an act of sheer depravity to seize a fluffy, furry, innocent little dog, and toss it onto a roadway, and most certainly to be crushed under tons of onrushing steel, iron, glass, and rubber, while its terrified owner, and perhaps other people in other vehicles, watched.

There is no minimizing such cruelty and resorting to the lame excuse that, ''after all, it was just a dog.''

The dog owner, Ms. McBurnett, puts the incident in perspective. Here is what she said: It wasn't just a dog to me. For me, it was my child. A majority of pet owners do believe their pets to be family members. That is the way I look at my little dog, my little dog Billy—Billy Byrd. I look at him as a family member. When he passes away, I will shed tears. I know that. He is a little white Maltese Terrier. As a pet owner and dog lover, I know exactly what that lady means, and so did millions of other dog lovers who could never even fathom such an act.

For my wife and me, Billy Byrd is a key part of our lives at the Byrd House in McLean. He brings us great joy and wonderful companionship. As I said on this floor just a few months ago, if I ever saw in this world anything that was made by the Creator's hand that is more dedicated, more true, more faithful, more trusting, more undeviant than this little dog, I am at a loss to state what it is. Such are the feelings of many dog owners.

Dogs have stolen our hearts and made a place in our homes for thousands of years. Dogs fill an emotional need in man and they have endured as our close companions. They serve as guards and sentries and watchdogs; they are hunting companions. Some, like Lassie and Rin Tin Tin, have become famous actors. But mostly, these sociable little creatures are valued especially as loyal comforters to their human masters. Petting a dog can make our blood pressure drop. Try it. Our heart rate slows down. Try it. Our sense of anxiety diminishes, just goes away. Researchers in Australia have found that dog owners have a lower risk of heart disease, lower blood pressure, and lower cholesterol levels than those people who do not own dogs. Researchers in England have demonstrated that dog owners have far fewer minor health complaints than those people without a dog. Our dogs are about the most devoted, steadfast companions that the Creator could have designed. They are said to be man's best friend and, indeed, who can dispute it?

The affection that a dog provides is not only unlimited, it is unqualified, unconditional. A faithful dog does not judge its owner, it does not criticize him or her, it simply accepts him or her; it accepts us as we are, for who we are, no matter how we dress, no matter how much money we have or don't have, and no matter what our social standing might be or might not be. No matter what happens, one's dog is still one's friend.

A long, frustrating day at work melts into insignificance—gone—with the healing salve of warm, excited greetings from one's ever faithful, eternally loyal dog.

President Truman was supposed to have remarked: If you want a friend in Washington, buy a dog. I often think about Mr. Truman's words. No wonder so many political leaders have chosen the dog as a faithful companion and canine confidante. Former Senate Republican leader, Robert Dole, was constantly bringing his dog, ''Leader''—every day—to work with him. President Bush has ''Barney'' and ''Spot.'' President Truman had an Irish setter named ''Mike.'' President Ford had a golden retriever named ''Lucky.'' The first President Bush had Millie.

Of course, there was President Franklin Roosevelt and his dog, ''Fala.'' They had such a close relationship that his political opponents once attempted to attack him by attacking his dog. Eleanor Roosevelt recalled that for months after the death of her husband, every time someone approached the door of her house, Fala would run to it in excitement, hoping that it was President Roosevelt coming home.

The only time I remember President Nixon becoming emotional, except when he was resigning the Presidency, perhaps more so in the first instance, was in reference to his dog ''Checkers.''

At the turn of the century, George G. Vest delivered a deeply touching summation before the jury in the trial involving the killing of a dog, Old Drum. This occurred, I think, in 1869. There were two brothers-in-law, both of whom had fought in the Union Army. They lived in Johnson County, MO. One was named Leonidas Hornsby. The other was named Charles Burden.

Burden owned a dog, and he was named ''Old Drum.'' He was a great hunting dog. Any time that dog barked one could know for sure that it was on the scent of a raccoon or other animal.

Leonidas Hornsby was a farmer who raised livestock and some of his calves and lambs were being killed by animals. He, therefore, swore to shoot any animal, any dog that appeared on his property.

One day there appeared on his property a hound. Someone said: ''There's a dog out there in the yard.'' Hornsby said: ''Shoot him.''

The dog was killed. Charles Burden, the owner of the dog, was not the kind of man to take something like this lightly. He went to court. He won his case and was awarded $25. Hornsby appealed, and, if I recall, on the appeal there was a reversal, whereupon the owner of the dog decided to employ the best lawyer that he could find in the area.

He employed a lawyer by the name of George Graham Vest. This lawyer gave a summation to the jury. Here is what he said:

The best friend that a man has in this world may turn against him and become his enemy. His son or daughter whom he has reared with loving care may prove ungrateful. Those who are nearest and dearest to us, those whom we trust with our happiness and our good name may become traitors to their faith. The money that a man has, he may lose. It flies away from him perhaps when he needs it most. A man may sacrifice his reputation in a moment of ill-considered action.

The people who are prone to fall on their knees and do us honor when success is with us may be the first to throw the stone of malice when failure settles its cloud upon our heads. The one absolutely unselfish friend that a man can have in this selfish world, the one that never deserts him, the one that never proves ungrateful or treacherous, is the dog.

Gentlemen of the jury, a man's dog stands by him in prosperity and in poverty, in health and in sickness. He will sleep on the cold ground when the wintry winds blow, and the snow drives fiercely, if only he can be near his master's side. He will kiss the hand that has no food to offer, he will lick the wounds and sores that come in encounter with the roughness of the world. He guards the sleep of his pauper master as if he were a prince.

When all other friends desert, he remains. When riches take wings and reputation falls to pieces, he is as constant in his love as the Sun in its journey through the heavens.

If fortune drives the master forth and outcast into the world, friendless and homeless, the faithful dog asks no higher privilege than that of accompanying him, to guard him against danger, to fight against his enemies.

And when the last scene of all comes, death takes the master in its embrace and his body is laid in the cold ground, no matter if all other friends desert him and pursue their way, there by his graveside will the noble dog be found, his head between his paws and his eyes sad but open in alert watchfulness, faithful and true, even unto death.

Well, of course, George Vest won the case. It was 1869 or 1870. In 1879 he ran for the U.S. Senate and was elected and served in the Senate for 24 years. The citizens in Warrensburg, MO, decided to build a statue to Old Drum, and that statue stands today in the courtyard at Warrensburg. Harry Truman contributed $250 to the building of the statue. I generally ask new Senators from Missouri have they heard about Old Drum. I asked that of KIT BOND one day and he remembered, so upon his first occasion to visit Warrensburg, MO, after that, he brought me a picture of the statue of Old Drum.

So, just a little pat, a little treat, a little attention for the dog is all that a pet asks. How many members of the human species can love so completely? How does man return that kind of affection?

I remember a recent news program that told of a man who was going around killing dogs and selling the meat from them. A couple of years ago, NBC News reported that American companies were importing and selling toys made in China that were decorated with the fur from dogs that were raised and then slaughtered just for that purpose.

And now we have this monster—I do not hesitate to overrate him—who, because of cruelty and rage, decided that he had the right to grab a harmless little dog and hurl it to its certain death. It makes one ponder the question, doesn't it, Which was the animal? Burnett, or Leo, the little dog? Of course we know the answer.

The point is this: We have a responsibility to roundly condemn such abject cruelty. Apathy regarding incidents such as this will only lead to more deviant behavior. And respect for life, all life, and for humane treatment of all creatures is something that must never be lost.

The Scriptures say in the Book of Proverbs, ''A righteous man regardeth the life of his beast, but the tender mercies of the wicked are cruel.''

Mr. President, I am concerned that cruelty toward our faithful friend, the dog, may be reflective of an overall trend toward animal cruelty. Recent news accounts have been saturated with accounts of such brutal behavior. A year or two ago, it was revealed that macabre videos showing small animals, including hamsters, kittens, and monkeys, being crushed to death were selling for as much as $300 each. And just a few day ago, there were local news accounts of incidents in Maryland involving decapitated geese being left on the doorsteps of several homes in a Montgomery County community.

Our inhumane treatment of livestock is becoming widespread and more and more barbaric. Six-hundred-pound hogs—they were pigs at one time—raised in 2-foot-wide metal cages called gestation crates, in which the poor beasts are unable to turn around or lie down in natural positions, and this way they live for months at a time.

On profit-driven factory farms, veal calves are confined to dark wooden crates so small that they are prevented from lying down or scratching themselves. These creatures feel; they know pain. They suffer pain just as we humans suffer pain. Egg-laying hens are confined to battery cages. Unable to spread their wings, they are reduced to nothing more than an egg-laying machine.

Last April, the Washington Post detailed the inhumane treatment of livestock in our Nation's slaughterhouses. A 23-year-old Federal law requires that cattle and hogs to be slaughtered must first be stunned, thereby rendered insensitive to pain, but mounting evidence indicates that this is not always being done, that these animals are sometimes cut, skinned, and scalded while still able to feel pain.

A Texas beef company, with 22 citations for cruelty to animals, was found chopping the hooves off live cattle. In another Texas plant with about two dozen violations, Federal officials found nine live cattle dangling from an overhead chain. Secret videos from an Iowa pork plant show hogs squealing and kicking as they are being lowered into the boiling water that will soften their hides, soften the bristles on the hogs and make them easier to skin.

I used to kill hogs. I used to help lower them into the barrels of scalding water, so that the bristles could be removed easily. But those hogs were dead when we lowered them into the barrels.

The law clearly requires that these poor creatures be stunned and rendered insensitive to pain before this process begins. Federal law is being ignored. Animal cruelty abounds. It is sickening. It is infuriating. Barbaric treatment of helpless, defenseless creatures must not be tolerated even if these animals are being raised for food—and even more so, more so. Such insensitivity is insidious and can spread and is dangerous. Life must be respected and dealt with humanely in a civilized society.

So for this reason I have added language in the supplemental appropriations bill that directs the Secretary of Agriculture to report on cases of inhumane animal treatment in regard to livestock production, and to document the response of USDA regulatory agencies.

The U.S. Department of Agriculture agencies have the authority and the capability to take action to reduce the disgusting cruelty about which I have spoken.

Oh, these are animals, yes. But they, too, feel pain. These agencies can do a better job, and with this provision they will know that the U.S. Congress expects them to do better in their inspections, to do better in their enforcement of the law, and in their research for new, humane technologies. Additionally, those who perpetuate such barbaric practices will be put on notice that they are being watched.

I realize that this provision will not stop all the animal life in the United States from being mistreated. It will not even stop all beef, cattle, hogs and other livestock from being tortured. But it can serve as an important step

toward alleviating cruelty and unnecessary suffering by these creatures.

Let me read from the Book of Genesis. First chapter, versus 24–26 reads:

And God said—

Who said? God said.

And God said, Let the Earth bring forth the living creature after his kind, cattle, and creeping thing, and beast of the Earth after his kind: and it was so.

And God made—

Who made?

And God made the beasts of the earth after his kind, and cattle after their kind, and every thing that creepeth upon the earth after his kind: and God saw that it was good.

And God said—

Who said? God said. Who said?

And God said, Let us make man in our image, after our likeness: and let them have dominion over the fish of the sea, and over the fowl of the air, and over the cattle, and over all the earth, and over every creeping thing that creepeth upon the Earth.

Thus, Mr. President, God gave man dominion over the Earth. We are only the stewards of this planet. We are only the stewards of His planet. Let us not fail in our Divine mission. Let us strive to be good stewards and not defile God's creatures or ourselves by tolerating unnecessary, abhorrent, and repulsive cruelty.

Mr. President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant bill clerk proceeded to call the roll.

SUPPLEMENTAL APPROPRIATIONS ACT, 2001—Continued

Mr. BYRD. Mr. President, I ask unanimous consent the order for the quorum call be dispensed with.

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

Mr. BYRD. Mr. President, I wish to request—I understand my colleague, Senator STEVENS, has already done this with respect to his cloakroom—that our cloakrooms send out a call to various Senators and staffs who are in town to let Senator STEVENS and me and the floor staffs know by 3 p.m. today if they have amendments which they expect to offer. If Senators expect to offer amendments and have not already informed Senator STEVENS and myself and our floor staffs, they should do so by 3 p.m. today.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant bill clerk proceeded to call the roll.

AMENDMENT NO. 862

Mr. REID. Mr. President, on behalf of Senator SCHUMER and others, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The senior assistant bill clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. SCHUMER, Mr. REED, Mr. REID, Mr. DODD, Mr. LIEBERMAN, and Mr. CORZINE, proposes an amendment numbered 862.

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

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

The amendment is as follows:

(Purpose: To rescind $33,900,000 for the printing and postage costs of the notices to be sent by the Internal Revenue Service before and after the tax rebate, such amount to remain available for debt reduction)

On page 44, line 20, strike ''$66,200,000'' and insert ''$32,300,000''.

Mr. REID. Mr. President, this amendment has been sent to the desk on behalf of Senators SCHUMER, REED, DODD, LIEBERMAN, and CORZINE that would rescind $33.9 million in unnecessary spending from the supplemental appropriations bill.

This money would finance an unnecessary and inappropriate notice to taxpayers on the rebate they will receive as part of the Economic Growth and Tax Relief Reconciliation Act of 2001.

This amendment is offered to help uphold the standards of professionalism and integrity that the Internal Revenue Service has historically tried to maintain.

These standards are threatened by this partisan notification.

The letter reads:

We are pleased to inform you that the United States Congress passed and President George W. Bush signed into law the Economic Growth and Tax Relief Reconciliation Act of 2001, which provides long-term relief for all Americans who pay income taxes. The new tax law provides immediate tax relief in 2001 and long-term tax relief for the years to come.

In 1975, a similar rebate was made available to taxpayers and it was simply included in the refunds.

I look forward to working with my colleague on this amendment, as does Senator SCHUMER, as debate on the supplemental appropriations proceeds. I hope this amendment will be accepted.

Mr. President, I ask unanimous consent that the amendment be laid aside.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

AMENDMENT NO. 863

Mr. REID. Mr. President, on behalf of Senator FEINGOLD, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The senior assistant bill clerk read as follows:

The Senator from Nevada [Mr. REID] for Mr. FEINGOLD, proposes an amendment numbered 863.

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

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

The amendment is as follows:

(Purpose: To increase the amount provided to combat HIV/AIDS, malaria, and tuberculosis, and to offset that increase by rescinding amounts appropriated to the Navy for the V–22 Osprey aircraft program)

On page 28, beginning on line 9, strike ''$100,000,000'' and all that follows through line 13, and insert the following: ''$693,000,000, to remain available until expended: *Provided,* That this amount may be made available, notwithstanding any other provision of law, for a United States contribution to a global trust fund to combat HIV/AIDS, malaria, and tuberculosis: *Provided, further,* That the entire amount made available under this heading is designated by the Congress as an emergency requirement pursuant to section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended: *Provided, further,* That the entire amount under this heading shall be available only to the extent that an official budget request for that specific dollar amount that includes the designation of the entire amount of the request as an emergency requirement as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, is transmitted by the President to the Congress: *Provided, further,* That the total amount of the rescission for 'Aircraft Procurement, Navy, 2001/2003' under section 1204 is hereby increased by $594,000,000.''.

Mr. REID. Mr. President, I ask unanimous consent that amendment be laid aside.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

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

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant bill clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. GRAHAM). Without objection, it is so ordered.

RECESS SUBJECT TO THE CALL OF THE CHAIR

Mr. BYRD. Mr. President, I am going to ask that the Senate recess awaiting the call of the Chair. I will be available, and Senator STEVENS will be available anytime a Senator comes to the floor and wishes to offer an amendment or to make a statement on any matter. This will merely free the floor staff for a moment to have lunch, if necessary.

Mr. President, seeing no Senator seeking recognition, I ask unanimous consent that the Senate stand in recess awaiting the call of the Chair.

There being no objection, the Senate, at 3:24 p.m., recessed until 3:27 p.m. and reassembled when called to order by the Presiding Officer (Mr. GRAHAM).

The PRESIDING OFFICER. The Senator from Idaho is recognized.

AMENDMENT NO. 864

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

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Idaho [Mr. CRAIG], for Mr. ROBERTS, for himself, Mr. CLELAND, Mr. CRAIG, Mr. MILLER, Mr. CRAPO, and Mr. BROWNBACK, proposes an amendment numbered 864.

Mr. CRAIG. 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 prohibit the use of funds for reorganizing certain B–1 bomber forces)

At the appropriate place, insert the following:

SEC. . None of the funds available to the Department of Defense for fiscal year 2001 may be obligated or expended for retiring or dismantling, or for preparing to retire or dismantle, any of the 93 B–1B Lancer bombers in service as of June 1, 2001, or for transferring or reasigning any of those aircraft from the unit, or the facility; to which assigned as of that date.

Mr. CRAIG. Mr. President, recently the Air Force revealed as part of its programmed budget decision its plan to cut the B–1B force structure by more than one-third. This has a substantial impact on a variety of Air Force bases that currently have a B–1B mission, and actually eliminates the B–1B entirely from Mountain Home Air Force Base in my State, from McConnell Air Force Base in Kansas, and from Robbins Air Force Base in Georgia.

Such a drawdown in the B–1B fleet has the same national impact as would BRAC. Clearly, decisions of this magnitude should not be made without consultation with Congress. There was no opportunity for advice and consent on the part of the Air Force or the Office of the Secretary of Defense.

Therefore, I offer this amendment on behalf of myself and Senator ROBERTS to preempt any precipitous action by the Department of Defense that could circumvent the right of Congress to review such a significant change in our Air Force defense structure.

This amendment will prevent any 2001 funds from being used for the preparation of retiring, dismantling, or reassigning any portion of the B–1B fleet. This would allow Congress the necessary time to consider the significance of the Air Force's decision and its impact with regard to the fiscal year 2002 defense budget.

The B–1B satisfies a very specific warfighting requirement as our fastest long-range strategic bomber capable of flying intercontinental missions without refueling. With its flexible weapons payloads and a high carrying capacity, it is extremely effective against time-sensitive and mobile targets.

While cutting the force structure is advocated as a means of cost savings and weapons upgrade, it comes at a significant national security cost. Removal of the B–1B from Mountain Home Air Force Base calls into question DOD's support of the composite wing which is the basis for the air expeditionary wing concept and raises other long-term strategic and mission questions.

The composite wing is our Nation's ''911 call'' in times of conflict that require rapid reaction and deployment over long distances. Do we want to eliminate our nation's 911 call, particularly in light of a future defense strategy that requires the increase capabilities that the B–1B offers as a long-range, low-altitude, fast-penetration bomber?

Mountain Home Air Force Base is unique.

At Mountain Home, we train our men and women in uniform as they are expected to fight by bringing together the composite wing and an adjacent premier training range with significant results that will ensure that we are the next generation air power leader. We have composite wing training twice a month, premier night low-altitude training, dissimilar air combat training, and the current composite wing configuration fulfills the air expeditionary wing requirement 100 percent. Without the B1–B in the composite wing, our target load capability is reduced by 60 percent.

Removal of the B1–B from the three bases will actually increase costs while reducing operational readiness: The B1 missions for the National Guard at McConnell and Robbins Air Force bases have a 15 percent higher mission capable rate than active duty units at Dyess Air Force Base in Texas and Ellsworth Air Force Base in South Dakota, with 25 percent less cost per flying hour, due to decreased wear and tear on the aircraft. Also, the National Guard repairs B–1 engines for the whole fleet at 60 percent of the depot cost. As a result of the high costs associated with traveling to others bases for training, other B1–B wings from Dyess Air Force Base and Ellsworth Air Force Base take part only once a year in composite wing training, whereas the B1–B wing at Mountain Home Air Force Base conducts this type of training twenty four times per year. The result is that aviators from Mountain Home are rated higher in operational inspections and training because of the enhanced training opportunities which they receive at reduced cost to the government.

The Department of Defense shouldn't make budget decisions which change major national security objectives without congressional review. Military budget decision should be made for the right reasons and not be based on playing political favors, especially when it impacts our operational capability and readiness, and will cost the government more money in the long run. Therefore, I urge my colleagues to support this amendment which will provide Congress with time to review the Air Force's decision and its effects on our national defense structure.

I have another amendment for proposal that is to be drafted and that I believe the ranking member will offer before the 6 o'clock deadline. I will speak briefly to that amendment. It deals with grain and commodity sales to Israel.

Israel, as we all know, began to receive cash transfer assistance in 1979 which replaced, in part, commodity import program assistance. In lieu of assistance specifically for commodity purchases, Israel agreed to continue to purchase United States grain, of which it has purchased 1.6 million metric tons every year since, or until this year, 2001, and ship half of it in privately owned United States-flagged commercial vessels. That, in essence, was the agreement in 1979.

Despite a level of United States aid in every year since 1984 that has been higher than the 1979–1983 level, Israel never increased its grain imports. That was kind of the quid pro quo: As our rates increased, support would go up, and so would their purchases of commodities. Had proportionality been the test, Israel would have reached the 2.45 million tons at least at one point. It never has. However, Israel has consistently cited proportionality in reference to the 2001 Foreign Operations appropriation act in stating its intent to cut purchases of approximately 1.2 million metric tons in this fiscal year. This cut is disproportionately greater than the reduction of the U.S. aid from the 2000–2001 fiscal period and is not consistent with congressional intent.

My amendment, which will be proposed later this afternoon, reshapes this, ensuring that a side letter agreement, with the terms of at least as favorable treatment as those in the year 2001, would be more consistent with past congressional intent and previous bilateral relations. Proportionality is something that I don't think can be or should be effectively argued whereas they did not respond when our aid increases went up.

We will be bringing a letter to the floor insisting that Israel stay consistent with what was agreed to following 1979 as it related to turning, if you will, commodity import programs into cash transfer assistance. We think we have honored our agreement with Israel. The amendment simply requires them to honor their agreement with us.

I yield the floor.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. CONRAD. Mr. President, I ask unanimous consent the order for the quorum call be dispensed with.

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

USE OF MEDICARE AND SOCIAL SECURITY TRUST FUNDS

Mr. CONRAD. Mr. President, I enjoyed reading the Washington Post this morning and listening to the weekend talk shows. I noticed I was the subject of a number of the articles and a number of the shows. I must say, I didn't recognize the policy that was being ascribed to me. Somehow, people have taken what I have proposed and twisted it and distorted it in a way that is almost unrecognizable. I think after examination it is clear why they have done that, but we will get into that in a moment.

The first article I would refer to is Robert Novak's piece in this morning's Washington Post that was headlined, ''Kent Conrad's Show Trial.''

Mr. Novak asserted that a hearing that I will be chairing later this week to talk about the fiscal condition of the country and where we are headed is some kind of a show trial. I want to assure Mr. Novak and anyone else who is listening, I have no interest in show trials. I do have a very serious interest in where we find ourselves after the fiscal policy that the President proposed has been adopted in the Congress because I think it has created serious problems.

Mr. Daniels, the head of the Office of Management and Budget, was on one of the talk shows this weekend and said I was engaged in what he referred to as ''medieval economics.'' I kind of like better the way Mr. Novak referred to me. He accused me of ''antique fiscal conservatism.'' ''Antique fiscal conservatism,'' that is the characterization he applied to the policies I proposed. Mr. Daniels called it ''medieval economics.''

What is it that I have talked about that has aroused such ire? All I have said is I don't think we ought to be using the trust funds of Medicare and Social Security for other purposes.

That is what I have said. I think that is the right policy. I don't think we should be using the trust funds of Social Security and Medicare for other purposes. After I made that statement, and after I noted that the latest numbers that come from this administration suggest that in fact we will be doing precisely that this year and next year, Mr. Daniels responded by suggesting that means Senator CONRAD favors a tax increase at a time of an economic slowdown.

That is not my proposal. That is not what I suggested. In fact, my record is precisely the opposite of that. They know that. They know that as the ranking Democrat on the Budget Committee this year, I didn't propose a tax increase in the midst of an economic slowdown. It is precisely the opposite of that. I proposed a $60 billion tax reduction as part of the Democratic alternative to the budget the President proposed. In fact, I supported much more tax relief as fiscal stimulus in this year than the President had in his plan.

So, please, let's not be mischaracterizing my position and suggesting I was for a tax increase at a time of economic slowdown. That is not the truth. That isn't my record. My record is absolutely clear. Through all of the records of the Budget Committee and the debate on the floor, both during the budget resolution and the tax bill, my record is as clear as it can be. I favored fiscal stimulus this year, more fiscal stimulus than the President proposed—not a tax increase, a tax cut.

We are going to have a debate, and the debate is required because we have a serious problem developing. Let's have it in honest terms. Let's not mischaracterize people's positions. Mr. Daniels, don't mischaracterize my position. You know full well I have not called for a tax increase in times of an economic slowdown. You know full well that my record was calling for a tax cut—in fact, more of a tax cut in this year of economic slowdown than the President was calling for.

It is true that over the 10 years of the budget resolution I called for a substantially smaller tax cut than the President proposed because I was concerned about exactly what happened. Let's turn to that because this is what set off this discussion.

As we look at the year we are now in, fiscal year 2001, if we start with the total surplus of $275 billion and take out the Social Security trust fund surplus of $156 billion and the Medicare trust fund of $28 billion, that leaves us with $92 billion. The cost of the President's tax cut which actually passed the Congress wasn't what he proposed. It was substantially different than he proposed because it was more front-end loaded, $74 billion this year. And $33 billion of that is a transfer out of this year into next year—a 2-week delay in corporate tax receipts in order to make 2002 look better, because they knew they were going to have a problem of raiding the Medicare trust fund in 2002.

What did they do? They delayed certain corporate receipts by 2 weeks—$33 billion worth—and put them over into 2002. That added to the cost of the tax bill.

There is only $40 billion of real stimulus in this tax bill that is going to go out into the hands of the American people during this year. But the cost is $74 billion because of this cynical device they use to delay corporate tax receipts to make 2002 look better.

As we go down and look at the cost of other budget resolution policies for this year—largely the bill that is on the floor right now, the supplemental appropriations bill for certain emergencies—and we look at possible economic revisions that their own administration has suggested will come—that is, we are not going to receive the amount of revenue anticipated—we then see that we are into the Medicare trust fund by $17 billion this year. That is what it shows for this year.

We had distinguished economists testify before the Budget Committee. Based on what they said, next year we are going to not only be using the entire Medicare trust fund surplus but we are actually going to be using some of the Social Security trust fund as well, $24 billion next year; that is, if we take into account a series of other policy choices that are going to have to be made.

That is the question I am raising. Mr. Daniels wants to change that into a discussion of having a tax increase this year. I don't know anyone who is advocating a tax increase this year. I am certainly not. I advocated a tax reduction. But we don't have a forecast of economic slowdown for the next 10 years. That is not the forecast of the administration. They are forecasting strong economic growth. That is their forecast. Yet with a forecast of strong economic growth starting next year, we see that we are into the Medicare trust fund and the Social Security trust fund next year. We have problems with the two funds in 2003 and 2004, and that is before a single appropriations bill has passed.

This is not a question of the Congress spending more money and putting us back into the deficit ditch. That is not this situation. We are in trouble just based on the budget resolution that was passed—the Republican budget resolution, I might add.

Their tax cut—the tax cut supported by this President, and the reduction in revenue that they themselves are predicting—we have trouble going into the Medicare and Social Security trust funds just on the basis of those factors: The budget resolution that they endorsed, the tax cut that they proposed and the President signed, and the economic slowdown that they are predicting.

We are into the trust funds already. That is before the President's request for additional funding for defense. He has already asked for $18 billion for next year. That has a 10-year effect of over $200 billion.

The question I am raising is, Where should that money come from? We are already into the trust fund before the President's defense request. Should that come out of the trust funds of Medicare and Social Security? Should we raise taxes to fund it? Should we cut other spending to fund it? Where should the money come from? Or, does the administration believe we should just go further into the Social Security and Medicare trust funds? I hope that is not what they believe because I think that would be a mistake.

Again, this is all within the context of their forecast of a stronger economy, of a growing economy. Is that circumstance the right policy to fund the President's additional spending requests for defense and the right policy to take it out of the Medicare trust fund or the Social Security trust fund? I don't think so. I think that is a serious mistake. As I say, we are already in trouble. We are already into the trust funds before the President's defense request, before any new spending for education.

Remember that the Senate just passed, almost unanimously, a bill that authorized more than $300 billion of new spending for education. It is not in the budget resolution. We can see that if we fund just a part of that—if we only fund $150 billion of it—that makes the situation with the trust funds more serious.

This is before any funding for natural disasters. There is no funding for natural disasters in the budget. Yet we know we spend $5 billion to $6 billion a year on natural disasters. Should that funding come out of the Medicare and Social Security trust funds? That is exactly where we are headed.

The question is, Is that the right policy? That is before the tax extenders are dealt with. Those are popular measures such as the research and development tax credit and the wind and solar energy credits. Some of them run out this year. We are going to extend them. Yet that is not in the budget.

Is it the right policy to take the funds necessary to extend those tax credits out of the Medicare and Social Security trust funds? Because that is what we are poised to do.

The alternative minimum tax—that now affects some 2 million taxpayers, but under the tax bill that has passed it is going to affect 35 million taxpayers—just to fix the part of the alternative minimum tax that is caused by the tax bill we just passed would cost over $200 billion to fix. That is not in the budget. Should that money come out of the Medicare and Social Security trust funds? Because that is what we are poised to do.

I have said I do not think that is a good policy. I do not think we should pay for a defense buildup out of the trust funds of Social Security and Medicare. I do not think we should pay for additional education funding out of the trust funds. I do not think we should pay for natural disasters or tax extenders or the alternative minimum tax fix out of the Medicare and Social Security trust funds. Because we need to run surpluses there to prepare for the retirement of the baby boom generation. That is the money that is being used to pay down the publicly held debt.

I think, as I have said, at a time of strong economic growth—which is what is in the forecast—as a policy we should not be using the Medicare and Social Security trust funds to fund other parts of governmental responsibility. I think that is a profoundly wrong policy. Any private-sector organization in America that tried to use the retirement funds of their employees to fund the operations of the organization would be headed for a Federal institution, but it would not be the Congress of the United States; they would be headed for a Federal prison because that is fraud, to take money that is intended for one purpose and to use it for another.

We have stopped that practice. In the last year we stopped raiding the trust funds to use those moneys for other purposes. We have stopped it. We have used that money to pay down debt. That is the right policy.

I hope very much we do not go back to the bad old days of raiding every trust fund in sight in order to make the bottom line look as if it balances. I suggest to my colleagues, using the Medicare trust fund or the Social Security trust fund for the other costs of Government is not a responsible way to operate. That is the point I have made.

I do not advocate a tax increase at a time of economic slowdown. I want to repeat, my proposal that I gave my colleagues was for a substantial tax cut this year, fiscal stimulus, $60 billion of fiscal stimulus that I supported in this year. But we are not talking about an economic slowdown being projected by this administration for the next 10 years. They are projecting a strong return to economic growth.

I just saw the Secretary of the Treasury, the top spokesman on economic policy for this administration, at a meeting overseas saying they anticipate a return to strong economic growth next year. That is their projection. That is their forecast.

What I am saying is, if we are in a period of strong economic growth, it is not right to raid the trust funds of Medicare and Social Security for other purposes. It is just wrong. It should not be done. But that is exactly where we are headed. The record is just as clear as it can be. We are going to be into the Medicare trust fund and even the Social Security trust fund next year just with the budget resolution that has passed, just with the tax cut that has passed, and just with the slowdown in the economy that we already see. That is where we are. That is before any additional money for defense. That is before any additional funding for education. That is before any money for natural disasters or tax extenders or to fix the AMT problem. And that is before additional economic revisions we anticipate receiving in August from the Congressional Budget Office.

When we factor in those matters, what we see is a sea of red ink, what we see is a very heavy invasion of both the Medicare trust fund and the Social Security trust fund. That is where we are headed.

The question I am posing to my colleagues, and to this administration, is, Does that make any sense as a policy? I do not think so. I do not think this is where we want to go, especially given the fact that we know in 11 years the baby boomers start to retire and then our fiscal circumstance changes dramatically.

We have to get ready for that eventuality. The first thing to get ready is not to raid the Medicare trust fund and the Social Security trust fund at a time of surpluses. That is just wrong. They can call me an antique fiscal conservative. They can call me somebody who is advocating medieval economics. I do not think so. I do not think this is antique fiscal conservatism. I think this is good old-fashioned, Midwestern common sense. You do not take the retirement funds of your citizens to fund the operation of Government. You do not take the health care funds of your people for other operations of Government. There is not a private-sector company in America that could do that.

I think this is very clear, the circumstance we face. We are already in trouble just with the budget resolution that has passed, just with the tax cut that has passed, and just with the economic slowdown that is being forecasted in the next 2 years. The trouble only gets more severe, only gets deeper, when you factor in the President's request for a big increase in defense. I think it is fair to ask the President, and this administration, how do you intend to pay for it? Do you intend to use the money from the trust funds to pay for this big buildup in defense? Do you intend to use the Medicare and Social Security trust funds to pay for natural disasters? Do you intend to use the Medicare and Social Security trust funds to pay for the tax extenders? I think people deserve to know what their recommendation is.

Mr. President, I will conclude as I began by saying I am not for a tax increase at a time of economic slowdown. That does not make good economic sense. The administration is not forecasting an economic slowdown next year or for the years to follow. They are forecasting strong economic growth. Yet the policies they have laid out and the plan they have put in place lead to huge, dramatic raids on both the Medicare and the Social Security trust funds each and every year for the next 9 years. I believe that is a mistake. I do not support that policy.

I support, certainly, fiscal stimulus at a time of economic downturn. But when we have forecasts of strong economic growth, to build in a policy that says the way we pay for the operations of this Government is to take money from the Medicare trust fund and the Social Security trust fund—count me out. I don't care what name you call me, I don't want any part of it. I don't care if I am the only vote that says: I am not, at a time of economic growth, for using the trust funds of Medicare and Social Security to fund the other operations of Government. That is wrong. I believe it is wrong in every way. And I want no part of it. But that is where we are headed.

Mr. DORGAN. I wonder if the Senator would yield for a question.

Mr. CONRAD. I am happy to yield.

Mr. DORGAN. Mr. President, I noticed some press coverage today by some folks who were raising some questions about my colleague's numbers. I wonder if the Senator would answer this question. Is it not the case that this question of tax cuts and fiscal policy was always based on surpluses we do not yet have? Is it not the case that this rosy scenario everybody talked about—especially conservatives coming to the floor of the Senate—was: ''This economy is going to grow forever. Let's anticipate surpluses year after year after year. And let's put in place tax and spending decisions that anticipate that''?

My colleague, Senator CONRAD, and I and others repeatedly said the conservative viewpoint would be a viewpoint that says let's be cautious. Yes, when we have surpluses, let's provide some tax cuts. Let's provide some investments we need. But let's be a little bit cautious in case those surpluses don't materialize.

Yet here we are, just a couple of months from those fiscal policy decisions, and we are going to have a midsession review by the Office of Management and Budget which is what I would like to ask the chairman of the Budget Committee about. That midsession review almost certainly will tell us this economy is much softer than anticipated and we will not have the surpluses we expected. Things might get better, but they might not. And if they don't, we might very well head back into very significant deficit problems.

I ask my colleague, when does the Office of Management and Budget give us their midsession review? Is that supposed to be in July?

Mr. CONRAD. Typically, we would get it in July or August. We are hearing already from the Congressional Budget Office that they anticipate that the forecast will be somewhat reduced because economic growth is not as strong as was anticipated. That means we will have less revenue than was in the forecast.

My colleague and I warned repeatedly that these 10-year forecasts are uncertain. Nobody should be counting on every penny to actually be realized.

Some said to us in rejoinder: There is going to even be more money. I remember some of my colleagues on the Budget Committee saying they think the forecast is too low.

I hope over time that will be the case. I hope the economy strongly recovers. I hope we have even more revenue. That would be terrific. But I don't think we can base Government policy on that. We certainly can't bet on every dime of the revenue that is in a 10-year forecast.

The reason it matters so much is because if we look ahead—these are the years of surpluses we are in now—but, according to the Social Security, what happens, starting in the year 2016, we start to run into deficits in both Medicare and Social Security. Medicare is the yellow part of the bars; Social Security is the red. These surpluses that we now enjoy turn to massive deficits.

That is why some of us think we have to save the Social Security trust fund for Social Security and the Medicare trust fund for Medicare, and that while that is necessary, it is not sufficient. We need to do even more than that to prepare for what is to come because we have a demographic tidal wave called the baby boom generation. They are going to turn these surpluses we have now into deficits. And if we start, at a time of surpluses, by raiding the trust funds, this situation becomes much worse, far more serious.

I don't think name calling is going to carry the question here. They can accuse me of medieval economics or antique fiscal conservatism. I don't think it is either one to say you ought to reserve the trust funds of Medicare and Social Security for the purposes intended. You ought not to use the money to finance the other functions of Government, however worthy the other functions are. I don't think we should use the money at a time of economic growth, which is what the administration is projecting for next year and beyond. Yet we see, according to the most recent numbers, that we are already into the trust funds. That is before a single appropriations bill has passed the Senate, before a single one has passed.

The question is, Are we going to dig the hole deeper? What are we going to do about the President's defense request? He wants $18 billion next year. The effect over 10 years is in the range of $200 billion from a request like that. That is not in the budget. Since we are already into the trust funds, it simply means that if we were to approve such a request, we would go deeper into the trust funds and Medicare and Social Security to defend or to finance that defense buildup.

How are we going to pay for natural disasters? At a time of economic growth, should we be funding natural disasters out of the trust funds of Medicare and Social Security? I don't think so. Should we fund the tax extenders by taking the money out of the trust funds of Social Security and Medicare? I don't think so.

They may call that antique fiscal conservatism. I will wear that as a badge of honor, that policy of protecting the trust funds of Medicare and Social Security. Call me any name you want. That is exactly the right thing to do. Certainly in a time of economic growth, you should not be using trust fund money to fund the other needs of Government. That is shortsighted. It is irresponsible. It is wrong. I am not going to support it.

I believe at the end of the day the American people will not support it because they have common sense. They know this doesn't add up. They know if you have already got a problem, you don't dig the hole deeper before you start filling it in. That is just common sense.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. NELSON of Nebraska). The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

RECESS

Mr. BYRD. Mr. President, I ask unanimous consent that the Senate stand in recess until the hour of 5 p.m. today.

Mr. STEVENS. Reserving the right to object, Mr. President, will the Senator indicate whether we can get some time limit to make sure people understand the time limit of submission of amendments today? Parliamentary inquiry, Mr. President, if the Senator will yield for a moment.

Mr. BYRD. Yes, I yield for that purpose.

Mr. STEVENS. Is it not the case that all amendments to this bill must be filed and presented by 6 p.m. today?

The PRESIDING OFFICER. The Senator is correct; all amendments must be offered.

Mr. STEVENS. Offered on the floor of the Senate or they will not be eligible for consideration.

The PRESIDING OFFICER. First-degree amendments must be offered by 6 p.m. today.

The Senator from West Virginia.

Mr. BYRD. I renew my request.

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

Thereupon, the Senate, at 4:31 p.m, recessed until 5 p.m. and reassembled when called to order by the Presiding Officer (Mr. DAYTON).

SUPPLEMENTAL APPROPRIATIONS ACT, 2001—Continued

The PRESIDING OFFICER. The Senator from Ohio.

AMENDMENT NO. 865

Mr. VOINOVICH. I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The pending amendment is laid aside. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Ohio [Mr. VOINOVICH], for himself, Mr. HELMS, Mr. SESSIONS, and Mr. CRAPO, proposes an amendment numbered 865.

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

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

The amendment is as follows:

(Purpose: To protect the social security surpluses by preventing on-budget deficits)

At the appropriate place, insert the following:

SEC. ___. PROTECT SOCIAL SECURITY SURPLUSES ACT OF 2001.

(a) SHORT TITLE.—This section may be cited as the ''Protect Social Security Surpluses Act of 2001''.

(b) REVISION OF ENFORCING DEFICIT TARGETS.—Section 253 of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 903) is amended—

(1) by striking subsection (b) and inserting the following:

''(b) EXCESS DEFICIT; MARGIN.—The excess deficit is, if greater than zero, the estimated deficit for the budget year, minus the margin for that year. In this subsection, the margin for each fiscal year is 0.5 percent of estimated total outlays for that fiscal year.'';

(2) by striking subsection (c) and inserting the following:

''(c) ELIMINATING EXCESS DEFICIT.—Each non-exempt account shall be reduced by a dollar amount calculated by multiplying the baseline level of sequesterable budgetary resources in that account at that time by the uniform percentage necessary to eliminate an excess deficit.''; and

(3) by striking subsections (g) and (h).

(c) ECONOMIC AND TECHNICAL ASSUMPTIONS.—Notwithstanding section 254(j) of the Balanced Budget and Emergency Deficit

Control Act of 1985 (2 U.S.C. 904(j)), the Office of Management and Budget shall use the economic and technical assumptions underlying the report issued pursuant to section 1106 of title 31, United States Code, for purposes of determining the excess deficit under section 253(b) of the Balanced Budget and Emergency Deficit Control Act of 1985, as added by subsection (b).

(d) APPLICATION OF SEQUESTRATION TO BUDGET ACCOUNTS.—Section 256(k) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 906(k)) is amended by—

(1) striking paragraph (2); and

(2) redesignating paragraphs (3) through (6) as paragraphs (2) through (5), respectively.

(e) STRENGTHENING SOCIAL SECURITY POINTS OF ORDER..—

(1) IN GENERAL.—Section 312 of the Congressional Budget Act of 1974 (2 U.S.C. 643) is amended by inserting at the end the following:

''(g) STRENGTHENING SOCIAL SECURITY POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider a concurrent resolution on the budget (or any amendment thereto or conference report thereon) or any bill, joint resolution, amendment, motion, or conference report that would violate or amend section 13301 of the Budget Enforcement Act of 1990.''.

(2) SUPER MAJORITY REQUIREMENT.—

(A) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(B) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(3) ENFORCEMENT IN EACH FISCAL YEAR.—The Congressional Budget Act of 1974 is amended in—

(A) section 301(a)(7) (2 U.S.C. 632(a)(7)), by striking ''for the fiscal year'' through the period and inserting ''for each fiscal year covered by the resolution''; and

(B) section 311(a)(3) (2 U.S.C. 642(a)(3)), by striking beginning with ''for the first fiscal year'' through the period and insert the following: ''for any of the fiscal years covered by the concurrent resolution.''.

(f) EFFECTIVE DATE.—This section and the amendments made by this section shall apply to fiscal years 2002 through 2006.

Mr. VOINOVICH. Mr. President, one of the primary reasons I wanted to serve as a Senator was to have an opportunity to bring fiscal responsibility to our Nation and help reduce our national debt. As many of my colleagues know, for decades successive Congresses and Presidents spent money on items that, while important, they were unwilling to pay for or, in the alternative, do without. In the process, Washington ran up a staggering debt and mortgaged our future. Today our national debt stands at about $5.7 trillion. That costs about $200 billion a year in interest payments.

From the time I arrived in the Senate, I have worked to rein in spending and lower the national debt. Over the past 2½ years, I have cosponsored and sponsored a number of amendments designed to bring fiscal discipline to the Federal Government. In March of 1999, I offered an amendment to use whatever on-budget surplus as calculated in the fiscal year 2000 budget to pay down the debt. In March of 2000, I again offered my amendment to use the on-budget surplus calculated for fiscal year 2001 for debt reduction. In an effort to bring spending under control, Senator ALLARD and I offered an amendment in June of 2000 to direct $12 billion of fiscal year 2000 on-budget surplus toward debt reduction. The amendment passed by an overwhelming 95–3 and committed Congress to designate the on-budget surpluses to reduce the national debt, keeping these funds from being used for additional Government spending. Our amendment provided the mechanism to assure that Congress would begin the serious task of paying down the debt.

Further, this past April, Senator FEINGOLD, Senator GREGG, and I offered an amendment to the fiscal year 2002 budget designed to tighten enforcement of existing spending controls. Our amendment created an explicit point of order against directed scoring and abuses of emergency spending.

Even with all the amendments I proposed and cosponsored to bring Federal spending under control, I have never lost sight of the fact that we need to enact a Social Security lockbox. Make no mistake, adopting a Social Security lockbox is not about Social Security benefits. Social Security beneficiaries will not know the difference if we pass or do not pass a Social Security lockbox. What we are doing today will not have an impact at all on the beneficiaries. The amendment I am offering today will permanently lockbox the Social Security surplus and prevent it from being used for any other purpose.

For decades, the Social Security surplus was used by Congress after Congress and President after President to offset Federal spending. For many of those years, Members of both the House and Senate worked to put the Social Security surplus off limits from being used for such Federal spending. We talked a lot about it. In 1999, after years of wrangling, in a landmark budget agreement passed in 1995, the Federal Government finally achieved a balanced budget. With this good news, it became apparent that Congress and the President would not need to use the Social Security surplus for spending. This was made possible by our economic prosperity which guaranteed and generated a huge increase in tax revenues, which we know about, and in turn a massive on-budget surplus. Because the United States was running in the black for the first time in recent memory, Social Security surpluses were used to pay down the national debt instead of being used for spending. Indeed, since 1999, there has been a political consensus not to return to spending that surplus.

However, the economic prosperity this Nation enjoyed as recently as months ago is fading, although I hope this is only a temporary situation. Surplus projections are likely to be revised downward. Yet Congressional yearning for more spending has not abated.

For fiscal year 2001, Congress, with the encouragement of the Clinton administration, increased nondefense discretionary spending 14.3 percent. That is something people have not taken into consideration. Nondefense discretionary spending in the last budget was 14.3 percent above the year before and increased overall spending by 8 percent, which was way above inflation. All of this was on top of large increases in the previous years' budgets.

If we fund the education bill that the Senate recently passed, which increases spending by 62 percent or $14 billion, and if we spend the $18.4 billion increase in defense spending that the administration is talking about, we could end up spending a portion of the on-budget surplus of fiscal year 2003 and beyond. Part of the reason for this is the fact that the tax reduction was more front-end loaded than the President had originally planned.

Frankly, if the economy really falters, we could bump up against the Social Security trust fund next year. Nearly everyone in this Chamber agrees we should not spend that surplus, and the public has grown to expect that Congress won't return to spending it. This year's budget resolution was designed in part to avoid spending that surplus.

At the moment, we are de facto lockboxing Social Security. Therefore, it makes perfect sense to take the next step and lockbox these funds permanently. It is the best possible action we could take to bring fiscal discipline to the 107th Congress.

On the one hand, it guarantees we don't touch Social Security, and on the other it ensures we will continue to pay down debt, which fulfills the commitment we have all made and which will give us the interest savings. It is a two-for: We won't spend it; second, it will allow us to continue to pay down the national debt substantially. That is part of what I refer to as the three-legged stool. That three-legged stool in terms of my support for the budget resolution was: Hold spending down, reduce debt, and reduce taxes. But all three of them have to be present. We have to preserve that one stool of reducing the national debt.

If my colleagues think back to the 1980s, they will remember the dramatic increase in the national debt, primarily because of the use of the Social Security surplus. I was here. I was president of the National League of Cities. I came to this Congress before the Finance Committee and supported the Republican proposal to limit spending in 1985. What we saw happen during that period of time was that taxes were reduced and spending went up. Republicans wanted to spend on defense, the Democrats wanted to spend on social programs, and the way they paid for it was to use the Social Security surplus.

I don't want that to happen while I am a Member of the Senate. I don't think any of my other colleagues want that to happen again.

The 1999 budget was the first time in over three decades that Congress did

not use Social Security to pay for Federal spending. Again, in 2000, Congress did not use Social Security spending, although I must say it was hand-to-hand combat to make sure it wasn't used. There was direct scoring, there was emergency spending, and all kinds of other gimmicks because CBO had said we were spending the Social Security surplus, and the only thing that saved us was we got back here in January and CBO came out with new projections and said the budget surplus was more than what we had originally anticipated it to be.

Although the economy is not as robust as it was a year ago, we must resist the temptation to fall off the wagon of fiscal responsibility and resist the urge to resume spending that Social Security trust fund. The amendment we are offering guarantees we will not fall off the wagon. It contains two enforcement mechanisms: A supermajority point of order written in statute and automatic across-the-board spending cuts. Our amendment creates a statutory point of order against any bill, amendment, or resolution that would spend the Social Security surplus any of the next 10 years. Waiving the point of order would require the votes of 60 Senators. In addition, if the Social Security surplus were spent, the Office of Management and Budget would impose automatic across-the-board cuts in discretionary and mandatory spending to reduce the amount of the surplus that was spent.

We are talking about mandatory spending; we are talking about the fact that it will exempt Social Security and those things that are contained in the Deficit Control Act of 1985. My understanding is that is about $33 billion that would be subject to sequester or reduction.

This amendment will only trigger the automatic reduction if spending of the surplus exceeds one-half of 1 percent of the total outlay expenditure. In other words, it is not going to be one of those things that will happen automatically. It has a provision that says, if it is shown you have spent over one-half of 1 percent of the Social Security surplus, then the trigger will go into effect.

That is because we are talking about a $2 trillion budget and I think there ought to be some kind of flexibility in the amendment. I think, frankly, it is something that is intellectually honest to do. The only exceptions to the lockbox would be a state of war as declared by Congress or a recession defined as two successive quarters of negative economic growth.

For the past 2½ years I have fought to make sure we in the Senate hold ourselves accountable for the spending decisions that we make. Thus far, our spending choices, whether I have agreed with them or not, have involved on-budget surplus dollars. But I believe we need to prepare to protect Social Security funds from being used for even more spending, should our budget surplus fade. That is what will happen. If we keep this spending up, and then the surplus isn't there, there is going to be a great temptation for this body to invade the Social Security surplus.

Some of my colleagues in the Senate might argue we do not need a separate law establishing a Social Security lockbox since it already exists in the budget. Some of my colleagues might also swear that we would never return to the days when the Social Security trust fund was used as the Government's private piggy bank. Invariably we are told to have faith that this institution called Congress will do the right thing when it comes to spending.

I am a firm believer in Ronald Reagan's philosophy: Trust but verify. In my view, a permanent statutory Social Security lockbox is the best way to verify that the Social Security surplus remains untouched by those who would spend it. It would also force Congress to fiscal discipline and to make the hard choices in prioritizing our spending with the funds that we have today at our disposal.

I urge my colleagues to join me in support of this amendment.

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

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

The yeas and nays were ordered.

Mr. VOINOVICH. I yield the floor.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. BYRD. Did the distinguished Senator from Ohio offer his amendment?

The PRESIDING OFFICER. Yes, he offered his amendment.

AMENDMENT NO. 866 TO AMENDMENT NO. 865

Mr. BYRD. Mr. President, on behalf of Senator CONRAD, I offer an amendment authored by Mr. CONRAD to be an amendment in the second degree to the amendment offered by Mr. VOINOVICH.

I ask unanimous consent that after the clerk states the title of this amendment, that it and the amendment in the first degree be temporarily laid aside.

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

The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from West Virginia [Mr. BYRD] for Mr. CONRAD, proposes amendment numbered 866 to amendment No. 865.

The amendment is as follows:

(Purpose: To establish an off-budget lockbox to strengthen Social Security and Medicare)

Strike all after the first word and insert the following:

TITLE ____—SOCIAL SECURITY AND MEDICARE OFF-BUDGET LOCKBOX ACT OF 2001

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Social Security and Medicare Off-Budget Lockbox Act of 2001''.

SEC. ___02. STRENGTHENING SOCIAL SECURITY POINTS OF ORDER.

(a) IN GENERAL.—Section 312 of the Congressional Budget Act of 1974 (2 U.S.C. 643) is amended by inserting at the end the following:

''(g) STRENGTHENING SOCIAL SECURITY POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider a concurrent resolution on the budget (or any amendment thereto or conference report thereon) or any bill, joint resolution, amendment, motion, or conference report that would violate or amend section 13301 of the Budget Enforcement Act of 1990.''.

(b) SUPER MAJORITY REQUIREMENT.—

(1) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(2) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(c) ENFORCEMENT IN EACH FISCAL YEAR.—The Congressional Budget Act of 1974 is amended in—

(1) section 301(a)(7) (2 U.S.C. 632(a)(7)), by striking ''for the fiscal year'' through the period and inserting ''for each fiscal year covered by the resolution''; and

(2) section 311(a)(3) (2 U.S.C. 642(a)(3)), by striking beginning with ''for the first fiscal year'' through the period and insert the following: ''for any of the fiscal years covered by the concurrent resolution.''.

SEC. ___03. MEDICARE TRUST FUND OFF-BUDGET.

(a) IN GENERAL.—

(1) GENERAL EXCLUSION FROM ALL BUDGETS.—Title III of the Congressional Budget Act of 1974 is amended by adding at the end the following:

''EXCLUSION OF MEDICARE TRUST FUND FROM ALL BUDGETS

''SEC. 316. (a) EXCLUSION OF MEDICARE TRUST FUND FROM ALL BUDGETS.—Notwithstanding any other provision of law, the receipts and disbursements of the Federal Hospital Insurance Trust Fund shall not be counted as new budget authority, outlays, receipts, or deficit or surplus for purposes of—

''(1) the budget of the United States Government as submitted by the President;

''(2) the congressional budget; or

''(3) the Balanced Budget and Emergency Deficit Control Act of 1985.

''(b) STRENGTHENING MEDICARE POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider a concurrent resolution on the budget (or any amendment thereto or conference report thereon) or any bill, joint resolution, amendment, motion, or conference report that would violate or amend this section.''.

(2) SUPER MAJORITY REQUIREMENT.—

(A) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''316,'' after ''313,''.

(B) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''316,'' after ''313,''.

(b) EXCLUSION OF MEDICARE TRUST FUND FROM CONGRESSIONAL BUDGET.—Section 301(a) of the Congressional Budget Act of 1974 (2 U.S.C. 632(a)) is amended by adding at the end the following: ''The concurrent resolution shall not include the outlays and revenue totals of the Federal Hospital Insurance Trust Fund in the surplus or deficit totals required by this subsection or in any other surplus or deficit totals required by this title.''

(c) BUDGET TOTALS.—Section 301(a) of the Congressional Budget Act of 1974 (2 U.S.C. 632(a)) is amended by inserting after paragraph (7) the following:

''(8) For purposes of Senate enforcement under this title, revenues and outlays of the Federal Hospital Insurance Trust Fund for

each fiscal year covered by the budget resolution.''.

(d) BUDGET RESOLUTIONS.—Section 301(i) of the Congressional Budget Act of 1974 (2 U.S.C. 632(i)) is amended by—

(1) striking ''SOCIAL SECURITY POINT OF ORDER.—It shall'' and inserting ''SOCIAL SECURITY AND MEDICARE POINTS OF ORDER.—

''(1) SOCIAL SECURITY.—It shall''; and

(2) inserting at the end the following:

''(2) MEDICARE.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget (or amendment, motion, or conference report on the resolution) that would cause a decrease in surpluses or an increase in deficits of the Federal Hospital Insurance Trust Fund in any of the fiscal years covered by the concurrent resolution.''.

(e) MEDICARE FIREWALL.—Section 311(a) of the Congressional Budget Act of 1974 (2 U.S.C. 642(a)) is amended by adding after paragraph (3), the following:

''(4) ENFORCEMENT OF MEDICARE LEVELS IN THE SENATE.—After a concurrent resolution on the budget is agreed to, it shall not be in order in the Senate to consider any bill, joint resolution, amendment, motion, or conference report that would cause a decrease in surpluses or an increase in deficits of the Federal Hospital Insurance Trust Fund in any year relative to the levels set forth in the applicable resolution.''.

(f) BASELINE TO EXCLUDE HOSPITAL INSURANCE TRUST FUND.—Section 257(b)(3) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking ''shall be included in all'' and inserting ''shall not be included in any''.

(g) MEDICARE TRUST FUND EXEMPT FROM SEQUESTERS.—Section 255(g)(1)(B) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by adding at the end the following:

''Medicare as funded through the Federal Hospital Insurance Trust Fund.''.

(h) BUDGETARY TREATMENT OF HOSPITAL INSURANCE TRUST FUND.—Section 710(a) of the Social Security Act (42 U.S.C. 911(a)) is amended—

(1) by striking ''and'' the second place it appears and inserting a comma; and

(2) by inserting after ''Federal Disability Insurance Trust Fund'' the following: '', Federal Hospital Insurance Trust Fund''.

SEC. ___04. PREVENTING ON-BUDGET DEFICITS.

(a) POINTS OF ORDER TO PREVENT ON-BUDGET DEFICITS.—Section 312 of the Congressional Budget Act of 1974 (2 U.S.C. 643) is amended by adding at the end the following:

''(h) POINTS OF ORDER TO PREVENT ON-BUDGET DEFICITS.—

''(1) CONCURRENT RESOLUTIONS ON THE BUDGET.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget, or conference report thereon or amendment thereto, that would cause or increase an on-budget deficit for any fiscal year.

''(2) SUBSEQUENT LEGISLATION.—It shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, motion, or conference report if—

''(A) the enactment of that bill or resolution as reported;

''(B) the adoption and enactment of that amendment; or

''(C) the enactment of that bill or resolution in the form recommended in that conference report, would cause or increase an on-budget deficit for any fiscal year.''.

(b) SUPER MAJORITY REQUIREMENT.—

(1) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''312(h),'' after ''312(g),''.

(2) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''312(h),'' after ''312(g),''.

The PRESIDING OFFICER. The amendments are laid aside. The Senator from North Dakota.

Mr. CONRAD. Mr. President, very briefly, I thank Senator BYRD for introducing my amendment in the second degree to the amendment of the Senator from Ohio, and indicate to my colleagues the nature of the amendment. I think the Senator from Ohio is going in basically the right direction, but I do not think he is protecting both of the trust funds. I have offered, in the second degree, my amendment that would protect both the Social Security trust fund and the Medicare trust fund because I think both deserve protection. I think both are in danger.

Unfortunately, as I said several moments ago with respect to where we find ourselves, after the budget resolution is passed, after the tax cut is passed, and with the anticipated reduction in the revenue forecast because of the slowdown in the economy, we see we are headed for being into the Medicare trust fund this year, the Medicare and Social Security trust fund next year and for all the years that follow. That is before any appropriations have passed. That is before the President's major request for additional defense spending.

We are already in trouble. We are already headed for raiding the trust funds of Medicare and Social Security. So I am glad the Senator from Ohio has sent up an amendment. I have provided an amendment in the second degree that I think is stronger and provides additional protection and acknowledges that we have a responsibility not just to the Social Security trust fund but to the Medicare trust fund as well.

AMENDMENT NO. 867

Mr. CONRAD. If I could at this moment, on a separate matter, I send an amendment to the desk to the underlying bill. This amendment is to provide emergency funding for a situation we have just encountered on one of the Indian reservations in my State, the Turtle Mountain Indian Reservation. It is offset so it does not add to the overall cost of the supplemental. But we have found a situation that is extraordinarily serious on the Turtle Mountain Indian Reservation.

Very briefly, I will just describe that and then end so my colleague from Missouri, who is seeking recognition, can gain the floor.

Over 200 homes on the Turtle Mountain Reservation are infested with black mold; 40 percent of them that have been tested have the worst kind of black mold. This is throughout the structures. It is in the basements. It is running up the studs, in the ceilings, in the insulation. People in these homes are sick. We have had two infants die. People who are in the families and medical experts on the reservations believe their deaths are related to the conditions in these homes.

It is because of extraordinarily wet conditions in that part of our State. We have had 7 years of wet conditions. It is as though these houses are in a sponge and the sponge is full and the houses are wicking up the surface water. In fact, if you look in the crawl spaces of these homes, they are filled with water and that water has found its way up through the entire structure and has created the perfect environment for this black mold growth.

We have had the CDC there, the Corps of Engineers, and FEMA. It is a crisis situation that requires emergency housing for some 200 families.

The tribal chairman told me he is about to move people into a school gymnasium because the conditions in these homes are so bad.

I went there personally over the break. I can testify it is the worst situation I have seen, and I have dealt with black mold in our own home here in Washington, DC, in just one small area, where seven times our home flooded because the city sewer system could not handle torrential downpours here. We are the low spot on the block. It cost me $4,000 and three contractors to fix just a small part of one corner of our house.

These are houses that have it throughout. The basements are loaded with black mold. It is in the studding. In fact you can see it in the beams across the ceilings of these homes.

In every home we went into, people testified to the illnesses. In fact, the tribal chairman himself is ill from these circumstances.

This is an emergency situation that simply must be addressed. Obviously, the committee could not have known about it because nobody knew about it. But I offer that amendment for that purpose, and I thank my colleagues.

The PRESIDING OFFICER. The clerk will report the amendment.

Mr. STEVENS addressed the Chair.

The PRESIDING OFFICER. The Senator will suspend until the clerk reports the amendment.

The assistant legislative clerk read as follows:

The Senator from North Dakota [Mr. CONRAD] proposes an amendment numbered 867.

Mr. STEVENS. Mr. President, I ask unanimous consent these amendments not be read. They are being offered for purposes of qualification under the time agreement, and I ask that apply to all amendments, unless Senators wish to make their statements.

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

The amendment is as follows:

(Purpose: To provide funds for emergency housing on the Turtle Mountain Indian Reservation)

On page 47, between lines 20 and 21, insert the following:

COMMUNITY DEVELOPMENT BLOCK GRANTS

For emergency housing for Indians on the Turtle Mountain Indian Reservation, there shall be made available $10,000,000 through the Indian community development block

grant program under the Housing and Community Development Act of 1974. Amounts made available for programs administered by the Department of Housing and Urban Development for fiscal year 2001 shall be reduced on a pro rata basis by $10,000,000. The Federal Emergency Management Agency shall provide technical assistance to Indians with respect to the acquisition of emergency housing on the Turtle Mountain Indian Reservation.

AMENDMENTS NO. 868 AND NO. 869, EN BLOC

Mr. STEVENS. Mr. President, on behalf of Senator MCCAIN, I send two amendments to the desk and ask they be qualified under the time agreement.

The PRESIDING OFFICER. The clerk will report the amendments.

The assistant legislative clerk read as follows:

The Senator from Alaska [Mr. STEVENS] for Mr. MCCAIN, proposes amendments numbered 868 and 869, en bloc.

The amendments are as follows:

AMENDMENT NO. 868

(Purpose: To increase amounts appropriated to the Department of Defense)

On page 11, between lines 8 and 9, insert the following:

SEC. 1207. In addition to the amounts appropriated to the Department of Defense for fiscal year 2001 in other provisions of this Act or in the Department of Defense Appropriations Act, 2001 (Public Law 106–259), $2,736,100 is hereby appropriated, out of any funds in the Treasury not otherwise appropriated, to the Department of Defense for the fiscal year ending September 30, 2001, for purposes under headings in the Department of Defense Appropriations Act, 2001, and in amounts, as follows:

''Military Personnel, Army'', $30,000,000;

''Military Personnel, Navy'', $10,000,000;

''Military Personnel, Air Force'', $332,500,000;

''Reserve Personnel, Army'', $30,000,000;

''Operation and Maintenance, Army'', $916,400,000;

''Operation and Maintenance, Navy'', $514,500,000;

''Operation and Maintenance, Marine Corps'', $295,700,000;

''Operation and Maintenance, Air Force'', $59,600,000;

''Operation and Maintenance, Defense-Wide'', $9,000,000;

''Operation and Maintenance, Army Reserve'', $30,000,000;

''Operation and Maintenance, Army National Guard'', $106,000,000;

''Aircraft Procurement, Army'', $50,000,000, to remain available for obligation until September 30, 2003;

''Procurement of Weapons and Tracked Combat Vehicles, Army'', $10,000,000, to remain available for obligation until September 30, 2003;

''Procurement of Ammunition, Army'', $14,000,000, to remain available for obligation until September 30, 2003;

''Other Procurement, Army'', $40,000,000, to remain available for obligation until September 30, 2003;

''Aircraft Procurement, Navy'', $65,000,000, to remain available for obligation until September 30, 2003;

''Aircraft Procurement, Air Force'', $108,100,000, to remain available for obligation until September 30, 2003;

''Other Procurement, Air Force'', $33,300,000, to remain available for obligation until September 30, 2003;

''Research, Development, Test and Evaluation, Air Force'', $8,000,000, to remain available for obligation until September 30, 2002; and

''USS Cole'', $49,000,000;

Provided, That the entire amount made available in this section is designated by the Congress as an emergency requirement pursuant to section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended: *Provided, further,* That the entire amount under this section shall be available only to the extent that an official budget request for that specific dollar amount that includes the designation of the entire amount of the request as an emergency requirement as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, is transmitted by the President to the Congress.

AMENDMENT NO. 869

(Purpose: To provide additional funds for military personnel, working-capital funds, mission-critical maintenance, force protection, and other purposes by increasing amounts appropriated to the Department of Defense, and to offset the increases by reducing and rescinding certain appropriations)

After section 3002, insert the following:

SEC. 3003. (a) In addition to the amounts appropriated to the Department of Defense for fiscal year 2001 by other provisions of this Act or the Department of Defense Appropriations Act, 2001 (Public Law 106–259), funds are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, to the Department of Defense for the fiscal year ending September 30, 2001, for purposes under headings in the Department of Defense Appropriations Act, 2001, and in amounts, as follows:

(1) Under the heading ''MILITARY PERSONNEL, NAVY'', $181,000,000, of which $1,000,000 shall be available for the supplemental subsistence allowance under section 402a of title 37, United States Code.

(2) Under the heading ''MILITARY PERSONNEL, MARINE CORPS'', $21,000,000.

(3) Under the heading ''RESERVE PERSONNEL, NAVY'', $1,800,000, which shall be available for enhancement of force protection for United States forces in the Persian Gulf region and elsewhere worldwide.

(4) Under the heading ''OPERATION AND MAINTENANCE, ARMY'', $103,000,000.

(5) Under the heading ''OPERATION AND MAINTENANCE, NAVY'', $72,000,000, of which $36,000,000 shall be available for enhancement of force protection for United States forces in the Persian Gulf region and elsewhere worldwide.

(6) Under the heading ''OPERATION AND MAINTENANCE, MARINE CORPS'', $6,000,000.

(7) Under the heading ''OPERATION AND MAINTENANCE, AIR FORCE'', $397,000,000.

(8) Under the heading ''OPERATION AND MAINTENANCE, ARMY RESERVE'', $21,000,000.

(9) Under the heading ''OTHER PROCUREMENT, NAVY'', $45,000,000, to remain available for obligation until September 30, 2003, which shall be available for enhancement of force protection for United States forces in the Persian Gulf region and elsewhere worldwide.

(b) The amount appropriated by chapter 10 of title II to the Department of the Treasury for Departmental Offices under the heading ''SALARIES AND EXPENSES'' is hereby reduced by $30,000,000.

(c) The matter in chapter 11 of title II under the heading ''NATIONAL AERONAUTICS AND SPACE ADMINISTRATION HUMAN SPACE FLIGHT'' shall not take effect.

(RESCISSION)

(d) Of the unobligated balance of the total amount in the Treasury that is to be disbursed from special accounts established pursuant to section 754(e) of the Tariff Act of 1930, $200,000,000 may not be disbursed under that section.

(RESCISSIONS)

(e) The following amounts are hereby rescinded:

(1) Of the funds appropriated to the National Aeronautics and Space Administration under the heading ''HUMAN SPACE FLIGHT'' in the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2001 (as enacted into law by Public Law 106–377), the following amounts:

(A) From the amounts for the life and micro-gravity science mission for the human space flight, $40,000,000.

(B) From the amount for the Electric Auxiliary Power Units for Space Shuttle Safety Upgrades, $19,000,000.

(2) Of the funds appropriated to the Department of Commerce for the National Institute of Standards and Technology under the heading ''INDUSTRIAL TECHNOLOGY SERVICES'' in the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 2001 (as enacted into law by Public Law 106–553), $67,000,000 for the Advanced Technology Program.

(3) Of the funds appropriated to the Department of Commerce for the International Trade Administration under the heading ''OPERATIONS AND ADMINISTRATION'', $19,000,000 of the amount available for Trade Development.

(4) Of the funds appropriated by chapter 1 of the Emergency Steel Loan Guarantee and Emergency Oil and Gas Guaranteed Loan Act of 1999 (Public Law 106–51, $126,800,000.

(5) Of the funds appropriated to the Department of Transportation for the Maritime Administration under the heading ''MARITIME GUARANTEED LOAN (TITLE XI) PROGRAM ACCOUNT'' in the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 2001 (as enacted into law by Public Law 106–553), $21,000,000.

(6) Of the funds appropriated for the Export-Import Bank under the heading ''SUBSIDY APPROPRIATION'' in the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 2001 (as enacted into law by Public Law 106–429), $80,000,000.

(7) Of the funds appropriated to the Department of Labor for the Employment and Training Administration under the heading ''TRAINING AND EMPLOYMENT SERVICES'' in the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2001 (as enacted into law by Public Law 106–554), the following amounts:

(A) From the amounts for Dislocated Worker Employment and Training Activities, $41,500,000.

(B) From the amounts Adult Employment and Training Activities, $100,000,000.

(8) Of the unobligated balance of funds previously appropriated to the Department of Transportation for the Federal Transit Administration that remain available for obligation in fiscal year 2001, the following amounts:

(A) From the amounts for Transit Planning and Research, $34,000,000.

(B) From the amounts for Job Access and Reverse Commute Grants, $76,000,000.

AMENDMENT NO. 870

Mr. STEVENS. Mr. President, I send an amendment to the desk for the Senator from Arkansas, Mr. HUTCHINSON, and ask that it be qualified.

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

The pending amendment is laid aside.

The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Alaska [Mr. STEVENS] proposes an amendment numbered 870.

The amendment is as follows:

(Purpose: To provide additional amounts to repair damage caused by ice storms in the States of Arkansas and Oklahoma)

On page 13, between lines 23 and 24, insert the following:

FOREST SERVICE

STATE AND PRIVATE FORESTRY

For an additional amount for ''State and Private Forestry'' to repair damage caused by ice storms in the States of Arkansas and Oklahoma, $10,000,000, to remain available until expended: *Provided*, That the entire amount is designated by Congress as an emergency requirement under section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901(b)(2)(A)).

NATIONAL FOREST SYSTEM

For an additional amount for the ''National Forest System'' to repair damage caused by ice storms in the States of Arkansas and Oklahoma, $10,000,000, to remain available until expended: *Provided*, That the entire amount is designated by Congress as an emergency requirement under section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901(b)(2)(A)).

CAPITAL IMPROVEMENT AND MAINTENANCE

For an additional amount for ''Capital Improvement and Maintenance'' to repair damage caused by ice storms in the States of Arkansas and Oklahoma, $4,000,000, to remain available until expended: *Provided*, That the entire amount is designated by Congress as an emergency requirement under section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901(b)(2)(A)).

AMENDMENT NO. 871

Mr. STEVENS. Mr. President, I send an amendment to the desk for the Senator from Idaho, Mr. CRAIG, and ask that it be qualified.

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

The pending amendment is laid aside.

The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Alaska [Mr. STEVENS], for Mr. CRAIG, proposes an amendment numbered 871.

The amendment is as follows:

(Purpose: Regarding the proportionality of the level of non-military exports purchased by Israel to the amount of United States cash transfer assistance for Israel)

On page 29, between lines 2 and 3, insert the following:

SEC. 2502. In exercising the authority to provide cash transfer assistance for Israel for the fiscal year ending September 30, 2001, the President shall—

(1) ensure that the level of such assistance does not cause an adverse impact on the total level of non-military exports from the United States to Israel; and

(2) enter into a side letter agreement with Israel providing for the purchase of grain in the same amount and in accordance with terms at least as favorable as the side letter agreement in effect for the fiscal year ending September 30, 2000.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. BOND. Mr. President, I thank the Chair, and I thank my distinguished colleague, the manager of the bill.

I have two matters which I wish to address today.

First, I say to my colleague from North Dakota that we are very concerned about the situation he described. And, with the chairman of the VA–HUD subcommittee, we will look into this serious problem he has outlined. We thank him and commend him for bringing it to the attention of this body.

I have two measures.

First, I don't believe there is a Member of this body who has waterways in his or her State who doesn't understand the importance of the work done by the U.S. Army Corps of Engineers. Within the beltway, however, items such as flood control and river transportation are viewed as some sort of luxury we can do without. We can't do without them. I have been there. I have seen the devastation and the heartbreak. I have seen the families in great crisis. I have seen the farms and the homes and the communities destroyed. Unless you have been there, you cannot really appreciate it.

Clearly, the view in some eastern editorial boardrooms is rather clouded, and elite drawing rooms can't see that there are people who live and work along and depend upon the river. These are the people about whom we should be concerned.

I invite those who can tell us how to manage the rivers to come out and take a look at our rivers sometime. They might be very surprised at what they find.

In the State of Missouri, we have nearly 1,000 miles of land bordering the Missouri and Mississippi Rivers. Water transportation is low cost, safe, fuel efficient, and provides an insurance policy against runaway shipping costs charged by railroads that otherwise would face no competition. The environmental community assumes that monopolists don't raise prices. They do. But on the environmental side, to put the benefits of water transportation in perspective, One medium-sized 15-barge tow carries the same amount of grain as 870 tractor trailor trucks. Clearly, this comparison demonstrates the fuel efficiency and clean air benefits to the environment. It also reduces congestion, reduces highway wear and tear, improves safety, and costs less.

In Missouri, one-third of our agricultural production comes from the 100-year-flood plain. The Washington Post, that still believes food comes from the grocery store and not the farm, believes that this land should not be in production and flood protection should be a low priority.

Those who criticize the projects administered by the Corps typically do it from a safe distance. One of the biggest critics of the Corps in the Midwest sits safely behind a 500-year urban flood wall.

Policymakers in Washington stress exports and jobs but many fail to make the connection between exports and the transportation necessary to export. Unless we have purged the laws of physics and unless there are strange new business practices which don't require buyers to take delivery of sold goods, then transportation ultimately remains necessary.

Policymakers in Washington stress the need for additional power production that is good for the environment but propose inadequate budgets and policies for hydropower generation.

In the last Administration, policy and budgets to undermine the Corps where almost an annual event. Regrettably, the most recent budget proposed for fiscal year 2002 shows no recognition of how important the mission of the Corps is. I have a flood control project in Kansas City that will protect industries employing 12,000 people. The budget request for 2002 asks for enough money to keep the contractors busy for a fraction of the year. So not only is the project delayed, and not only does delay subject the citizens to prolonged flood risk unnecessarily, but the delay increases the cost of the project which I would expect the number-crunchers at OMB to find compelling if nothing else gets their attention.

Regrettably, the supplemental request does not include one red cent for operations and maintenance for the Corps of Engineers notwithstanding flood control, navigation, hydropower generation and environmental needs resulting from Midwestern flooding on the upper Mississippi, a Pacific earthquake which occurred in February, Tropical Storm Allison which occurred weeks ago as well as remaining problems associated with Hurricane Floyd and ice storms in the South.

Specifically, there are needs estimated to be: $50 million in response to the Midwest flooding; $47 million in the Southwest impacted by ice storms; $37 million for the Atlantic Seaboard in response to Hurricane Floyd and other weather events; $59 million for the Pacific Northwest to repair earthquake damage, stabilize hydropower facilities and correct major environmental deficiencies; and $30 million in response to the tropical storm which occurred early this month that affected Galveston and the New Orleans District.

My office has made inquiries at several districts that serve Missouri and have learned that they expect to be out of O&M funds to dredge the Mississippi River in a matter of weeks, which will risk the execution of water commerce on the nation's most important waterway.

When weather events occur, sediments build up, damage is done to levees and engineering structures such as wing dikes making repairs necessary and resources to dredge our ports and rivers necessary.

The House recognized this omission and included an additional $130 million for O&M for the Corps. Their markup occurred before there was any idea of what Allison had left behind.

I do not want to have to wait for economic decline, either regional or national, to try to make the case that we cannot continue to take our factors of production for granted. The growing estrangement of some decisionmakers and the media from the history and reality behind food, energy, and natural resource production in this country must be corrected. It will either be corrected ahead of a crisis or in response to a crisis. We have a strong economy for a reason and if we do not take care of our infrastructure, we will go into economic decline for a reason.

While we are undermining our infrastructure, competing nations are updating theirs. How many states have to have their lights turned out before we consider how are factories are powered, how our trucks are fueled and how our homes are heated? I regret that the need for efficient transportation, energy, and protection of people and property is a case that must be made but we can take action now for a fraction of what neglect, inaction and apathy will cost us later.

I know there is a bipartisan recognition that our water infrastructure is growing old and not serving the American people adequately. While there has always been bipartisan support for the mission of the Corps, I fear that the budgets do not match the need.

Over the last two years Corps projects have experienced a series of weather-related events that have left much of our water resources infrastructure in an alarming state of disrepair. In the most severe cases, temporary repairs were made to correct immediate hazards to public health and safety, while other work still awaits adequate funding. Harbor channels have lost sufficient depth and width for safe navigation, rivers are choked with debris, embankments are dangerously eroded, power outages are more frequent, and environmental preservation measures are short-changed. Unless the Corps receives supplemental funding, many navigation channels will not be able to accommodate normal commercial flow and flood control projects will be in serious jeopardy of failure. Recent damages and deterioration of hydroelectric facilities coupled with the national energy crisis have underscored the urgent need to undertake necessary repairs to hydropower projects in the Pacific Northwest.

While I will withhold offering an amendment at this time, I will do what I can do in conference to urge conferees to accept the House correction of the omission.

I ask unanimous consent that the pending amendment be set aside.

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

Mr. BOND. Mr. President, my second item deals with the defense budget.

While the administration's request for a supplemental appropriations bill for the Department of Defense includes what the administration believes is the minimum needed to get by for the remainder of this fiscal year (01), I respectfully disagree with their definition of ''minimum.''

Although we are hearing promises of an amended '02 budget with a huge defense plus-up, it is clear that the Defense Department appropriations bill for 2002 may indeed be the last of the 13 appropriations bills we will consider this year. That unfortunate timing may threaten the availability of all the extra funds many believe the Pentagon desperately needs. Simply put, there is no guarantee that the money the Pentagon needs will be there when the Senate takes up the amended Defense appropriation bill for 2002.

We must stop kicking the can down the road with promises to our forces—their need is urgent, they need help now. The problem will only continue to worsen, we need to act now.

Just last week, the Navy's top officer, Admiral Vern Clark, said he is trying to rid the United States Navy of the ''psychology of deficiency''—the acceptance of sustained resource shortages as a normal condition.

Sadly, Mr. President, this ''psychology of deficiency'' has not only infected the culture of our Armed Forces, but I am afraid it has become the culture.

The vast majority of the enlisted troops and officers on active duty today know only a culture of getting by on the minimum funding possible. They call it ''doing more with less,'' but the reality has been for almost a decade now, one of ''doing too much with too little.''

That is simply unacceptable. Every day, soldiers, sailors, airmen and marines risk their very lives for the values that have made this country the more powerful beacon of freedom the world has every known.

And in exchange for their lives, what do we do? We give them barely enough money to accomplish their mission safely. The bare minimum and no more. That is how we repay our troops? No wonder our Armed Forces have suffered from a persistent morale problem that has manifested itself in a chronic inability to hold onto large numbers of our most talented troops.

The ''bare minimum'' of funding is no way for our society to uphold our end of the social contract with our troops. That is not how we keep faith with those who defend our Nation's interests at their own personal risk.

How badly have we fallen short on our end of the social contract?

At the current level of funding, it will take 160 years to replace the Navy's shore infrastructure. The backlog of maintenance and repair exceeds $5.5 billion.

Recently the Marine Corps Commandant spoke about the terrible funding choices we force him to make. In order to keep marines ready for combat in case war breaks out in the near-term, the Commandant has to steal money from accounts dedicated to modernizing the Marine Corps for tomorrow's wars. If this persists, the Marine Corps may find itself on a battlefield in the future without the proper, modern equipment to help guarantee a quick victory with few U.S. casualties.

Even with the supplemental, the Army does not have the $145.1 million it needs to run its specialty training and schools. That means thousands of soldiers may not qualify in their combat specialties, which directly affects the combat readiness of Army units. When we tell our soldiers ''sorry, we don't have enough money to train you properly to do your job,'' what do you think the effect is on morale? The impact is devastating. That is what each of our services has had so much difficulty holding onto: Retaining its most skilled workers.

Our U.S. Air Force is currently operating and maintaining the oldest fleet in our history. On average, our aircraft are about 22 years old and getting older. An aging fleet costs more, both in effort and dollars, to operate and maintain.

Last year, while we flew only 97 percent of our programmed flying hours, doing so cost us 103 percent of our budget. Over the past 5 years, our costs per flying hour have risen almost 50 percent. That is a terrible cycle: Older planes cost more to maintain, which robs money from accounts to buy new planes, and so on. It is a death spiral for our Air Force.

Time and again history has shown us the folly of funding our troops as if peace will persist forever, as if war will never come. I thought this country learned that lesson in the opening days of the Korean war when Americans were caught unprepared, underequipped, and undertrained, and many paid with their lives.

I know the President of the United States knows this. I know Secretary of Defense Rumsfeld knows this. These are good men who know it is time to get the U.S. military on a more solid footing. I have worked closely with them in the past. I will continue to work with them. They will find me to be their most loyal supporter in this effort. But we can no longer afford to wait. We must act now.

That is why I am rising today to offer an amendment to add $1.45 billion to the fiscal year 2001 supplemental appropriations for the Defense Department. The amendment seeks to add the funds to the Defense Department that are needed, and can be spent, in what remains of the fourth quarter of the current fiscal year.

The amendment includes funds that will be directed exclusively to the operations and maintenance accounts of each of the four services. This is money the Pentagon needs right now to ensure that critical repairs and training are not delayed further.

There are emergency designations in this measure. All the money appropriated must be obligated by September 30 of this year. And the money shall be available only to the extent

that an official budget request for that specific dollar amount includes the designation of the entire amount of the request as an emergency requirement as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and is transmitted by the President to the Congress. We must begin to tell our troops that indeed help is on the way, that this is the time to send the help.

AMENDMENT NO. 872

Mr. President, I send the amendment to the desk and ask unanimous consent that it be included in the qualified list of amendments.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Missouri [Mr. BOND] proposes an amendment numbered 872.

Mr. BOND. I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To increase amounts appropriated for the Department of Defense)

At the end of title III, add the following:

SEC. . (a) In addition to the amounts appropriated to the Department of Defense for fiscal year 2001 by other provisions of this Act or the Department of Defense Appropriations Act, 2001 (Public Law 106–259), funds are hereby appropriated to the Department of Defense for the fiscal year ending September 30, 2001, for purposes under headings in the Department of Defense Appropriations Act, 2001, and in amounts, as follows:

(1) Under the heading ''MILITARY PERSONNEL, MARINE CORPS'', $21,000,000.

(2) Under the heading ''RESERVE PERSONNEL, ARMY'', $30,000,000.

(3) Under the heading ''OPERATION AND MAINTENANCE, ARMY'', $600,000,000.

(4) Under the heading ''OPERATION AND MAINTENANCE, NAVY'', $577,250,000.

(5) Under the heading ''OPERATION AND MAINTENANCE, MARINE CORPS'', $6,000,000.

(6) Under the heading ''OPERATION AND MAINTENANCE, AIR FORCE'', $100,200,000.

(7) Under the heading ''OPERATION AND MAINTENANCE, ARMY RESERVE'', $30,000,000.

(8) Under the heading ''OPERATION AND MAINTENANCE, NAVY RESERVE'', $19,100,000.

(9) Under the heading ''OPERATION AND MAINTENANCE, ARMY NATIONAL GUARD'', $39,400,000.

(b) The total amount appropriated under subsection (a) shall be available only to the extent that an official budget request for that specific dollar amount that includes the designation of the entire amount of the request as an emergency requirement as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, is transmitted by the President to the Congress.

(c) The total amount appropriated under subsection (a) is hereby designated by Congress as an emergency requirement pursuant to section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

(d) All of the funds appropriated and available under this section shall be obligated not later than September 30, 2001.

Mr. BOND. I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

AMENDMENT NO. 873

Mr. REID. Mr. President, I send an amendment to the desk for Senator HOLLINGS under my name under the authorized list.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. HOLLINGS, proposes an amendment numbered 873.

The amendment is as follows:

(Purpose: Ensuring funding for defense and education and the supplemental appropriation by repealing tax cuts for 2001)

At the appropriate place, insert the following:

___. ENSURING FUNDING FOR DEFENSE AND EDUCATION AND THE SUPPLEMENTAL APPROPRIATION BY REPEALING TAX CUTS FOR 2001.

(a) REPEAL.—

(1) IN GENERAL.—Section 101 of the Economic Growth and Tax Relief Reconciliation Act of 2001 is repealed.

(2) APPLICATION OF CODE.—The Internal Revenue Code of 1986 shall be applied and administered as if such section 101 (and the amendments made by such section) had never been enacted.

(3) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 1 of the Internal Revenue Code of 1986 (relating to tax imposed) is amended by adding at the end the following new subsection:

''(i) RATE REDUCTIONS AFTER 2001.—

''(1) 10-PERCENT RATE BRACKET.—

''(A) IN GENERAL.—In the case of taxable years beginning after December 31, 2001—

''(i) the rate of tax under subsections (a), (b), (c), and (d) on taxable income not over the initial bracket amount shall be 10 percent, and

''(ii) the 15 percent rate of tax shall apply only to taxable income over the initial bracket amount but not over the maximum dollar amount for the 15-percent rate bracket.

''(B) INITIAL BRACKET AMOUNT.—For purposes of this paragraph, the initial bracket amount is—

''(i) $14,000 ($12,000 in the case of taxable years beginning before January 1, 2008) in the case of subsection (a),

''(ii) $10,000 in the case of subsection (b), and

''(iii) ½ the amount applicable under clause (i) (after adjustment, if any, under subparagraph (C)) in the case of subsections (c) and (d).

''(C) INFLATION ADJUSTMENT.—In prescribing the tables under subsection (f) which apply with respect to taxable years beginning in calendar years after 2001—

''(i) the Secretary shall make no adjustment to the initial bracket amount for any taxable year beginning before January 1, 2009,

''(ii) the cost-of-living adjustment used in making adjustments to the initial bracket amount for any taxable year beginning after December 31, 2008, shall be determined under subsection (f)(3) by substituting '2007' for '1992' in subparagraph (B) thereof, and

''(iii) such adjustment shall not apply to the amount referred to in subparagraph (B)(iii).

If any amount after adjustment under the preceding sentence is not a multiple of $50, such amount shall be rounded to the next lowest multiple of $50.

''(2) REDUCTIONS IN RATES AFTER DECEMBER 31, 2001.—In the case of taxable years beginning in a calendar year after 2001, the corresponding percentage specified for such calendar year in the following table shall be substituted for the otherwise applicable tax rate in the tables under subsections (a), (b), (c), (d), and (e).

''In the case of taxable years beginning during calendar year:	The corresponding percentages shall be substituted for the following percentages:			
	28%	31%	36%	39.6%
2002 and 2003	27.0%	30.0%	35.0%	38.6%
2004 and 2005	26.0%	29.0%	34.0%	37.6%
2006 and thereafter	25.0%	28.0%	33.0%	35.0%

''(3) ADJUSTMENT OF TABLES.—The Secretary shall adjust the tables prescribed under subsection (f) to carry out this subsection.''.

(B) CONFORMING AMENDMENTS.—

(i) Subparagraph (B) of section 1(g)(7) of such Code is amended by striking ''15 percent'' in clause (ii)(II) and inserting ''10 percent.''.

(ii) Section 1(h) of such Code is amended—

(I) by striking ''28 percent'' both places it appears in paragraphs (1)(A)(ii)(I) and (1)(B)(i) and inserting ''25 percent'', and

(II) by striking paragraph (13).

(iii) Section 531 of such Code is amended by striking ''equal to'' and all that follows and inserting ''equal to the product of the highest rate of tax under section 1(c) and the accumulated taxable income.''.

(iv) Section 541 of such Code is amended by striking ''equal to'' and all that follows and inserting ''equal to the product of the highest rate of tax under section 1(c) and the undistributed personal holding company income.''.

(v) Section 3402(p)(1)(B) of such Code is amended by striking ''7, 15, 28, or 31 percent'' and inserting ''7 percent, any percentage applicable to any of the 3 lowest income brackets in the table under section 1(c),''.

(vi) Section 3402(p)(2) of such Code is amended by striking ''15 percent'' and inserting ''10 percent''.

(vii) Section 3402(q)(1) of such Code is amended by striking ''equal to 28 percent of such payment'' and inserting ''equal to the product of the third lowest rate of tax applicable under section 1(c) and such payment''.

(viii) Section 3402(r)(3) of such Code is amended by striking ''31 percent'' and inserting ''the fourth lowest rate of tax applicable under section 1(c)''.

(ix) Section 3406(a)(1) of such Code is amended by striking ''equal to 31 percent of such payment'' and inserting ''equal to the product of the fourth lowest rate of tax applicable under section 1(c) and such payment''.

(x) Section 13273 of the Revenue Reconciliation Act of 1993 is amended by striking ''28 percent'' and inserting ''the third lowest rate of tax applicable under section 1(c) of the Internal Revenue Code of 1986''.

(C) EFFECTIVE DATES.—

(i) IN GENERAL.—Except as provided in clause (ii), the amendments made by this paragraph shall apply to taxable years beginning after December 31, 2001.

(ii) AMENDMENTS TO WITHHOLDING PROVISIONS.—The amendments made by clauses (v), (vi), (vii), (viii), (ix), and (x) of subparagraph (B) shall apply to amounts paid after December 31, 2001.

(b) RESERVE FUND FOR DEFENSE AND EDUCATION.—Subtitle B of title II of H. Con. Res. 83 (107th Congress) is amended by inserting at the end the following:

''SEC. 219. STRATEGIC RESERVE FUND FOR DEFENSE AND EDUCATION.

If legislation is reported by the Committee on Appropriations of the Senate or the Committee on Appropriations of the House of Representatives, or an amendment thereto is

offered or a conference report thereon is submitted, that would increase funding for defense or education, the chairman of the appropriate Committee on the Budget shall revise the aggregates, functional totals, allocations, and other appropriate levels and limits in this resolution for that measure by not exceeding the amount resulting from the repeal and amendments made by section ___(a) of the Supplemental Appropriations Act, 2001 for fiscal years 2001 and 2002, as long as that measure will not, when taken together with all other previously enacted legislation, reduce the on-budget surplus below the level of the Medicare Hospital Insurance Trust Fund surplus in any fiscal year provided in this resolution.''.

Mr. REID. Mr. President, I ask unanimous consent that the amendment be set aside.

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

AMENDMENT NO. 874

Mr. REID. Mr. President, I send an amendment to the desk for Senator WELLSTONE under the authorized list.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. WELLSTONE, proposes an amendment numbered 874.

The amendment is as follows:

(Purpose: To increase funding for the Low-Income Home Energy Assistance Program, with an offset)

On page 11, between lines 8 and 9, insert the following:

(RESCISSIONS)

SEC. 1207. (a)(1) Effective July 31, 2001, of the funds provided to the Secretary of Defense, for fiscal year 2001 administrative expenses, under the Department of Defense Appropriations Act, 2001, the Military Construction Appropriations Act, 2001, and the Energy and Water Development Appropriations Act, 2001, and remaining in Federal appropriations accounts, an amount equal to $150,000,000 is rescinded.

(2) Such amount shall be rescinded from such Federal appropriations accounts as the Secretary of Defense shall specify before July 31, 2001. In determining the accounts to specify, the Secretary of Defense shall take into consideration the need to promote efficiency, cost-effectiveness, and productivity within the Department of Defense, as well as to maintain readiness and troop quality of life.

(b) Effective August 1, 2001, if the Secretary of Defense has not specified accounts for rescissions under subsection (a), of the funds described in subsection (a)(1) and remaining in Federal appropriations accounts, an amount equal to $150,000,000 is rescinded through proportional reductions to the portions of such accounts that contain such funds.

On page 36, line 9, strike ''$300,000,000'' and insert ''$450,000,000''.

AMENDMENT NO. 875

Mr. REID. Mr. President, I ask unanimous consent that the amendment be set aside, and I send an amendment to the desk on behalf of Senator JOHNSON.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. JOHNSON, proposes an amendment numbered 875.

The amendment is as follows:

(Purpose: To amend the Higher Education Act of 1965 to make certain interest rate changes permanent)

At the appropriate place, insert the following:

SEC. ___. EXTENSION OF INTEREST RATE PROVISIONS.

(a) TECHNICAL CORRECTION.—Paragraph (6) of section 455(b) of the Higher Education Act of 1965 (20 U.S.C. 1087e(b)), as redesignated by section 8301(c)(1) of the Transportation Equity Act for the 21st Century (Public Law 105–178; 112 Stat. 498) is redesignated as paragraph (8) and inserted after paragraph (7) of that section.

(b) EXTENSION.—

(1) AMENDMENTS.—Sections 427A(k), 428C(c)(1), 438(b)(2)(I), and 455(b)(6) of such Act (20 U.S.C. 1077a(k), 1078–3(c)(1), 1087–1(b)(2)(I), 1087e(b)(6)) are each amended by striking ''and before July 1, 2003,'' each place it appears.

(2) CONFORMING AMENDMENTS.—

(A) Section 427A(k) of such Act is amended by striking the subsection heading and inserting the following: ''INTEREST RATES FOR NEW LOANS ON OR AFTER OCTOBER 1, 1998.—''.

(B) Section 438(b)(2)(I) of such Act is amended—

(i) by striking the subparagraph heading and inserting the following: ''LOANS DISBURSED ON OR AFTER JANUARY 1, 2000.—''; and

(ii) in clause (i), by striking ''2000,'' and inserting ''2000''.

(C) Section 455(b)(6) of such Act is amended—

(i) by striking the paragraph heading and inserting the following: ''INTEREST RATE PROVISION FOR NEW LOANS ON OR AFTER OCTOBER 1, 1998.—''; and

(ii) in subparagraph (D), by striking ''1999,'' and inserting ''1999''.

Mr. REID. Mr. President, this amendment for Senator JOHNSON preserves a bipartisan compromise achieved in the 1998 Higher Education Act that reduced and stabilized higher education loan interest rates. The amendment that has been offered amends the Higher Education Act to continue the current student loan interest rate formulas, preserving the successful system that helps put millions of students through school every year.

The budget resolution includes a Technical Reserve Fund that makes it possible to fix the problem in 2001 before a crisis develops in 2003 when the current formula for calculating interest rates is due to expire. But the reserve fund in the resolution will expire early next year. Therefore, action is needed now so that Congress and the financial aid community can turn to improving financial aid programs all over this country.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. REID. Mr. President, in relation to the amendment I offered on behalf of Senator HOLLINGS, the RECORD should reflect that I have spoken to the Senator from South Carolina on several occasions today. He feels very strongly about the subject matter of this amendment. I am glad I had this slot available for the Senator, and I am happy to have offered this amendment on his behalf. Senator HOLLINGS will be available to speak more on the subject at a later time.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. KERRY). Without objection, it is so ordered.

The Senator from West Virginia is recognized.

Mr. BYRD. Mr. President, under the order, Senators, to be eligible to call up their amendments, had to offer those amendments by no later than 6 p.m. today; am I correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. BYRD. Will the Chair please have the clerk state the amendments that qualify on the morrow?

The PRESIDING OFFICER. The clerk will read the qualified amendments.

The assistant legislative clerk read as follows:

Senator SCHUMER, amendment No. 862; Senator FEINGOLD, amendment No. 863; Senator ROBERTS, amendment No. 864; Senator VOINOVICH, amendment No. 865; Senator CONRAD, second-degree amendment No. 866 to amendment No. 865; Senator CONRAD, amendment No. 867; Senator MCCAIN, amendment No. 868; Senator MCCAIN, amendment No. 869; Senator HUTCHINSON, amendment No. 870; Senator CRAIG, amendment No. 871; Senator BOND, amendment No. 872; Senator REID for Senator HOLLINGS, amendment No. 873; Senator WELLSTONE, amendment No. 874; and Senator JOHNSON, amendment No. 875.

Mr. BYRD. I take it that the hour of 6 p.m. has arrived?

The PRESIDING OFFICER. The Senator is correct; it has arrived.

Mr. BYRD. I thank the Chair and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. BYRD. Mr. President, subject to change by the leadership, I ask unanimous consent that there now be a period for the transaction of morning business, not to extend beyond the hour of 6:30 p.m., and that Senators may be permitted to speak for not to exceed 10 minutes each.

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

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. HELMS. I ask it be in order for me to deliver my remarks seated at my desk.

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

RES IPSA LOQUITUR

Mr. HELMS. Mr. President, the July edition of the American Legion magazine features a remarkable statement of obvious truth by a much maligned American who deserves far better than the petty sniping he endures at the hands of cunning politicians and the media, neither of whom would acknowledge the truth if they fell over it in the middle of the street.

U.S. Supreme Court Justice Clarence Thomas pulled no punches in this article. His piece in the American Legion magazine was headed, appropriately, ''Courage v. Civility.'' Mr. Justice Thomas knows a good bit about both. He is, himself, a civil gentleman who possesses great courage.

The subhead on his piece pinpoints a great deal about how a good many American freedoms are being lost. One of the things he says is, those who censor themselves put fear ahead of freedom. I will quote briefly from two or three statements made by the distinguished Justice of the Supreme Court.

He said:

I do not believe that one should fight over things that don't really matter. But what about things that do matter? It is not comforting to think that the natural tendency inside us is to settle for the bottom, or even the middle of the stream.

This tendency, in large part, results from an overemphasis on civility. None of us should be uncivil in our manner as we debate issues of consequence. No matter how difficult it is, good manners should be routine. However, in the effort to be civil in conduct, many who know better actually dilute firmly held views to avoid appearing ''judgmental.'' They curb their tongues not only in form but also in substance. The insistence on civility in the form of our debates has the perverse effect of cannibalizing our principles, the very essence of a civil society. That is why civility cannot be the governing principle of citizenship or leadership.

By yielding to a false form of civility, we sometimes allow our critics to intimidate us. As I have said, active citizens are often subjected to truly vile attacks; they are branded as mean-spirited, racist, Uncle Tom, homophobic, sexist, etc. To this we often respond (if not succumb), so as not to be constantly fighting, by trying to be tolerant and nonjudgmental—i.e., we censor ourselves. This is not civility. It is cowardice, or well-intentioned self-deception at best.

I shall not quote further from this super article written by Mr. Justice Clarence Thomas, but I do ask unanimous consent the article by him be printed in the RECORD.

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

[From the American Legion Magazine, July 2001]

COURAGE *v.* CIVILITY

THOSE WHO CENSOR THEMSELVES PUT FEAR AHEAD OF FREEDOM

(By Clarence Thomas)

My beliefs about personal fortitude and the importance of defending timeless principles of justice grew out of the wonderful years I spent with my grandparents, the years I have spent in Washington and my interest in world history—especially the history of countries in which the rule of law was surrendered to the rule of fear, such as during the rise of Nazism in what was then one of the most educated and cultured countries in Europe.

I have now been in Washington, D.C., for more than two decades. When I first arrived here in 1979, I thought there would be great debates about principles and policies in this city.

I expected citizens to feel passionately about what was happening in our country, to candidly and passionately debate the policies that had been implemented and suggest new ones.

I was disabused of this heretical notion in December 1980, when I was unwittingly candid with a young Washington Post reporter. He fairly and thoroughly displayed my naive openness in his op-ed about our discussion, in which I had raised what I thought were legitimate objections to a number of sacred policies, such as affirmative action, welfare, school busing—policies I felt were not well serving their intended beneficiaries. In my innocence, I was shocked at the public reaction. I had never been called such names in my entire life.

Why were these policies beyond question? What or who placed them off limits? Would it not be useful for those who felt strongly about these matters, and who wanted to solve the same problems, to have a point of view and to be heard? Sadly, in most forums of public dialogue in this country, the answer is no.

It became clear in rather short order that on very difficult issues, such as race, there was no real debate or honest discussion. Those who raised questions that suggested doubt about popular policies were subjected to intimidation. Debate was not permitted. Orthodoxy was enforced.

Today, no one can honestly claim surprise at the venomous attacks against those who take positions that are contrary to the canon laid down by those who claim to shape opinions. Such attacks have been standard fare for some time.

If you trim your sails, you appease those who lack the honesty and decency to disagree on the merits but prefer to engage in personal attacks. A good argument diluted to avoid criticism is not nearly as good as the undiluted argument, because we best arrive at truth through a process of honest and vigorous debate. Arguments should not sneak around in disguise, as if dissent were somehow sinister. One should not be cowed by criticism.

In my humble opinion, those who come to engage in debates of consequence, and who challenge accepted wisdom, should expect to be treated badly. Nonetheless, they must stand undaunted. That is required. And that should be expected, for it is bravery that is required to secure freedom. * * * For brutes, the most effective tactic is to intimidate an opponent into the silence of self-censorship.

In September 1975, The Wall Street Journal published a book review by Michael Novak of Thomas Sowell's book, ''Race and Economics.'' The opening paragraph changed my life. It reads:

''Honesty on questions of race is rare in the United States. So many and unrecognized have been the injustices committed against blacks that no one wishes to be unkind, or subject himself to intimidating charges. Hence, even simple truths are commonly evaded.''

This insight applies with equal force to very many conversations of consequence today. Who wants to be denounced as a heartless monster? On important matters, crucial matters, silence is enforced.

Even if one has a valid position, and is intellectually honest, he has to anticipate nasty responses aimed at the messenger rather than the argument. The objective is to limit the range of the debate, the number of messengers and the size of the audience. The aim is to pressure dissenters to sanitize their message, so as to avoid being subjected to hurtful ad hominem criticism. Who wants to be caluminated? It's not worth the trouble.

But is it worth it? Just what is worth it, and what is not? If one wants to be popular, it is counterproductive to disagree with the majority. If one just wants to tread water until the next vacation, it isn't worth the agony. If one just wants to muddle through, it is not worth it. In my office, a little sign reads: ''To avoid criticism, say nothing, do nothing, be nothing.''

None of us really believes that the things we fear discussing honestly these days are really trivial—and the reaction of our critics shows that we are right. If our dissents are so trivial, why are their reactions so intense? If our ideas are trivial, why the headhunting? Like you, I do not want to waste my time on the trivial. I certainly have no desire to be browbeaten and intimidated for the trivial.

What makes it all worthwhile? What makes it worthwhile is something greater than all of us. There are those things that at one time we all accepted as more important than our comfort or discomfort—if not our very lives: Duty, honor, country! There was a time when all was to be set aside for these. The plow was left idle, the hearth without fire, the homestead abandoned.

To enter public life is to step outside our more confined, comfortable sphere, and to face the broader, national sphere of citizenship. What makes it all worthwhile is to devote ourselves to the common good.

It goes without saying that we must participate in the affairs of our country if we think they are important and have an impact on our lives. But how are we to do that? In what manner should we participate?

I do not believe that one should fight over things that don't really matter. But what about things that do matter? It is not comforting to think that the natural tendency inside us is to settle for the bottom, or even the middle of the stream.

This tendency, in large part, results from an overemphasis on civility. None of us should be uncivil in our manner as we debate issues of consequence. No matter how difficult it is, good manners should be routine. However, in the effort to be civil in conduct, many who know better actually dilute firmly held views to avoid appearing ''judgmental.'' They curb their tongues not only in form but also in substance. The insistence on civility in the form of our debates has the perverse effect of cannibalizing our principles, the very essence of a civil society. That is why civility cannot be the governing principle of citizenship or leadership.

By yielding to a false form of civility, we sometimes allow our critics to intimidate us. As I have said, active citizens are often subjected to truly vile attacks; they are branded as mean-spirited, racist, Uncle Tom, homophobic, sexist, etc. To this we often respond (if not succumb), so as not to be constantly fighting, by trying to be tolerant and

nonjudgmental—i.e., we censor ourselves. This is not civility. It is cowardice, or well-intentioned self-deception at best.

The little-known story of Dimitar Peshev shows both the power of self-deception and the explosive effect of telling the truth and the dangers inherent in allowing the rule of law and the truth to succumb to political movements of the moment.

Peshev was the vice president of the Bulgarian Parliament during World War II. He was a man like many—simple and straightforward, not a great intellectual, not a military hero—just a civil servant doing his job as best he could, raising his family, struggling through a terrible moment in European history.

Bulgaria was pretty lucky because it managed to stay out of the fighting, even though the Nazis had placed the Bulgarian government—and the king—under enormous pressure to enter the war on the side of the Axis, or at a minimum to permit the destruction of the Bulgarian Jews. Bulgaria had no tradition of widespread anti-semitism, and the leaders of the country were generally unwilling to turn over their own citizens to certain death. But like all the other European countries, Bulgaria moved toward the Holocaust in small steps.

Peshev was one of many Bulgarian officials who heard rumors of the new policy and constantly queried his ministers. They lied to him, and for a time he believed their lies. Perhaps the ministers somehow believed the lies themselves. But in the final hours, a handful of citizens from Peshev's hometown raced to Sofia to tell him the truth: that Jews were being rounded up, that the rains were waiting.

According to the law, such actions were illegal. So Peshev forced his way into the office of the interior minister, demanding to know the truth. The minister repeated the official line, but Peshev didn't believe him. He demanded that the minister place a telephone call to the local authorities and remind them of their legal obligations. This brave act saved the lives of the Bulgarian Jews. Peshev then circulated a letter to members of Parliament, condemning the violation of the law and demanding that the government ensure that no such thing take place.

According to his biographer, Peshev's words moved all those ''who until that moment had not imagined what could happen but who now could not accept what they had discovered.'' He had broken through the wall of self-deception and forced his colleagues to face the truth.

There is no monument to this brave man. Quite the contrary, the ministers were embarrassed and made him pay the price of their wickedness. He was removed from the position of vice president, publicly chastised for breaking ranks and politically isolated.

But he had won nonetheless: The king henceforth found ways to stall the Nazis; the leader of the Bulgarian Orthodox Church publicly defended the country's Jews; and even the most convinced anti-Semites in the Bulgarian government dared not advocate active cooperation with the Third Reich.

After the war, when the communists took over Bulgaria, they rewrote the wartime history to give the Communist Party credit for saving the Jews. Peshev was sent to the Gulag, and his story was only rediscovered after the collapse of the Soviet Union.

Pope John Paul II has traveled the entire world challenging tyrants and murderers of all sorts, speaking to millions of people, bringing them a single, simple message: ''Be not afraid.''

He preached this message to people living under communist tyranny in Poland, in Czechoslovakia, in Nicaragua and in China: ''Be not afraid.'' He preached it to Africans facing death from marauding tribes and murderous disease: ''Be not afraid.'' And he preached it to us, warning us how easy it is to be trapped in a ''culture of death'' even in our comfortable and luxurious country: ''Be not afraid.''

Those three little words hold the power to transform individuals and change the world. They can supply the quiet resolve and unvoiced courage necessary to endure the inevitable intimidation.

Today we are not called upon to risk our lives against some monstrous tyranny. America is not a barbarous country. Our people are not oppressed, and we face no pressing international threat to our way of life, such as the Soviet Union once posed.

Though the war in which we are engaged is cultural, not civil, it tests whether this ''nation: conceived in liberty . . . can long endure.'' President Lincoln's words do endure: ''It is . . . for us [the living] to be here dedicated to the great task remaining before us . . . that from these honored dead we take increased devotion to the cause for which they gave the last full measure of devotion . . . that we here highly resolve that these dead shall not have died in vain . . . that this nation, under God, shall have a new birth of freedom . . . and that government of the people . . . by the people . . . for the people . . . shall not perish from the earth.

The founders warned us that freedom requires constant vigilance and repeated action. It is said that, when asked what sort of government the founders had created. Benjamin Franklin replied that they had given us ''a republic, if you can keep it.'' Today, as in the past, we need a brave civic virtue, not a timid civility, to keep our republic. Be not afraid.

THE ANNUAL MEETING OF THE CORPORATION FOR NATIONAL SERVICE

Mr. LOTT. Mr. President, I would like to take this opportunity to recognize the recent meeting of the board of directors of the Corporation for National Service which was hosted by my home State of Mississippi. Mississippians are known for their hospitality and compassion, so playing host to this meeting in Jackson was a natural fit.

The board members used this forum to elect Stephen Goldsmith, chairman of the board of directors for the Corporation for National Service. As the former mayor of Indianapolis, Chairman Goldsmith earned a reputation for innovative thinking, reducing spending, and improving infrastructure. I wish him the best of luck in his new role as chairman.

I also understand that at this year's meeting of the board, a coalition of religious and community leaders praised President Bush for his faith-based and community initiatives, and announced the creation of the Mississippi Faith-Based Coalition for Community Renewal. My constituents advise me that this coalition will work with the President to implement his faith-based plan and bring hope and opportunity to all Mississippians.

Mississippi is truly proud to have been chosen as the host site for the 2001 meeting of the board of directors of the Corporation for National Service. I want to encourage other boards, organizations, corporations, and groups to hold their special events in Mississippi and share in all we have to offer.

HONORING NOBEL LAUREATES

Mr. BIDEN. Mr. President, on July 18 here in Washington, the American College of Neuropsychopharmacology will be honoring its members who have won the Nobel Prize for Medicine or Physiology. The honorees include the three Nobel Prize winners from the year 2000: Dr. Arvid Carlsson from Goteborg University in Sweden, Dr. Paul Greengard from Rockefeller University in New York City, and Dr. Eric Kandel from Columbia University in New York City. Also being honored is the 1970 Nobel Prize winner, Dr. Julius Axelrod from the National Institutes of Health in Maryland. Together, these Nobel Prize winners have helped us begin to understand how that most mysterious and important human organ, the brain, actually works.

The brain is a huge collection of nerve cells, connected to each other in complicated networks. Nerve impulses, which are the means of communicating information from the brain to the various parts of the body, are conducted from one end of a nerve cell to another by a form of electrical action. Dr. Axelrod's work set the stage for our modern knowledge of brain neurochemistry by establishing the important role of neurotransmitters, which are chemicals that serve to transmit these nerve impulses from one nerve cell to another through a connecting region called the synapse. A key first step in understanding the brain was this discovery that, as nerve impulses move from nerve cell to nerve cell, they switch from an electrical conduction to a chemical conduction and then back again to an electrical conduction.

Dr. Carlsson started to fill in this general outline by discovering that the chemical dopamine was one of these important chemicals that transmits nerve signals from one nerve cell to another. Moreover, dopamine seemed to be very important in controlling body motions. Dr. Carlsson's work with experimental animals who were deficient in dopamine led to the seminal discovery that Parkinson's disease in humans, a disabling and progressive disease associated with tremors and impaired mobility, was directly related to a deficiency of dopamine in certain parts of the brain. This landmark finding led directly to the treatment of Parkinson's disease with L-dopa, a drug that is converted to dopamine in the body. To this very day, the foundation for treatment of this illness is the use of medications that increase dopamine in the brain or mimic its action there.

Dr. Carlsson also discovered that the drugs used to treat schizophrenia, a severe mental illness affecting thought processes, also seemed to work by affecting the action of dopamine in the

brain. In contrast to the situation with Parkinson's disease, in which administration of L-dopa seemed to work by increasing dopamine in the brain, the antipsychotic drugs such as thorazine, which are used to treat schizophrenia, seemed to work by blocking the action of dopamine in the brain. To this very day, medications that block the effects of dopamine remain the mainstay of treatment for schizophrenia. Dr. Carlsson's work was instrumental in establishing the biological foundation of mental illness, which has led to our ability to target treatment of such disorders with medications based on their specific biochemical cause.

Dr. Greengard carried this line of work one step further, examining exactly how such neurotransmitters work as they transfer nerve impulses from one nerve cell to another through the connecting region called the synapse. He described in detail the cascade of chemical reactions that occurs as the neurotransmitter chemicals stimulate the next nerve cell in the nerve pathway, which results in conversion of the nerve impulse back into an electrical signal. Particularly important was the discovery of the different speeds at which these nerve signals are transmitted across the synapse. This framework enabled him to establish, on a molecular and biochemical level, the mechanism of action of various drugs that act on the central nervous system.

Finally, Dr. Kandel expanded the context of this research area by showing how such complex processes as memory and learning are directly related to the basic biochemical foundations outlined by Drs. Greengard, Carlsson, and Axelrod. In detailed studies in animals, Dr. Kandel showed that the process of memory was associated with specific changes in the shape and functioning of the synapse region that connects pairs of nerve cells. This research revealed that these connections between nerve cells, rather than being just passive junctions, are actually vitally important in the complicated processes of the nervous system.

The brain could be said to be the ultimate human frontier. As scientists pieced together the function of all the other organs in the body over the last few centuries, the brain remained an enigma. The work of Drs. Axelrod, Carlsson, Greengard, and Kandel starts to clear away some of the mystery that surrounds the brain, and this research has already led to practical, clinical advances to help millions of people with neurological and mental disorders such as Parkinson's disease and schizophrenia. This basic understanding of how the brain works is clearly necessary for understanding of the numerous brain disorders that affect many more millions of people worldwide, some of which are just starting to be elucidated. Moreover, these pioneering studies have opened the door to the development of targeted medications to treat such illnesses. I am particularly excited about the possibility that this research will unlock the key to the medical treatment of substance abuse disorders, whose social impact in our country is enormous. On behalf of the many people who stand to live longer and more fulfilling lives as a result of their discoveries, I extend my deepest congratulations to these esteemed Nobel laureates.

LOCAL LAW ENFORCEMENT ACT OF 2001

Mr. SMITH of Oregon. Mr. President, I rise today to speak about hate crimes legislation I introduced with Senator KENNEDY in March of this year. The Local law Enforcement Act of 2001 would add new categories to current hate crimes legislation sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred June 2, 1999 in Greenfield, MA. Jonathan Shapiro, 18, and Matthew Rogers, 20, used a pocketknife to cut an anti-gay slur into the back of a high school classmate.

Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act of 2001 is now a symbol that can become substance. I believe that by passing this legislation, we can change hearts and minds as well.

UNITED NATIONS CONFERENCE ON THE ILLICIT TRADE IN SMALL ARMS AND LIGHT WEAPONS IN ALL ITS ASPECTS

Mrs. FEINSTEIN. Mr. President, today in New York the United Nations convened the conference on the Illicit Trade in Small Arms and Light Weapons in All its Aspects, the first effort by the U.N. to address the pressing issue of small arms trafficking.

The mass proliferation of small arms—shoulder-mounted missiles, assault weapons, grenade launchers, high-powered sniper rifles and other tools of death—is fueling civil wars, terrorism and the international drug trade throughout the world.

The grimmest figures come from developing countries where light, cheap and easy to use small arms and light weapons, such as AK–47s and similar military assault rifles, have become the weapons of choice of narco-traffickers, terrorists and insurgents.

The problem is staggering: An estimated 500 million illicit small arms and light weapons are in circulation around the globe, and in the past decade four million people have been killed by them in civil war and bloody fighting.

Nine out of 10 of these deaths are attributed to small arms and light weapons. According to the International Committee of the Red Cross, more than 50 percent of those killed are believed to be civilians.

Starting today, the United Nations will host a conference on the Illicit Trade in Small Arms and Light Weapons in All its Aspects. At this conference, the U.N., for the first time, will seek to devise international standards and procedures for curtailing small arms trafficking. It is an issue of extreme importance to the United States. Not only because of the violence and devastation itself, but because of the threat these weapons pose to our political, economic and security interests.

The volume of weaponry has fueled cycles of violence and been a major factor in the devastation witnessed in recent conflicts in Africa, the Balkans, and South Asia, among other places. These conflicts undermine regional stability and endanger the spread of democracy and free-markets around the world. Here are a few examples.

In Mexico a lethal flow of guns south from the United States has fed that nation's drug war. Hundreds of thousands of weapons over the last decade have flooded into Mexico from the United States. Authorities recently traced a sale of 80 Chinese assault weapons from a San Diego gunshop to a Tijuana weapons dealer for $27,000. Many of these ended up in the hands of the Arellano Felix drug cartel and are believed responsible for at least 21 deaths, including two infants, six children and a pregnant 17- year-old girl shot and killed during a mass murder at Rancho el Rodeo in September 1998.

In Albania more than 650,000 weapons and 20,000 tons of explosives disappeared from government depots in the three years leading up to the outbreak of violence in the Balkans, according to the U.N. The continued presence of the weapons poses a very real threat to NATO and U.S. peacekeepers in the region.

And in Colombia, the continued instability is in part due to the torrential flow of rifles and pistols to rebel groups and drug gangs who have used the imported weapons to murder judges, journalists, police officers, as well as innocent passers-by.

The increased access by terrorists, guerrilla groups, criminals, and others to small arms and light weapons puts in jeopardy U.S. law enforcement efforts, business people based or traveling overseas, and even U.S. tourists.

In approaching the United Nations Conference, it is critical that the U.S. government negotiate and support making the trafficking of small arms traceable and eliminate the secrecy that permits thousands of weapons to fuel crime and war without anyone's knowledge of their source.

It is my hope the United Nations will move to create international procedures to control the proliferation of small arms and light weapons. The United States has some of the strongest arms export controls in the world, and it is in the U.S. interest to see that those standards are equaled by the world community.

In addition, the United States has a moral responsibility to push for the development of measures that stop weapons from winding up in the hands of abusive government forces, terrorists and drug-traffickers.

Specifically, the U.S. Government should champion a conference program of action that mandates countries' early negotiations on legally binding procedures: a Framework Convention on International Arms Transfers that sets out export criteria based on countries' current obligations under international law; and an International Agreement on Marking and Tracing that develops systems for adequate and reliable marking of arms at manufacture and import and record-keeping on arms production, possession and transfer.

The Program of Action must also include the establishment of regional and international transparency mechanisms and concrete steps to achieve improved implementation and enforcement of arms embargoes.

United States leadership should ensure that the conference is the first step, not the last, in the international community's efforts to control the spread of small arms and light weapons.

Mr. SESSIONS. Mr. President, several people who opposed the nomination of Theodore B. Olson to be Solicitor General made charges that contained serious factual errors. These are not, I believe, debatable questions of interpretation when the facts are carefully examined. We have had our bipartisan investigation and hearing, and we have confirmed Mr. Olson, and we should move on; but we owe it to Mr. Olson, to future nominees, and to the Senate as an institution to make sure that the record is correct.

Before turning to some specific errors, I want to emphasize that Mr. Olson responded to all of the committee's questions. Mr. Olson is one of the Nation's most talented lawyers and most dedicated public servants. He completed our questionnaire; he answered the questions asked at the hearing; he responded to more than one hundred written follow-up questions; and he repeatedly offered to meet with any Senator who had any further questions. He was clear, he was candid, he was responsive. Indeed, every thing that critics suggest Mr. Olson tried to hide, Mr. Olson in fact volunteered to the Committee, either in his response to the committee's questionnaire or in his responses to our questions.

One inaccurate claim was that Mr. Olson engaged in word games in his answers about the American Spectator's ''Arkansas Project.'' In fact, at the committee hearing, it was clear that the committee and Mr. Olson had a shared understanding of that phrase, and Mr. Olson's answers expressly responded within that framework. The questions specifically characterized the ''Arkansas Project'' as involving only the project pursuant to which ''Richard Mellon Scaife funneled money through the American Spectator'' to investigate the Clintons. Those were the words used in the question, and Mr. Olson adopted those words in his answers. There is no indication that any Senator, or Mr. Olson, intended the term ''Arkansas Project'' to refer to anything other than the Scaife-funded journalistic efforts to investigate the Clintons' history in Arkansas.

Thus, there were no word games by Mr. Olson. It is Mr. Olson's critics who played word games, by retroactively changing the meaning of the ''Arkansas Project'' to embrace essentially every Clinton-related article published or even considered by the American Spectator magazine in the 1990s. That was not the way the committee or Mr. Olson used that term at the hearing, and it is wrong and unfair to suggest otherwise.

At the very least, if any Senator was somehow personally uncertain what Mr. Olson intended when he was answering questions concerning the ''Arkansas Project,'' that Senator could have followed up at the hearing. No Senator did.

Second, some have argued that Mr. Olson improperly attempted to minimize his role in the so-called ''Arkansas Project'' during his confirmation hearing. The charges include allegations that only belatedly did Mr. Olson ''admit'' that he and his firm provided legal services to the American Spectator, that he had discussions in social settings with those working on Arkansas Project matters, and that he himself authored articles for the magazine paid for out of the special Richard Mellon Scaife fund.

Each of these allegations, however, is contradicted by the factual record. Mr. Olson consistently stated that he and others at his law firm performed legal services for the American Spectator beginning in 1994, that they billed the magazine for those services at their normal market rates, and that the magazine paid them only for the legal services actually performed. Indeed, that Mr. Olson's firm provided legal services to the American Spectator has been widely known and a matter of public record for several years. It is not something that he ''admitted'' under close questioning. Those legal services—involving such things as book contracts and employee disputes—were not ''in connection with'' the ''Arkansas Project,'' and any suggestion to the contrary, based on the record as I know it, is wrong as a matter of fact.

As for Mr. Olson's presence in social settings with individuals associated with the ''Arkansas Project,'' the questions were asked and Mr. Olson never made any attempt to conceal or minimize his attendance at those social events. He stated that he was unaware of any discussions at those events concerning the Scaife-funded efforts to investigate Clinton scandals, and no one has contradicted that testimony. Indeed, every knowledgeable individual—including one of Mr. Olson's chief critics—has confirmed that testimony. I also understand that journalists employed by other magazines and newspapers—competitors of the American Spectator—and a wide range of other persons also attended those social events. Thus, they also had discussions ''in social settings'' with those working on Arkansas Project matters, but no responsible person would assert that their attendance at those events made them participants in the American Spectator's ''Arkansas Project.''

Mr. Olson also testified during his hearing about his authorship and coauthorship of several articles critical of the Clintons and other public officials. Indeed, he voluntarily provided copies of those American Spectator articles to the Judiciary Committee in his response to the committee's standard questionnaire, well in advance of his confirmation hearing. It is simply not correct, as a matter of fact, to suggest that he only ''admitted'' his authorship of the articles after the committee hearing.

As to the American Spectator's internal bookkeeping for its payments to Mr. Olson or his law firm, it seems plain that Mr. Olson had no way of knowing how the Spectator categorized those payments for its own purposes, any more than taxpayers will know from the face of the check to what internal account the Government will charge the rebate checks flowing from President Bush's tax cut. Mr. Olson said that he never even saw the checks which were sent to his law firm's headquarters in Los Angeles in payment of routine client billings. All of this is in the record.

There was no ''expansion'' or change in Mr. Olson's testimony on the foregoing points over the last several weeks. It is similarly inaccurate to say, as some critics do, that Mr. Olson ''modified'' his answers, ''changed'' his recollections, or ''conceded'' additional knowledge. To a remarkable degree, Mr. Olson has clearly and consistently answered the questions we asked him. His testimony, moreover, has been fully confirmed by the individuals most closely associated with the ''Arkansas Project,'' including the editor-in-chief, editor, and publisher of the American Spectator magazine during the relevant time period, as well as the three individuals who primarily performed the investigative journalism funded by the ''Arkansas Project.'' Each of these individuals stepped forward voluntarily to confirm the accuracy of Mr. Olson's testimony. Indeed, there is no one with percipient knowledge of these events who has contradicted Mr. Olson.

Third, some mistakenly attempt to create a conflict in Mr. Olson's testimony by confusing the amounts he was paid for writing articles for the American Spectator with the very different amounts that Mr. Olson's law firm received for providing legal services to the American Spectator over a span of

many years. Mr. Olson told the Senate that he was paid from $500 to $1,000 for his articles that appeared in the American Spectator magazine, whereas his firm received $94,405 for legal services.

The attempt to create a conflict on this issue requires mixing apples with oranges. There were two different types of payments, for different types of services. In his April 19 answers, Mr. Olson explained that in addition to the $500 to $1,000 fees he received for the articles, his law firm ''has received payments for legal services rendered to the [American Spectator] Foundation from time to time, by me and by others at the firm, at our normal market rates.'' Given that those legal fees were for legal services provided to the magazine over a period of more than 5 years, involving the work of several attorneys, the $94,405 figure is in no way surprising. More significantly, Mr. Olson at all times distinguished between the firm's legal fees, and the separate, comparatively modest amounts he received personally for writing articles for the magazine. It is, again, a factual mistake to suggest that he ever sought to confuse those two amounts.

Fourth, some have criticized Mr. Olson for allegedly refusing to respond to an allegation about American Spectator dinner parties. I question whether the Senate should even get into this issue of who attended what dinner parties, given the absence of any serious issue here, and the freedom of speech and press values inherent in a magazine's activities. But this particular allegation was dubious and made by a source who publicly contradicted himself on this very allegation. The allegation appeared only in the pages of the Washington Post. No Senator asked Mr. Olson about that particular allegation, and we have never imposed on nominees of either party an obligation to track down and respond to every farfetched or baseless charge that might find its way into print. Moreover, one member of the committee did make an inquiry about Mr. Olson's social contacts with employees of the American Spectator and Mr. Olson fully answered that question in writing. So it is factually incorrect to state that he refused to respond to that question.

Fifth, Mr. Olson's statement that his legal services for the American Spectator magazine were not for the purpose of conducting investigations of the Clintons is allegedly contradicted by the fact that Mr. Olson's firm was compensated for legal research to prepare a chart outlining the Clintons' criminal exposure, as research for a February 1994 article Mr. Olson co-authored entitled, 'Criminal Laws Implicated by the Clinton Scandals: A Partial List.' This charge again is contradicted by record facts. The 1994 engagement letter for Mr. Olson's professional services expressly provided that Mr. Olson and his firm were not engaged ''to do any independent factual research.'' In fact, there is nothing in the public record to suggest that Mr. Olson's work in connection with that article, or for the magazine at any time, involved factual investigation of the Clintons. Comparing the publicly-available applicable Federal criminal code provisions, to publicly-available newspaper stories concerning allegations regarding the Clintons, cannot be described as an ''investigation'' of the Clintons.

While there were other factual inaccuracies in the attacks on Mr. Olson, this list demonstrates that the concerns raised regarding Mr. Olson's candor before the Judiciary Committee were unjustified.

It is particularly noteworthy that Robert Bennett, one of the most notable lawyers in this country and counsel to then-President Clinton, rejected the claim that Mr. Olson was less than candid in his responses to the Senate Judiciary Committee. More than almost any other person, he knows that facts of the Clinton matters. During an interview with Wolf Blitzer on CNN on May 22, Mr. Bennett stated: ''I have recently read [Mr. Olson's] responses to the Senate, and I have looked at a lot of the material, and if I were voting, I would say that Ted Olson was more than candid with the Senate.'' Mr. Bennett is independent; he had no partisan axe to grind in favor of Mr. Olson in connection with this nomination; he, in fact, was a lead counsel for President Clinton for several years; he was not maneuvering for advantage in future nomination battles; he is a lawyer experienced in weighing evidence and cross-examining witnesses; he looked at the evidence; and his conclusion that these allegations are ill-founded is worthy of our respect.

I agree wholeheartedly with Mr. Bennett. I too have reviewed Mr. Olson's statements before the committee regarding his role in the ''Arkansas Project,'' and I find Mr. Olson's statements to be clear and accurate.

The Washington Post editorial board also shares this view. On May 18, after all of the questions regarding the ''Arkansas Project'' had been raised, the Washington Post endorsed Mr. Olson's nomination to be Solicitor General, noting ''Mr. Olson is one of Washington's most talented and successful appellate lawyers, a man who served with distinction in the Justice Department during the 1980s and whose work is widely admired across party lines.'' According to the Washington Post, ''Mr. Olson's prior service at the Justice Department indicates that he understands the difference between the roles of private citizen and public servant.'' As for Mr. Olson's testimony regarding his role in the ''Arkansas Project,'' the Washington Post concluded that ''*there's no evidence that his testimony was inaccurate in any significant way*,'' and that ''the Democrats would be wrong to block Mr. Olson.'' [Emphasis added.]

The Senate thus far has not done a good job of reviewing President Bush's nominees, and in many cases has made upstanding individuals the victims of partisan attacks. The deeply partisan vote over the Solicitor Generalship was a low point. I strongly believe that every nominee deserves fairness in this process and a full chance to get his or her position into the record and considered. It is not right to leave the record incomplete. I hope that, by setting the record straight, the Senate can move on and treat future nominees more fairly.

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business Friday, July 6, 2001, the Federal debt stood at $5,710,979,327,576.62, five trillion, seven hundred ten billion, nine hundred seventy-nine million, three hundred twenty-seven thousand, five hundred seventy-six dollars and sixty-two cents.

One year ago, July 6, 2000, the Federal debt stood at $5,665,885,000,000, five trillion, six hundred sixty-five billion, eight hundred eighty-five million.

Twenty-five years ago, July 6, 1976, the Federal debt stood at $613,075,000,000, six hundred thirteen billion, seventy-five million, which reflects a debt increase of more than $5 trillion, $5,097,904,327,576.62, five trillion, ninety-seven billion, nine hundred four million, three hundred twenty-seven thousand, five hundred seventy-six dollars and sixty-two cents during the past 25 years.

ADDITIONAL STATEMENTS

IN RECOGNITION OF REVEREND HURLEY J. COLEMAN SR.

• Mr. LEVIN. Mr. President, today I acknowledge the life and accomplishments of a distinguished and principled public servant who served as a minister in my home State of Michigan, Reverend Hurley J. Coleman Sr. Today, people will be gathering in Saginaw, MI, to pay tribute to and celebrate the life of a man who for nearly five decades, served as a leader, spiritual mentor and role model in his community.

Throughout his life, Reverend Coleman dedicated himself to serving his family, his church and his God. The esteem in which he was held by all who knew him is due to the fact that Pastor Coleman's life was a powerful testimony to the message he preached weekly at Coleman Temple Church of God in Christ.

Considered one of the deans of the Saginaw clergy, Pastor Coleman's career had a humble beginning. Licensed as a minister in the Church of God in Christ in 1953, Pastor Coleman's first congregation gathered for worship in his home. A short four years after the inception of this congregation, they broke ground for a new church. This facility now serves over 300 members—an amazing number considering that the Pastor's first congregation included only six members.

During his tenure as pastor, Hurley Coleman played a pivotal role in the struggle for racial equality and other civil rights causes. In these efforts, he has been able to unite people of different races and denominations around the common goal of improving life for all people.

I believe that nothing bears witness to the depth and integrity of Pastor Coleman's ministry and life more than his family. Pastor Coleman and his wife Martha were married for 51 years. During this time they served the community and were able to raise 10 children. These children: Hurlette Dickens, Hurley Jr., Charles, Ritchie, Ronnie, E. Yvonne Lewis, Myra Williams, Elaine Bonner, Evelyn Yeager and Edna Coleman, are pillars in their community who have followed their parent's example of service to others.

The vitality and strength of our Nation is due, in a large part, to the dedication and efforts of individuals like the Reverend Hurley J. Coleman Sr. Reverend Coleman and his wife were a dedicated couple whose love for one another and their family touched the entire community that they tirelessly sought to serve. I am sure that my Senate colleagues will join me in honoring the memory of the Reverend Hurley J. Coleman Sr., and in wishing his family well in the years ahead.●

TRIBUTE TO ANGELA PEREZ BARAQUIO

● Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to Angela Perez Baraquio of Honolulu, HI, on being named as Miss America 2001.

Angela received a BA in education from the University of Hawaii, Manoa, and earned academic awards in college including: University Dean's List, Golden Key National Honor Society Member, 1998–1999, Donna Mercado Kim Academic Scholarship, Sibyl Nyborg Haide Student Teaching Grant and Evelyn Siu Foo Scholarship in Elementary Education.

Angela is a K–3rd grade physical education teacher and 5th-8th grade coach and athletic director at Holy Family Catholic Academy. She is active in her local community as Choir Director at St. Augustine by the Sea Catholic Church in Waikiki.

Her platform, Character in the Classroom: Teaching Values, Valuing Teachers, recognizes the important contributions that teachers make in our country and encourages the adoption of character development programs in schools throughout the United States. Angela aspires to complete a Master's degree in Education to accomplish her platform goals.

Angela is visiting New Hampshire for the first time on July 11, 2001. She has been invited by the University of New Hampshire to be a keynote speaker at ''New Hampshire Celebrates Team Nutrition Day.'' The special event held during the University of New Hampshire's 2-week institute for school professionals recognizes the efforts of administrators and teachers who develop programs that provide nutritional and fitness instruction for the youth of the state. Now in its fifth year, the institute is the only one of its kind in the United States.

The Miss America Organization is one of the Nation's leading achievement programs and the world's largest provider of scholarships for young women. The Miss American Organization provides young women with the opportunity to grow personally and professionally while instilling a spirit of community service through a variety of community-based programs.

As a former schoolteacher, I commend Angela for her selfless dedication to the education of the young people of Hawaii and our country. I wish her well as she continues her education and continues to enrich the lives of the children in Hawaii.●

WESTMINSTER CHRISTIAN ACADEMY

● Mr. BOND. Mr. President, I rise to recognize Westminster Christian Academy in St. Louis on winning the Region 3 award at the We the People . . . The Citizen and the Constitution national finals held on April 21–23, 2001.

This award is presented to the school in each of five geographic regions with the highest cumulative score during the national finals. The students of Westminster Christian Academy competed against 49 classes throughout the Nation. They demonstrated a remarkable understanding of the fundamental ideas and values of American constitutional Government.

I had the pleasure to meet with this group of outstanding students during their visit in April, and I am pleased to congratulate them and their teacher Mr. Ken Boesch on such a fine accomplishment. I also congratulate Westminster Christian Academy as well, for proving to be a model school that has installed an example that should be followed by schools throughout the nation. Through hard work, dedication, and discipline they have surpassed the medium.●

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. HUTCHINSON (for himself and Mr. DURBIN):

S. Con. Res. 59. A concurrent resolution expressing the sense of Congress that there should be established a National Community Health Center Week to raise awareness of health services provided by community, migrant, public housing, and homeless health centers; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 258

At the request of Ms. SNOWE, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 258, a bill to amend title XVIII of the Social Security Act to provide for coverage under the medicare program of annual screening pap smear and screening pelvic exams.

S. 281

At the request of Mr. HAGEL, the name of the Senator from Wisconsin (Mr. KOHL) was added as a cosponsor of S. 281, a bill to authorize the design and construction of a temporary education center at the Vietnam Veterans Memorial.

S. 326

At the request of Ms. COLLINS, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 326, a bill to amend title XVIII of the Social Security Act to eliminate the 15 percent reduction in payment rates under the prospective payment system for home health services and to permanently increase payments for such services that are furnished in rural areas.

S. 392

At the request of Mr. SARBANES, the names of the Senator from Connecticut (Mr. LIEBERMAN) and the Senator from Alabama (Mr. SESSIONS) were added as cosponsors of S. 392, a bill to grant a Federal Charter to Korean War Veterans Association, Incorporated, and for other purposes.

S. 452

At the request of Mr. MURKOWSKI, the name of the Senator from Virginia (Mr. ALLEN) was added as a cosponsor of S. 452, a bill to amend title XVIII of the Social Security Act to ensure that the Secretary of Health and Human Services provides appropriate guidance to physicians, providers of services, and ambulance providers that are attempting to properly submit claims under the medicare program to ensure that the Secretary does not target inadvertent billing errors.

S. 543

At the request of Mr. DOMENICI, the name of the Senator from New Mexico (Mr. BINGAMAN) was added as a cosponsor of S. 543, a bill to provide for equal coverage of mental health benefits with respect to health insurance coverage unless comparable limitations are imposed on medical and surgical benefits.

S. 583

At the request of Mr. KENNEDY, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 583, a bill to amend the Food Stamp Act of 1977 to improve nutrition assistance for working families and the elderly, and for other purposes.

S. 588

At the request of Mr. SCHUMER, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 588, a bill to reduce acid

deposition under the Clean Air Act, and for other purposes.

S. 657

At the request of Mr. LUGAR, the name of the Senator from Kentucky (Mr. BUNNING) was added as a cosponsor of S. 657, a bill to authorize funding for the National 4–H Program Centennial Initiative.

S. 661

At the request of Mr. BREAUX, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 661, a bill to amend the Internal Revenue Code of 1986 to repeal the 4.3-cent motor fuel exercise taxes on railroads and inland waterway transportation which remain in the general fund of the Treasury.

S. 690

At the request of Mr. WELLSTONE, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 690, a bill to amend title XVIII of the Social Security Act to expand and improve coverage of mental health services under the medicare program.

S. 754

At the request of Mr. LEAHY, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. 754, a bill to enhance competition for prescription drugs by increasing the ability of the Department of Justice and Federal Trade Commission to enforce existing antitrust laws regarding brand name drugs and generic drugs.

S. 804

At the request of Mrs. FEINSTEIN, the names of the Senator from Rhode Island (Mr. CHAFEE) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. 804, a bill to amend title 49, United States Code, to require phased increases in the fuel efficiency standards applicable to light trucks; to required fuel economy standards for automobiles up to 10,000 pounds gross vehicle weight; to raise the fuel economy of the Federal fleet of vehicles, and for other purposes.

S. 913

At the request of Ms. SNOWE, the names of the Senator from South Dakota (Mr. JOHNSON) and the Senator from Massachusetts (Mr. KENNEDY) were added as cosponsors of S. 913, a bill to amend title XVIII of the Social Security Act to provide for coverage under the medicare program of all oral anticancer drugs.

S. 1025

At the request of Mr. LIEBERMAN, the name of the Senator from Pennsylvania (Mr. SANTORUM) was added as a cosponsor of S. 1025, a bill to provide for savings for working families.

S. 1078

At the request of Mr. LEVIN, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 1078, a bill to promote brownfields redevelopment in urban and rural areas and spur community revitalization in low-income and moderate-income neighborhoods.

S. 1079

At the request of Mr. LEVIN, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 1079, a bill to amend the Public Works and Economic Development Act of 1965 to provide assistance to communities for the redevelopment of brownfield sites.

S. 1095

At the request of Mr. THOMPSON, the names of the Senator from Nebraska (Mr. HAGEL) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of S. 1095, a bill to amend title 38, United States Code, to restore promised GI Bill educational benefits to Vietnam era veterans, and for other purposes.

S. 1153

At the request of Mr. CRAIG, the name of the Senator from Wyoming (Mr. THOMAS) was added as a cosponsor of S. 1153, a bill to amend the Food Security Act of 1985 to establish a grassland reserve program to assist owners in restoring and protecting grassland.

S. RES. 61

At the request of Mr. HUTCHINSON, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. Res. 61, a resolution expressing the sense of the Senate that the Secretary of Veterans Affairs should recognize board certifications from the American Association of Physician Specialists, Inc., for purposes of the payment of special pay by the Veterans Health Administration.

S. RES. 71

At the request of Mr. HARKIN, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. Res. 71, a resolution expressing the sense of the Senate regarding the need to preserve six day mail delivery.

S. RES. 72

At the request of Mr. SPECTER, the name of the Senator from Alaska (Mr. STEVENS) was added as a cosponsor of S. Res. 72, a resolution designating the month of April as ''National Sexual Assault Awareness Month.''

S. RES. 119

At the request of Mr. BAYH, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. Res. 119, a resolution combating the Global AIDS pandemic.

S. CON. RES. 3

At the request of Mr. FEINGOLD, the names of the Senator from Illinois (Mr. DURBIN) and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of S. Con. Res. 3, a concurrent resolution expressing the sense of Congress that a commemorative postage stamp should be issued in honor of the U.S.S. *Wisconsin* and all those who served aboard her.

S. CON. RES. 45

At the request of Mr. FITZGERALD, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. Con. Res. 45, a concurrent resolution expressing the sense of Congress that the Humane Methods of Slaughter Act of 1958 should be fully enforced so as to prevent needless suffering of animals.

S. CON. RES. 53

At the request of Mr. HAGEL, the names of the Senator from Delaware (Mr. BIDEN) and the Senator from California (Mrs. BOXER) were added as cosponsors of S. Con. Res. 53, concurrent resolution encouraging the development of strategies to reduce hunger and poverty, and to promote free market economies and democratic institutions, in sub-Saharan Africa.

SUBMITTED RESOLUTIONS

SENATE CONCURRENT RESOLUTION 59—EXPRESSING THE SENSE OF CONGRESS THAT THERE SHOULD BE ESTABLISHED A NATIONAL COMMUNITY HEALTH CENTER WEEK TO RAISE AWARENESS OF HEALTH SERVICES PROVIDED BY COMMUNITY, MIGRANT, PUBLIC HOUSING, AND HOMELESS HEALTH CENTERS

Mr. HUTCHINSON (for himself and Mr. DURBIN) submitted the following concurrent resolution; which was referred to the Committee on the Judiciary:

S. CON. RES. 59

Whereas community, migrant, public housing, and homeless health centers are nonprofit and community owned and operated health providers that are vital to the Nation's communities;

Whereas there are more than 1,029 of these health centers serving nearly 12,000,000 people at 3,200 health delivery sites, spanning urban and rural communities in the 50 States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands;

Whereas these health centers have provided cost-effective, quality health care to the Nation's poor and medically underserved, including the working poor, the uninsured, and many high-risk and vulnerable populations;

Whereas these health centers act as a vital safety net in the Nation's health delivery system, meeting escalating health needs and reducing health disparities;

Whereas these health centers provide care to 1 of every 9 uninsured Americans, 1 of every 8 low-income Americans, and 1 of every 10 rural Americans, who would otherwise lack access to health care;

Whereas these health centers, and other innovative programs in primary and preventive care, reach out to 600,000 homeless persons and more than 650,000 farm workers;

Whereas these health centers make health care responsive and cost-effective by integrating the delivery of primary care with aggressive outreach, patient education, translation, and enabling support services;

Whereas these health centers increase the use of preventive health services such as immunizations, Pap smears, mammograms, and glaucoma screenings;

Whereas in communities served by these health centers, infant mortality rates have been reduced between 10 and 40 percent;

Whereas these health centers are built by community initiative;

Whereas Federal grants provide seed money empowering communities to find partners and resources and to recruit doctors and health professionals;

Whereas Federal grants, on average, contribute 28 percent of these health centers' budgets, with the remainder provided by State and local governments, Medicare, Medicaid, private contributions, private insurance, and patient fees;

Whereas these health centers are community oriented and patient focused;

Whereas these health centers tailor their services to fit the special needs and priorities of communities, working together with schools, businesses, churches, community organizations, foundations, and State and local governments;

Whereas these health centers contribute to the health and well-being of their communities by keeping children healthy and in school and helping adults remain productive and on the job;

Whereas these health centers engage citizen participation and provide jobs for 50,000 community residents; and

Whereas the establishment of a National Community Health Center Week for the week beginning August 19, 2001, would raise awareness of the health services provided by these health centers: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That it is the sense of Congress that—

(1) there should be established a National Community Health Center Week to raise awareness of health services provided by community, migrant, public housing, and homeless health centers; and

(2) the President should issue a proclamation calling on the people of the United States and interested organizations to observe such a week with appropriate programs and activities.

AMENDMENTS SUBMITTED AND PROPOSED

SA 861. Mr. BYRD (for himself and Mr. STEVENS) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes.

SA 862. Mr. REID (for Mr. SCHUMER (for himself, Mr. REED, Mr. DODD, Mr. LIEBERMAN, Mr. CORZINE, and Mr. REID)) proposed an amendment to the bill S. 1077, supra.

SA 863. Mr. REID (for Mr. FEINGOLD) proposed an amendment to the bill S. 1077, supra.

SA 864. Mr. CRAIG (for Mr. ROBERTS (for himself, Mr. CLELAND, Mr. CRAIG, Mr. MILLER, Mr. CRAPO, and Mr. BROWNBACK)) proposed an amendment to the bill S. 1077, supra.

SA 865. Mr. VOINOVICH (for himself, Mr. HELMS, Mr. SESSIONS, and Mr. CRAPO) proposed an amendment to the bill S. 1077, supra.

SA 866. Mr. BYRD (for Mr. CONRAD) proposed an amendment to amendment SA 865 proposed by Mr. VOINOVICH to the bill (S. 1077) supra.

SA 867. Mr. CONRAD proposed an amendment to the bill S. 1077, supra.

SA 868. Mr. STEVENS (for Mr. MCCAIN (for himself, Mr. LIEBERMAN, and Ms. LANDRIEU)) proposed an amendment to the bill S. 1077, supra.

SA 869. Mr. STEVENS (for Mr. MCCAIN (for himself, Mr. LIEBERMAN, and Ms. LANDRIEU)) proposed an amendment to the bill S. 1077, supra.

SA 870. Mr. STEVENS (for Mr. HUTCHINSON) proposed an amendment to the bill S. 1077, supra.

SA 871. Mr. STEVENS (for Mr. CRAIG) proposed an amendment to the bill S. 1077, supra.

SA 872. Mr. BOND (for himself and Mr. MCCAIN) proposed an amendment to the bill S. 1077, supra.

SA 873. Mr. REID (for Mr. HOLLINGS) proposed an amendment to the bill S. 1077, supra.

SA 874. Mr. REID (for Mr. WELLSTONE) proposed an amendment to the bill S. 1077, supra.

SA 875. Mr. REID (for Mr. JOHNSON) proposed an amendment to the bill S. 1077, supra.

TEXT OF AMENDMENTS

SA 861. Mr. BYRD (for himself and Mr. STEVENS) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

On page 11, after line 8, insert the following:

''SEC. 1207. Of the amounts appropriated in this Act under the heading 'Operation and Maintenance, Army', $8,000,000 shall be available for the purpose of repairing storm damage at Fort Sill, Oklahoma, and Red River Army Depot, Texas.''.

On page 11, after line 8, insert the following:

''SEC. 1208. (a) Of the total amount appropriated under this Act to the Army for operation and maintenance, such amount as may be necessary shall be available for a conveyance by the Secretary of the Army, without consideration, of all right, title, and interest of the United States in and to the firefighting and rescue vehicles described in subsection (b) to the City of Bayonne, New Jersey.

''(b) The firefighting and rescue vehicles referred to in subsection (a) are a rescue hazardous materials truck, a 2,000 gallon per minute pumper, and a 100-foot elevating platform truck, all of which are at Military Ocean Terminal, Bayonne, New Jersey.''.

On page 11, line 15, before the period, insert: '': *Provided,* That funding is authorized for Project 01–D–107, Atlas Relocation and Operations, and Project 01–D–108, Microsystems and Engineering Science Application Complex''.

On page 13, after line 8, insert the following:

''GENERAL PROVISIONS—THIS CHAPTER

''SEC. 1401. (a) In addition to amounts appropriated or otherwise made available elsewhere in the Military Construction Appropriations Act, 2001, and in this Act, the following amounts are hereby appropriated as authorized by section 2854 of title 10, United States Code, as follows for the purpose of repairing storm damage at Ellington Air National Guard Base, Texas, and Fort Sill, Oklahoma:

'' 'Military Construction, Air National Guard', $6,700,000;

'' 'Family Housing, Army', $1,000,000: ''*Provided,* That the funds in this section shall remain available until September 30, 2005.

''(b) Of the funds provided in the Military Construction Appropriations Acts, 2000 and 2001, the following amounts are rescinded:

'' 'Military Construction, Defense-Wide', $6,700,000;

'' 'Family Housing, Army'. $1,000,000.''.

On page 13, after line 8, insert the following:

''SEC. 1402. Notwithstanding any other provision of law, the amount authorized, and authorized to be appropriated, for the Defense Agencies for the TRICARE Management Agency for a military construction project for Bassett Army Hospital at Fort Wainwright, Alaska, shall be $215,000,000.''.

On page 13, after line 12 insert the following:

OFFICE OF THE SECRETARY

For an additional amount for ''Office of the Secretary'', $3,000,000, to remain available until September 30, 2002: *Provided,* That of these funds, no less than $1,000,000 shall be used for enforcement of the Animal Welfare Act: *Provided further,* That of these funds, no less than $1,000,000 shall be used to enhance human slaughter practices under the Federal Meat Inspections Act: *Provided further,* That no more than $500,000 of these funds shall be made available to the Under Secretary for Research, Education and Economics for development and demonstration of technologies to promote the humane treatment of animals: *Provided further,* That these funds may be transferred to and merged with appropriations for agencies performing this work.

On page 14, after line 25, insert the following:

''SEC. 2103. (a) Not later than August 1, 2001, the Federal Crop Insurance Corporation shall promulgate final regulations to carry out section 522(b) of the Federal Crop Insurance Act (7 U.S.C. 522(b)), without regard to:

''(1) the notice and comment provisions of section 553 of title 5, United States Code;

''(2) the Statement of Policy of the Secretary of Agriculture effective July 24, 1971 (36 FR 13804), relating to notices of proposed rulemaking and public participation in rulemaking; and

''(3) chapter 35 of title 44, United States Code (commonly known as the 'Paperwork Reduction Act').

''(b) In carrying out this section, the Corporation shall use the authority provided under section 808 of title 5, United States Code.

''(c) The final regulations promulgated under subsection (a) shall take effect on the date of publication of the final regulations.''.

On page 14, after line 25, insert the following:

SEC. 2104. In addition to amounts otherwise available, $20,000,000 from amounts pursuant to 15 U.S.C. 713a–4 for the Secretary of Agriculture to make available financial assistance related to water conservation to eligible producers in the Klamath Basin, as determined by the Secretary.

On page 14, after line 25 insert the following new section:

SEC. 2105. Under the heading of ''Food Stamp Program'' in Public Law 106–387, the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2001, in the sixth proviso, strike ''$194,000,000'' and insert in lieu thereof ''$191,000,000''.

On page 15, after line 22, strike ''$110,000,000'' and insert ''$114,800,000''.

On page 16, beginning with line 25, strike all through line 4 on page 17.

On page 17, line 5, strike ''2202'' and insert ''2201''.

On page 17, line 24, strike ''2203'' and insert ''2202''.

On page 22, line 13, after ''purposes of D.C. Code, sec. 5–513:'', strike ''*Provided*,'' and insert: ''*Provided*, That the Department shall transfer all local funds resulting from the lapse of personnel vacancies, caused by transferring Department of Consumer and Regulatory Affairs employees into NSO positions without the filling of the resultant vacancies, into the general fund to be used to implement the provisions in DC Bill 13–646, the Abatement and Condemnation of Nuisance Properties Omnibus Amendment Act of 2000, pertaining to the prevention of the

demolition by neglect of historic properties: *Provided further*,''.

On page 28, after line 2, insert the following:

''SEC. 2402. Of the funds provided under the heading 'Power Marketing Administration, Construction, Rehabilitation, Operation and Maintenance, Western Area Power Administration', in Public Law 106–377, not less than $250,000 shall be provided for a study to determine the costs and feasibility of transmission expansion: *Provided*, That these funds shall be non-reimbursable: *Provided further*, That these funds shall be available until expended.''.

On page 29, after line 4, insert the following:

''BUREAU OF LAND MANAGEMENT

''MANAGEMENT OF LANDS AND RESOURCES

''(INCLUDING TRANSFERS OF FUNDS)

''For an additional amount to address increased permitting responsibilities related to energy needs, $3,000,000, to remain available until expended, and to be derived by transfer from unobligated balances available to the Department of the Interior for the acquisition of lands and interests in lands.''.

On page 34, before the colon on line 18, insert the following: '': *Provided further*, That the rescission of funds under section 132(a)(2)(B) is effective at the time the Secretary re-allots excess unexpended balances to the States''.

On page 39, line 22, strike ''PROVISION'' and insert ''PROVISIONS''.

On page 41, line 6 strike ''September 30, 2001'' and insert ''August 4, 2001''.

On page 41, after line 6, insert the following new section:

''SEC. 2702. (a) ESTABLISHMENT OF GRANT PROGRAM.—Section 396 of the Communications Act of 1934 (47 U.S.C. 396) is amended by adding the following new subsection:

'''GRANT ASSISTANCE FOR TRANSITION TO DIGITAL BROADCASTING.

'''(n)(1) The Corporation may, by grant, provide financial assistance to eligible entities for the purpose of supporting the transition of those entities from the use of analog to digital technology for the provision of public broadcasting services.

'''(2) Any ''public broadcasting entity'' as defined in section 397(11) of the Communications Act of 1934 (47 U.S.C. 397(11)) is an entity eligible to receive grants under this subsection.

'''(3) Proceeds of grants awarded under this subsection may be used for costs associated with the transition of public broadcasting stations to assure access to digital broadcasting services, including for the support of digital transmission facilities and for the development, production, and distribution of digital programs and services.

'''(4) The grants shall be distributed to the eligible entities in accordance with principles and criteria established by the Corporation in consultation with the public broadcasting licensees and officials of national organizations representing public broadcasting licensees. The principles and criteria shall include special priority for providing digital broadcast services to:

'''(A) rural or remote areas;

'''(B) areas under-served by public broadcasting stations; and

'''(C) areas where the conversion to, or establishment of primary digital public broadcasting services, is impaired by an insufficient availability of private funding for that purpose by reason of the small size of the population or the low average income of the residents of the area.' ''.

''(b) AUTHORIZATION OF APPROPRIATIONS.—Subsection (k)(1) of section 396 of the Communications Act of 1934 (47 U.S.C. 396) is amended—

''(1) by re-designating subparagraphs (D) and (E) as subparagraphs (E) and (F), respectively; and

''(2) by inserting after subparagraph (C) the following new subparagraph (D):

'''(D) In addition to any amounts authorized under any other provision of this or any other Act to be appropriated to the Fund, funds are hereby authorized to be appropriated to the Fund solely (notwithstanding any other provision of this subsection) for carrying out the purposes of subsection (n) as follows:

'''(i) For fiscal year 2001, $20,000,000 to carry out the purposes of subsection (n);

'''(ii) For fiscal year 2002, such sums as may be necessary to carry out the purposes of subsection (n).' ''.

On page 42, after line 19, insert the following:

''SEC. 2803. Notwithstanding any limitation in 31 U.S.C. sec. 1553(b) and 1554, the Architect of the Capitol may use current year appropriations to reimburse the Department of the Treasury for prior year water and sewer services payments otherwise chargeable to closed accounts.''.

On page 42, after line 25, insert the following:

''ACQUISITION, CONSTRUCTION, AND IMPROVEMENTS

''For an additional amount for 'Acquisition, Construction, and Improvements', $4,000,000, to remain available until expended, for the repair of Coast Guard facilities damaged during the Nisqually earthquake or for costs associated with moving the affected Coast Guard assets to an alternative site within Seattle, Washington.

''FEDERAL AVIATION ADMINISTRATION

''GRANTS-IN-AID FOR AIRPORTS

''(AIRPORT AND AIRWAY TRUST FUND)

''(RESCISSION OF CONTRACT AUTHORIZATION)

''Of the unobligated balances authorized under 49 U.S.C. 48103, as amended, $30,000,000 are rescinded.''.

On page 43, after line 1, insert the following:

''EMERGENCY HIGHWAY RESTORATION

''For the costs associated with the long term restoration or replacement of seismically-vulnerable highways recently damaged during the Nisqually earthquake, $12,800,000, to remain available until expended: *Provided*, That of the amount made available under this head, $3,800,000 shall be for the Alaskan Way Viaduct in Seattle, Washington and $9,000,000 shall be for the Magnolia Bridge in Seattle, Washington.''.

On page 43, at the end of line 6, insert the following: ''Public Law 102–240,''.

On page 43, line 7, strike ''$10,000,000'' and insert ''$14,000,000''.

On page 43, after line 7, insert the following:

''ALASKA RAILROAD COMMISSION

''To enable the Secretary of Transportation to make an additional grant to the Alaska Railroad, $2,000,000 for a joint United States-Canada commission to study the feasibility of connecting the rail system in Alaska to the North American continental rail system.''.

On page 43, after line 24, insert the following:

SEC. 2902. Notwithstanding section 47105(b)(2) of title 49, United States Code or any other provision of law, an application for a project grant under chapter 471 of that title may propose projects at Abbeville Municipal Airport and Akutan Airport, and the Secretary may make project grants for such projects.

SEC. 2903. Hereafter, funds made available under 'Capital Investment Grants' in Public Law 105–277 for item number 15 and for any new fixed guideway system project cited as a 'fixed guideway modernization' project shall not be made available for any other federal transit project.''.

On page 44, between lines 21 and 22, insert the following:

FEDERAL PAYMENT TO MORRIS K. UDALL SCHOLARSHIP AND EXCELLENCE IN NATIONAL ENVIRONMENTAL POLICY FOUNDATION

Of the funds available under this heading in H.R. 5658 of the 106th Congress, as incorporated by reference in Public Law 106–554, $1,000,000 shall be transferred and made available for necessary expenses incurred pursuant to section 6(7) of the Morris K. Udall Scholarship and Excellence in National Environmental and Native American Public Policy Act of 1992 (20 U.S.C. 5604(7)), to remain available until expended.

On page 48, after line 20, insert the following:

SEC. 3003. DESIGNATION OF ENGINEERING AND MANAGEMENT BUILDING AT NORFOLK NAVAL SHIPYARD, VIRGINIA, AFTER NORMAN SISISKY. The engineering and management building (also known as Building 1500) at Norfolk Naval Shipyard, Portsmouth, Virginia, shall be known as the Norman Sisisky Engineering and Management Building. Any reference to that building in any law, regulation, map, document, record, or other paper of the United States shall be considered to be a reference to the Norman Sisisky Engineering and Management Building.

SA 862. Mr. REID (for Mr. SCHUMER (for himself, Mr. REED, Mr. DODD, Mr. LIEBERMAN, Mr. CORZINE, and Mr. REID)) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

On page 44, line 20, strike ''$66,200,000'' and insert ''$32,300,000''.

SA 863. Mr. REID (for Mr. FEINGOLD) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

On page 28, beginning on line 9, strike ''$100,000,000'' and all that follows through line 13, and insert the following: ''$693,000,000, to remain available until expended: *Provided*, That this amount may be made available, notwithstanding any other provision of law, for a United States contribution to a global trust fund to combat HIV/AIDS, malaria, and tuberculosis: *Provided, further*, That the entire amount made available under this heading is designated by the Congress as an emergency requirement pursuant to section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended: *Provided, further*, That the entire amount under this heading shall be available only to the extent that an official budget request for that specific dollar amount that includes the designation of the entire amount of the request as an emergency requirement as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, is transmitted by the President to the Congress: *Provided, further*, That the total amount of the rescission for 'Aircraft Procurement, Navy, 2001/2003' under section 1204 is hereby increased by $594,000,000.''.

SA 864. Mr. CRAIG (for Mr. ROBERTS (for himself, Mr. CLELAND, Mr. MILLER, Mr. CRAPO, and Mr. BROWNBACK)) proposed an amendment to the bill S. 1077,

making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . None of the funds available to the Department of Defense for fiscal year 2001 may be obligated or expended for retiring or dismantling, or for preparing to retire or dismantle, any of the 93 B–1B Lancer bombers in service as of June 1, 2001, or for transferring or reassigning any of those aircraft from the unit, or the facility, to which assigned as of that date.

SA 865. Mr. VOINOVICH (for himself, Mr. HELMS, Mr. SESSIONS, and Mr. CRAPO) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. ___. PROTECT SOCIAL SECURITY SURPLUSES ACT OF 2001.

(a) SHORT TITLE.—This section may be cited as the ''Protect Social Security Surpluses Act of 2001''.

(b) REVISION OF ENFORCING DEFICIT TARGETS.—Section 253 of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 903) is amended—

(1) by striking subsection (b) and inserting the following:

''(b) EXCESS DEFICIT; MARGIN.—The excess deficit is, if greater than zero, the estimated deficit for the budget year, minus the margin for that year. In this subsection, the margin for each fiscal year is 0.5 percent of estimated total outlays for that fiscal year.'';

(2) by striking subsection (c) and inserting the following:

''(c) ELIMINATING EXCESS DEFICIT.—Each non-exempt account shall be reduced by a dollar amount calculated by multiplying the baseline level of sequesterable budgetary resources in that account at that time by the uniform percentage necessary to eliminate an excess deficit.''; and

(3) by striking subsections (g) and (h).

(c) ECONOMIC AND TECHNICAL ASSUMPTIONS.—Notwithstanding section 254(j) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 904(j)), the Office of Management and Budget shall use the economic and technical assumptions underlying the report issued pursuant to section 1106 of title 31, United States Code, for purposes of determining the excess deficit under section 253(b) of the Balanced Budget and Emergency Deficit Control Act of 1985, as added by subsection (b).

(d) APPLICATION OF SEQUESTRATION TO BUDGET ACCOUNTS.—Section 256(k) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 906(k)) is amended by—

(1) striking paragraph (2); and

(2) redesignating paragraphs (3) through (6) as paragraphs (2) through (5), respectively.

(e) STRENGTHENING SOCIAL SECURITY POINTS OF ORDER..—

(1) IN GENERAL.—Section 312 of the Congressional Budget Act of 1974 (2 U.S.C. 643) is amended by inserting at the end the following:

''(g) STRENGTHENING SOCIAL SECURITY POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider a concurrent resolution on the budget (or any amendment thereto or conference report thereon) or any bill, joint resolution, amendment, motion, or conference report that would violate or amend section 13301 of the Budget Enforcement Act of 1990.''.

(2) SUPER MAJORITY REQUIREMENT.—

(A) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(B) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(3) ENFORCEMENT IN EACH FISCAL YEAR.—The Congressional Budget Act of 1974 is amended in—

(A) section 301(a)(7) (2 U.S.C. 632(a)(7)), by striking ''for the fiscal year'' through the period and inserting ''for each fiscal year covered by the resolution''; and

(B) section 311(a)(3) (2 U.S.C. 642(a)(3)), by striking beginning with ''for the first fiscal year'' through the period and insert the following: ''for any of the fiscal years covered by the concurrent resolution.''.

(f) EFFECTIVE DATE.—This section and the amendments made by this section shall apply to fiscal years 2002 through 2006.

SA 866. Mr. BYRD (for Mr. CONRAD) proposed an amendment to amendment SA 865 proposed by Mr. VOINOVICH to the bill (S. 1077) making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

Strike all after the first word and insert the following:

TITLE ___—SOCIAL SECURITY AND MEDICARE OFF-BUDGET LOCKBOX ACT OF 2001

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Social Security and Medicare Off-Budget Lockbox Act of 2001''.

SEC. ___02. STRENGTHENING SOCIAL SECURITY POINTS OF ORDER.

(a) IN GENERAL.—Section 312 of the Congressional Budget Act of 1974 (2 U.S.C. 643) is amended by inserting at the end the following:

''(g) STRENGTHENING SOCIAL SECURITY POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider a concurrent resolution on the budget (or any amendment thereto or conference report thereon) or any bill, joint resolution, amendment, motion, or conference report that would violate or amend section 13301 of the Budget Enforcement Act of 1990.''.

(b) SUPER MAJORITY REQUIREMENT.—

(1) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(2) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(c) ENFORCEMENT IN EACH FISCAL YEAR.—The Congressional Budget Act of 1974 is amended in—

(1) section 301(a)(7) (2 U.S.C. 632(a)(7)), by striking ''for the fiscal year'' through the period and inserting ''for each fiscal year covered by the resolution''; and

(2) section 311(a)(3) (2 U.S.C. 642(a)(3)), by striking beginning with ''for the first fiscal year'' through the period and insert the following: ''for any of the fiscal years covered by the concurrent resolution.''.

SEC. ___03. MEDICARE TRUST FUND OFF-BUDGET.

(a) IN GENERAL.—

(1) GENERAL EXCLUSION FROM ALL BUDGETS.—Title III of the Congressional Budget Act of 1974 is amended by adding at the end the following:

''EXCLUSION OF MEDICARE TRUST FUND FROM ALL BUDGETS

''SEC. 316. (a) EXCLUSION OF MEDICARE TRUST FUND FROM ALL BUDGETS.—Notwithstanding any other provision of law, the receipts and disbursements of the Federal Hospital Insurance Trust Fund shall not be counted as new budget authority, outlays, receipts, or deficit or surplus for purposes of—

''(1) the budget of the United States Government as submitted by the President;

''(2) the congressional budget; or

''(3) the Balanced Budget and Emergency Deficit Control Act of 1985.

''(b) STRENGTHENING MEDICARE POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider a concurrent resolution on the budget (or any amendment thereto or conference report thereon) or any bill, joint resolution, amendment, motion, or conference report that would violate or amend this section.''.

(2) SUPER MAJORITY REQUIREMENT.—

(A) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''316,'' after ''313,''.

(B) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''316,'' after ''313,''.

(b) EXCLUSION OF MEDICARE TRUST FUND FROM CONGRESSIONAL BUDGET.—Section 301(a) of the Congressional Budget Act of 1974 (2 U.S.C. 632(a)) is amended by adding at the end the following: ''The concurrent resolution shall not include the outlays and revenue totals of the Federal Hospital Insurance Trust Fund in the surplus or deficit totals required by this subsection or in any other surplus or deficit totals required by this title.''

(c) BUDGET TOTALS.—Section 301(a) of the Congressional Budget Act of 1974 (2 U.S.C. 632(a)) is amended by inserting after paragraph (7) the following:

''(8) For purposes of Senate enforcement under this title, revenues and outlays of the Federal Hospital Insurance Trust Fund for each fiscal year covered by the budget resolution.''.

(d) BUDGET RESOLUTIONS.—Section 301(i) of the Congressional Budget Act of 1974 (2 U.S.C. 632(i)) is amended by—

(1) striking ''SOCIAL SECURITY POINT OF ORDER.—It shall'' and inserting ''SOCIAL SECURITY AND MEDICARE POINTS OF ORDER.—

''(1) SOCIAL SECURITY.—It shall''; and

(2) inserting at the end the following:

''(2) MEDICARE.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget (or amendment, motion, or conference report on the resolution) that would cause a decrease in surpluses or an increase in deficits of the Federal Hospital Insurance Trust Fund in any of the fiscal years covered by the concurrent resolution.''.

(e) MEDICARE FIREWALL.—Section 311(a) of the Congressional Budget Act of 1974 (2 U.S.C. 642(a)) is amended by adding after paragraph (3), the following:

''(4) ENFORCEMENT OF MEDICARE LEVELS IN THE SENATE.—After a concurrent resolution on the budget is agreed to, it shall not be in order in the Senate to consider any bill, joint resolution, amendment, motion, or conference report that would cause a decrease in surpluses or an increase in deficits of the Federal Hospital Insurance Trust Fund in any year relative to the levels set forth in the applicable resolution.''.

(f) BASELINE TO EXCLUDE HOSPITAL INSURANCE TRUST FUND.—Section 257(b)(3) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking ''shall be included in all'' and inserting ''shall not be included in any''.

(g) MEDICARE TRUST FUND EXEMPT FROM SEQUESTERS.—Section 255(g)(1)(B) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by adding at the end the following:

''Medicare as funded through the Federal Hospital Insurance Trust Fund.''.

(h) BUDGETARY TREATMENT OF HOSPITAL INSURANCE TRUST FUND.—Section 710(a) of the Social Security Act (42 U.S.C. 911(a)) is amended—

(1) by striking ''and'' the second place it appears and inserting a comma; and

(2) by inserting after ''Federal Disability Insurance Trust Fund'' the following: '', Federal Hospital Insurance Trust Fund''.

SEC. ___04. PREVENTING ON-BUDGET DEFICITS.

(a) POINTS OF ORDER TO PREVENT ON-BUDGET DEFICITS.—Section 312 of the Congressional Budget Act of 1974 (2 U.S.C. 643) is amended by adding at the end the following:

''(h) POINTS OF ORDER TO PREVENT ON-BUDGET DEFICITS.—

''(1) CONCURRENT RESOLUTIONS ON THE BUDGET.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget, or conference report thereon or amendment thereto, that would cause or increase an on-budget deficit for any fiscal year.

''(2) SUBSEQUENT LEGISLATION.—It shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, motion, or conference report if—

''(A) the enactment of that bill or resolution as reported;

''(B) the adoption and enactment of that amendment; or

''(C) the enactment of that bill or resolution in the form recommended in that conference report,

would cause or increase an on-budget deficit for any fiscal year.''.

(b) SUPER MAJORITY REQUIREMENT.—

(1) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''312(h),'' after ''312(g),''.

(2) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''312(h),'' after ''312(g),''.

SA 867. Mr. CONRAD proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

On page 47, between lines 20 and 21, insert the following:

COMMUNITY DEVELOPMENT BLOCK GRANTS

For emergency housing for Indians on the Turtle Mountain Indian Reservation, there shall be made available $10,000,000 through the Indian community development block grant program under the Housing and Community Development Act of 1974. Amounts made available for programs administered by the Department of Housing and Urban Development for fiscal year 2001 shall be reduced on a pro rata basis by $10,000,000. The Federal Emergency management Agency shall provide technical assistance to Indians with respect to the acquisition of emergency housing on the Turtle Mountain Indian Reservation.

SA 868. Mr. STEVENS (for Mr. MCCAIN (for himself, Mr. LIEBERMAN, and Ms. LANDRIEU)) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

On page 11, between lines 8 and 9, insert the following:

SEC. 1207. In addition to the amounts appropriated to the Department of Defense for fiscal year 2001 in other provisions of this Act or in the Department of Defense Appropriations Act, 2001 (Public Law 106–259), $2,736,1000 is hereby appropriated, out of any funds in the Treasury not otherwise appropriated, to the Department of Defense for the fiscal year ending September 30, 2001, for purposes under headings in the Department of Defense Appropriations Act, 2001, and in amounts, as follows:

''Military Personnel, Army'', $30,000,000;

''Military Personnel, Navy'', $10,000,000;

''Military Personnel, Air Force'', $332,500,000;

''Reserve Personnel, Army'', $30,000,000;

''Operation and Maintenance, Army'', $916,400,000;

''Operation and Maintenance, Navy'', $514,500,000;

''Operation and Maintenance, Marine Corps'', $295,700,000;

''Operation and Maintenance, Air Force'', $59,600,000;

''Operation and Maintenance, Defense-Wide'', $9,000,000;

''Operation and Maintenance, Army Reserve'', $30,000,000;

''Operation and Maintenance, Army National Guard'', $106,000,000;

''Aircraft Procurement, Army'', $50,000,000, to remain available for obligation until September 30, 2003;

''Procurement of Weapons and Tracked Combat Vehicles, Army'', $10,000,000, to remain available for obligation until September 30, 2003;

''Procurement of Ammunition, Army'', $14,000,000, to remain available for obligation until September 30, 2003;

''Other Procurement, Army'', $40,000,000, to remain available for obligation until September 30, 2003;

''Aircraft Procurement, Navy'', $65,000,000, to remain available for obligation until September 30, 2003;

''Aircraft Procurement, Air Force'', $108,100,000, to remain available for obligation until September 30, 2003;

''Other Procurement, Air Force'', $33,300,000, to remain available for obligation until September 30, 2003;

''Research, Development, Test and Evaluation, Air Force'', $8,000,000, to remain available for obligation until September 30, 2002; and

''USS Cole'', $49,000,000;

Provided, That the entire amount made available in this section is designated by the Congress as an emergency requirement pursuant to section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended: *Provided, further*, That the entire amount under this section shall be available only to the extent that an official budget request for that specific dollar amount that includes the designation of the entire amount of the request as an emergency requirement as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, is transmitted by the President to the Congress.

SA 869. Mr. STEVENS (for Mr. MCCAIN (for himself, Mr. LIEBERMAN, and Ms. LANDRIEU)) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

After section 3002, insert the following:

SEC. 3003. (a) In addition to the amounts appropriated to the Department of Defense for fiscal year 2001 by other provisions of this Act or the Department of Defense Appropriations Act, 2001 (Public Law 106–259), funds are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, to the Department of Defense for the fiscal year ending September 30, 2001, for purposes under headings in the Department of Defense Appropriations Act, 2001, and in amounts, as follows:

(1) Under the heading ''MILITARY PERSONNEL, NAVY'', $181,000,000, of which $1,000,000 shall be available for the supplemental subsistence allowance under section 402a of title 37, United States Code.

(2) Under the heading ''MILITARY PERSONNEL, MARINE CORPS'', $21,000,000.

(3) Under the heading ''RESERVE PERSONNEL, NAVY'', $1,800,000, which shall be available for enhancement of force protection for United States forces in the Persian Gulf region and elsewhere worldwide.

(4) Under the heading ''OPERATION AND MAINTENANCE, ARMY'', $103,000,000.

(5) Under the heading ''OPERATION AND MAINTENANCE, NAVY'', $72,000,000, of which $36,000,000 shall be available for enhancement of force protection for United States forces in the Persian Gulf region and elsewhere worldwide.

(6) Under the heading ''OPERATION AND MAINTENANCE, MARINE CORPS'', $6,000,000.

(7) Under the heading ''OPERATION AND MAINTENANCE, AIR FORCE'', $397,000,000.

(8) Under the heading ''OPERATION AND MAINTENANCE, ARMY RESERVE'', $21,000,000.

(9) Under the heading ''OTHER PROCUREMENT, NAVY'', $45,000,000, to remain available for obligation until September 30, 2003, which shall be available for enhancement of force protection for United States forces in the Persian Gulf region and elsewhere worldwide.

(b) The amount appropriated by chapter 10 of title II to the Department of the Treasury for Departmental Offices under the heading ''SALARIES AND EXPENSES'' is hereby reduced by $30,000,000.

(c) The matter in chapter 11 of title II under the heading ''NATIONAL AERONAUTICS AND SPACE ADMINISTRATION HUMAN SPACE FLIGHT'' shall not take effect.

(RESCISSION)

(d) Of the unobligated balance of the total amount in the Treasury that is to be disbursed from special accounts established pursuant to section 754(e) of the Tariff Act of 1930, $200,000,000 may not be disbursed under that section.

(RESCISSIONS)

(e) The following amounts are hereby rescinded:

(1) Of the funds appropriated to the National Aeronautics and Space Administration under the heading ''HUMAN SPACE FLIGHT'' in the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2001 (as enacted into law by Public Law 106–377), the following amounts:

(A) From the amounts for the life and micro-gravity science mission for the human space flight, $40,000,000.

(B) From the amount for the Electric Auxiliary Power Units for Space Shuttle Safety Upgrades, $19,000,000.

(2) Of the funds appropriated to the Department of Commerce for the National Institute of Standards and Technology under the heading ''INDUSTRIAL TECHNOLOGY SERVICES'' in the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 2001 (as enacted into law by Public Law 106–553), $67,000,000 for the Advanced Technology Program.

(3) Of the funds appropriated to the Department of Commerce for the International Trade Administration under the heading ''OPERATIONS AND ADMINISTRATION'', $19,000,000 of the amount available for Trade Development.

(4) Of the funds appropriated by chapter 1 of the Emergency Steel Loan Guarantee and Emergency Oil and Gas Guaranteed Loan Act of 1999 (Public Law 106–51), $126,800,000.

(5) Of the funds appropriated to the Department of Transportation for the Maritime Administration under the heading ''MARITIME GUARANTEED LOAN (TITLE XI) PROGRAM ACCOUNT'' in the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 2001 (as enacted into law by Public Law 106–553), $21,000,000.

(6) Of the funds appropriated for the Export-Import Bank under the heading ''SUBSIDY APPROPRIATION'' in the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 2001 (as enacted into law by Public Law 106–429), $80,000,000.

(7) Of the funds appropriated to the Department of Labor for the Employment and Training Administration under the heading ''TRAINING AND EMPLOYMENT SERVICES'' in the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2001 (as enacted into law by Public Law 106–554), the following amounts:

(A) From the amounts for Dislocated Worker Employment and Training Activities, $41,500,000.

(B) From the amounts Adult Employment and Training Activities, $100,000,000.

(8) Of the unobligated balance of funds previously appropriated to the Department of Transportation for the Federal Transit Administration that remain available for obligation in fiscal year 2001, the following amounts:

(A) From the amounts for Transit Planning and Research, $34,000,000.

(B) From the amounts for Job Access and Reverse Commute Grants, $76,000,000.

SA 870. Mr. STEVENS (for Mr. HUTCHINSON) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

On page 13, between lines 23 and 24, insert the following:

FOREST SERVICE

STATE AND PRIVATE FORESTRY

For an additional amount for ''State and Private Forestry'' to repair damage caused by ice storms in the States of Arkansas and Oklahoma, $10,000,000, to remain available until expended: *Provided*, That the entire amount is designated by Congress as an emergency requirement under section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901(b)(2)(A)).

NATIONAL FOREST SYSTEM

For an additional amount for the ''National Forest System'' to repair damage caused by ice storms in the States of Arkansas and Oklahoma, $10,000,000, to remain available until expended: *Provided*, That the entire amount is designated by Congress as an emergency requirement under section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901(b)(2)(A)).

CAPITAL IMPROVEMENT AND MAINTENANCE

For an additional amount for ''Capital Improvement and Maintenance'' to repair damage caused by ice storms in the States of Arkansas and Oklahoma, $4,000,000, to remain available until expended: *Provided*, That the entire amount is designated by Congress as an emergency requirement under section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901(b)(2)(A)).

SA 871. Mr. STEVENS (for Mr. CRAIG) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

On page 29, between lines 2 and 3, insert the following:

SEC. 2502. In exercising the authority to provide cash transfer assistance for Israel for the fiscal year ending September 30, 2001, the President shall—

(1) ensure that the level of such assistance does not cause an adverse impact on the total level of non-military exports from the United States to Israel; and

(2) enter into a side letter agreement with Israel providing for the purchase of grain in the same amount and in accordance with terms at least as favorable as the side letter agreement in effect for the fiscal year ending September 30, 2000.

SA 872. Mr. BOND (for himself and Mr. MCCAIN) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

At the end of title III, add the following:

SEC. . (a) In addition to the amounts appropriated to the Department of Defense for fiscal year 2001 by other provisions of this Act or the Department of Defense Appropriations Act, 2001 (Public Law 106–259), funds are hereby appropriated to the Department of Defense for the fiscal year ending September 30, 2001, for purposes under headings in the Department of Defense Appropriations Act, 2001, and in amounts, as follows:

(1) Under the heading ''MILITARY PERSONNEL, MARINE CORPS'', $21,000,000.

(2) Under the heading ''RESERVE PERSONNEL, ARMY'', $30,000,000.

(3) Under the heading ''OPERATION AND MAINTENANCE, ARMY'', $600,000,000.

(4) Under the heading ''OPERATION AND MAINTENANCE, NAVY'', $577,250,000.

(5) Under the heading ''OPERATION AND MAINTENANCE, MARINE CORPS'', $6,000,000.

(6) Under the heading ''OPERATION AND MAINTENANCE, AIR FORCE'', $100,200,000.

(7) Under the heading ''OPERATION AND MAINTENANCE, ARMY RESERVE'', $30,000,000.

(8) Under the heading ''OPERATION AND MAINTENANCE, NAVY RESERVE'', $19,100,000.

(9) Under the heading ''OPERATION AND MAINTENANCE, ARMY NATIONAL GUARD'', $39,400,000.

(b) The total amount appropriated under subsection (a) shall be available only to the extent that an official budget request for that specific dollar amount that includes the designation of the entire amount of the request as an emergency requirement as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, is transmitted by the President to the Congress.

(c) The total amount appropriated under subsection (a) is hereby designated by Congress as an emergency requirement pursuant to section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

(d) All of the funds appropriated and available under this section shall be obligated not later than September 30, 2001.

SA 873. Mr. REID (for Mr. HOLLINGS) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

At the appropriate place, insert the following:

. ENSURING FUNDING FOR DEFENSE AND EDUCATION AND THE SUPPLEMENTAL APPROPRIATION BY REPEALING TAX CUTS FOR 2001.

(a) REPEAL.—

(1) IN GENERAL.—Section 101 of the Economic Growth and Tax Relief Reconciliation Act of 2001 is repealed.

(2) APPLICATION OF CODE.—The Internal Revenue Code of 1986 shall be applied and administered as if such section 101 (and the amendments made by such section) had never been enacted.

(3) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 1 of the Internal Revenue Code of 1986 (relating to tax imposed) is amended by adding at the end the following new subsection:

''(i) RATE REDUCTIONS AFTER 2001.—

''(1) 10-PERCENT RATE BRACKET.—

''(A) IN GENERAL.—In the case of taxable years beginning after December 31, 2001—

''(i) the rate of tax under subsections (a), (b), (c), and (d) on taxable income not over the initial bracket amount shall be 10 percent, and

''(ii) the 15 percent rate of tax shall apply only to taxable income over the initial bracket amount but not over the maximum dollar amount for the 15-percent rate bracket.

''(B) INITIAL BRACKET AMOUNT.—For purposes of this paragraph, the initial bracket amount is—

''(i) $14,000 ($12,000 in the case of taxable years beginning before January 1, 2008) in the case of subsection (a),

''(ii) $10,000 in the case of subsection (b), and

''(iii) ½ the amount applicable under clause (i) (after adjustment, if any, under subparagraph (C)) in the case of subsections (c) and (d).

''(C) INFLATION ADJUSTMENT.—In prescribing the tables under subsection (f) which apply with respect to taxable years beginning in calendar years after 2001—

''(i) the Secretary shall make no adjustment to the initial bracket amount for any taxable year beginning before January 1, 2009,

''(ii) the cost-of-living adjustment used in making adjustments to the initial bracket amount for any taxable year beginning after December 31, 2008, shall be determined under subsection (f)(3) by substituting '2007' for '1992' in subparagraph (B) thereof, and

''(iii) such adjustment shall not apply to the amount referred to in subparagraph (B)(iii).

If any amount after adjustment under the preceding sentence is not a multiple of $50, such amount shall be rounded to the next lowest multiple of $50.

''(2) REDUCTIONS IN RATES AFTER DECEMBER 31, 2001.—In the case of taxable years beginning in a calendar year after 2001, the corresponding percentage specified for such calendar year in the following table shall be substituted for the otherwise applicable tax rate in the tables under subsections (a), (b), (c), (d), and (e).

''In the case of taxable years beginning during calendar year:	The corresponding percentages shall be substituted for the following percentages:			
	28%	31%	36%	39.6%
2002 and 2003	27.0%	30.0%	35.0%	38.6%
2004 and 2005	26.0%	29.0%	34.0%	37.6%
2006 and thereafter	25.0%	28.0%	33.0%	35.0%

''(3) ADJUSTMENT OF TABLES.—The Secretary shall adjust the tables prescribed under subsection (f) to carry out this subsection.''.

(B) CONFORMING AMENDMENTS.—

(i) Subparagraph (B) of section 1(g)(7) of such Code is amended by striking ''15 percent'' in clause (ii)(II) and inserting ''10 percent.''.

(ii) Section 1(h) of such Code is amended—

(I) by striking ''28 percent'' both places it appears in paragraphs (1)(A)(ii)(I) and (1)(B)(i) and inserting ''25 percent'', and

(II) by striking paragraph (13).

(iii) Section 531 of such Code is amended by striking ''equal to'' and all that follows and inserting ''equal to the product of the highest rate of tax under section 1(c) and the accumulated taxable income.''.

(iv) Section 541 of such Code is amended by striking ''equal to'' and all that follows and inserting ''equal to the product of the highest rate of tax under section 1(c) and the undistributed personal holding company income.''.

(v) Section 3402(p)(1)(B) of such Code is amended by striking ''7, 15, 28, or 31 percent'' and inserting ''7 percent, any percentage applicable to any of the 3 lowest income brackets in the table under section 1(c),''.

(vi) Section 3402(p)(2) of such Code is amended by striking ''15 percent'' and inserting ''10 percent''.

(vii) Section 3402(q)(1) of such Code is amended by striking ''equal to 28 percent of such payment'' and inserting ''equal to the product of the third lowest rate of tax applicable under section 1(c) and such payment''.

(viii) Section 3402(r)(3) of such Code is amended by striking ''31 percent'' and inserting ''the fourth lowest rate of tax applicable under section 1(c)''.

(ix) Section 3406(a)(1) of such Code is amended by striking ''equal to 31 percent of such payment'' and inserting ''equal to the product of the fourth lowest rate of tax applicable under section 1(c) and such payment''.

(x) Section 13273 of the Revenue Reconciliation Act of 1993 is amended by striking ''28 percent'' and inserting ''the third lowest rate of tax applicable under section 1(c) of the Internal Revenue Code of 1986''.

(C) EFFECTIVE DATES.—

(i) IN GENERAL.—Except as provided in clause (ii), the amendments made by this paragraph shall apply to taxable years beginning after December 31, 2001.

(ii) AMENDMENTS TO WITHHOLDING PROVISIONS.—The amendments made by clauses (v), (vi), (vii), (viii), (ix), and (x) of subparagraph (B) shall apply to amounts paid after December 31, 2001.

(b) RESERVE FUND FOR DEFENSE AND EDUCATION.—Subtitle B of title II of H. Con. Res. 83 (107th Congress) is amended by inserting at the end the following:

''SEC. 219. STRATEGIC RESERVE FUND FOR DEFENSE AND EDUCATION.

If legislation is reported by the Committee on Appropriations of the Senate or the Committee on Appropriations of the House of Representatives, or an amendment thereto is offered or a conference report thereon is submitted, that would increase funding for defense or education, the chairman of the appropriate Committee on the Budget shall revise the aggregates, functional totals, allocations, and other appropriate levels and limits in this resolution for that measure by not exceeding the amount resulting from the repeal and amendments made by section ___(a) of the Supplemental Appropriations Act, 2001 for fiscal years 2001 and 2002, as long as that measure will not, when taken together with all other previously enacted legislation, reduce the on-budget surplus below the level of the Medicare Hospital Insurance Trust Fund surplus in any fiscal year provided in this resolution.''.

SA 874. Mr. REID (for Mr. WELLSTONE) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

On page 11, between lines 8 and 9, insert the following:

(RESCISSIONS)

SEC. 1207. (a)(1) Effective July 31, 2001, of the funds provided to the Secretary of Defense, for fiscal year 2001 administrative expenses, under the Department of Defense Appropriations Act, 2001, the Military Construction Appropriations Act, 2001, and the Energy and Water Development Appropriations Act, 2001, and remaining in Federal appropriations accounts, an amount equal to $150,000,000 is rescinded.

(2) Such amount shall be rescinded from such Federal appropriations accounts as the Secretary of Defense shall specify before July 31, 2001. In determining the accounts to specify, the Secretary of Defense shall take into consideration the need to promote efficiency, cost-effectiveness, and productivity within the Department of Defense, as well as to maintain readiness and troop quality of life.

(b) Effective August 1, 2001, if the Secretary of Defense has not specified accounts for rescissions under subsection (a), of the funds described in subsection (a)(1) and remaining in Federal appropriations accounts, an amount equal to $150,000,000 is rescinded through proportional reductions to the portions of such accounts that contain such funds.

On page 36, line 9, strike ''$300,000,000'' and insert ''$450,000,000''.

SA 875. Mr. REID (for Mr. JOHNSON) proposed an amendment to the bill S. 1077, making supplemental appropriations for the fiscal year ending September 30, 2001, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. ___. EXTENSION OF INTEREST RATE PROVISIONS.

(a) TECHNICAL CORRECTION.—Paragraph (6) of section 455(b) of the Higher Education Act of 1965 (20 U.S.C. 1087e(b)), as redesignated by section 8301(c)(1) of the Transportation Equity Act for the 21st Century (Public Law 105–178; 112 Stat. 498) is redesignated as paragraph (8) and inserted after paragraph (7) of that section.

(b) EXTENSION.—

(1) AMENDMENTS.—Sections 427A(k), 428C(c)(1), 438(b)(2)(I), and 455(b)(6) of such Act (20 U.S.C. 1077a(k), 1078–3(c)(1), 1087–1(b)(2)(I), 1087e(b)(6)) are each amended by striking ''and before July 1, 2003,'' each place it appears.

(2) CONFORMING AMENDMENTS.—

(A) Section 427A(k) of such Act is amended by striking the subsection heading and inserting the following: ''INTEREST RATES FOR NEW LOANS ON OR AFTER OCTOBER 1, 1998.—''.

(B) Section 438(b)(2)(I) of such Act is amended—

(i) by striking the subparagraph heading and inserting the following: ''LOANS DISBURSED ON OR AFTER JANUARY 1, 2000.—''; and

(ii) in clause (i), by striking ''2000,'' and inserting ''2000''.

(C) Section 455(b)(6) of such Act is amended—

(i) by striking the paragraph heading and inserting the following: ''INTEREST RATE PROVISION FOR NEW LOANS ON OR AFTER OCTOBER 1, 1998.—''; and

(ii) in subparagraph (D), by striking ''1999,'' and inserting ''1999''.

NOTICES OF HEARINGS

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. HARKIN. Mr. President, I would like to announce that the Committee on Agriculture, Nutrition, and Forestry will meet on July 12, 2001, in SR–328A at 8:30 a.m. The purpose of this hearing will be to consider nominations for positions with the United States Department of Agriculture, and to discuss the next Federal farm bill.

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Mr. LEVIN. Mr. President, I would like to announce for the information of the Senate and the public that the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs will hold a hearing entitled ''What Is the U.S. Position on Offshore Tax Havens?'' The upcoming hearing will examine past and current U.S. efforts to convince offshore tax havens to cooperate with U.S. efforts to stop tax evasion, the role of the Organization of Economic Cooperation and Development, (OECD), tax haven project in light of U.S. objectives, and the current status of U.S. support for the project, in particular for the core element requiring information exchange.

The hearing will take place on Wednesday, July 18, 2001, at 2 p.m. in room 628 of the Dirksen Senate Office Building. For further information, please contact Linda J. Gustitus of the subcommittee staff at (202) 224–3721.

SUBCOMMITTEE ON NATIONAL PARKS

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on National Parks of the Committee on Energy and Natural Resources.

The hearing will take place on Tuesday, July 17, 2001, beginning at 2:30 p.m. in room 366 of the Dirksen Senate Office Building in Washington, DC.

The purpose of the hearing is to receive testimony on the following bills:

S. 281, to authorize the design and construction of a temporary education center at the Vietnam Veterans Memorial;

S. 386 and H.R. 146, to authorize the Secretary of the Interior to study the suitability and feasibility of designating the Great Falls Historic District in the city of Paterson, New Jersey, as a unit of the National Park System, and for other purposes;

S. 513 and H.R. 182, to amend the Wild and Scenic Rivers Act to designate a segment of the Eightmile River in the State of Connecticut for study for potential addition to the National Wild and Scenic Rivers System, and for other purposes;

S. 921 and H.R. 1000, to adjust the boundary of the William Howard Taft National Historic Site in the State of Ohio, to authorize an exchange of land in connection with the historic site, and for other purposes; and

S. 1097, to authorize the Secretary of the Interior to issue right-of-way permits for natural gas pipelines within

the boundary of the Great Smoky Mountains National Park.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Subcommittee on National Parks, Committee on Energy and Natural Resources, U.S. Senate, 312 Dirksen Senate Office Building, Washington, DC 20510.

For further information, please contact David Brooks of the committee staff at (202) 224–9863.

SUBCOMMITTEE ON NATIONAL PARKS

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on National Parks of the Committee on Energy and Natural Resources.

The hearing will take place on Thursday, July 26, 2001, beginning at 2:30 p.m. in room 366 of the Dirksen Senate Office Building in Washington, DC.

The purpose of the hearing is to receive testimony on the following bills:

S. 423, to amend the Act entitled ''An Act to provide for the establishment of Fort Clatsop National Memorial in the State of Oregon,'' and for other purposes:

S. 817, to amend the National Trails System Act to designate the Old Spanish Trail as a National Historic Trail;

S. 941, to revise the boundaries of the Golden Gate National Recreation Area in the State of California, to extend the term of the advisory commission for the recreation area, and for other purposes;

S. 1057, to authorize the addition of lands to Pùuhonua o Hōnaunau National Historical Park in the State of Hawaii, and for other purposes;

S. 1105, to provide for the expeditious completion of the acquisition of State of Wyoming lands within the boundaries of Grand Teton National Park, and for other purposes; and

H.R. 640, to adjust the boundaries of Santa Monica Mountains National Recreation Area, and for other purposes.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Subcommittee on National Parks, Committee on Energy and Natural Resources, U.S. Senate, 312 Dirksen Senate Office Building, Washington, DC 20510.

For further information, please contact David Brooks of the committee staff at (202) 224–9863.

BIPARTISAN PATIENT PROTECTION ACT

On June 29, 2001, the Senate passed S. 1052, as follows:

S. 1052

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Bipartisan Patient Protection Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Utilization Review; Claims; and Internal and External Appeals

SEC. 101. UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section and section 102.

(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

(1) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals,

as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for a participant, beneficiary, or enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for a periodic evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to an individual more frequently than is reasonably required to assess whether the services under review are medically necessary and appropriate.

SEC. 102. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.

(a) PROCEDURES OF INITIAL CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall—

(A) make a determination on an initial claim for benefits by a participant, beneficiary, or enrollee (or authorized representative) regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involved, including any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits; and

(B) notify a participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional involved regarding a determination on an initial claim for benefits made under the terms and conditions of the plan or coverage, including any cost-sharing amounts that the participant, beneficiary, or enrollee may be required to make with respect to such claim for benefits, and of the right of the participant, beneficiary, or enrollee to an internal appeal under section 103.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an initial claim for benefits, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the claim. Such access shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in subparagraph (B) or (C) of subsection (b)(1), by such earlier time as may be necessary to comply with the applicable timeline under such subparagraph.

(B) LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

(3) ORAL REQUESTS.—In the case of a claim for benefits involving an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for benefits, the making of the request (and the timing of such request) shall be treated as the making at that time of a claims for such benefits without regard to whether and when a written confirmation of such request is made.

(b) TIMELINE FOR MAKING DETERMINATIONS.—

(1) PRIOR AUTHORIZATION DETERMINATION.—

(A) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall make a prior authorization determination on a claim for benefits (whether oral or written) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the request for prior authorization and in no case later than 28 days after the date of the claim for benefits is received.

(B) EXPEDITED DETERMINATION.—Notwithstanding subparagraph (A), a group health plan, or health insurance issuer offering health insurance coverage, shall expedite a prior authorization determination on a claim for benefits described in such subparagraph when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination and a health care professional certifies, with the request, that a determination under the procedures described in subparagraph (A) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain or regain maximum function. Such determination shall be made in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the request is received by the plan or issuer under this subparagraph.

(C) ONGOING CARE.—

(i) CONCURRENT REVIEW.—

(I) IN GENERAL.—Subject to clause (ii), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan or issuer must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible, with sufficient time prior to the termination or reduction to allow for an appeal under section 103(b)(3) to be completed before the termination or reduction takes effect.

(II) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(ii) RULE OF CONSTRUCTION.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(2) RETROSPECTIVE DETERMINATION.—A group health plan, or health insurance issuer offering health insurance coverage, shall make a retrospective determination on a claim for benefits in accordance with the medical exigencies of the case and as soon as possible, but not later than 30 days after the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the claim, or, if earlier, 60 days after the date of receipt of the claim for benefits.

(c) NOTICE OF A DENIAL OF A CLAIM FOR BENEFITS.—Written notice of a denial made under an initial claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of the determination (or, in the case described in subparagraph (B) or (C) of subsection (b)(1), within the 72-hour or applicable period referred to in such subparagraph).

(d) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—The written notice of a denial of a claim for benefits determination under subsection (c) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(1) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination);

(2) the procedures for obtaining additional information concerning the determination; and

(3) notification of the right to appeal the determination and instructions on how to

initiate an appeal in accordance with section 103.

(e) DEFINITIONS.—For purposes of this part:

(1) AUTHORIZED REPRESENTATIVE.—The term ''authorized representative'' means, with respect to an individual who is a participant, beneficiary, or enrollee, any health care professional or other person acting on behalf of the individual with the individual's consent or without such consent if the individual is medically unable to provide such consent.

(2) CLAIM FOR BENEFITS.—The term ''claim for benefits'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(3) DENIAL OF CLAIM FOR BENEFITS.—The term ''denial'' means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this title.

(4) TREATING HEALTH CARE PROFESSIONAL.—The term ''treating health care professional'' means, with respect to services to be provided to a participant, beneficiary, or enrollee, a health care professional who is primarily responsible for delivering those services to the participant, beneficiary, or enrollee.

SEC. 103. INTERNAL APPEALS OF CLAIMS DENIALS.

(a) RIGHT TO INTERNAL APPEAL.—

(1) IN GENERAL.—A participant, beneficiary, or enrollee (or authorized representative) may appeal any denial of a claim for benefits under section 102 under the procedures described in this section.

(2) TIME FOR APPEAL.—

(A) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall ensure that a participant, beneficiary, or enrollee (or authorized representative) has a period of not less than 180 days beginning on the date of a denial of a claim for benefits under section 102 in which to appeal such denial under this section.

(B) DATE OF DENIAL.—For purposes of subparagraph (A), the date of the denial shall be deemed to be the date as of which the participant, beneficiary, or enrollee knew of the denial of the claim for benefits.

(3) FAILURE TO ACT.—The failure of a plan or issuer to issue a determination on a claim for benefits under section 102 within the applicable timeline established for such a determination under such section is a denial of a claim for benefits for purposes this subtitle as of the date of the applicable deadline.

(4) PLAN WAIVER OF INTERNAL REVIEW.—A group health plan, or health insurance issuer offering health insurance coverage, may waive the internal review process under this section. In such case the plan or issuer shall provide notice to the participant, beneficiary, or enrollee (or authorized representative) involved, the participant, beneficiary, or enrollee (or authorized representative) involved shall be relieved of any obligation to complete the internal review involved, and may, at the option of such participant, beneficiary, enrollee, or representative proceed directly to seek further appeal through external review under section 104 or otherwise.

(b) TIMELINES FOR MAKING DETERMINATIONS.—

(1) ORAL REQUESTS.—In the case of an appeal of a denial of a claim for benefits under this section that involves an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may request such appeal orally. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for an appeal of a denial, the making of the request (and the timing of such request) shall be treated as the making at that time of a request for an appeal without regard to whether and when a written confirmation of such request is made.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an appeal of a denial of a claim for benefits, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the appeal. Such access shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in subparagraph (B) or (C) of paragraph (3), by such earlier time as may be necessary to comply with the applicable timeline under such subparagraph.

(B) LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

(3) PRIOR AUTHORIZATION DETERMINATIONS.—

(A) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall make a determination on an appeal of a denial of a claim for benefits under this subsection in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the appeal and in no case later than 28 days after the date the request for the appeal is received.

(B) EXPEDITED DETERMINATION.—Notwithstanding subparagraph (A), a group health plan, or health insurance issuer offering health insurance coverage, shall expedite a prior authorization determination on an appeal of a denial of a claim for benefits described in subparagraph (A), when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination and a health care professional certifies, with the request, that a determination under the procedures described in subparagraph (A) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain or regain maximum function. Such determination shall be made in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the request for such appeal is received by the plan or issuer under this subparagraph.

(C) ONGOING CARE DETERMINATIONS.—

(i) IN GENERAL.—Subject to clause (ii), in the case of a concurrent review determination described in section 102(b)(1)(C)(i)(I), which results in a termination or reduction of such care, the plan or issuer must provide notice of the determination on the appeal under this section by telephone and in printed form to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible, with sufficient time prior to the termination or reduction to allow for an external appeal under section 104 to be completed before the termination or reduction takes effect.

(ii) RULE OF CONSTRUCTION.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(4) RETROSPECTIVE DETERMINATION.—A group health plan, or health insurance issuer offering health insurance coverage, shall make a retrospective determination on an appeal of a claim for benefits in no case later than 30 days after the date on which the plan or issuer receives necessary information that is reasonably necessary to enable the plan or issuer to make a determination on the appeal and in no case later than 60 days after the date the request for the appeal is received.

(c) CONDUCT OF REVIEW.—

(1) IN GENERAL.—A review of a denial of a claim for benefits under this section shall be conducted by an individual with appropriate expertise who was not involved in the initial determination.

(2) PEER REVIEW OF MEDICAL DECISIONS BY HEALTH CARE PROFESSIONALS.—A review of an appeal of a denial of a claim for benefits that is based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, or requires an evaluation of medical facts—

(A) shall be made by a physician (allopathic or osteopathic); or

(B) in a claim for benefits provided by a non-physician health professional, shall be made by reviewer (or reviewers) including at least one practicing non-physician health professional of the same or similar specialty;

with appropriate expertise (including, in the case of a child, appropriate pediatric expertise) and acting within the appropriate scope of practice within the State in which the service is provided or rendered, who was not involved in the initial determination.

(d) NOTICE OF DETERMINATION.—

(1) IN GENERAL.—Written notice of a determination made under an internal appeal of a denial of a claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of completion of the review (or, in the case described in subparagraph (B) or (C) of subsection (b)(3), within the 72-hour or applicable period referred to in such subparagraph).

(2) FINAL DETERMINATION.—The decision by a plan or issuer under this section shall be treated as the final determination of the plan or issuer on a denial of a claim for benefits. The failure of a plan or issuer to issue a determination on an appeal of a denial of a claim for benefits under this section within the applicable timeline established for such a determination shall be treated as a final determination on an appeal of a denial of a claim for benefits for purposes of proceeding to external review under section 104.

(3) REQUIREMENTS OF NOTICE.—With respect to a determination made under this section, the notice described in paragraph (1) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(A) the specific reasons for the determination (including a summary of the clinical or

scientific evidence used in making the determination);

(B) the procedures for obtaining additional information concerning the determination; and

(C) notification of the right to an independent external review under section 104 and instructions on how to initiate such a review.

SEC. 104. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide in accordance with this section participants, beneficiaries, and enrollees (or authorized representatives) with access to an independent external review for any denial of a claim for benefits.

(b) INITIATION OF THE INDEPENDENT EXTERNAL REVIEW PROCESS.—

(1) TIME TO FILE.—A request for an independent external review under this section shall be filed with the plan or issuer not later than 180 days after the date on which the participant, beneficiary, or enrollee receives notice of the denial under section 103(d) or notice of waiver of internal review under section 103(a)(4) or the date on which the plan or issuer has failed to make a timely decision under section 103(d)(2) and notifies the participant or beneficiary that it has failed to make a timely decision and that the beneficiary must file an appeal with an external review entity within 180 days if the participant or beneficiary desires to file such an appeal.

(2) FILING OF REQUEST.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a group health plan, and a health insurance issuer offering health insurance coverage, may—

(i) except as provided in subparagraph (B)(i), require that a request for review be in writing;

(ii) limit the filing of such a request to the participant, beneficiary, or enrollee involved (or an authorized representative);

(iii) except if waived by the plan or issuer under section 103(a)(4), condition access to an independent external review under this section upon a final determination of a denial of a claim for benefits under the internal review procedure under section 103;

(iv) except as provided in subparagraph (B)(ii), require payment of a filing fee to the plan or issuer of a sum that does not exceed $25; and

(v) require that a request for review include the consent of the participant, beneficiary, or enrollee (or authorized representative) for the release of necessary medical information or records of the participant, beneficiary, or enrollee to the qualified external review entity only for purposes of conducting external review activities.

(B) REQUIREMENTS AND EXCEPTION RELATING TO GENERAL RULE.—

(i) ORAL REQUESTS PERMITTED IN EXPEDITED OR CONCURRENT CASES.—In the case of an expedited or concurrent external review as provided for under subsection (e), the request may be made orally. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. Such written confirmation shall be treated as a consent for purposes of subparagraph (A)(v). In the case of such an oral request for such a review, the making of the request (and the timing of such request) shall be treated as the making at that time of a request for such an external review without regard to whether and when a written confirmation of such request is made.

(ii) EXCEPTION TO FILING FEE REQUIREMENT.—

(I) INDIGENCY.—Payment of a filing fee shall not be required under subparagraph (A)(iv) where there is a certification (in a form and manner specified in guidelines established by the appropriate Secretary) that the participant, beneficiary, or enrollee is indigent (as defined in such guidelines).

(II) FEE NOT REQUIRED.—Payment of a filing fee shall not be required under subparagraph (A)(iv) if the plan or issuer waives the internal appeals process under section 103(a)(4).

(III) REFUNDING OF FEE.—The filing fee paid under subparagraph (A)(iv) shall be refunded if the determination under the independent external review is to reverse or modify the denial which is the subject of the review.

(IV) COLLECTION OF FILING FEE.—The failure to pay such a filing fee shall not prevent the consideration of a request for review but, subject to the preceding provisions of this clause, shall constitute a legal liability to pay.

(c) REFERRAL TO QUALIFIED EXTERNAL REVIEW ENTITY UPON REQUEST.—

(1) IN GENERAL.—Upon the filing of a request for independent external review with the group health plan, or health insurance issuer offering health insurance coverage, the plan or issuer shall immediately refer such request, and forward the plan or issuer's initial decision (including the information described in section 103(d)(3)(A)), to a qualified external review entity selected in accordance with this section.

(2) ACCESS TO PLAN OR ISSUER AND HEALTH PROFESSIONAL INFORMATION.—With respect to an independent external review conducted under this section, the participant, beneficiary, or enrollee (or authorized representative), the plan or issuer, and the treating health care professional (if any) shall provide the external review entity with information that is necessary to conduct a review under this section, as determined and requested by the entity. Such information shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in clause (ii) or (iii) of subsection (e)(1)(A), by such earlier time as may be necessary to comply with the applicable timeline under such clause.

(3) SCREENING OF REQUESTS BY QUALIFIED EXTERNAL REVIEW ENTITIES.—

(A) IN GENERAL.—With respect to a request referred to a qualified external review entity under paragraph (1) relating to a denial of a claim for benefits, the entity shall refer such request for the conduct of an independent medical review unless the entity determines that—

(i) any of the conditions described in clauses (ii) or (iii) of subsection (b)(2)(A) have not been met;

(ii) the denial of the claim for benefits does not involve a medically reviewable decision under subsection (d)(2);

(iii) the denial of the claim for benefits relates to a decision regarding whether an individual is a participant, beneficiary, or enrollee who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage); or

(iv) the denial of the claim for benefits is a decision 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 conditions of the plan or coverage unless the decision is a denial described in subsection (d)(2).

Upon making a determination that any of clauses (i) through (iv) applies with respect to the request, the entity shall determine that the denial of a claim for benefits involved is not eligible for independent medical review under subsection (d), and shall provide notice in accordance with subparagraph (C).

(B) PROCESS FOR MAKING DETERMINATIONS.—

(i) NO DEFERENCE TO PRIOR DETERMINATIONS.—In making determinations under subparagraph (A), there shall be no deference given to determinations made by the plan or issuer or the recommendation of a treating health care professional (if any).

(ii) USE OF APPROPRIATE PERSONNEL.—A qualified external review entity shall use appropriately qualified personnel to make determinations under this section.

(C) NOTICES AND GENERAL TIMELINES FOR DETERMINATION.—

(i) NOTICE IN CASE OF DENIAL OF REFERRAL.—If the entity under this paragraph does not make a referral to an independent medical reviewer, the entity shall provide notice to the plan or issuer, the participant, beneficiary, or enrollee (or authorized representative) filing the request, and the treating health care professional (if any) that the denial is not subject to independent medical review. Such notice—

(I) shall be written (and, in addition, may be provided orally) in a manner calculated to be understood by a participant or enrollee;

(II) shall include the reasons for the determination;

(III) include any relevant terms and conditions of the plan or coverage; and

(IV) include a description of any further recourse available to the individual.

(ii) GENERAL TIMELINE FOR DETERMINATIONS.—Upon receipt of information under paragraph (2), the qualified external review entity, and if required the independent medical reviewer, shall make a determination within the overall timeline that is applicable to the case under review as described in subsection (e), except that if the entity determines that a referral to an independent medical reviewer is not required, the entity shall provide notice of such determination to the participant, beneficiary, or enrollee (or authorized representative) within such timeline and within 2 days of the date of such determination.

(d) INDEPENDENT MEDICAL REVIEW.—

(1) IN GENERAL.—If a qualified external review entity determines under subsection (c) that a denial of a claim for benefits is eligible for independent medical review, the entity shall refer the denial involved to an independent medical reviewer for the conduct of an independent medical review under this subsection.

(2) MEDICALLY REVIEWABLE DECISIONS.—A denial of a claim for benefits is eligible for independent medical review if the benefit for the item or service for which the claim is made would be a covered benefit under the terms and conditions of the plan or coverage but for one (or more) of the following determinations:

(A) DENIALS BASED ON MEDICAL NECESSITY AND APPROPRIATENESS.—A determination that the item or service is not covered because it is not medically necessary and appropriate or based on the application of substantially equivalent terms.

(B) DENIALS BASED ON EXPERIMENTAL OR INVESTIGATIONAL TREATMENT.—A determination that the item or service is not covered because it is experimental or investigational or based on the application of substantially equivalent terms.

(C) DENIALS OTHERWISE BASED ON AN EVALUATION OF MEDICAL FACTS.—A determination that the item or service or condition is not covered based on grounds that require an evaluation of the medical facts by a health

care professional in the specific case involved to determine the coverage and extent of coverage of the item or service or condition.

(3) INDEPENDENT MEDICAL REVIEW DETERMINATION.—

(A) IN GENERAL.—An independent medical reviewer under this section shall make a new independent determination with respect to whether or not the denial of a claim for a benefit that is the subject of the review should be upheld, reversed, or modified.

(B) STANDARD FOR DETERMINATION.—The independent medical reviewer's determination relating to the medical necessity and appropriateness, or the experimental or investigation nature, or the evaluation of the medical facts of the item, service, or condition shall be based on the medical condition of the participant, beneficiary, or enrollee (including the medical records of the participant, beneficiary, or enrollee) and valid, relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and including expert opinion.

(C) 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 (and which are disclosed under section 121(b)(1)(C)). Notwithstanding any other provision of this Act, any exclusion of an exact medical procedure, any exact time limit on the duration or frequency of coverage, and any exact dollar limit on the amount of coverage that is specifically enumerated and defined (in the plain language of the plan or coverage documents) under the plan or coverage offered by a group health plan or health insurance issuer offering health insurance coverage and that is disclosed under section 121(b)(1) shall be considered to govern the scope of the benefits that may be required: *Provided*, That the terms and conditions of the plan or coverage relating to such an exclusion or limit are in compliance with the requirements of law.

(D) EVIDENCE AND INFORMATION TO BE USED IN MEDICAL REVIEWS.—In making a determination under this subsection, the independent medical reviewer shall also consider appropriate and available evidence and information, including the following:

(i) The determination made by the plan or issuer with respect to the claim upon internal review and the evidence, guidelines, or rationale used by the plan or issuer in reaching such determination.

(ii) The recommendation of the treating health care professional and the evidence, guidelines, and rationale used by the treating health care professional in reaching such recommendation.

(iii) Additional relevant evidence or information obtained by the reviewer or submitted by the plan, issuer, participant, beneficiary, or enrollee (or an authorized representative), or treating health care professional.

(iv) The plan or coverage document.

(E) INDEPENDENT DETERMINATION.—In making determinations under this subtitle, a qualified external review entity and an independent medical reviewer shall—

(i) consider the claim under review without deference to the determinations made by the plan or issuer or the recommendation of the treating health care professional (if any); and

(ii) consider, but not be bound by the definition used by the plan or issuer of ''medically necessary and appropriate'', or ''experimental or investigational'', or other substantially equivalent terms that are used by the plan or issuer to describe medical necessity and appropriateness or experimental or investigational nature of the treatment.

(F) DETERMINATION OF INDEPENDENT MEDICAL REVIEWER.—An independent medical reviewer shall, in accordance with the deadlines described in subsection (e), prepare a written determination to uphold, reverse, or modify the denial under review. Such written determination shall include—

(i) the determination of the reviewer;

(ii) the specific reasons of the reviewer for such determination, including a summary of the clinical or scientific evidence used in making the determination; and

(iii) with respect to a determination to reverse or modify the denial under review, a timeframe within which the plan or issuer must comply with such determination.

(G) NONBINDING NATURE OF ADDITIONAL RECOMMENDATIONS.—In addition to the determination under subparagraph (F), the reviewer may provide the plan or issuer and the treating health care professional with additional recommendations in connection with such a determination, but any such recommendations shall not affect (or be treated as part of) the determination and shall not be binding on the plan or issuer.

(e) TIMELINES AND NOTIFICATIONS.—

(1) TIMELINES FOR INDEPENDENT MEDICAL REVIEW.—

(A) PRIOR AUTHORIZATION DETERMINATION.—

(i) IN GENERAL.—The independent medical reviewer (or reviewers) shall make a determination on a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days after the date of receipt of information under subsection (c)(2) if the review involves a prior authorization of items or services and in no case later than 21 days after the date the request for external review is received.

(ii) EXPEDITED DETERMINATION.—Notwithstanding clause (i) and subject to clause (iii), the independent medical reviewer (or reviewers) shall make an expedited determination on a denial of a claim for benefits described in clause (i), when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination, and a health care professional certifies, with the request, that a determination under the timeline described in clause (i) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain or regain maximum function. Such determination shall be made as soon in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the request for external review is received by the qualified external review entity.

(iii) ONGOING CARE DETERMINATION.—Notwithstanding clause (i), in the case of a review described in such subclause that involves a termination or reduction of care, the notice of the determination shall be completed not later than 24 hours after the time the request for external review is received by the qualified external review entity and before the end of the approved period of care.

(B) RETROSPECTIVE DETERMINATION.—The independent medical reviewer (or reviewers) shall complete a review in the case of a retrospective determination on an appeal of a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) in no case later than 30 days after the date of receipt of information under subsection (c)(2) and in no case later than 60 days after the date the request for external review is received by the qualified external review entity.

(2) NOTIFICATION OF DETERMINATION.—The external review entity shall ensure that the plan or issuer, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) receives a copy of the written determination of the independent medical reviewer prepared under subsection (d)(3)(F). Nothing in this paragraph shall be construed as preventing an entity or reviewer from providing an initial oral notice of the reviewer's determination.

(3) FORM OF NOTICES.—Determinations and notices under this subsection shall be written in a manner calculated to be understood by a participant.

(f) COMPLIANCE.—

(1) APPLICATION OF DETERMINATIONS.—

(A) EXTERNAL REVIEW DETERMINATIONS BINDING ON PLAN.—The determinations of an external review entity and an independent medical reviewer under this section shall be binding upon the plan or issuer involved.

(B) COMPLIANCE WITH DETERMINATION.—If the determination of an independent medical reviewer is to reverse or modify the denial, the plan or issuer, upon the receipt of such determination, shall authorize coverage to comply with the medical reviewer's determination in accordance with the timeframe established by the medical reviewer.

(2) FAILURE TO COMPLY.—

(A) IN GENERAL.—If a plan or issuer fails to comply with the timeframe established under paragraph (1)(B) with respect to a participant, beneficiary, or enrollee, where such failure to comply is caused by the plan or issuer, the participant, beneficiary, or enrollee may obtain the items or services involved (in a manner consistent with the determination of the independent external reviewer) from any provider regardless of whether such provider is a participating provider under the plan or coverage.

(B) REIMBURSEMENT.—

(i) IN GENERAL.—Where a participant, beneficiary, or enrollee obtains items or services in accordance with subparagraph (A), the plan or issuer involved shall provide for reimbursement of the costs of such items or services. Such reimbursement shall be made to the treating health care professional or to the participant, beneficiary, or enrollee (in the case of a participant, beneficiary, or enrollee who pays for the costs of such items or services).

(ii) AMOUNT.—The plan or issuer shall fully reimburse a professional, participant, beneficiary, or enrollee under clause (i) for the total costs of the items or services provided (regardless of any plan limitations that may apply to the coverage of such items or services) so long as the items or services were provided in a manner consistent with the determination of the independent medical reviewer.

(C) FAILURE TO REIMBURSE.—Where a plan or issuer fails to provide reimbursement to a professional, participant, beneficiary, or enrollee in accordance with this paragraph, the professional, participant, beneficiary, or enrollee may commence a civil action (or utilize other remedies available under law) to recover only the amount of any such reimbursement that is owed by the plan or issuer and any necessary legal costs or expenses (including attorney's fees) incurred in recovering such reimbursement.

(D) AVAILABLE REMEDIES.—The remedies provided under this paragraph are in addition to any other available remedies.

(3) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL REVIEW ENTITY.—

(A) MONETARY PENALTIES.—

(i) IN GENERAL.—In any case in which the determination of an external review entity is not followed by a group health plan, or by a health insurance issuer offering health insurance coverage, any person who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external review entity until the date the refusal to provide the benefit is corrected.

(ii) ADDITIONAL PENALTY FOR FAILING TO FOLLOW TIMELINE.—In any case in which treatment was not commenced by the plan in accordance with the determination of an independent external reviewer, the Secretary shall assess a civil penalty of $10,000 against the plan and the plan shall pay such penalty to the participant, beneficiary, or enrollee involved.

(B) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in subparagraph (A) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such subparagraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity to be covered, or has failed to take an action for which such person is responsible under the terms and conditions of the plan or coverage and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

(i) to cease and desist from the alleged action or failure to act; and

(ii) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

(C) ADDITIONAL CIVIL PENALTIES.—

(i) IN GENERAL.—In addition to any penalty imposed under subparagraph (A) or (B), the appropriate Secretary may assess a civil penalty against a person acting in the capacity of authorizing a benefit determined by an external review entity for one or more group health plans, or health insurance issuers offering health insurance coverage, for—

(I) any pattern or practice of repeated refusal to authorize a benefit determined by an external appeal entity to be covered; or

(II) any pattern or practice of repeated violations of the requirements of this section with respect to such plan or coverage.

(ii) STANDARD OF PROOF AND AMOUNT OF PENALTY.—Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice and shall be in an amount not to exceed the lesser of—

(I) 25 percent of the aggregate value of benefits shown by the appropriate Secretary to have not been provided, or unlawfully delayed, in violation of this section under such pattern or practice; or

(II) $500,000.

(D) REMOVAL AND DISQUALIFICATION.—Any person acting in the capacity of authorizing benefits who has engaged in any such pattern or practice described in subparagraph (C)(i) with respect to a plan or coverage, upon the petition of the appropriate Secretary, may be removed by the court from such position, and from any other involvement, with respect to such a plan or coverage, and may be precluded from returning to any such position or involvement for a period determined by the court.

(4) PROTECTION OF LEGAL RIGHTS.—Nothing in this subsection or subtitle shall be construed as altering or eliminating any cause of action or legal rights or remedies of participants, beneficiaries, enrollees, and others under State or Federal law (including sections 502 and 503 of the Employee Retirement Income Security Act of 1974), including the right to file judicial actions to enforce rights.

(g) QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.—

(1) IN GENERAL.—In referring a denial to 1 or more individuals to conduct independent medical review under subsection (c), the qualified external review entity shall ensure that—

(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

(B) with respect to each review at least 1 such reviewer meets the requirements described in paragraphs (4) and (5); and

(C) compensation provided by the entity to the reviewer is consistent with paragraph (6).

(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

(3) INDEPENDENCE.—

(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

(i) not be a related party (as defined in paragraph (7));

(ii) not have a material familial, financial, or professional relationship with such a party; and

(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

(i) prohibit an individual, solely on the basis of affiliation with the plan or issuer, from serving as an independent medical reviewer if—

(I) a non-affiliated individual is not reasonably available;

(II) the affiliated individual is not involved in the provision of items or services in the case under review;

(III) the fact of such an affiliation is disclosed to the plan or issuer and the participant, beneficiary, or enrollee (or authorized representative) and neither party objects; and

(IV) the affiliated individual is not an employee of the plan or issuer and does not provide services exclusively or primarily to or on behalf of the plan or issuer;

(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the plan or issuer and the participant, beneficiary, or enrollee (or authorized representative), and neither party objects; or

(iii) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

(ii) by a non-physician health care professional, a reviewer (or reviewers) shall include at least one practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

(B) PRACTICING DEFINED.—For purposes of this paragraph, the term ''practicing'' means, with respect to an individual who is a physician or other health care professional that the individual provides health care services to individual patients on average at least 2 days per week.

(5) PEDIATRIC EXPERTISE.—In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified external review entity to an independent medical reviewer in connection with a review under this section shall—

(A) not exceed a reasonable level; and

(B) not be contingent on the decision rendered by the reviewer.

(7) RELATED PARTY DEFINED.—For purposes of this section, the term ''related party'' means, with respect to a denial of a claim under a plan or coverage relating to a participant, beneficiary, or enrollee, any of the following:

(A) The plan, plan sponsor, or issuer involved, or any fiduciary, officer, director, or employee of such plan, plan sponsor, or issuer.

(B) The participant, beneficiary, or enrollee (or authorized representative).

(C) The health care professional that provides the items or services involved in the denial.

(D) The institution at which the items or services (or treatment) involved in the denial are provided.

(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

(F) Any other party determined under any regulations to have a substantial interest in the denial involved.

(h) QUALIFIED EXTERNAL REVIEW ENTITIES.—

(1) SELECTION OF QUALIFIED EXTERNAL REVIEW ENTITIES.—

(A) LIMITATION ON PLAN OR ISSUER SELECTION.—The appropriate Secretary shall implement procedures—

(i) to assure that the selection process among qualified external review entities will not create any incentives for external review entities to make a decision in a biased manner; and

(ii) for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

No such selection process under the procedures implemented by the appropriate Secretary may give either the patient or the plan or issuer any ability to determine or influence the selection of a qualified external review entity to review the case of any participant, beneficiary, or enrollee.

(B) STATE AUTHORITY WITH RESPECT TO QUALIFIED EXTERNAL REVIEW ENTITIES FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers offering health insurance coverage in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that

is selected by the State in a manner determined by the State to assure an unbiased determination.

(2) CONTRACT WITH QUALIFIED EXTERNAL REVIEW ENTITY.—Except as provided in paragraph (1)(B), the external review process of a plan or issuer under this section shall be conducted under a contract between the plan or issuer and 1 or more qualified external review entities (as defined in paragraph (4)(A)).

(3) TERMS AND CONDITIONS OF CONTRACT.—The terms and conditions of a contract under paragraph (2) shall—

(A) be consistent with the standards the appropriate Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external review activities; and

(B) provide that the costs of the external review process shall be borne by the plan or issuer.

Subparagraph (B) shall not be construed as applying to the imposition of a filing fee under subsection (b)(2)(A)(iv) or costs incurred by the participant, beneficiary, or enrollee (or authorized representative) or treating health care professional (if any) in support of the review, including the provision of additional evidence or information.

(4) QUALIFICATIONS.—

(A) IN GENERAL.—In this section, the term ''qualified external review entity'' means, in relation to a plan or issuer, an entity that is initially certified (and periodically recertified) under subparagraph (C) as meeting the following requirements:

(i) The entity has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to carry out duties of a qualified external review entity under this section on a timely basis, including making determinations under subsection (b)(2)(A) and providing for independent medical reviews under subsection (d).

(ii) The entity is not a plan or issuer or an affiliate or a subsidiary of a plan or issuer, and is not an affiliate or subsidiary of a professional or trade association of plans or issuers or of health care providers.

(iii) The entity has provided assurances that it will conduct external review activities consistent with the applicable requirements of this section and standards specified in subparagraph (C), including that it will not conduct any external review activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

(iv) The entity has provided assurances that it will provide information in a timely manner under subparagraph (D).

(v) The entity meets such other requirements as the appropriate Secretary provides by regulation.

(B) INDEPENDENCE REQUIREMENTS.—

(i) IN GENERAL.—Subject to clause (ii), an entity meets the independence requirements of this subparagraph with respect to any case if the entity—

(I) is not a related party (as defined in subsection (g)(7));

(II) does not have a material familial, financial, or professional relationship with such a party; and

(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified external review entity of compensation from a plan or issuer for the conduct of external review activities under this section if the compensation is provided consistent with clause (iii).

(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by a plan or issuer to a qualified external review entity in connection with reviews under this section shall—

(I) not exceed a reasonable level; and

(II) not be contingent on any decision rendered by the entity or by any independent medical reviewer.

(C) CERTIFICATION AND RECERTIFICATION PROCESS.—

(i) IN GENERAL.—The initial certification and recertification of a qualified external review entity shall be made—

(I) under a process that is recognized or approved by the appropriate Secretary; or

(II) by a qualified private standard-setting organization that is approved by the appropriate Secretary under clause (iii).

In taking action under subclause (I), the appropriate Secretary shall give deference to entities that are under contract with the Federal Government or with an applicable State authority to perform functions of the type performed by qualified external review entities.

(ii) PROCESS.—The appropriate Secretary shall not recognize or approve a process under clause (i)(I) unless the process applies standards (as promulgated in regulations) that ensure that a qualified external review entity—

(I) will carry out (and has carried out, in the case of recertification) the responsibilities of such an entity in accordance with this section, including meeting applicable deadlines;

(II) will meet (and has met, in the case of recertification) appropriate indicators of fiscal integrity;

(III) will maintain (and has maintained, in the case of recertification) appropriate confidentiality with respect to individually identifiable health information obtained in the course of conducting external review activities; and

(IV) in the case recertification, shall review the matters described in clause (iv).

(iii) APPROVAL OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—For purposes of clause (i)(II), the appropriate Secretary may approve a qualified private standard-setting organization if such Secretary finds that the organization only certifies (or recertifies) external review entities that meet at least the standards required for the certification (or recertification) of external review entities under clause (ii).

(iv) CONSIDERATIONS IN RECERTIFICATIONS.—In conducting recertifications of a qualified external review entity under this paragraph, the appropriate Secretary or organization conducting the recertification shall review compliance of the entity with the requirements for conducting external review activities under this section, including the following:

(I) Provision of information under subparagraph (D).

(II) Adherence to applicable deadlines (both by the entity and by independent medical reviewers it refers cases to).

(III) Compliance with limitations on compensation (with respect to both the entity and independent medical reviewers it refers cases to).

(IV) Compliance with applicable independence requirements.

(V) Compliance with the requirement of subsection (d)(1) that only medically reviewable decisions shall be the subject of independent medical review and with the requirement of subsection (d)(3) that independent medical reviewers may not require coverage for specifically excluded benefits.

(v) PERIOD OF CERTIFICATION OR RECERTIFICATION.—A certification or recertification provided under this paragraph shall extend for a period not to exceed 2 years.

(vi) REVOCATION.—A certification or recertification under this paragraph may be revoked by the appropriate Secretary or by the organization providing such certification upon a showing of cause. The Secretary, or organization, shall revoke a certification or deny a recertification with respect to an entity if there is a showing that the entity has a pattern or practice of ordering coverage for benefits that are specifically excluded under the plan or coverage.

(vii) PETITION FOR DENIAL OR WITHDRAWAL.—An individual may petition the Secretary, or an organization providing the certification involves, for a denial of recertification or a withdrawal of a certification with respect to an entity under this subparagraph if there is a pattern or practice of such entity failing to meet a requirement of this section.

(viii) SUFFICIENT NUMBER OF ENTITIES.—The appropriate Secretary shall certify and recertify a number of external review entities which is sufficient to ensure the timely and efficient provision of review services.

(D) PROVISION OF INFORMATION.—

(i) IN GENERAL.—A qualified external review entity shall provide to the appropriate Secretary, in such manner and at such times as such Secretary may require, such information (relating to the denials which have been referred to the entity for the conduct of external review under this section) as such Secretary determines appropriate to assure compliance with the independence and other requirements of this section to monitor and assess the quality of its external review activities and lack of bias in making determinations. Such information shall include information described in clause (ii) but shall not include individually identifiable medical information.

(ii) INFORMATION TO BE INCLUDED.—The information described in this subclause with respect to an entity is as follows:

(I) The number and types of denials for which a request for review has been received by the entity.

(II) The disposition by the entity of such denials, including the number referred to a independent medical reviewer and the reasons for such dispositions (including the application of exclusions), on a plan or issuer-specific basis and on a health care specialty-specific basis.

(III) The length of time in making determinations with respect to such denials.

(IV) Updated information on the information required to be submitted as a condition of certification with respect to the entity's performance of external review activities.

(iii) INFORMATION TO BE PROVIDED TO CERTIFYING ORGANIZATION.—

(I) IN GENERAL.—In the case of a qualified external review entity which is certified (or recertified) under this subsection by a qualified private standard-setting organization, at the request of the organization, the entity shall provide the organization with the information provided to the appropriate Secretary under clause (i).

(II) ADDITIONAL INFORMATION.—Nothing in this subparagraph shall be construed as preventing such an organization from requiring additional information as a condition of certification or recertification of an entity.

(iv) USE OF INFORMATION.—Information provided under this subparagraph may be used by the appropriate Secretary and qualified private standard-setting organizations to conduct oversight of qualified external review entities, including recertification of such entities, and shall be made available to the public in an appropriate manner.

(E) LIMITATION ON LIABILITY.—No qualified external review entity having a contract with a plan or issuer, and no person who is

employed by any such entity or who furnishes professional services to such entity (including as an independent medical reviewer), shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(5) REPORT.—Not later than 12 months after the general effective date referred to in section 501, the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning—

(A) the information that is provided under paragraph (3)(D);

(B) the number of denials that have been upheld by independent medical reviewers and the number of denials that have been reversed by such reviewers; and

(C) the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded under the plan or coverage.

SEC. 105. HEALTH CARE CONSUMER ASSISTANCE FUND.

(a) GRANTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a fund, to be known as the ''Health Care Consumer Assistance Fund'', to be used to award grants to eligible States to carry out consumer assistance activities (including programs established by States prior to the enactment of this Act) designed to provide information, assistance, and referrals to consumers of health insurance products.

(2) STATE ELIGIBILITY.—To be eligible to receive a grant under this subsection a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a State plan that describes—

(A) the manner in which the State will ensure that the health care consumer assistance office (established under paragraph (4)) will educate and assist health care consumers in accessing needed care;

(B) the manner in which the State will coordinate and distinguish the services provided by the health care consumer assistance office with the services provided by Federal, State and local health-related ombudsman, information, protection and advocacy, insurance, and fraud and abuse programs;

(C) the manner in which the State will provide information, outreach, and services to underserved, minority populations with limited English proficiency and populations residing in rural areas;

(D) the manner in which the State will oversee the health care consumer assistance office, its activities, product materials and evaluate program effectiveness;

(E) the manner in which the State will ensure that funds made available under this section will be used to supplement, and not supplant, any other Federal, State, or local funds expended to provide services for programs described under this section and those described in subparagraphs (C) and (D);

(F) the manner in which the State will ensure that health care consumer office personnel have the professional background and training to carry out the activities of the office; and

(G) the manner in which the State will ensure that consumers have direct access to consumer assistance personnel during regular business hours.

(3) AMOUNT OF GRANT.—

(A) IN GENERAL.—From amounts appropriated under subsection (b) for a fiscal year, the Secretary shall award a grant to a State in an amount that bears the same ratio to such amounts as the number of individuals within the State covered under a group health plan or under health insurance coverage offered by a health insurance issuer bears to the total number of individuals so covered in all States (as determined by the Secretary). Any amounts provided to a State under this subsection that are not used by the State shall be remitted to the Secretary and reallocated in accordance with this subparagraph.

(B) MINIMUM AMOUNT.—In no case shall the amount provided to a State under a grant under this subsection for a fiscal year be less than an amount equal to 0.5 percent of the amount appropriated for such fiscal year to carry out this section.

(C) NON-FEDERAL CONTRIBUTIONS.—A State will provide for the collection of non-Federal contributions for the operation of the office in an amount that is not less than 25 percent of the amount of Federal funds provided to the State under this section.

(4) PROVISION OF FUNDS FOR ESTABLISHMENT OF OFFICE.—

(A) IN GENERAL.—From amounts provided under a grant under this subsection, a State shall, directly or through a contract with an independent, nonprofit entity with demonstrated experience in serving the needs of health care consumers, provide for the establishment and operation of a State health care consumer assistance office.

(B) ELIGIBILITY OF ENTITY.—To be eligible to enter into a contract under subparagraph (A), an entity shall demonstrate that it has the technical, organizational, and professional capacity to deliver the services described in subsection (b) to all public and private health insurance participants, beneficiaries, enrollees, or prospective enrollees.

(C) EXISTING STATE ENTITY.—Nothing in this section shall prevent the funding of an existing health care consumer assistance program that otherwise meets the requirements of this section.

(b) USE OF FUNDS.—

(1) BY STATE.—A State shall use amounts provided under a grant awarded under this section to carry out consumer assistance activities directly or by contract with an independent, non-profit organization. An eligible entity may use some reasonable amount of such grant to ensure the adequate training of personnel carrying out such activities. To receive amounts under this subsection, an eligible entity shall provide consumer assistance services, including—

(A) the operation of a toll-free telephone hotline to respond to consumer requests;

(B) the dissemination of appropriate educational materials on available health insurance products and on how best to access health care and the rights and responsibilities of health care consumers;

(C) the provision of education on effective methods to promptly and efficiently resolve questions, problems, and grievances;

(D) the coordination of educational and outreach efforts with health plans, health care providers, payers, and governmental agencies;

(E) referrals to appropriate private and public entities to resolve questions, problems and grievances; and

(F) the provision of information and assistance, including acting as an authorized representative, regarding internal, external, or administrative grievances or appeals procedures in nonlitigative settings to appeal the denial, termination, or reduction of health care services, or the refusal to pay for such services, under a group health plan or health insurance coverage offered by a health insurance issuer.

(2) CONFIDENTIALITY AND ACCESS TO INFORMATION.—

(A) STATE ENTITY.—With respect to a State that directly establishes a health care consumer assistance office, such office shall establish and implement procedures and protocols in accordance with applicable Federal and State laws.

(B) CONTRACT ENTITY.—With respect to a State that, through contract, establishes a health care consumer assistance office, such office shall establish and implement procedures and protocols, consistent with applicable Federal and State laws, to ensure the confidentiality of all information shared by a participant, beneficiary, enrollee, or their personal representative and their health care providers, group health plans, or health insurance insurers with the office and to ensure that no such information is used by the office, or released or disclosed to State agencies or outside persons or entities without the prior written authorization (in accordance with section 164.508 of title 45, Code of Federal Regulations) of the individual or personal representative. The office may, consistent with applicable Federal and State confidentiality laws, collect, use or disclose aggregate information that is not individually identifiable (as defined in section 164.501 of title 45, Code of Federal Regulations). The office shall provide a written description of the policies and procedures of the office with respect to the manner in which health information may be used or disclosed to carry out consumer assistance activities. The office shall provide health care providers, group health plans, or health insurance issuers with a written authorization (in accordance with section 164.508 of title 45, Code of Federal Regulations) to allow the office to obtain medical information relevant to the matter before the office.

(3) AVAILABILITY OF SERVICES.—The health care consumer assistance office of a State shall not discriminate in the provision of information, referrals, and services regardless of the source of the individual's health insurance coverage or prospective coverage, including individuals covered under a group health plan or health insurance coverage offered by a health insurance issuer, the medicare or medicaid programs under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 and 1396 et seq.), or under any other Federal or State health care program.

(4) DESIGNATION OF RESPONSIBILITIES.—

(A) WITHIN EXISTING STATE ENTITY.—If the health care consumer assistance office of a State is located within an existing State regulatory agency or office of an elected State official, the State shall ensure that—

(i) there is a separate delineation of the funding, activities, and responsibilities of the office as compared to the other funding, activities, and responsibilities of the agency; and

(ii) the office establishes and implements procedures and protocols to ensure the confidentiality of all information shared by a participant, beneficiary, or enrollee or their personal representative and their health care providers, group health plans, or health insurance issuers with the office and to ensure that no information is disclosed to the State agency or office without the written authorization of the individual or their personal representative in accordance with paragraph (2).

(B) CONTRACT ENTITY.—In the case of an entity that enters into a contract with a State under subsection (a)(3), the entity shall provide assurances that the entity has no conflict of interest in carrying out the activities of the office and that the entity is independent of group health plans, health insurance issuers, providers, payers, and regulators of health care.

(5) SUBCONTRACTS.—The health care consumer assistance office of a State may carry out activities and provide services through contracts entered into with 1 or more nonprofit entities so long as the office can demonstrate that all of the requirements of this section are complied with by the office.

(6) TERM.—A contract entered into under this subsection shall be for a term of 3 years.

(c) REPORT.—Not later than 1 year after the Secretary first awards grants under this section, and annually thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning the activities funded under this section and the effectiveness of such activities in resolving health care-related problems and grievances.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle B—Access to Care

SEC. 111. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If—

(1) a health insurance issuer providing health insurance coverage in connection with a group health plan offers to enrollees health insurance coverage which provides for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the issuer to provide such services, or

(2) a group health plan offers to participants or beneficiaries health benefits which provide for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the plan to provide such services,

then the issuer or plan shall also offer or arrange to be offered to such enrollees, participants, or beneficiaries (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage or health benefits which provide for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless such enrollees, participants, or beneficiaries are offered such non-network coverage through another group health plan or through another health insurance issuer in the group market.

(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer or group health plan for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee, participant, or beneficiary unless it is paid by the health plan sponsor or group health plan through agreement with the health insurance issuer.

(c) OPEN SEASON.—An enrollee, participant, or beneficiary, may change to the offering provided under this section only during a time period determined by the health insurance issuer or group health plan. Such time period shall occur at least annually.

SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary and appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating health care professionals with respect to such care.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 114 (relating to access to specialty care).

SEC. 113. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization, or

(ii) by a participating health care provider without prior authorization,

the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(C) STABILIZE.—The term ''to stabilize'', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance coverage offered by a health insurance issuer, must provide reimbursement for maintenance care and post-stabilization care in accordance with the requirements of section 1852(d)(2) of the Social Security Act (42 U.S.C. 1395w–22(d)(2)). Such reimbursement shall be provided in a manner consistent with subsection (a)(1)(C).

(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2)) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term ''emergency ambulance services'' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

SEC. 114. TIMELY ACCESS TO SPECIALISTS.

(a) TIMELY ACCESS.—

(1) IN GENERAL.—A group health plan or health insurance issuer offering health insurance coverage shall ensure that participants, beneficiaries, and enrollees receive timely access to specialists who are appropriate to the condition of, and accessible to, the participant, beneficiary, or enrollee, when such specialty care is a covered benefit under the plan or coverage.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

(A) to require the coverage under a group health plan or health insurance coverage of benefits or services;

(B) to prohibit a plan or issuer from including providers in the network only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees; or

(C) to override any State licensure or scope-of-practice law.

(3) ACCESS TO CERTAIN PROVIDERS.—

(A) IN GENERAL.—With respect to specialty care under this section, if a participating specialist is not available and qualified to provide such care to the participant, beneficiary, or enrollee, the plan or issuer shall provide for coverage of such care by a nonparticipating specialist.

(B) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a participant, beneficiary, or enrollee receives care from a nonparticipating specialist pursuant to subparagraph (A), such specialty care shall be provided at no additional cost to the participant, beneficiary, or enrollee beyond what the participant, beneficiary, or enrollee would otherwise pay for such specialty care if provided by a participating specialist.

(b) REFERRALS.—

(1) AUTHORIZATION.—Subject to subsection (a)(1), a group health plan or health insurance issuer may require an authorization in

order to obtain coverage for specialty services under this section. Any such authorization—

(A) shall be for an appropriate duration of time or number of referrals, including an authorization for a standing referral where appropriate; and

(B) may not be refused solely because the authorization involves services of a nonparticipating specialist (described in subsection (a)(3)).

(2) REFERRALS FOR ONGOING SPECIAL CONDITIONS.—

(A) IN GENERAL.—Subject to subsection (a)(1), a group health plan or health insurance issuer shall permit a participant, beneficiary, or enrollee who has an ongoing special condition (as defined in subparagraph (B)) to receive a referral to a specialist for the treatment of such condition and such specialist may authorize such referrals, procedures, tests, and other medical services with respect to such condition, or coordinate the care for such condition, subject to the terms of a treatment plan (if any) referred to in subsection (c) with respect to the condition.

(B) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ''ongoing special condition'' means a condition or disease that—

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(c) TREATMENT PLANS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may require that the specialty care be provided—

(A) pursuant to a treatment plan, but only if the treatment plan—

(i) is developed by the specialist, in consultation with the case manager or primary care provider, and the participant, beneficiary, or enrollee, and

(ii) is approved by the plan or issuer in a timely manner, if the plan or issuer requires such approval; and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan or issuer from requiring the specialist to provide the plan or issuer with regular updates on the specialty care provided, as well as all other reasonably necessary medical information.

(d) SPECIALIST DEFINED.—For purposes of this section, the term ''specialist'' means, with respect to the condition of the participant, beneficiary, or enrollee, a health care professional, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

SEC. 115. PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) GENERAL RIGHTS.—

(1) DIRECT ACCESS.—A group health plan, or health insurance issuer offering health insurance coverage, described in subsection (b) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in subsection (b)(2)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.

(2) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in subsection (b) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (1), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(b) APPLICATION OF SECTION.—A group health plan, or health insurance issuer offering health insurance coverage, described in this subsection is a group health plan or coverage that—

(1) provides coverage for obstetric or gynecologic care; and

(2) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(c) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

SEC. 116. ACCESS TO PEDIATRIC CARE.

(a) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

SEC. 117. CONTINUITY OF CARE.

(a) TERMINATION OF PROVIDER.—

(1) IN GENERAL.—If—

(A) a contract between a group health plan, or a health insurance issuer offering health insurance coverage, and a treating health care provider is terminated (as defined in paragraph (e)(4)), or

(B) benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such plan or coverage,

the plan or issuer shall meet the requirements of paragraph (3) with respect to each continuing care patient.

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

(3) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

(A) notify the continuing care patient involved, or arrange to have the patient notified pursuant to subsection (d)(2), on a timely basis of the termination described in paragraph (1) (or paragraph (2), if applicable) and the right to elect continued transitional care from the provider under this section;

(B) provide the patient with an opportunity to notify the plan or issuer of the patient's need for transitional care; and

(C) subject to subsection (c), permit the patient to elect to continue to be covered with respect to the course of treatment by such provider with the provider's consent during a transitional period (as provided for under subsection (b)).

(4) CONTINUING CARE PATIENT.—For purposes of this section, the term ''continuing care patient'' means a participant, beneficiary, or enrollee who—

(A) is undergoing a course of treatment for a serious and complex condition from the provider at the time the plan or issuer receives or provides notice of provider, benefit, or coverage termination described in paragraph (1) (or paragraph (2), if applicable);

(B) is undergoing a course of institutional or inpatient care from the provider at the time of such notice;

(C) is scheduled to undergo non-elective surgery from the provider at the time of such notice;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider at the time of such notice; or

(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of such notice, but only with respect to a provider that was treating the terminal illness before the date of such notice.

(b) TRANSITIONAL PERIODS.—

(1) SERIOUS AND COMPLEX CONDITIONS.—The transitional period under this subsection with respect to a continuing care patient described in subsection (a)(4)(A) shall extend for up to 90 days (as determined by the treating health care professional) from the date of the notice described in subsection (a)(3)(A).

(2) INSTITUTIONAL OR INPATIENT CARE.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(B) shall extend until the earlier of—

(A) the expiration of the 90-day period beginning on the date on which the notice under subsection (a)(3)(A) is provided; or

(B) the date of discharge of the patient from such care or the termination of the period of institutionalization, or, if later, the date of completion of reasonable follow-up care.

(3) SCHEDULED NON-ELECTIVE SURGERY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(C) shall extend until the completion of the surgery involved and post-surgical follow-up care relating to the surgery and occurring within 90 days after the date of the surgery.

(4) PREGNANCY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(D) shall extend through the provision of post-partum care directly related to the delivery.

(5) TERMINAL ILLNESS.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(E) shall extend for the remainder of the patient's life for care that is directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under this section upon the provider agreeing to the following terms and conditions:

(1) The treating health care provider agrees to accept reimbursement from the plan or issuer and continuing care patient involved (with respect to cost-sharing) at the rates applicable prior to the start of the

transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or coverage after the date of the termination of the contract with the group health plan or health insurance issuer) and not to impose cost-sharing with respect to the patient in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The treating health care provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The treating health care provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(d) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

(1) to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider; or

(2) with respect to the termination of a contract under subsection (a) to prevent a group health plan or health insurance issuer from requiring that the health care provider—

(A) notify participants, beneficiaries, or enrollees of their rights under this section; or

(B) provide the plan or issuer with the name of each participant, beneficiary, or enrollee who the provider believes is a continuing care patient.

(e) DEFINITIONS.—In this section:

(1) CONTRACT.—The term ''contract'' includes, with respect to a plan or issuer and a treating health care provider, a contract between such plan or issuer and an organized network of providers that includes the treating health care provider, and (in the case of such a contract) the contract between the treating health care provider and the organized network.

(2) HEALTH CARE PROVIDER.—The term ''health care provider'' or ''provider'' means—

(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(3) SERIOUS AND COMPLEX CONDITION.—The term ''serious and complex condition'' means, with respect to a participant, beneficiary, or enrollee under the plan or coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, is an ongoing special condition (as defined in section 114(b)(2)(B)).

(4) TERMINATED.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

SEC. 118. ACCESS TO NEEDED PRESCRIPTION DRUGS.

(a) IN GENERAL.—To the extent that a group health plan, or health insurance coverage offered by a health insurance issuer, provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan or issuer shall—

(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary;

(2) provide for disclosure of the formulary to providers; and

(3) in accordance with the applicable quality assurance and utilization review standards of the plan or issuer, provide for exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate and, in the case of such an exception, apply the same cost-sharing requirements that would have applied in the case of a drug covered under the formulary.

(b) COVERAGE OF APPROVED DRUGS AND MEDICAL DEVICES.—

(1) IN GENERAL.—A group health plan (or health insurance coverage offered in connection with such a plan) that provides any coverage of prescription drugs or medical devices shall not deny coverage of such a drug or device on the basis that the use is investigational, if the use—

(A) in the case of a prescription drug—

(i) is included in the labeling authorized by the application in effect for the drug pursuant to subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act, without regard to any postmarketing requirements that may apply under such Act; or

(ii) is included in the labeling authorized by the application in effect for the drug under section 351 of the Public Health Service Act, without regard to any postmarketing requirements that may apply pursuant to such section; or

(B) in the case of a medical device, is included in the labeling authorized by a regulation under subsection (d) or (3) of section 513 of the Federal Food, Drug, and Cosmetic Act, an order under subsection (f) of such section, or an application approved under section 515 of such Act, without regard to any postmarketing requirements that may apply under such Act.

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any coverage of prescription drugs or medical devices.

SEC. 119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the enrollee's participation in such trial.

(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(1)(A) The individual has a life-threatening or serious illness for which no standard treatment is effective.

(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

(2) Either—

(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) PAYMENT.—

(1) IN GENERAL.—Under this section a group health plan or health insurance issuer shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected (as determined by the appropriate Secretary) to be paid for by the sponsors of an approved clinical trial.

(2) PAYMENT RATE.—In the case of covered items and services provided by—

(A) a participating provider, the payment rate shall be at the agreed upon rate; or

(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

(d) APPROVED CLINICAL TRIAL DEFINED.—

(1) IN GENERAL.—In this section, the term ''approved clinical trial'' means a clinical research study or clinical investigation—

(A) approved and funded (which may include funding through in-kind contributions) by one or more of the following:

(i) the National Institutes of Health;

(ii) a cooperative group or center of the National Institutes of Health, such as a qualified nongovernmental research entity to which the National Cancer Institute has awarded a center support grant;

(iii) either of the following if the conditions described in paragraph (2) are met—

(I) the Department of Veterans Affairs;

(II) the Department of Defense; or

(B) approved by the Food and Drug Administration.

(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the appropriate Secretary determines—

(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(B) assures unbiased review of the highest ethical standards by qualified individuals

who have no interest in the outcome of the review.

(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

SEC. 120. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

(a) INPATIENT CARE.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

(A) a mastectomy;

(B) a lumpectomy; or

(C) a lymph node dissection for the treatment of breast cancer.

(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage, may not modify the terms and conditions of coverage based on the determination by a participant, beneficiary, or enrollee to request less than the minimum coverage required under subsection (a).

(c) SECONDARY CONSULTATIONS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan or coverage with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan or issuer.

(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

(d) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage, may not—

(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant, beneficiary, or enrollee in accordance with this section;

(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant, beneficiary, or enrollee for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (c).

Subtitle C—Access to Information

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) REQUIREMENT.—

(1) DISCLOSURE.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer that provides coverage in connection with health insurance coverage, shall provide for the disclosure to participants, beneficiaries, and enrollees—

(i) of the information described in subsection (b) at the time of the initial enrollment of the participant, beneficiary, or enrollee under the plan or coverage;

(ii) of such information on an annual basis—

(I) in conjunction with the election period of the plan or coverage if the plan or coverage has such an election period; or

(II) in the case of a plan or coverage that does not have an election period, in conjunction with the beginning of the plan or coverage year; and

(iii) of information relating to any material reduction to the benefits or information described in such subsection or subsection (c), in the form of a notice provided not later than 30 days before the date on which the reduction takes effect.

(B) PARTICIPANTS, BENEFICIARIES, AND ENROLLEES.—The disclosure required under subparagraph (A) shall be provided—

(i) jointly to each participant, beneficiary, and enrollee who reside at the same address; or

(ii) in the case of a beneficiary or enrollee who does not reside at the same address as the participant or another enrollee, separately to the participant or other enrollees and such beneficiary or enrollee.

(2) PROVISION OF INFORMATION.—Information shall be provided to participants, beneficiaries, and enrollees under this section at the last known address maintained by the plan or issuer with respect to such participants, beneficiaries, or enrollees, to the extent that such information is provided to participants, beneficiaries, or enrollees via the United States Postal Service or other private delivery service.

(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each option available under the group health plan or health insurance coverage the following:

(1) BENEFITS.—A description of the covered benefits, including—

(A) any in- and out-of-network benefits;

(B) specific preventive services covered under the plan or coverage if such services are covered;

(C) any specific exclusions or express limitations of benefits described in section 104(d)(3)(C);

(D) any other benefit limitations, including any annual or lifetime benefit limits and any monetary limits or limits on the number of visits, days, or services, and any specific coverage exclusions; and

(E) any definition of medical necessity used in making coverage determinations by the plan, issuer, or claims administrator.

(2) COST SHARING.—A description of any cost-sharing requirements, including—

(A) any premiums, deductibles, coinsurance, copayment amounts, and liability for balance billing, for which the participant, beneficiary, or enrollee will be responsible under each option available under the plan;

(B) any maximum out-of-pocket expense for which the participant, beneficiary, or enrollee may be liable;

(C) any cost-sharing requirements for out-of-network benefits or services received from nonparticipating providers; and

(D) any additional cost-sharing or charges for benefits and services that are furnished without meeting applicable plan or coverage requirements, such as prior authorization or precertification.

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

(4) SERVICE AREA.—A description of the plan or issuer's service area, including the provision of any out-of-area coverage.

(5) PARTICIPATING PROVIDERS.—A directory of participating providers (to the extent a plan or issuer provides coverage through a network of providers) that includes, at a minimum, the name, address, and telephone number of each participating provider, and information about how to inquire whether a participating provider is currently accepting new patients.

(6) CHOICE OF PRIMARY CARE PROVIDER.—A description of any requirements and procedures to be used by participants, beneficiaries, and enrollees in selecting, accessing, or changing their primary care provider, including providers both within and outside of the network (if the plan or issuer permits out-of-network services), and the right to select a pediatrician as a primary care provider under section 116 for a participant, beneficiary, or enrollee who is a child if such section applies.

(7) PREAUTHORIZATION REQUIREMENTS.—A description of the requirements and procedures to be used to obtain preauthorization for health services, if such preauthorization is required.

(8) EXPERIMENTAL AND INVESTIGATIONAL TREATMENTS.—A description of the process for determining whether a particular item, service, or treatment is considered experimental or investigational, and the circumstances under which such treatments are covered by the plan or issuer.

(9) SPECIALTY CARE.—A description of the requirements and procedures to be used by participants, beneficiaries, and enrollees in accessing specialty care and obtaining referrals to participating and nonparticipating specialists, including any limitations on choice of health care professionals referred to in section 112(b)(2) and the right to timely access to specialists care under section 114 if such section applies.

(10) CLINICAL TRIALS.—A description of the circumstances and conditions under which participation in clinical trials is covered under the terms and conditions of the plan or coverage, and the right to obtain coverage for approved clinical trials under section 119 if such section applies.

(11) PRESCRIPTION DRUGS.—To the extent the plan or issuer provides coverage for prescription drugs, a statement of whether such coverage is limited to drugs included in a formulary, a description of any provisions and cost-sharing required for obtaining on- and off-formulary medications, and a description of the rights of participants, beneficiaries, and enrollees in obtaining access to access to prescription drugs under section 118 if such section applies.

(12) EMERGENCY SERVICES.—A summary of the rules and procedures for accessing emergency services, including the right of a participant, beneficiary, or enrollee to obtain emergency services under the prudent layperson standard under section 113, if such

section applies, and any educational information that the plan or issuer may provide regarding the appropriate use of emergency services.

(13) CLAIMS AND APPEALS.—A description of the plan or issuer's rules and procedures pertaining to claims and appeals, a description of the rights (including deadlines for exercising rights) of participants, beneficiaries, and enrollees under subtitle A in obtaining covered benefits, filing a claim for benefits, and appealing coverage decisions internally and externally (including telephone numbers and mailing addresses of the appropriate authority), and a description of any additional legal rights and remedies available under section 502 of the Employee Retirement Income Security Act of 1974 and applicable State law.

(14) ADVANCE DIRECTIVES AND ORGAN DONATION.—A description of procedures for advance directives and organ donation decisions if the plan or issuer maintains such procedures.

(15) INFORMATION ON PLANS AND ISSUERS.—The name, mailing address, and telephone number or numbers of the plan administrator and the issuer to be used by participants, beneficiaries, and enrollees seeking information about plan or coverage benefits and services, payment of a claim, or authorization for services and treatment. Notice of whether the benefits under the plan or coverage are provided under a contract or policy of insurance issued by an issuer, or whether benefits are provided directly by the plan sponsor who bears the insurance risk.

(16) TRANSLATION SERVICES.—A summary description of any translation or interpretation services (including the availability of printed information in languages other than English, audio tapes, or information in Braille) that are available for non-English speakers and participants, beneficiaries, and enrollees with communication disabilities and a description of how to access these items or services.

(17) ACCREDITATION INFORMATION.—Any information that is made public by accrediting organizations in the process of accreditation if the plan or issuer is accredited, or any additional quality indicators (such as the results of enrollee satisfaction surveys) that the plan or issuer makes public or makes available to participants, beneficiaries, and enrollees.

(18) NOTICE OF REQUIREMENTS.—A description of any rights of participants, beneficiaries, and enrollees that are established by the Bipartisan Patient Protection Act (excluding those described in paragraphs (1) through (17)) if such sections apply. The description required under this paragraph may be combined with the notices of the type described in sections 711(d), 713(b), or 606(a)(1) of the Employee Retirement Income Security Act of 1974 and with any other notice provision that the appropriate Secretary determines may be combined, so long as such combination does not result in any reduction in the information that would otherwise be provided to the recipient.

(19) AVAILABILITY OF ADDITIONAL INFORMATION.—A statement that the information described in subsection (c), and instructions on obtaining such information (including telephone numbers and, if available, Internet websites), shall be made available upon request.

(20) DESIGNATED DECISIONMAKERS.—A description of the participants and beneficiaries with respect to whom each designated decisionmaker under the plan has assumed liability under section 502(o) of the Employee Retirement Income Security Act of 1974 and the name and address of each such decisionmaker.

(c) ADDITIONAL INFORMATION.—The informational materials to be provided upon the request of a participant, beneficiary, or enrollee shall include for each option available under a group health plan or health insurance coverage the following:

(1) STATUS OF PROVIDERS.—The State licensure status of the plan or issuer's participating health care professionals and participating health care facilities, and, if available, the education, training, specialty qualifications or certifications of such professionals.

(2) COMPENSATION METHODS.—A summary description by category of the applicable methods (such as capitation, fee-for-service, salary, bundled payments, per diem, or a combination thereof) used for compensating prospective or treating health care professionals (including primary care providers and specialists) and facilities in connection with the provision of health care under the plan or coverage.

(3) PRESCRIPTION DRUGS.—Information about whether a specific prescription medication is included in the formulary of the plan or issuer, if the plan or issuer uses a defined formulary.

(4) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, timeframes, and appeals rights) under any utilization review program under sections 101 and 102, including any drug formulary program under section 118.

(5) EXTERNAL APPEALS INFORMATION.—Aggregate information on the number and outcomes of external medical reviews, relative to the sample size (such as the number of covered lives) under the plan or under the coverage of the issuer.

(d) MANNER OF DISCLOSURE.—The information described in this section shall be disclosed in an accessible medium and format that is calculated to be understood by a participant or enrollee.

(e) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a group health plan, or a health insurance issuer in connection with health insurance coverage, from—

(1) distributing any other additional information determined by the plan or issuer to be important or necessary in assisting participants, beneficiaries, and enrollees in the selection of a health plan or health insurance coverage; and

(2) complying with the provisions of this section by providing information in brochures, through the Internet or other electronic media, or through other similar means, so long as—

(A) the disclosure of such information in such form is in accordance with requirements as the appropriate Secretary may impose, and

(B) in connection with any such disclosure of information through the Internet or other electronic media—

(i) the recipient has affirmatively consented to the disclosure of such information in such form,

(ii) the recipient is capable of accessing the information so disclosed on the recipient's individual workstation or at the recipient's home,

(iii) the recipient retains an ongoing right to receive paper disclosure of such information and receives, in advance of any attempt at disclosure of such information to him or her through the Internet or other electronic media, notice in printed form of such ongoing right and of the proper software required to view information so disclosed, and

(iv) the plan administrator appropriately ensures that the intended recipient is receiving the information so disclosed and provides the information in printed form if the information is not received.

SEC. 122. GENETIC INFORMATION.

(a) DEFINITIONS.—In this section:

(1) FAMILY MEMBER.—The term ''family member'' means with respect to an individual—

(A) the spouse of the individual;

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

(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

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

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

(4) GENETIC TEST.—The term ''genetic test'' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include a physical test, such as a chemical, blood, or urine analysis of an individual, including a cholesterol test, or a physical exam of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.

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

(6) PREDICTIVE GENETIC INFORMATION.—

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

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

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

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

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

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

(ii) information about chemical, blood, or urine analyses of the individual, including cholesterol tests, unless these analyses are genetic tests, as defined in paragraph (4); or

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

(b) NONDISCRIMINATION.—

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

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

(or information about a request for or the receipt of genetic services by such individual or a family member of such individual).

(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

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

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

(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage, that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

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

(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

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

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

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

(C) a description of the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage, shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan or issuer.

(3) COMPLIANCE WITH CERTAIN STANDARDS.—With respect to the establishment and maintenance of safeguards under this subsection or subsection (c)(2)(B), a group health plan, or a health insurance issuer offering health insurance coverage, shall be deemed to be in compliance with such subsections if such plan or issuer is in compliance with the standards promulgated by the Secretary of Health and Human Services under—

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

(B) section 264(c) of Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(e) SPECIAL RULE IN CASE OF GENETIC INFORMATION.—With respect to health insurance coverage offered by a health insurance issuer, the provisions of this section relating to genetic information (including information about a request for or the receipt of genetic services by an individual or a family member of such individual) shall not be construed to supersede any provision of State law that establishes, implements, or continues in effect a standard, requirement, or remedy that more completely—

(1) protects the confidentiality of genetic information (including information about a request for or the receipt of genetic services by an individual or a family member of such individual) or the privacy of an individual or a family member of the individual with respect to genetic information (including information about a request for or the receipt of genetic services by the individual or a family member of such individual); or

(2) prohibits discrimination on the basis of genetic information than does this section.

Subtitle D—Protecting the Doctor-Patient Relationship

SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

(a) IN GENERAL.—A group health plan, and a health insurance issuer with respect to health insurance coverage, shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

(b) CONSTRUCTION.—Subsection (a) shall not be construed—

(1) as requiring the coverage under a group health plan or health insurance coverage of a particular benefit or service or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

(2) to override any State licensure or scope-of-practice law; or

(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer.

SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

SEC. 134. PAYMENT OF CLAIMS.

A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or issuer, in a manner consistent with the provisions of section 1842(c)(2) of the Social Security Act (42 U.S.C. 1395u(c)(2)).

SEC. 135. PROTECTION FOR PATIENT ADVOCACY.

(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—A group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title.

(b) PROTECTION FOR QUALITY ADVOCACY BY HEALTH CARE PROFESSIONALS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may not retaliate or discriminate against a protected health care professional because the professional in good faith—

(A) discloses information relating to the care, services, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries, or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

(2) GOOD FAITH ACTION.—For purposes of paragraph (1), a protected health care professional is considered to be acting in good faith with respect to disclosure of information or participation if, with respect to the information disclosed as part of the action—

(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with the same licensure or certification and the same experience;

(B) the professional reasonably believes the information to be true;

(C) the information evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider established for the purpose of addressing quality concerns before making the disclosure.

(3) EXCEPTION AND SPECIAL RULE.—

(A) GENERAL EXCEPTION.—Paragraph (1) does not protect disclosures that would violate Federal or State law or diminish or impair the rights of any person to the continued protection of confidentiality of communications provided by such law.

(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

(C) INTERNAL PROCEDURE EXCEPTION.—Subparagraph (D) of paragraph (2) also shall not apply if—

(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

(5) NOTICE.—A group health plan, health insurance issuer, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

(6) CONSTRUCTIONS.—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and protected health care professionals under other applicable Federal or State laws.

(7) PROTECTED HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term ''protected health care professional'' means an individual who is a licensed or certified health care professional and who—

(A) with respect to a group health plan or health insurance issuer, is an employee of the plan or issuer or has a contract with the plan or issuer for provision of services for which benefits are available under the plan or issuer; or

(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the provider respecting the provision of health care services.

Subtitle E—Definitions

SEC. 151. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2791 of the Public Health Service Act shall apply for purposes of this title in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this title under section 713 of the Employee Retirement Income Security Act of 1974.

(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

(1) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of this title, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

(2) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(3) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974, except that such term includes a employee welfare benefit plan treated as a group health plan under section 732(d) of such Act or defined as such a plan under section 607(1) of such Act.

(4) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(6) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(7) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(8) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(9) PRIOR AUTHORIZATION.—The term ''prior authorization'' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

(10) TERMS AND CONDITIONS.—The term ''terms and conditions'' includes, with respect to a group health plan or health insurance coverage, requirements imposed under this title with respect to the plan or coverage.

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this title.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(3) CONSTRUCTION.—In applying this section, a State law that provides for equal access to, and availability of, all categories of licensed health care providers and services shall not be treated as preventing the application of any requirement of this title.

(b) APPLICATION OF SUBSTANTIALLY COMPLIANT STATE LAWS.—

(1) IN GENERAL.—In the case of a State law that imposes, with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan, a requirement that substantially complies (within the meaning of subsection (c)) with a patient protection requirement (as defined in paragraph (3)) and does not prevent the application of other requirements under this Act (except in the case of other substantially compliant requirements), in applying the requirements of this title under section 2707 and 2753 (as applicable) of the Public Health Service Act (as added by title II), subject to subsection (a)(2)—

(A) the State law shall not be treated as being superseded under subsection (a); and

(B) the State law shall apply instead of the patient protection requirement otherwise applicable with respect to health insurance coverage and non-Federal governmental plans.

(2) LIMITATION.—In the case of a group health plan covered under title I of the Employee Retirement Income Security Act of 1974, paragraph (1) shall be construed to apply only with respect to the health insurance coverage (if any) offered in connection with the plan.

(3) DEFINITIONS.—In this section:

(A) PATIENT PROTECTION REQUIREMENT.—The term ''patient protection requirement'' means a requirement under this title, and includes (as a single requirement) a group or related set of requirements under a section or similar unit under this title.

(B) SUBSTANTIALLY COMPLIANT.—The terms ''substantially compliant'', substantially complies'', or ''substantial compliance'' with respect to a State law, mean that the State law has the same or similar features as the patient protection requirements and has a similar effect.

(c) DETERMINATIONS OF SUBSTANTIAL COMPLIANCE.—

(1) CERTIFICATION BY STATES.—A State may submit to the Secretary a certification that a State law provides for patient protections that are at least substantially compliant with one or more patient protection requirements. Such certification shall be accompanied by such information as may be required to permit the Secretary to make the determination described in paragraph (2)(A).

(2) REVIEW.—

(A) IN GENERAL.—The Secretary shall promptly review a certification submitted under paragraph (1) with respect to a State law to determine if the State law substantially complies with the patient protection requirement (or requirements) to which the law relates.

(B) APPROVAL DEADLINES.—

(i) INITIAL REVIEW.—Such a certification is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification is disapproved (and the reasons for disapproval) or that specified additional information is needed to make the determination described in subparagraph (A).

(ii) ADDITIONAL INFORMATION.—With respect to a State that has been notified by the Secretary under clause (i) that specified additional information is needed to make the determination described in subparagraph (A), the Secretary shall make the determination within 60 days after the date on which such specified additional information is received by the Secretary.

(3) APPROVAL.—

(A) IN GENERAL.—The Secretary shall approve a certification under paragraph (1) unless—

(i) the State fails to provide sufficient information to enable the Secretary to make a determination under paragraph (2)(A); or

(ii) the Secretary determines that the State law involved does not provide for patient protections that substantially comply with the patient protection requirement (or requirements) to which the law relates.

(B) STATE CHALLENGE.—A State that has a certification disapproved by the Secretary under subparagraph (A) may challenge such disapproval in the appropriate United States district court.

(C) DEFERENCE TO STATES.—With respect to a certification submitted under paragraph (1), the Secretary shall give deference to the State's interpretation of the State law involved and the compliance of the law with a patient protection requirement.

(D) PUBLIC NOTIFICATION.—The Secretary shall—

(i) provide a State with a notice of the determination to approve or disapprove a certification under this paragraph;

(ii) promptly publish in the Federal Register a notice that a State has submitted a certification under paragraph (1);

(iii) promptly publish in the Federal Register the notice described in clause (i) with respect to the State; and

(iv) annually publish the status of all States with respect to certifications.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the certification (and approval of certification) of a State law under this subsection solely because it provides for greater protections for patients than those protections otherwise required to establish substantial compliance.

(5) PETITIONS.—

(A) PETITION PROCESS.—Effective on the date on which the provisions of this Act become effective, as provided for in section 501, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this title.

(B) OPINION.—The Secretary shall issue an advisory opinion with respect to a petition submitted under subparagraph (A) within the 60-day period beginning on the date on which such petition is submitted.

(d) DEFINITIONS.—For purposes of this section:

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term ''State'' includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

SEC. 153. EXCLUSIONS.

(a) NO BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to require a group health plan or a health insurance issuer offering health insurance coverage to include specific items and services under the terms of such a plan or coverage, other than those provided under the terms and conditions of such plan or coverage.

(b) EXCLUSION FROM ACCESS TO CARE MANAGED CARE PROVISIONS FOR FEE-FOR-SERVICE COVERAGE.—

(1) IN GENERAL.—The provisions of sections 111 through 117 shall not apply to a group health plan or health insurance coverage if the only coverage offered under the plan or coverage is fee-for-service coverage (as defined in paragraph (2)).

(2) FEE-FOR-SERVICE COVERAGE DEFINED.—For purposes of this subsection, the term ''fee-for-service coverage'' means coverage under a group health plan or health insurance coverage that—

(A) reimburses hospitals, health professionals, and other providers on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary reimbursement for such a provider based on an agreement to contract terms and conditions or the utilization of health care items or services relating to such provider;

(C) allows access to any provider that is lawfully authorized to provide the covered services and that agrees to accept the terms and conditions of payment established under the plan or by the issuer; and

(D) for which the plan or issuer does not require prior authorization before providing for any health care services.

SEC. 154. COVERAGE OF LIMITED SCOPE PLANS.

Only for purposes of applying the requirements of this title under sections 2707 and 2753 of the Public Health Service Act and section 714 of the Employee Retirement Income Security Act of 1974, section 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee Retirement Income Security Act of 1974 shall be deemed not to apply.

SEC. 155. REGULATIONS.

The Secretaries of Health and Human Services and Labor shall issue such regulations as may be necessary or appropriate to carry out this title. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this title.

SEC. 156. INCORPORATION INTO PLAN OR COVERAGE DOCUMENTS.

The requirements of this title with respect to a group health plan or health insurance coverage are deemed to be incorporated into, and made a part of, such plan or the policy, certificate, or contract providing such coverage and are enforceable under law as if directly included in the documentation of such plan or such policy, certificate, or contract.

TITLE II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2707. PATIENT PROTECTION STANDARDS.

''Each group health plan shall comply with patient protection requirements under title I of the Bipartisan Patient Protection Act, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2707)'' after ''requirements of such subparts''.

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

''SEC. 2753. PATIENT PROTECTION STANDARDS.

''Each health insurance issuer shall comply with patient protection requirements under title I of the Bipartisan Patient Protection Act with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

SEC. 203. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.) is amended by adding at the end the following:

''SEC. 2793. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under title I of the Bipartisan Patient Protection Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if

authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

SEC. 204. ELIMINATION OF OPTION OF NON-FEDERAL GOVERNMENTAL PLANS TO BE EXCEPTED FROM REQUIREMENTS CONCERNING GENETIC INFORMATION.

Section 2721(b)(2) of the Public Health Service Act (42 U.S. C. 300gg–21(b)(2)) is amended—

(1) in subparagraph (A), by striking ''If the plan sponsor'' and inserting ''Except as provided in subparagraph (D), if the plan sponsor''; and

(2) by adding at the end the following:

''(D) ELECTION NOT APPLICABLE TO REQUIREMENTS CONCERNING GENETIC INFORMATION.—The election described in subparagraph (A) shall not be available with respect to the provisions of subsections (b), (c), and (d) of section 122 of the Bipartisan Patient Protection Act and the provisions of section 2702(b) to the extent that the subsections and section apply to genetic information (or information about a request for or the receipt of genetic services by an individual or a family member of such individual).''.

TITLE III—APPLICATION OF PATIENT PROTECTION STANDARDS TO FEDERAL HEALTH CARE PROGRAMS

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO FEDERAL HEALTH CARE PROGRAMS.

(a) APPLICATION OF STANDARDS.—

(1) IN GENERAL.—Each Federal health care program shall comply with the patient protection requirements under title I, and such requirements shall be deemed to be incorporated into this section.

(2) CAUSE OF ACTION RELATING TO PROVISION OF HEALTH BENEFITS.—Any individual who receives a health care item or service under a Federal health care program shall have a cause of action against the Federal Government under sections 502(n) and 514(d) of the Employee Retirement Income Security Act of 1974, and the provisions of such sections shall be deemed to be incorporated into this section.

(3) RULES OF CONSTRUCTION.—For purposes of this subsection—

(A) each Federal health care program shall be deemed to be a group health plan;

(B) the Federal Government shall be deemed to be the plan sponsor of each Federal health care program; and

(C) each individual eligible for benefits under a Federal health care program shall be deemed to be a participant, beneficiary, or enrollee under that program.

(b) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this section, the term ''Federal health care program'' has the meaning given that term under section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b) except that, for purposes of this section, such term includes the Federal employees health benefits program established under chapter 89 of title 5, United States Code.

TITLE IV—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 401. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 714. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Bipartisan Patient Protection Act (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Bipartisan Patient Protection Act with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 111 (relating to consumer choice option).

''(B) Section 112 (relating to choice of health care professional).

''(C) Section 113 (relating to access to emergency care).

''(D) Section 114 (relating to timely access to specialists).

''(E) Section 115 (relating to patient access to obstetrical and gynecological care).

''(F) Section 116 (relating to access to pediatric care).

''(G) Section 117 (relating to continuity of care), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(H) Section 118 (relating to access to needed prescription drugs).

''(I) Section 119 (relating to coverage for individuals participating in approved clinical trials).

''(J) Section 120 (relating to required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations).

''(K) Section 134 (relating to payment of claims).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 121 of the Bipartisan Patient Protection Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

''(3) INTERNAL APPEALS.—With respect to the internal appeals process required to be established under section 103 of such Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 104 of such Act, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections of the Bipartisan Patient Protection Act, the group health plan shall not be liable for such violation unless the plan caused such violation:

''(A) Section 131 (relating to prohibition of interference with certain medical communications).

''(B) Section 132 (relating to prohibition of discrimination against providers based on licensure).

''(C) Section 133 (relating to prohibition against improper incentive arrangements).

''(D) Section 135 (relating to protection for patient advocacy).

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(7) TREATMENT OF SUBSTANTIALLY COMPLIANT STATE LAWS.—For purposes of applying this subsection, any reference in this subsection to a requirement in a section or other provision in the Bipartisan Patient Protection Act with respect to a health insurance issuer is deemed to include a reference to a requirement under a State law that substantially complies (as determined under section 152(c) of such Act) with the requirement in such section or other provisions.

''(8) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 135(b)(1) of the Bipartisan Patient Protection Act, for purposes of this subtitle the term 'group health plan' is deemed to include a reference to an institutional health care provider.

''(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

''(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation of section 135(b)(1) of the Bipartisan Patient Protection Act may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

''(2) INVESTIGATION.—The Secretary shall investigate such complaints and shall determine if a violation of such section has occurred and, if so, shall issue an order to ensure that the protected health care professional does not suffer any loss of position, pay, or benefits in relation to the plan, issuer, or provider involved, as a result of the violation found by the Secretary.

''(d) CONFORMING REGULATIONS.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under the other provisions of this title. In order to reduce duplication and clarify the rights of participants and beneficiaries with respect to information that is required to be provided, such regulations shall coordinate the information disclosure requirements under section 121 of the Bipartisan Patient Protection Act with the reporting and disclosure requirements imposed under part 1, so long as such coordination does not result in any reduction in the information that would otherwise be provided to participants and beneficiaries.''.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle A of title I of the Bipartisan Patient Protection Act, and compliance with regulations promulgated by the Secretary, in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Patient protection standards.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 135(b))'' after ''part 7''.

SEC. 402. AVAILABILITY OF CIVIL REMEDIES.

(a) AVAILABILITY OF FEDERAL CIVIL REMEDIES IN CASES NOT INVOLVING MEDICALLY REVIEWABLE DECISIONS.—

(1) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new subsections:

''(n) CAUSE OF ACTION RELATING TO PROVISION OF HEALTH BENEFITS.—

''(1) IN GENERAL.—In any case in which—

''(A) a person who is a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with the plan, or an agent of the plan, issuer, or plan sponsor upon consideration of a claim for benefits of a participant or beneficiary under section 102 of the Bipartisan Patient Protection Act of 2001 (relating to procedures for initial claims for benefits and prior authorization determinations) or upon review of a denial of such a claim under section 103 of such Act (relating to internal appeal of a denial of a claim for benefits), fails to exercise ordinary care in making a decision—

''(i) regarding whether an item or service is covered under the terms and conditions of the plan or coverage,

''(ii) regarding whether an individual is a participant or beneficiary who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage), or

''(iii) 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 conditions of the plan or coverage, and

''(B) such failure is a proximate cause of personal injury to, or the death of, the participant or beneficiary,

such plan, plan sponsor or issuer shall be liable to the participant or beneficiary (or the estate of such participant or beneficiary) for economic and noneconomic damages (but not exemplary or punitive damages) in connection with such personal injury or death.

''(2) CAUSE OF ACTION MUST NOT INVOLVE MEDICALLY REVIEWABLE DECISION.—

''(A) IN GENERAL.—A cause of action is established under paragraph (1)(A) only if the decision referred to in paragraph (1)(A) does not include a medically reviewable decision.

''(B) MEDICALLY REVIEWABLE DECISION.—For purposes of this subsection, the term 'medically reviewable decision' means a denial of a claim for benefits under the plan which is described in section 104(d)(2) of the Bipartisan Patient Protection Act of 2001 (relating to medically reviewable decisions).

''(3) LIMITATION REGARDING CERTAIN TYPES OF ACTIONS SAVED FROM PREEMPTION OF STATE LAW.—A cause of action is not established under paragraph (1)(A) in connection with a failure described in paragraph (1)(A) to the extent that a cause of action under State law (as defined in section 514(c)) for such failure would not be preempted under section 514.

''(4) DEFINITIONS.—For purposes of this subsection.—

''(A) ORDINARY CARE.—The term 'ordinary care' means, with respect to a determination on a claim for benefits, that degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved.

''(B) PERSONAL INJURY.—The term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(C) CLAIM FOR BENEFITS; DENIAL.—The terms 'claim for benefits' and 'denial of a claim for benefits' have the meanings provided such terms in section 102(e) of the Bipartisan Patient Protection Act of 2001.

''(D) TERMS AND CONDITIONS.—The term 'terms and conditions' includes, with respect to a group health plan or health insurance coverage, requirements imposed under title I of the Bipartisan Patient Protection Act of 2001.

''(E) GROUP HEALTH PLAN AND OTHER RELATED TERMS.—The provisions of sections 732(d) and 733 apply for purposes of this subsection in the same manner as they apply for purposes of part 7, except that the term 'group health plan' includes a group health plan (as defined in section 607(1)).

''(5) EXCLUSION OF EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) CAUSES OF ACTION AGAINST EMPLOYERS AND PLAN SPONSORS PRECLUDED.—Subject to subparagraph (B), 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).

''(B) CERTAIN CAUSES OF ACTION PERMITTED.—Notwithstanding subparagraph (A), a cause of action may arise against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment) under paragraph (1)(A), to the extent there was direct participation by the employer or other plan sponsor (or employee) in the decision of the plan under section 102 of the Bipartisan Patient Protection Act of 2001 upon consideration of a claim for benefits or under section 103 of such Act upon review of a denial of a claim for benefits.

''(C) DIRECT PARTICIPATION.—

''(i) IN GENERAL.—For purposes of subparagraph (B), the term 'direct participation' means, in connection with a decision described in paragraph (1)(A), the actual making of such decision or the actual exercise of control in making such decision.

''(ii) RULES OF CONSTRUCTION.—For purposes of clause (i), the employer or plan sponsor (or employee) shall not be construed to be engaged in direct participation because of any form of decisionmaking or other conduct that is merely collateral or precedent to the decision described in paragraph (1)(A) on a particular claim for benefits of a participant or beneficiary, including (but not limited to)—

''(I) any participation by the employer or other plan sponsor (or employee) in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent;

''(II) any engagement by the employer or other plan sponsor (or employee) in any cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved;

''(III) any participation by the employer or other plan sponsor (or employee) in the process of creating, continuing, modifying, or terminating the plan or any benefit under the plan, if such process was not substantially focused solely on the particular situation of the participant or beneficiary referred to in paragraph (1)(A); and

''(IV) any participation by the employer or other plan sponsor (or employee) in the design of any benefit under the plan, including the amount of copayment and limits connected with such benefit.

''(iii) IRRELEVANCE OF CERTAIN COLLATERAL EFFORTS MADE BY EMPLOYER OR PLAN SPONSOR.—For purposes of this subparagraph, an employer or plan sponsor shall not be treated as engaged in direct participation in a decision with respect to any claim for benefits or denial thereof in the case of any particular participant or beneficiary solely by reason of—

''(I) any efforts that may have been made by the employer or plan sponsor to advocate for authorization of coverage for that or any other participant or beneficiary (or any group of participants or beneficiaries), or

''(II) any provision that may have been made by the employer or plan sponsor for benefits which are not covered under the terms and conditions of the plan for that or any other participant or beneficiary (or any group of participants or beneficiaries).

''(D) APPLICATION TO CERTAIN PLANS.—

''(i) IN GENERAL.—Notwithstanding any other provision of this subsection, no group health plan described in clause (ii) shall be liable under paragraph (1) for the performance of, or the failure to perform, any non-medically reviewable duty under the plan.

''(ii) DEFINITION.—A group health plan described in this clause is—

''(I) a group health plan that is self-insured and self administered by an employer (including an employee of such an employer acting within the scope of employment); or

''(II) a multiemployer plan as defined in section 3(37)(A) (including an employee of a contributing employer or of the plan, or a fiduciary of the plan, acting within the scope of employment or fiduciary responsibility) that is self-insured and self-administered.

''(6) EXCLUSION OF PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS.—

''(A) IN GENERAL.—No treating physician or other treating health care professional of the participant or beneficiary, and no person acting under the direction of such a physician or health care professional, shall be liable under paragraph (1) for the performance of, or the failure to perform, any non-medically reviewable duty of the plan, the plan sponsor, or any health insurance issuer offering health insurance coverage in connection with the plan.

''(B) DEFINITIONS.—For purposes of subparagraph (A)—

''(i) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''(ii) NON-MEDICALLY REVIEWABLE DUTY.—The term 'non-medically reviewable duty' means a duty the discharge of which does not include the making of a medically reviewable decision.

''(7) EXCLUSION OF HOSPITALS.—No treating hospital of the participant or beneficiary shall be liable under paragraph (1) for the performance of, or the failure to perform, any non-medically reviewable duty (as defined in paragraph (6)(B)(ii)) of the plan, the plan sponsor, or any health insurance issuer offering health insurance coverage in connection with the plan.

''(8) RULE OF CONSTRUCTION RELATING TO EXCLUSION FROM LIABILITY OF PHYSICIANS, HEALTH CARE PROFESSIONALS, AND HOSPITALS.—Nothing in paragraph (6) or (7) shall be construed to limit the liability (whether direct or vicarious) of the plan, the plan sponsor, or any health insurance issuer offering health insurance coverage in connection with the plan.

''(9) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—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.

''(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) or paragraph (10)(B), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

''(C) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

''(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

''(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

The court in any action commenced under this subsection shall take into account any receipt of benefits during such administrative processes or such action in determining the amount of the damages awarded.

''(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 103 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal court proceeding and shall be presented to the trier of fact.

''(10) STATUTORY DAMAGES.—

''(A) IN GENERAL.—The remedies set forth in this subsection (n) shall be the exclusive remedies for causes of action brought under this subsection.

''(B) ASSESSMENT OF CIVIL PENALTIES.—In addition to the remedies provided for in paragraph (1) (relating to the failure to provide contract benefits in accordance with the plan), a civil assessment, in an amount not to exceed $5,000,000, payable to the claimant may be awarded in any action under such paragraph if the claimant establishes by clear and convincing evidence that the alleged conduct carried out by the defendant demonstrated bad faith and flagrant disregard for the rights of the participant or beneficiary under the plan and was a proximate cause of the personal injury or death that is the subject of the claim.

''(11) LIMITATION ON ATTORNEYS' FEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrangement, agreement, or contract regarding an attorney's fee, the amount of an attorney's contingency fee allowable for a cause of action brought pursuant to this subsection shall not exceed ⅓ of the total amount of the plaintiff's recovery (not including the reimbursement of actual out-of-pocket expenses of the attorney).

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

''(12) LIMITATION OF ACTION.—Paragraph (1) shall not apply in connection with any action commenced after 3 years after the later of—

''(A) the date on which the plaintiff first knew, or reasonably should have known, of the personal injury or death resulting from the failure described in paragraph (1), or

''(B) the date as of which the requirements of paragraph (9) are first met.

''(13) TOLLING PROVISION.—The statute of limitations for any cause of action arising under State law relating to a denial of a claim for benefits that is the subject of an action brought in Federal court under this subsection shall be tolled until such time as the Federal court makes a final disposition, including all appeals, of whether such claim should properly be within the jurisdiction of the Federal court. The tolling period shall be determined by the applicable Federal or State law, whichever period is greater.

''(14) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action under subsection (a)(1)(C) and this subsection.

''(15) EXCLUSION OF DIRECTED RECORDKEEPERS.—

''(A) IN GENERAL.—Subject to subparagraph (C), paragraph (1) shall not apply with respect to a directed recordkeeper in connection with a group health plan.

''(B) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term 'directed recordkeeper' means, in connection with a group health plan, a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan or the employer or other plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title I of the Bipartisan Patient Protection Act of 2001 and whose duties do not include making decisions on claims for benefits.

''(C) LIMITATION.—Subparagraph (A) does not apply in connection with any directed recordkeeper to the extent that the directed recordkeeper fails to follow the specific instruction of the plan or the employer or other plan sponsor.

''(16) EXCLUSION OF HEALTH INSURANCE AGENTS.—Paragraph (1) does not apply with respect to a person whose sole involvement with the group health plan is providing advice or administrative services to the employer or other plan sponsor relating to the selection of health insurance coverage offered in connection with the plan.

''(17) NO EFFECT ON STATE LAW.—No provision of State law (as defined in section 514(c)(1)) shall be treated as superseded or otherwise altered, amended, modified, invalidated, or impaired by reason of the provisions of subsection (a)(1)(C) and this subsection.

''(18) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

''(A) IN GENERAL.—Notwithstanding the direct participation (as defined in paragraph (5)(C)(i)) of an employer or plan sponsor, in any case in which there is deemed to be a designated decisionmaker under subparagraph (B) that meets the requirements of subsection (o)(1) for an employer or other plan sponsor—

''(i) all liability of such employer or plan sponsor (and any employee thereof acting within the scope of employment) under this subsection in connection with any participant or beneficiary shall be transferred to, and assumed by, the designated decisionmaker, and

''(ii) with respect to such liability, the designated decisionmaker shall be substituted for the employer or plan sponsor (or employee) in the action and may not raise any defense that the employer or plan sponsor (or employee) could not raise if such a decisionmaker were not so deemed.

''(B) AUTOMATIC DESIGNATION.—A health insurance issuer shall be deemed to be a designated decisionmaker for purposes of subparagraph (A) with respect to the participants and beneficiaries of an employer or plan sponsor, whether or not the employer or plan sponsor makes such a designation, and shall be deemed to have assumed unconditionally all liability of the employer or plan sponsor under such designation in accordance with subsection (o), unless the employer or plan sponsor affirmatively enters into a contract to prevent the service of the designated decisionmaker.

''(19) PREVIOUSLY PROVIDED SERVICES.—

''(A) IN GENERAL.—Except as provided in this paragraph, a cause of action shall not arise under paragraph (1) where the denial involved relates to an item or service that has already been fully provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures;

''(ii) prohibit a cause of action under paragraph (1) relating to quality of care; or

''(iii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure.

''(20) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

''(o) REQUIREMENTS FOR DESIGNATED DECISIONMAKERS OF GROUP HEALTH

''(1) IN GENERAL.—For purposes of subsection (n)(18) and section 514(d)(9), a designated decisionmaker meets the requirements of this paragraph with respect to any participant or beneficiary if—

''(A) such designation is in such form as may be prescribed in regulations of the Secretary,

''(B) the designated decisionmaker—

''(i) meets the requirements of paragraph (2),

''(ii) assumes unconditionally all liability of the employer or plan sponsor involved (and any employee thereof acting within the scope of employment) either arising under subsection (n) or arising in a cause of action permitted under section 514(d) in connection with actions (and failures to act) of the employer or plan sponsor (or employee) occurring during the period in which the designation under subsection (n)(18) or section 514(d)(9) is in effect relating to such participant and beneficiary,

''(iii) agrees to be substituted for the employer or plan sponsor (or employee) in the action and not to raise any defense with respect to such liability that the employer or plan sponsor (or employee) may not raise, and

''(iv) where paragraph (2)(B) applies, assumes unconditionally the exclusive authority under the group health plan to make medically reviewable decisions under the plan with respect to such participant or beneficiary, and

''(C) the designated decisionmaker and the participants and beneficiaries for whom the decisionmaker has assumed liability are identified in the written instrument required under section 402(a) and as required under section 121(b)(19) of the Bipartisan Patient Protection Act.

Any liability assumed by a designated decisionmaker pursuant to this subsection shall be in addition to any liability that it may otherwise have under applicable law.

''(2) QUALIFICATIONS FOR DESIGNATED DECISIONMAKERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), an entity is qualified under this paragraph to serve as a designated decisionmaker with respect to a group health plan if the entity has the ability to assume the liability described in paragraph (1) with respect to participants and beneficiaries under such plan, including requirements relating to the financial obligation for timely satisfying the assumed liability, and maintains with the plan sponsor and the Secretary certification of such ability. Such certification shall be provided to the plan sponsor or named fiduciary and to the Secretary upon designation under subsection (n)(18)(B) or section 517(d)(9)(B) and not less frequently than annually thereafter, or if such designation constitutes a multiyear arrangement, in conjunction with the renewal of the arrangement.

''(B) SPECIAL QUALIFICATION IN THE CASE OF CERTAIN REVIEWABLE DECISIONS.—In the case of a group health plan that provides benefits consisting of medical care to a participant or beneficiary only through health insurance coverage offered by a single health insurance issue, such issuer is the only entity that may be qualified under this paragraph to serve as a designated decisionmaker with respect to such participant or beneficiary, and shall serve as the designated decisionmaker unless the employer or other plan sponsor acts affirmatively to prevent such service.

''(3) REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of paragraph (2)(A), the requirements relating to the financial obligation of an entity for liability shall include—

''(A) coverage of such entity under an insurance policy or other arrangement, secured and maintained by such entity, to effectively insure such entity against losses arising from professional liability claims, including those arising from its service as a designated decisionmaker under this part; or

''(B) evidence of minimum capital and surplus levels that are maintained by such entity to cover any losses as a result of liability arising from its service as a designated decisionmaker under this part.

The appropriate amounts of liability insurance and minimum capital and surplus levels for purposes of subparagraphs (A) and (B) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and in accordance with such regulations as the Secretary may prescribe and shall be maintained throughout the term for which the designation is in effect. The provisions of this paragraph shall not apply in the case of a designated decisionmaker that is a group health plan, plan sponsor, or health insurance issuer and that is regulated under Federal law or a State financial solvency law.

''(4) LIMITATION ON APPOINTMENT OF TREATING PHYSICIANS.—A treating physician who directly delivered the care, treatment, or provided the patient service that is the subject of a cause of action by a participant or beneficiary under subsection (n) or section 514(d) may not be designated as a designated decisionmaker under this subsection with respect to such participant or beneficiary.''.

(2) CONFORMING AMENDMENT.—Section 502(a)(1) of such Act (29 U.S.C. 1132(a)(1)) is amended—

(A) by striking ''or'' at the end of subparagraph (A);

(B) in subparagraph (B), by striking ''plan;'' and inserting ''plan, or''; and

(C) by adding at the end the following new subparagraph:

''(C) for the relief provided for in subsection (n) of this section.''.

(b) RULES RELATING TO ERISA PREEMPTION.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended—

(1) by redesignating subsection (d) as subsection (f); and

(2) by inserting after subsection (c) the following new subsections:

''(d) PREEMPTION NOT TO APPLY TO CAUSES OF ACTION UNDER STATE LAW INVOLVING MEDICALLY REVIEWABLE DECISION.—

''(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

''(A) IN GENERAL.—Except as provided in this subsection, nothing in this title (including section 502) shall be construed to supersede or otherwise alter, amend, modify, invalidate, or impair any cause of action under State law of a participant or beneficiary under a group health plan (or the estate of such a participant or beneficiary) to recover damages resulting from personal injury or for wrongful death against any person if such cause of action arises by reason of a medically reviewable decision.

''(B) MEDICALLY REVIEWABLE DECISION.—For purposes of subparagraph (A), the term 'medically reviewable decision' means a denial of a claim for benefits under the plan which is described in section 104(d)(2) of the Bipartisan Patient Protection Act of 2001 (relating to medically reviewable decisions).

''(C) LIMITATION ON PUNITIVE DAMAGES.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), with respect to a cause of action described in subparagraph (A) brought with respect to a participant or beneficiary, State law is superseded insofar as it provides any punitive, exemplary, or similar damages if, as of the time of the personal injury or death, all the requirements of the following sections of the Bipartisan Patient Protection Act of 2001 were satisfied with respect to the participant or beneficiary:

''(I) Section 102 (relating to procedures for initial claims for benefits and prior authorization determinations).

''(II) Section 103 of such Act (relating to internal appeals of claims denials).

''(III) Section 104 of such Act (relating to independent external appeals procedures).

''(ii) EXCEPTION FOR CERTAIN ACTIONS FOR WRONGFUL DEATH.—Clause (i) shall not apply with respect to an action for wrongful death if the applicable State law provides (or has been construed to provide) for damages in such an action which are only punitive or exemplary in nature.

''(iii) EXCEPTION FOR WILLFUL OR WANTON DISREGARD FOR THE RIGHTS OR SAFETY OF OTHERS.—Clause (i) shall not apply with respect to any cause of action described in subparagraph (A) if, in such action, the plaintiff establishes by clear and convincing evidence that conduct carried out by the defendant with willful or wanton disregard for the rights or safety of others was a proximate cause of the personal injury or wrongful death that is the subject of the action.

''(2) DEFINITIONS.—For purposes of this subsection and subsection (e)—

''(A) GROUP HEALTH PLAN AND OTHER RELATED TERMS.—The provisions of sections 732(d) and 733 apply for purposes of this subsection in the same manner as they apply for purposes of part 7, except that the term 'group health plan' includes a group health plan (as defined in section 607(1)).

''(B) PERSONAL INJURY.—The term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(C) CLAIM FOR BENEFIT; DENIAL.—The terms 'claim for benefits' and 'denial of a claim for benefits' shall have the meaning provided such terms under section 102(e) of the Bipartisan Patient Protection Act of 2001.

''(3) EXCLUSION OF EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) CAUSES OF ACTION AGAINST EMPLOYERS AND PLAN SPONSORS PRECLUDED.—Subject to subparagraph (B), paragraph (1) does not apply with respect to—

''(i) any 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), or

''(ii) a right of recovery, indemnity, or contribution by a person against an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action to which paragraph (1) applies.

''(B) CERTAIN CAUSES OF ACTION PERMITTED.—Notwithstanding subparagraph (A), paragraph (1) applies with respect to any cause of action that is brought by a participant or beneficiary under a group health plan (or the estate of such a participant or beneficiary) to recover damages resulting from personal injury or for wrongful death against any employer or other plan sponsor maintaining the plan (or against an employee of such an employer or sponsor acting within the scope of employment) if such cause of action arises by reason of a medically reviewable decision, to the extent that there was direct participation by the employer or other plan sponsor (or employee) in the decision.

''(C) DIRECT PARTICIPATION.—

''(i) DIRECT PARTICIPATION IN DECISIONS.—For purposes of subparagraph (B), the term 'direct participation' means, in connection with a decision described in subparagraph (B), the actual making of such decision or the actual exercise of control in making such decision or in the conduct constituting the failure.

''(ii) RULES OF CONSTRUCTION.—For purposes of clause (i), the employer or plan sponsor (or employee) shall not be construed to be engaged in direct participation because of any form of decisionmaking or other conduct that is merely collateral or precedent to the decision described in subparagraph (B)

on a particular claim for benefits of a particular participant or beneficiary, including (but not limited to)—

''(I) any participation by the employer or other plan sponsor (or employee) in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent;

''(II) any engagement by the employer or other plan sponsor (or employee) in any cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved;

''(III) any participation by the employer or other plan sponsor (or employee) in the process of creating, continuing, modifying, or terminating the plan or any benefit under the plan, if such process was not substantially focused solely on the particular situation of the participant or beneficiary referred to in paragraph (1)(A); and

''(IV) any participation by the employer or other plan sponsor (or employee) in the design of any benefit under the plan, including the amount of copayment and limits connected with such benefit.

''(iv) IRRELEVANCE OF CERTAIN COLLATERAL EFFORTS MADE BY EMPLOYER OR PLAN SPONSOR.—For purposes of this subparagraph, an employer or plan sponsor shall not be treated as engaged in direct participation in a decision with respect to any claim for benefits or denial thereof in the case of any particular participant or beneficiary solely by reason of—

''(I) any efforts that may have been made by the employer or plan sponsor to advocate for authorization of coverage for that or any other participant or beneficiary (or any group of participants or beneficiaries), or

''(II) any provision that may have been made by the employer or plan sponsor for benefits which are not covered under the terms and conditions of the plan for that or any other participant or beneficiary (or any group of participants or beneficiaries).

''(4) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—Except as provided in subparagraph (D), 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, 103, and 104 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

''(B) LATE MANIFESTATION OF INJURY.—

''(i) IN GENERAL.—A participant or beneficiary shall not be precluded from pursuing a review under section 104 of the Bipartisan Patient Protection Act regarding an injury that such participant or beneficiary has experienced if the external review entity first determines that the injury of such participant or beneficiary is a late manifestation of an earlier injury.

''(ii) DEFINITION.—In this subparagraph, the term 'late manifestation of an earlier injury' means an injury sustained by the participant or beneficiary which was not known, and should not have been known, by such participant or beneficiary by the latest date that the requirements of subparagraph (A) should have been met regarding the claim for benefits which was denied.

''(C) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) unless the requirements of subparagraph (A) are met.

''(D) FAILURE TO REVIEW.—

''(i) IN GENERAL.—If the external review entity fails to make a determination within the time required under section 104(e)(1)(A)(i), a participant or beneficiary may bring an action under section 514(d) after 10 additional days after the date on which such time period has expired and the filing of such action shall not affect the duty of the independent medical reviewer (or reviewers) to make a determination pursuant to section 104(e)(1)(A)(i).

''(ii) EXPEDITED DETERMINATION.—If the external review entity fails to make a determination within the time required under section 104(e)(1)(A)(ii), a participant or beneficiary may bring an action under this subsection and the filing of such an action shall not affect the duty of the independent medical reviewer (or reviewers) to make a determination pursuant to section 104(e)(1)(A)(ii).

''(E) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

''(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

''(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

''(F) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 104 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal or State court proceeding and shall be presented to the trier of fact.

''(5) TOLLING PROVISION.—The statute of limitations for any cause of action arising under section 502(n) relating to a denial of a claim for benefits that is the subject of an action brought in State court shall be tolled until such time as the State court makes a final disposition, including all appeals, of whether such claim should properly be within the jurisdiction of the State court. The tolling period shall be determined by the applicable Federal or State law, whichever period is greater.

''(6) EXCLUSION OF DIRECTED RECORDKEEPERS.—

''(A) IN GENERAL.—Subject to subparagraph (C), paragraph (1) shall not apply with respect to a directed recordkeeper in connection with a group health plan.

''(B) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term 'directed recordkeeper' means, in connection with a group health plan, a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan or the employer or other plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title I of the Bipartisan Patient Protection Act of 2001 and whose duties do not include making decisions on claims for benefits.

''(C) LIMITATION.—Subparagraph (A) does not apply in connection with any directed recordkeeper to the extent that the directed recordkeeper fails to follow the specific instruction of the plan or the employer or other plan sponsor.

''(7) CONSTRUCTION.—Nothing in this subsection shall be construed as—

''(A) saving from preemption a cause of action under State law for the failure to provide a benefit for an item or service which is specifically excluded under the group health plan involved, except to the extent that—

''(i) the application or interpretation of the exclusion involves a determination described in section 104(d)(2) of the Bipartisan Patient Protection Act of 2001, or

''(ii) the provision of the benefit for the item or service is required under Federal law or under applicable State law consistent with subsection (b)(2)(B);

''(B) preempting a State law which requires an affidavit or certificate of merit in a civil action;

''(C) affecting a cause of action or remedy under State law in connection with the provision or arrangement of excepted benefits (as defined in section 733(c)), other than those described in section 733(c)(2)(A); or

''(D) affecting a cause of action under State law other than a cause of action described in paragraph (1)(A).

''(8) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action described in paragraph (1)(A).

''(9) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

''(A) IN GENERAL.—Paragraph (1) shall not apply with respect to any cause of action described in paragraph (1)(A) under State law insofar as such cause of action provides for liability of an employer or plan sponsor (or an employee thereof acting within the scope of employment) with respect to a participant or beneficiary, if with respect to the employer or plan sponsor there is deemed to be a designated decisionmaker that meets the requirements of section 502(o)(1) with respect to such participant or beneficiary. Such paragraph (1) shall apply with respect to any cause of action described in paragraph (1)(A) under State law against the designated decisionmaker of such employer or other plan sponsor with respect to the participant or beneficiary.

''(B) AUTOMATIC DESIGNATION.—A health insurance issuer shall be deemed to be a designated decisionmaker for purposes of subparagraph (A) with respect to the participants and beneficiaries of an employer or plan sponsor, whether or not the employer or plan sponsor makes such a designation, and shall be deemed to have assumed unconditionally all liability of the employer or plan sponsor under such designation in accordance with subsection (o), unless the employer or plan sponsor affirmatively enters into a contract to prevent the service of the designated decisionmaker.

''(10) PREVIOUSLY PROVIDED SERVICES.—

''(A) IN GENERAL.—Except as provided in this paragraph, a cause of action shall not arise under paragraph (1) where the denial involved relates to an item or service that has already been fully provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures;

''(ii) prohibit a cause of action under paragraph (1) relating to quality of care; or

''(iii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure.

''(11) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

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

''(13) LIMITATION ON ATTORNEYS' FEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrangement, agreement, or contract regarding an attorney's fee, the amount of an attorney's contingency fee allowable for a cause of action brought under paragraph (1) shall not exceed ⅓ of the total amount of the plaintiff's recovery (not including the reimbursement of actual out-of-pocket expenses of the attorney).

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

''(C) NO PREEMPTION OF STATE LAW.—Subparagraph (A) shall not apply with respect to a cause of action under paragraph (1) that is brought in a State that has a law or framework of laws with respect to the amount of an attorney's contingency fee that may be incurred for the representation of a participant or beneficiary (or the estate of such participant or beneficiary) who brings such a cause of action.

''(e) RULES OF CONSTRUCTION RELATING TO HEALTH CARE.—Nothing in this title shall be construed as—

''(1) affecting any State law relating to the practice of medicine or the provision of, or the failure to provide, medical care, or affecting any action (whether the liability is direct or vicarious) based upon such a State law,

''(2) superseding any State law permitted under section 152(b)(1)(A) of the Bipartisan Patient Protection Act of 2001, or

''(3) affecting any applicable State law with respect to limitations on monetary damages.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions (from which a cause of action arises) occurring on or after October 1, 2002.

SEC. 403. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 402, is further amended by adding at the end the following:

''(p) LIMITATION ON CLASS ACTION LITIGATION.—

''(1) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.

''(2) EFFECTIVE DATE.—This subsection shall apply to all civil actions that are filed on or after January 1, 2002.''.

SEC. 404. LIMITATIONS ON ACTIONS.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) (as amended by section 402(a)) is amended further by adding at the end the following new subsection:

''(q) LIMITATIONS ON ACTIONS RELATING TO GROUP HEALTH PLANS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of any provision in section 101, subtitle B, or subtitle D of title I of the Bipartisan Patient Protection Act (as incorporated under section 714).

''(2) CERTAIN ACTIONS ALLOWABLE.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of section 101, 113, 114, 115, 116, 117, 118(a)(3), 119, or 120 of the Bipartisan Patient Protection Act (as incorporated under section 714) to the individual circumstances of that participant or beneficiary, except that—

''(A) such an action may not be brought or maintained as a class action; and

''(B) in such an action, relief may only provide for the provision of (or payment of) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

''(3) OTHER PROVISIONS UNAFFECTED.—Nothing in this subsection shall be construed as affecting subsections (a)(1)(C) and (n) or section 514(d).

''(4) ENFORCEMENT BY SECRETARY UNAFFECTED.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.''.

SEC. 405. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191 et seq.) is amended by adding at the end the following new section:

''SEC. 735. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under title I of the Bipartisan Patient Protection Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

SEC. 406. SENSE OF THE SENATE CONCERNING THE IMPORTANCE OF CERTAIN UNPAID SERVICES.

It is the sense of the Senate that the court should consider the loss of a nonwage earning spouse or parent as an economic loss for the purposes of this section. Furthermore, the court should define the compensation for the loss not as minimum services, but, rather, in terms that fully compensate for the true and whole replacement cost to the family.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2) and subsection (d), the amendments made by sections 201(a), 401, and 403 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after October 1, 2002 (in this section referred to as the ''general effective date'').

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by sections 201(a), 401, and 403 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (excluding any extension thereof agreed to after the date of the enactment of this Act); or

(B) the general effective date;

but shall apply not later than 1 year after the general effective date. For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Subject to subsection (d), the amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

(c) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

(1) IN GENERAL.—Nothing in this Act (or the amendments made thereby) shall be construed to—

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage, to include as providers religious nonmedical providers;

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers;

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals regarding coverage for care by religious nonmedical providers; or

(iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider; or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other required data, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

(2) RELIGIOUS NONMEDICAL PROVIDER.—For purposes of this subsection, the term ''religious nonmedical provider'' means a provider who provides no medical care but who provides only religious nonmedical treatment or religious nonmedical nursing care.

(d) TRANSITION FOR NOTICE REQUIREMENT.—The disclosure of information required under section 121 of this Act shall first be provided pursuant to—

(1) subsection (a) with respect to a group health plan that is maintained as of the general effective date, not later than 30 days before the beginning of the first plan year to which title I applies in connection with the plan under such subsection; or

(2) subsection (b) with respect to a individual health insurance coverage that is in effect as of the general effective date, not later than 30 days before the first date as of which title I applies to the coverage under such subsection.

SEC. 502. COORDINATION IN IMPLEMENTATION.

The Secretary of Labor and the Secretary of Health and Human Services shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

SEC. 503. SEVERABILITY.

If any provision of this Act, an amendment made by this Act, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this Act, the amendments made by this Act, and the application of the provisions of such to any person or circumstance shall not be affected thereby.

TITLE VI—MISCELLANEOUS PROVISIONS

SEC. 601. NO IMPACT ON SOCIAL SECURITY TRUST FUND.

(a) IN GENERAL.—Nothing in this Act (or an amendment made by this Act) shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(b) TRANSFERS.—

(1) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this Act has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(2) TRANSFER OF FUNDS.—If, under paragraph (1), the Secretary of the Treasury estimates that the enactment of this Act has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such Act.

SEC. 602. CUSTOMS USER FEES.

Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended by striking ''2003'' and inserting ''2011, except that fees may not be charged under paragraphs (9) and (10) of such subsection after March 31, 2006''.

SEC. 603. FISCAL YEAR 2002 MEDICARE PAYMENTS.

Notwithstanding any other provision of law, any letter of credit under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) that would otherwise be sent to the Treasury or the Federal Reserve Board on September 30, 2002, by a carrier with a contract under section 1842 of that Act (42 U.S.C. 1395u) shall be sent on October 1, 2002.

SEC. 604. 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.

(11) While information obtained from clinical trials is essential to finding cures for diseases, it is still research which carries the risk of fatal results. Future efforts should be taken to protect the health and safety of adults and children who enroll in clinical trials.

(12) While employers and health plans should be responsible for covering the routine costs associated with federally approved or funded clinical trials, such employers and health plans should not be held legally responsible for the design, implementation, or outcome of such clinical trials, consistent with any applicable State or Federal liability statutes.

(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 requirements 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.

SEC. 605. SENSE OF THE SENATE REGARDING FAIR REVIEW PROCESS.

(a) FINDINGS.—The Senate finds the following:

(1) A fair, timely, impartial independent external appeals process is essential to any meaningful program of patient protection.

(2) The independence and objectivity of the review organization and review process must be ensured.

(3) It is incompatible with a fair and independent appeals process to allow a health maintenance organization to select the review organization that is entrusted with providing a neutral and unbiased medical review.

(4) The American Arbitration Association and arbitration standards adopted under chapter 44 of title 28, United States Code (28 U.S.C. 651 et seq.) both prohibit, as inherently unfair, the right of one party to a dispute to choose the judge in that dispute.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) every patient who is denied care by a health maintenance organization or other health insurance company should be entitled to a fair, speedy, impartial appeal to a review organization that has not been selected by the health plan;

(2) the States should be empowered to maintain and develop the appropriate process for selection of the independent external review entity;

(3) a child battling a rare cancer whose health maintenance organization has denied a covered treatment recommended by its physician should be entitled to a fair and impartial external appeal to a review organization that has not been chosen by the organization or plan that has denied the care; and

(4) patient protection legislation should not pre-empt existing State laws in States where there already are strong laws in place regarding the selection of independent review organizations.

SEC. 606. ANNUAL REVIEW.

(a) IN GENERAL.—Not later than 24 months after the general effective date referred to in section 501(a)(1), and annually thereafter for each of the succeeding 4 calendar years (or until a repeal is effective under subsection (b)), the Secretary of Health and Human Services shall request that the Institute of Medicine of the National Academy of Sciences prepare and submit to the appropriate committees of Congress a report concerning the impact of this Act, and the amendments made by this Act, on the number of individuals in the United States with health insurance coverage.

(b) LIMITATION WITH RESPECT TO CERTAIN PLANS.—If the Secretary, in any report submitted under subsection (a), determines that more than 1,000,000 individuals in the United States have lost their health insurance coverage as a result of the enactment of this Act, as compared to the number of individuals with health insurance coverage in the 12-month period preceding the date of enactment of this Act, section 402 of this Act shall be repealed effective on the date that is 12 month after the date on which the report is submitted, and the submission of any further reports under subsection (a) shall not be required.

(c) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 2003 and 2004, the Secretary of Health and Human Services shall provide for such funding as the Secretary determines necessary for the conduct of the study of the National Academy of Sciences under this section.

SEC. 607. DEFINITION OF BORN-ALIVE INFANT.

(a) IN GENERAL.—Chapter 1 of title 1, United States Code, is amended by adding at the end the following:

''§ 8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant

''(a) In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words 'person', 'human being', 'child', and 'individual', shall include every infant member of the species homo sapiens who is born alive at any stage of development.

''(b) As used in this section, the term 'born alive', with respect to a member of the species homo sapiens, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, caesarean section, or induced abortion.

''(c) Nothing in this section shall be construed to affirm, deny, expand, or contract any legal status or legal right applicable to any member of the species homo sapiens at any point prior to being born alive as defined in this section.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 1 of title 1, United States Code, is amended by adding at the end the following new item:

''8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant.''.

BANKRUPTCY ABUSE PREVENTION AND CONSUMER PROTECTION ACT OF 2001—MOTION TO PROCEED

Mr. REID. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 17, H.R. 333, the House bankruptcy reform bill.

The PRESIDING OFFICER. Is there objection?

Mr. WELLSTONE. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. REID. Mr. President, therefore, I move to proceed to the consideration of H.R. 333, and I will send a cloture motion to the desk. I also ask unanimous consent that on Thursday, July 12, beginning at 9 a.m., there be a period for debate of 3 hours prior to the cloture vote to be divided as follows: 2 hours under Senator WELLSTONE's control, and 1 hour equally divided between the chairman and ranking member of the Judiciary Committee, or their designees; that if cloture is invoked, the Senate proceed to the bill by consent and Senator LEAHY, or his designee, be recognized to offer the text of S. 420, the Senate-passed bankruptcy bill, as a substitute amendment; that if a cloture motion is filed on that amendment, the cloture motion on the substitute amendment mature on Tuesday, July 17; that prior to that vote, there be a period for debate beginning at 9 a.m., divided as follows: 2 hours under the control of the senior Senator from Minnesota, Mr. WELLSTONE, and 1 hour equally divided between the chairman and ranking member of the Judiciary Committee, or their designees; that once the substitute amendment has been offered and cloture filed, the bill be laid aside until Tuesday, July 17; and that both mandatory quorum calls be waived.

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

CLOTURE MOTION

Mr. REID. I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on the motion to proceed to Calendar No. 17, H.R. 333, the bankruptcy reform bill:

Harry Reid, John Breaux, James M. Jeffords, Ben Nelson, Daniel K. Inouye, Max Baucus, Blanche L. Lincoln, Evan Bayh, Zell Miller, Joseph I. Lieberman, Byron L. Dorgan, Daniel K. Akaka, Kent Conrad, Chuck Grassley, Robert Torricelli, Joe Biden.

UNANIMOUS CONSENT AGREEMENT—S. 1077

Mr. REID. Mr. President, I ask unanimous consent that when the Senate resumes consideration of the supplemental appropriations bill tomorrow, Tuesday, at 10 a.m., there be 2 hours of concurrent debate equally divided between Senator VOINOVICH and Senator CONRAD, or their designees, in relation to the lockbox amendments, No. 866 and No. 865. Further, that following the use or yielding back of time, the amendments be laid aside.

The PRESIDING OFFICER (Mr. WELLSTONE). Without objection, it is so ordered.

Mr. REID. Mr. President, I also announce to the Senate that there will be every attempt made to have a vote at 2:15 p.m. on this or in relation to these two amendments. We are working on that now. We were very close to having agreement on that but were unable to do it.

ORDERS FOR TUESDAY, JULY 10, 2001

Mr. REID. Mr. President, I ask consent when the Senate completes its business today, it adjourn until the hour of 10 a.m. Tuesday, July 10. I further ask consent that on Tuesday, immediately following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the supplemental appropriations bill; further, that the Senate recess from 12:30 to 2:15 for our weekly party conferences.

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

PROGRAM

Mr. REID. Mr. President, on Tuesday, the Senate will convene at 10 a.m. and resume consideration of the supplemental appropriations bill. The Senate is going to recess from 12:30 to 2:15 for the weekly party conferences. Rollcall votes are expected as the Senate works to complete action on the supplemental appropriations bill tomorrow. It could be a late evening. We have a number of amendments we are trying to resolve. Senator BYRD and Senator STEVENS want to finish that, as does the majority leader, Senator DASCHLE.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. REID. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 7:20 p.m., adjourned until Tuesday, July 10, 2001, at 10 a.m.