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Senate

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

PRAYER

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

Dear God, omnipresent Lord of all life, we do not presume to invite You into this Chamber or into the deliberations of this week. You are already here. This is Your Nation; this historic Chamber is the sanctuary for the sacred work of government. All the Senators are here by Your choice, and all of us who work to support their leadership have been led here by Your providence.

The one place You will not enter without our invitation is our soul. You have ordained that we must ask You to take up residence in our inner being and to control our thinking, desires, vision, and plans. The latch string to our hearts is on the inside. You stand at the door of each of our hearts, persistently knocking. We open the door and receive You as absolute Sovereign of our lives. Just as You reign as Sovereign of this Nation and our ultimate Leader to whom we relinquish our own will and control, may Your very best for your beloved Nation be accomplished through what is debated and decided this week. You are our Lord and Savior. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore. Senator ROBERTS from Kansas is now designated to lead the Senate in the Pledge of Allegiance.

The Honorable PAT ROBERTS, a Senator from the State of Kansas, 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.

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDENT pro tempore. The acting majority leader is now recognized.

SCHEDULE

Mr. ROBERTS. Mr. President, today the Senate will immediately proceed to a period of morning business until 1 o'clock. By previous consent, at 1 p.m. the Patients' Bill of Rights will be the pending business. Amendments to that legislation are possible. However, any votes ordered will not take place until tomorrow at a time to be determined by the two leaders. Following this week's debate on health care, the Senate will resume consideration of the remaining appropriations bills. It is imperative that these funding bills be completed prior to the next legislative break.

As a reminder to all Senators, a cloture vote on the pending lockbox amendment to S. 557 is scheduled to take place on Friday, July 16.

MEASURE PLACED ON CALENDAR

Mr. ROBERTS. Mr. President, I understand there is a bill at the desk due for its second reading.

The PRESIDENT pro tempore. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 1218) to amend title 18, United States Code, to prohibit taking minors across State lines in circumvention of laws requiring the involvement of parents in abortion decisions.

Mr. ROBERTS. Mr. President, I now object to further proceedings on this matter at this time.

The PRESIDENT pro tempore. The bill will be placed on the calendar.

Mr. ROBERTS. I yield the floor.

MORNING BUSINESS

The PRESIDENT pro tempore. The able Senator from Nevada.

Mr. REID. Mr. President, it is my understanding we are now in the hour of morning business. Is that true?

The PRESIDENT pro tempore. The Senator is correct.

TITLE IX

Mr. REID. Mr. President, this past Saturday we watched a very interesting spectacle. It was an athletic contest. There were no arguments with referees. There was no vile language. There were no lewd gestures. There were no demands by the participants for more money. There were no pleas from any of the players that they didn't get a fair opportunity to play, that they should have had more opportunities to shoot for a goal. It appeared to be a real team effort, a team effort by daughters and mothers.

We watched a great athletic contest between the United States and China for the World Cup soccer championship. The U.S. women's soccer team won on penalty kicks. There could not have been a more exciting game.

I have had the opportunity to watch many soccer games, as my youngest boy played on three national championship soccer teams at the University of Virginia. It is a great sport. Certainly the sport was exemplified in the work of these women last Saturday. Throughout the tournament, the U.S. team emphasized what it means to play as a team. This was a team effort. It was team spirit that helped them win on Saturday.

There were really no standouts, even though there are great athletes on both sides. The final penalty kick was by Brandi Chastain, but she was just one of the players that day. Briana Scurry made her most crucial save against China's third penalty kicker, Liu Ying, by diving to her left based particularly on instinct. Kristine Lilly saved what looked to be China's winning shot with a header while standing at the goal line in the first overtime. Mia Hamm, who

is a superstar, the Michael Jordan of women's athletics, led the attack. While she failed to score, she kept pressure on the Chinese for most all of the game. Michelle Akers, at 33 the oldest team member, a woman who suffers from Epstein-Barr, or chronic fatigue syndrome, played as if she would never be fatigued until the last minute of regulation play. She literally was carried off the field, succumbing to dehydration and exhaustion. She was certainly a stalwart of this team effort.

This team has captured America's heart. A crowd of over 90,000 people watched that game. Cumulative attendance for the U.S. team's 6 victories was 412,486, an average of almost 70,000 a game. The 90,000-plus that watched this game was the largest crowd to watch an athletic contest among women. This team, that averaged 70,000 people watching each of its contests, was a constant reminder that this event was seen as a bellwether for women's athletics in America. Could women's teams fill stadiums? Could they draw advertising and television viewers in a nonolympic event? The answer to each of those questions was a resounding yes.

While most of their success is a result of the hard work and dedication of each team member to the sport of soccer, their brilliant play on the field, and their personalities off the field, they were aided even more in the fact this came about as a result of title IX.

There are many heroes in bringing about title IX. We could name Molly Yard, who more than four decades ago started talking about why women deserve to be treated equally in athletics. We could talk about Senators Birch Bayh from Indiana and George McGovern of South Dakota who led the way in the Senate against sex discrimination in higher education programs.

But there is no need to talk about any one individual. The fact is that title IX makes a great case for American women.

I indicated that my youngest son is a good athlete. He really is a great athlete. But the fact of the matter is, he inherited his athleticism from his mother, not from his father. The fact is, his mother and I went to high school together.

The only thing that his mother, my wife, could do in high school was be a cheerleader. As athletic as she was, she could not do anything else because there was nothing else for her to do. She was not entitled to play any other athletics. Title IX says that is not the way it is to be.

Title IX has been an outstanding program. It has allowed women to build their character and athleticism just as men did for many decades. They are building their character, as seen in this team, this women's athletic team—the World Cup champions.

Women are now seen as sports stars in their own right, not through their sons but through themselves, from Mia Hamm in soccer to Sheryl Swoopes in basketball, and as shown by the inspiring story of Dr. Dot Richardson, the captain of the American Olympic softball team, who left her triumph in Atlanta to go to medical school. That is what title IX is all about. And Dot Richardson exemplifies what has been accomplished on and off the field because of women's athletics.

Before the passage of title IX, athletic scholarships for college women were rare, no matter how great their talent. After winning two gold medals in the 1964 Olympics, swimmer Donna de Varona could not find a college anyplace in the United States that offered a swimming scholarship. She was one of the finest, if not the finest swimmer in the world at that time. She could not find one because it did not exist.

It took time and effort to improve the opportunities for young women. Two years after title IX was voted into law, an estimated 50,000 men were attending U.S. colleges and universities on athletic scholarships but only about 50 women.

In 1973, the University of Miami in Florida awarded the first athletic scholarships to women—a total of 15 in swimming, diving, tennis, and golf. Today, college women receive about a third of all the athletic scholarships that are given. That is good. It should be half. But a third is certainly a step in the right direction.

It is important to recognize that there is no mandate under title IX that requires a college to eliminate men's teams to achieve compliance.

The critical values learned, though, are that women are entitled to equality. Those things learned from sports participation—including teamwork, standards, leadership, discipline, self-sacrifice, and pride in accomplishment—are equally important for young women as they are for young men.

These women who have captured America's attention over the last 3 weeks are all children of title IX. They came to age athletically at a time when high schools and colleges were required by law—a law that we passed—to treat them fairly.

These women have set an excellent example for the thousands and thousands of young girls who have followed their World Cup play over the last 3 weeks.

I was listening to something on public radio this morning where they interviewed young girls who attended their celebrations yesterday. They were saying they wanted to be just like them. That is important.

So I congratulate all them and wish them continued success in the future.

I have a resolution that I would like to introduce later in the day. I certainly invite everyone to join with me. I would certainly be willing to take a back seat to the women of the Senate, as we do a lot of times around here, to allow them to be first in line to sponsor this resolution. So at a later time today, I would like to introduce this resolution and hope that it would clear both sides of the aisle to give these women the recognition they deserve today, to congratulate the U.S. women's soccer team on winning the 1999 Women's World Cup championship.

Mr. DORGAN. I wonder if the Senator will yield?

Mr. REID. I am happy to yield.

Mr. DORGAN. I have come to the floor to speak on another issue, but I watched the entire soccer game on Saturday. It was exciting and wonderful. I also thought about the fact that it is an example of a regulation that works. Title IX says: Equal opportunity; you must provide equal opportunity in academics and athletics.

Before title IX, of course, there was not equal opportunity. I think Saturday's game was such a testament to the regulations and requirements from title IX that have improved athletics and academics in this country.

Mr. REID. I appreciate very much my friend from North Dakota commenting. I say to my friend from North Dakota, it is extremely interesting that young girls recognize that they do now have equal opportunity.

I was at a small school in rural Nevada and getting ready to speak to a group of students who were assembling. I was in a holding room waiting to speak, and there were two girls in the room with me. They were wearing their letter sweaters. One of them was a sprinter and one played softball.

I said: Do you know why you can participate in athletics?

They said: No. Why?

Because we passed a law saying if boys have a program in athletics, girls have to have something that is equal to the program the boys have.

They did not know that. They just thought girls had always participated in athletics. One of the girls said: I would just die without my athletics.

Title IX is a program that of which we should all be proud. It has really done a great deal to equalize athletics for boys and girls in America. That is the way it should be.

Mr. DORGAN addressed the Chair.

The PRESIDING OFFICER (Mr. ROBERTS). The Senator from North Dakota is recognized.

PRIVILEGE OF THE FLOOR

Mr. DORGAN. Mr. President, I ask unanimous consent that Tony Blaylock, a fellow on my staff, be given floor privileges today.

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

COMPREHENSIVE TEST BAN TREATY

Mr. DORGAN. Mr. President, we are now turning to a 4-week period here in the Senate in which we will work, prior to the August recess, on a range of issues—today beginning with the Patients' Bill of Rights, and then turning to appropriations bills and other matters.

I want to call to everyone's attention two issues that are of vital concern that I think ought to be and must be part of the Senate agenda. The first is an issue dealing with the Comprehensive Test Ban Treaty.

The Comprehensive Test Ban Treaty is something that has been before the Senate now for some long while. Efforts to achieve a nuclear test ban treaty originated with President Eisenhower. It has been around a long time. This President, after long negotiations through many administrations, finally signed the treaty. It has now been sent to the Senate for ratification. But it has languished in the Senate for 658 days, during which time there has not been even a hearing on the Comprehensive Nuclear Test Ban Treaty.

I will put up a couple of charts to describe the circumstances with this treaty.

The rule in the Senate requires that the Senate should consider treaties as soon as possible after their submission.

In fact, the Limited Nuclear Test Ban Treaty in 1963 was considered by the Senate in 3 weeks; SALT I, 3 months; the ABM Treaty, 10 weeks; ABM Treaty Protocols, 14 months; START I, 11 months.

We have had the Comprehensive Test Ban Treaty before the Senate for 658 days with not even a hearing. I think that is a shame. This treaty ought to be part of this Senate's agenda. If we do not have a hearing and do not ratify this treaty by the end of September, we will have only a limited role when a conference is formed in October of the countries that have ratified this treaty to discuss its entry into force. It does not make any sense to me.

This country ought to lead on issues concerning the nonproliferation of nuclear weapons. One way to lead on those issues is to ratify the Comprehensive Test Ban Treaty. It does not make any sense for the treaty to have been signed, negotiated and sent to this Senate, and then to have it languish for all of these days.

I would like to put up a chart which shows a concern that some of the critics have. They say: Well, gosh, with all this Chinese espionage, the last thing we want, is to do something with respect to a treaty on banning nuclear tests.

The Cox report on the Chinese espionage makes references to the CTBT. The report says it will be more difficult for the Chinese to develop advanced nuclear weapons if we have this treaty in place. If the People's Republic of China violated the Comprehensive Test Ban Treaty by testing surreptitiously to further accelerate its nuclear development, we could detect it given the monitoring system imposed by the treaty. If the Chinese are signatories to the treaty and the Russians are signatories to the treaty—and they are waiting for us—and we can stop testing, the only conceivable way they could validate any kind of nuclear stockpile is through the use of advanced computers. The restrictions imposed by the CTBT make it extremely difficult or impossible to improve nuclear weapons designs except by high performance computers.

The Cox report appears to make the point that it is more important for us to restrict the shipment of advanced computers to the Chinese. The point is this—we deserve an opportunity to debate the Comprehensive Nuclear Test Ban Treaty. We should have done so long ago. I don't mean to argue the merits of it on the floor today.

My hope is, we will not go through July as if this treaty doesn't exist. It was negotiated, signed, and has been before the Senate over 600 days. There hasn't been one hearing. There ought to be a hearing. It ought to be brought to the floor so the American people can, through this Senate, debate that treaty.

Finally, support for the nuclear test ban: 75 percent, 74 percent, 85 percent, 80 percent, these are national polls over time, always consistently high support for this kind of a treaty. This Congress has a responsibility. I say to my colleagues who really don't want to do this: You have a responsibility to the country to do this. I hope that in the month of July we can make progress in passing this Comprehensive Nuclear Test Ban Treaty.

Mr. REID. Mr. President, I ask unanimous consent to send a resolution to the desk.

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

THE FARM CRISIS

Mr. DORGAN. Mr. President, let me turn to an additional issue I believe Congress and the President must consider in the month of July. It deals with the urgent farm crisis that exists in farm country across America.

If there was a massive earthquake, a series of tornadoes, fires, or floods across the Midwest, we would see Congress, the Federal Emergency Management Agency, virtually everyone involved through the Federal agencies responding immediately. The President would likely fly out and view it. Congress would send emergency help. Federal agents would be there en masse setting up offices to help.

Yet in farm country we have a crisis that is just as real, not as dangerous to human health or human life as a tornado or a flood, perhaps, but just as real and just as dramatic as natural disasters.

The chart here shows what has happened to the price of wheat since 1996. You can see what has happened to the price of wheat. We have mostly wheat farmers up in our part of the country. The price of wheat has collapsed like a lead weight. Ask yourself: If your income collapsed, if a Senator's income collapsed like that, do you think there would be howls of protest? Do you think that would be an emergency? How about the minimum wage, if it went down like this? How about if the stock market looked like this? Do you think there would be a problem in this country? Of course, there would.

This is a huge problem in the farm belt. Family farmers are finding themselves on the precipice of going broke in record numbers. I had a call this morning from a family farmer who nearly choked up on the phone saying: I don't think my son and I can continue. We can't continue when prices have collapsed. We don't have the income to continue family farming.

For them it is a dream, a lifestyle, a way of life. It is not just a business.

This Congress, while prices have collapsed, largely is content to sort of meander around and talk as if it were theory. It is not theory. It is a crisis.

This chart shows what is happening across the farm belt. The red indicates the counties that have lost more than 10 percent of their population, 1980–1998. Take a look at the red. What does that show? The middle part of America is being depopulated, especially now with prices collapsing, people moving out and not in.

The question is, ''What are we going to do about that?'' Congress has a responsibility to do something about it and so does this President. This Congress passed the Freedom to Farm bill. The presumption of Freedom to Farm is, we will reduce support prices and you rely on the marketplace. If the marketplace has collapsed prices, there has to be a safety net. If you don't have a safety net, you won't have family farmers left.

Freedom to Farm hasn't worked, and this Congress needs to understand that and do something about it. The President also has a responsibility. He signed the Freedom to Farm bill. He complained a little about it when he signed it, but he signed it and said: We will make some improvements.

The Freedom to Farm bill hasn't worked. Our trade policies are bankrupt and not working. Concentration of agricultural industries means that farmers face monopolies in every direction. All of these combined together are conspiring to leave this country without family farmers in its future, and that will be, in my judgment, a massive failure for America.

In the month of July, in the coming 4 weeks, the President has a responsibility, in my judgment, to come to Congress with a bold approach in dealing with this issue. Congress has a responsibility to deal with it, as well, in a bold manner.

I know some in Congress say: We don't intend to do anything until the President sends us something. They didn't have that reticence about adding $6 billion to the defense bill. When the emergency bill came up for defense, they said: We don't care what the President said. We think he should have $6 billion more.

This is a joint responsibility. The Congress needs to act and the President needs to act. We need to do it together, and it needs to be done now.

Not later, now. If we don't take action soon, we won't have family farmers left. We won't have to worry about an emergency family farm bill because there won't be family farmers around to respond to.

Again, if there was an earthquake or a flood or fire or tornado or perhaps even some hog disease, as Will Rogers used to say, you'd have all the Federal agents coming out to talk about the hog disease. They would want to know, ''what is happening here and will it spread to other hogs?''

One way to get attention, it seems to me, is for Congress and the President to decide that this is a farm crisis. It is in my part of the country, with the collapse in prices and the natural disaster that has kept about 3 million acres from being planted in North Dakota because it was too wet. The floods and the worst crop disease in this century, all piled on top of family farmers' shoulders at a time when prices are collapsed. To add to their burden, we have a trade agreement that allows the Europeans to spend 10 times as much on their farm program as we do and undercuts prices on sales to foreign governments. We let them do that in excess of ours—we won't even use our export program for reasons I don't understand—at a time of mounting burdens on family farmers in a way that is fundamentally unfair.

We had better decide as a country that family farming matters to our future. If we don't, they won't be around. When they are not around, corporations will farm our country coast to coast. The price of food will go up and this country will have lost something and every small town will have lost something important.

This is not just about farmers. It is about small towns and Main Streets and boarded-up business and economies that are empty shells in a lot of our small communities.

My message is very simple: We have a responsibility this month. We have a responsibility now, all of us, and so does the President, to have a meeting. I want the White House to have a meeting on this with Republicans and Democrats. I want us to come together with an emergency package that responds to the farm crisis, does it boldly, does it in a way that helps real family farmers, and does it in a way that gives family farmers some hope that their future is a future in which they can make a decent living raising America's food supply.

If I might make one additional point: We have to rely on foreign markets as well. We produce more food than we consume in this country. Yet I heard last week that the amount of imported food in this country has doubled in the last 7 years.

We had protests at the Canadian border last weekend. It is unfair the level of imports coming from Canada. The thing I don't understand, however, is the grain market, all these folks that worship at the altar of the marketplace in the grain market. The grain market says to our farmers: Your food that you produce has no value. Yet all the testimony we hear from all around the world, Sudan included, tells us that old women are climbing trees foraging for leaves to eat because there is nothing to eat. We know that a substantial portion of the world's population goes to bed at night with an ache in their belly because of hunger.

It makes no sense for us to be told that our food has no value when people go to bed hungry each night. I want the White House and the Congress together to boldly respond to this issue in the coming weeks. This 4-week period is critical. We must put this on the agenda in a bipartisan way and do so boldly.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

THE AGRICULTURE CRISIS

Mr. BAUCUS. Mr. President, I commend the Senator from North Dakota for his statement. He is on target. He raises an issue that so far this Congress has not dealt with. It is as precipitous, as calamitous, as tragic, frankly, as the Senator indicated. I very much hope that Senators heard the statement of the Senator from North Dakota. I also hope the White House heard his statement, and others, too.

I do not know exactly what the answer is, but I do know we need an answer. We need a solution to the problems our farmers are facing because the conditions he described in North Dakota are the same conditions one would find in my State, particularly the eastern half, which produces a lot of grain and some barley. But it is a wheat-producing area that is experiencing very difficult conditions.

TEMPORARY TRADE RELIEF FOR THE U.S. LAMB INDUSTRY

Mr. BAUCUS. Mr. President, I want to acknowledge, and I very much appreciate, the action taken last week by the President in response to the recommendations of the International Trade Commission—otherwise known as the ITC—on relief for the American lamb industry. As you know, the industry has gone through very difficult times these last few years. Imports have surged dramatically and lamb prices have dropped precipitously. The package of trade relief and adjustment assistance announced by the President will help the industry adjust. It will allow our producers and feeders to keep their businesses and prosper in the future.

I am very grateful to the President and the staff of many agencies for their work on behalf of the American lamb industry and the American workers in that industry.

This was an important decision. Why? For several reasons. First, of course, it provides significant relief to the lamb industry, which is very important in my home State, as well as elsewhere in the Nation. Second, however, it demonstrates that section 201 of U.S. trade law can work. This is the so-called ''safeguard provision.'' It is designed to prevent serious disruption to the domestic industry whenever there is an import surge.

Third, the decision was important because I hope it shows a renewed commitment by the Clinton administration to assist American industries. This includes the agriculture sector that faces unprecedented challenges in the U.S. market for reasons not of their own making.

Section 201 has been little used in recent years. Both Democratic and Republican administrations have been reluctant to agressively apply its provisions. For example, in the mid-1980s President Reagan would not follow an ITC recommendation for trade relief for the American footwear industry.

That failure was a major contributor to the introduction of many legislative proposals that could have significantly closed the American market to foreign products. American industries and workers—whether in manufacturing, agriculture, or services—must think the Federal Government will use all available tools to help them when they are challenged suddenly by surges in imports. This is especially important today, when global financial disruption can change competitive positions of countries overnight.

In the case of lamb, we see an industry that has been severely damaged by imports. Without relief, the injury to the industry would have continued to worsen. The number of sheep being raised is at an all-time low. Prices have dropped precipitously. Lending institutions are increasingly unwilling to extend credit.

The industry did what it was supposed to do. It used the domestic legal process authorized by the WTO. That process is enforced through section 201 of the U.S. trade law. This is how the process should work and, in this case, is working.

I believe the reluctance of the executive branch over the past 15 years to take action under section 201 has been a serious mistake. The most recent example of this is the late action that was taken by the administration to deal with the surge of steel imports. The volume of steel imports now seems to be under control. But we are still faced with a dilemma. How can we ensure that the next time the steel sector, or any other sector, is threatened by a precipitous spike in imports, strong and rapid measures will be taken to provide relief to those industries?

Earlier this session, I introduced the Import Surge Relief Act. It would improve and expedite the way our Government deals with import surges. It would ease the standard that must be met to demonstrate that there is a causal link between imports and injury to an American industry. It would

speed up the process for addressing import surges. It would provide for an early warning about import surges so action can be taken before the American industry is irreversibly damaged. All this is perfectly legal under the WTO.

Let me address a few remarks to the principal exporters of lamb to the United States—Australia and New Zealand. There has been a lot of misinformation coming from the industry and governments in those two countries.

This is not an attack on the lamb industry in Australia or New Zealand. Rather, it is a measure taken under U.S. trade law to provide temporary—and I underline the word ''temporary''—relief to a devastated American industry. The actions announced by the President are compatible with the WTO. Australia and New Zealand will continue to ship large quantities of lamb to the United States. Their exports would be able to grow each year.

The only difference is that the American lamb industry will stay in business and American workers will keep their jobs. Australia and New Zealand have the right to appeal to WTO. I am sure they will do that, and I am confident that the appeal will not be successful. Everyone should understand that this action was necessary to provide temporary relief to an industry that was hurting.

Let me conclude by again thanking the President and the administration officials who made possible this important action to provide remedies to the devastated lamb industry in the United States.

I yield the floor, and 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.

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

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

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is now closed.

PATIENTS' BILL OF RIGHTS ACT OF 1999

The PRESIDING OFFICER. Under the previous order, the Senate will now proceed to the consideration of S. 1344, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1344) to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

The Senate proceeded to consider the bill.

Ms. COLLINS. Mr. President, I yield myself such time as I may consume from general debate on the bill under the unanimous consent agreement.

I am pleased that the Senate has begun debate on the Patients' Bill of Rights and the Patients' Bill of Rights Plus. There is a growing unease across this Nation about changes in how we receive our health care. People worry that if they or their loved ones become ill, their HMO may deny them coverage and force them to accept either inadequate care or financial ruin, or perhaps even both. They believe that vital decisions affecting their lives will be made not by a supportive family doctor but, rather, by an unfeeling bureaucracy.

Our goal this week should be to join together to work in a bipartisan way to enact legislation that accomplishes three major purposes.

First, it should protect patients' rights and hold HMOs accountable for the care they promise.

Second, it should expand, not contract, Americans' access to affordable health care.

And, third, it should improve health care quality and outcomes.

I believe all of us should be able to agree that medically necessary patient care should not be sacrificed to the bottom line and that health care decisions should be in the hands of medical professionals, not insurance accountants or trial lawyers.

We do face an extremely delicate balancing act as we attempt to respond to concerns about managed care without resorting to unduly burdensome Federal controls and mandates that will further drive up the cost of insurance and cause some people to lose their health insurance altogether.

That is the crux of the debate we are undertaking this week. The crux of this debate is how can we make sure that we address those critical concerns we all have about managed care without so driving up the cost of the health insurance people have—as the Kennedy bill would do—that we jeopardize coverage for thousands, indeed millions, of Americans.

As the President's Advisory Commission on Consumer Protection and Quality noted in its report, ''costs matter . . . the Commission has sought to balance the need for stronger consumer rights with the need to keep coverage affordable. . . Health coverage is the best consumer protection.''

I think President Clinton's quality commission hit it right. I believe they have stated exactly what the debate is before us. I, therefore, have been alarmed by recent reports that American employers everywhere, from giant multinational corporations to the tiny corner store, are facing huge hikes in medical insurance averaging 8 percent and sometimes soaring to 20 percent or more.

This is a remarkable contrast to the past few years when premiums rose less than 3 percent, if at all. I am particularly concerned about the impact these rising costs are having on small businesses and their employees.

A survey of small employers conducted by the United States Chamber of Commerce earlier this year found that, on average, small businesses were hit with a 20-percent premium hike last year. More important, of the small employers surveyed, 10 percent were forced to discontinue health care coverage for their employees because of these premium increases. Over half of the employers surveyed indicated that they switched to a lower cost plan, while an overwhelming majority indicated that they had passed the additional costs of these premium hikes on to their employees through increased deductibles, higher copays, or premium hikes.

This, too, is very troubling since it will induce many more employees, especially lower wage workers and their families, who are disproportionately affected by increased costs, to turn down coverage when it is offered to them. Indeed, in the HELP Committee, on which I serve, we saw a GAO report which indicated that an increasing number of American employees are turning down the health insurance offered by their employers because they simply cannot afford to pay their share of the costs.

It is no wonder that the ranks of uninsured Americans increased dramatically last year to 43 million people—the highest percentage in a decade. This is happening at a time when our economy is thriving. Imagine what could happen in an economic downturn.

We know that increasing health insurance premiums cause significant losses in coverage. That is the primary reason that I am so opposed to the Kennedy bill. According to the Congressional Budget Office, the Kennedy bill, that has been laid down before us, will increase health insurance premiums by an additional 6.1 percent over and above the premium increases we have already experienced or are likely to experience as a result of a resurgent increase in health care inflation.

The CBO report goes on to note that:

Employers could respond to premium increases in a variety of ways. They could drop health insurance [coverage] entirely, reduce the generosity of the benefit package [in other words, cut back on the benefits that are provided], increase cost-sharing by [their employees], or increase the employee's share of the premium.

CBO assumed that employers would deflect about 60 percent of the increase in premiums through these strategies. In other words, 60 percent of this increased cost is going to go right to American workers. The remaining increase in premiums would be passed on to workers in the form of lower wages. In short, it is the workers of America, it is the employees, who will be paying this increased cost.

Lewin Associates, a well-respected health consulting firm, in a study for

the AFL-CIO, has estimated that for every 1 percent increase in premiums, 300,000 Americans have their health insurance jeopardized. Based on these projections, passage of the Kennedy bill would result in the loss of coverage for more than 1.8 million Americans. That is more than the entire population of my home State of Maine.

The Kennedy bill should be more aptly titled the ''Patients Bill of Costs'' because ultimately it will be the patient who will get hit with higher health care costs if the Kennedy bill is approved.

Our legislation, by contrast, provides the key protections that consumers want without causing costs to soar. It responsibly applies these protections where they are needed. The legislation does not preempt but, rather, builds upon the good work that States have done in the area of patients' rights and protections. States have had the primary responsibility for the regulation of health insurance since the 1940s.

I spent 5 years in State government as a member of the Governor's cabinet and was responsible for the Bureau of Insurance. I know State insurance regulators have done a good job in protecting the rights and needs of their consumers in their State. In fact, they have been far ahead of the Federal Government in responding to concerns about managed care.

For example, 47 States have passed laws prohibiting ''gag clauses'' that restrict communications between patients and their doctors. As a consequence, as the CBO notes in its report on the Kennedy bill, ''Several studies have shown that few plans impose such restrictions today.''

Forty States have requirements for emergency care. All 50 States have requirements for grievance procedures. And 36 States require direct access to an OB/GYN.

States have acted without any mandate from Washington, without any prod from Washington, to protect their consumers. Moreover, one size does not fit all; what might be appropriate for one State may not fit for the consumers in another.

Florida, for example, provides for direct access to a dermatologist, which is understandable given the high rate of skin cancer in that State. In the State of Maine, another kind of mandate may be more appropriate. Similarly, what may be appropriate for California, which has a high penetration of HMOs, may simply not be necessary in a rural State such as Wyoming where there is little or no managed care. In such States, a new blanket of heavyhanded Federal mandates in coverage requirements will simply drive up costs and impede, not enhance, health care. That is why the National Association of Insurance Commissioners supports the approach we have taken in our bill.

Currently, Federal law prohibits States from regulating the self-funded, employer-sponsored health plans that cover 48 million Americans. Our bill, which is intended to protect the unprotected consumer, extends many of the same rights and protections to these individuals and their families that those in State-regulated health plans already enjoy.

For the first time, people in self-funded plans will be guaranteed the right to talk freely and openly with their doctors about treatment options without being subjected to any kind of ''gag clauses'' that limit their communications. They will be guaranteed coverage for emergency room care that a ''prudent layperson'' would consider medically necessary without having to get prior authorization from their health plan. They will be able to see their OB/GYN or pediatrician without a referral from their plan's ''gatekeeper.'' They will have the option of seeing a doctor who is outside the HMO's network. They will also be guaranteed access to nonformulary drugs when it is medically necessary, and they will have an assurance of continuity of care if their health care plan terminates its contract with their doctor or hospital.

The opponents of our legislation contend that the Federal Government should preempt the States' patient protection laws unless they have already enacted identical protections. However, the States' approaches vary widely—for good reasons. Moreover, if we start adopting a Washington-knows-best approach to health care, we will have HCFA deciding whether a State has met the test of a Federal regulation. Our experience with other laws should show that is not a good idea.

Other provisions of our bill provide new protections for additional millions of other Americans. These are the procedural protections that are in our bill. A key provision of our bill builds upon the existing regulatory framework under ERISA to give all 124 million Americans in employer-sponsored plans the assurance that they will get the care they need when they need it.

The legislation will enhance and improve current ERISA information disclosure requirements and penalties and strengthen existing requirements for coverage determinations, grievances and appeals, including—and this is the most important provision of our bill—the addition of a new requirement for strong, independent, external review that is available at no cost to the patient.

All 124 million Americans in employer-sponsored plans will be entitled to clear and complete information about their health plan—about what it covers and what it does not cover, about any cost-sharing requirements, and about the plan's providers. Helping patients understand their coverage before they need to use it will help to avoid disputes about coverage later.

The goal of any patients' rights legislation should be to resolve disputes about coverage up front when the care is needed, not months or even years later in a courtroom, as the Kennedy bill proposes. Our legislation would accomplish this goal by creating a strong internal and external review process. Both appeals processes are available at no cost to the patient.

Here is how it would work. First, patients or doctors who are unhappy with an HMO's decision could appeal it internally through a review conducted by individuals with appropriate expertise who are not involved in the initial decision. Moreover, this review would have to be conducted by a physician, if the denial is based on a determination that the service is not medically necessary or that it was experimental treatment. Patients would expect results from this review within 30 days, or 72 hours, in cases where delay poses a serious risk to the patient's health.

Let's say that after this internal review process is completed, the patient or the physician is still unhappy with the decision; let's say that the internal review upheld the HMO's decision. There is still another protection in our bill. Patients turned down by this internal review would then have the right to a free, independent, external review conducted by medical experts who are completely independent of the insurance plan.

This review must be completed within 30 days, and even faster, if there is a medical emergency or a risk to the patient's life or health. Moreover, the decision of these outside reviewers is binding on the health plan. It is not binding on the patient.

If you have been denied care you think you need, you can apply for an internal review. If you are not happy with that review, you can go on to an independent external review, and the decision of the physician, who has to have expertise in the condition at issue, is binding on the health plan, but it is not binding on you, if you are still unhappy. If you are still unhappy with the decision made, the patient would still have the right, would retain the right to sue in Federal or State court for attorney's fees, for court costs, for the value of the benefit, and injunctive relief. Really, it is a three-stage appeals process: First, an internal review, an external appeal, and then you can still go to court to sue for the benefit and for your attorney's fees and court costs.

The purpose of our legislation is to place treatment decisions in the hands of doctors, not insurance company accountants, and not in the hands of trial lawyers. If your HMO denies treatment that your physician believes is medically necessary, you should not have to resort to a costly and lengthy court battle to get the care you need. You should not have to hire a lawyer. You should not have to file an expensive lawsuit to get the treatment.

Our approach contrasts with the approach taken in the Kennedy bill, which encourages patients to sue their health plans. I simply do not believe you can sue your way to quality health care. We should solve problems about

health care coverage upfront, when the care is needed, not months or even years later, after the harm has occurred.

Let's look at the experience with medical malpractice cases. According to the GAO, it takes an average of 33 months to resolve malpractice cases. This does nothing to ensure a patient's right to timely and appropriate care. Moreover, patients receive only 43 cents out of every dollar awarded in malpractice cases. Exposing health plans and employers to greater liability would force plans to cover unnecessary services that do not benefit patients in order to avoid costly litigation and to make decisions based not on the best practice protocols but, rather, on the latest jury verdicts and court decisions or out of fear of being sued.

The noted Princeton health economist Uwe Reinhardt was quoted in this Sunday's Washington Post as saying that he believes the financial impact of the Kennedy bill's liability provisions would be profound. He noted:

> In the end, we're back again to basically the open-ended deal where the individual physician makes a judgment and no one dares question it.

Mr. President, all of us treasure the relationships we have with our physicians. We are also well aware of studies that have shown there have been unnecessary hysterectomies, for example, or the use of mastectomy when removal of a lump from a breast would suffice. That is why we need to have reviews based on the best medical evidence and decisionmaking possible.

The President's Advisory Commission on Consumer Protection and Quality specifically rejected expanded lawsuits for health plans because the commission believed it would have serious consequences for the entire health care industry. I agree with that assessment. The last thing we need is to introduce more costly litigation into our health care system.

At a time when the tort system of the United States has been criticized as inefficient, expensive, and of little benefit to the injured, the Kennedy bill would be bad medicine for American families, workers, and employers, driving up the cost of health insurance and jeopardizing coverage for some who need it most.

Our concern is not just theoretical. I met with a group, a very good group of Maine employers who care deeply about their employees. They expressed to me their serious concerns about the Kennedy proposal to expand liability for health plans and employers. For example, the representative from Bowdoin College in Maine talked about how moving to a self-funded ERISA plan had enabled the college to greatly improve the coverage it provided to Bowdoin's employees and to offer affordable coverage to them.

Since the college is self-funded, it has actually been able to lower premiums for its employees while at the same time providing an enhanced benefit package with such features as well baby care, free annual physicals, and prescription drug cards with low copayments. The people at Bowdoin College told me that the Kennedy proposal to expand liability would seriously jeopardize their ability to offer affordable coverage for their employees. In fact, they told me they would probably abandon their self-funded plan and go back into the insurance market and, thus, buy a plan that would have fewer benefits for their employees in order to avoid this increased risk of liability and litigation.

Similar concerns were expressed to me by the Maine Municipal Association, which represents cities and towns throughout Maine, L.L. Bean, Bath Iron Works, and many other responsible Maine employers.

Unlike the Kennedy bill, the Republican bill contains key provisions that will help hold down the cost of health care while improving health care quality and holding HMOs accountable.

For example, I am particularly pleased that our bill contains a proposal, introduced by my colleague, the senior Senator from Maine, that prohibits insurers from discriminating on the basis of predictive genetic information. Genetic testing holds tremendous promise for individuals who have a genetic predisposition to breast cancer and other diseases and conditions with a genetic link. However, this promise is significantly threatened when insurance companies use the results of such testing to deny or limit coverage to consumers on the basis of genetic information.

Our legislation also establishes the agency for health care research and quality, an initiative of our physician in the Senate, Mr. FRIST from Tennessee. The purpose of these provisions is to foster an overall improvement in health care quality, to bridge the gap between what we know and what we do in health care today.

Most important, the Republican bill will expand access to health insurance for millions more Americans by making it more affordable. This is the key difference between the two alternatives before the Senate. Our bill would expand access to health care, a critical issue at a time when we have 43 million uninsured Americans. The Kennedy bill would constrict access and jeopardize coverage for many Americans. The biggest obstacle to health care in the United States today is simply cost. This is due, in part, to the Tax Code's inequitable treatment of people who do not receive health insurance through their employers. Some 25 million Americans are in families headed by self-employed individuals, and, of these, 5 million are uninsured. The Republican bill will make health insurance more affordable for these Americans by allowing self-employed individuals to deduct the full amount of their health care premiums.

I have never understood the policy behind our Tax Code that allows a large corporation to deduct 100 percent of the cost of the health insurance premiums that it is providing to its employees but restricts a self-employed individual to a deduction of only 45 percent. Our bill would move that to 100 percent immediately. This would help reduce the number of uninsured working Americans. It would help make health insurance more affordable to the 82,000 people in Maine who are self-employed. They include our lobster men, our hair dressers, our electricians, our plumbers, and the owners of our gift shops, which we hope all of you will visit this summer along the coast of Maine. It includes so many hard-working Mainers for whom the cost of health insurance is simply out of reach.

Mr. President, I believe that the Republican approach strikes the right balance, as we effectively address concerns about quality and choice without resorting to unduly burdensome Federal controls and expensive, bureaucratic, new Federal mandates that will further drive up costs and cause some Americans to lose their health insurance altogether.

I urge my colleagues to join in supporting the Republican health task force legislation.

I reserve the remainder of our time.

Mr. DASCHLE addressed the Chair.

The PRESIDING OFFICER. The distinguished minority leader is recognized.

Mr. DASCHLE. Mr. President, this is truly a historic day. My Democratic colleagues and I have been trying for nearly 2 years to bring this debate to the floor of the Senate.

For the past 2 years, I have listened to people and their complaints about the health care system. I have come to the conclusion that the reason the insurance companies call them HMOs is that H-M-O sums up their patient philosophy: Having Minimal Options.

I thank the majority leader. It is no secret that Senator LOTT faced considerable pressure to prevent this debate. On behalf of the 161 million Americans who need the protections in our bill, we thank him for agreeing, finally, to bring this debate to the floor.

Most of all, I want to acknowledge my Democratic colleagues. We would not be having this debate were it not for their steadfast determination and hard work. That is particularly true of the senior Senator from Massachusetts, Mr. KENNEDY. They have each taken considerable risks to demand that this Senate listen to and deal with the real problems America's families are having with their HMOs. Every one of them deserves recognition.

The general debate on this bill is supposed to last 3 hours—which, according to an HMO, is enough time for a woman to check into a hospital, deliver a baby, and be sent home. Senator KENNEDY and I and others intend to use these 3 hours to talk about the extraordinary difference in approach between the Democratic and the Republican plans.

There are no bills pending in this Congress that will have a greater impact on the lives and health of America's families than this bill. There are no decisions we will make that will have a more profound effect than the decisions we make this week.

The issues we will debate these next 4 days are literally life-and-death issues.

The insurance industry has spent tens of millions of dollars to try to prevent us from ever having this debate. Many of our Republican colleagues responded and worked with them. The Republicans seem to protect insurance companies the way Briana Scurry protects a soccer goal. The insurance industry has spent millions of dollars on ads designed to confuse and frighten the American people, and intimidate us. They hope that by repeating untruths often enough they will be able to kill this bill and keep their license to practice bad medicine.

The truth is, this whole debate comes down to one critically important question: Who should make medical decisions, doctors or insurance company accountants?

We have all heard the horror stories.

In Georgia, a 6-month-old boy was burning up with a 105-degree fever. His mother called her HMO twice and begged to be allowed to take her son to the emergency room. Both times the HMO refused. She finally decided to take him to the hospital anyway. By the time they arrived, the infection that was causing the fever had destroyed the circulation in the baby's extremities. Both his hands and feet had to be amputated.

In Washington, DC, a 12-year-old boy was diagnosed with a cancerous tumor in his leg. His oncologist recommended a treatment that could save the leg. But when the doctor's office called the boy's HMO, they were told the only treatment the HMO would pay for was amputation. Four months and several appeals later, the HMO finally agreed to pay for the treatment the doctor ordered. But by then, the cancer had spread; the leg had to be amputated.

In Kentucky, a man with prostate cancer needed one chemotherapy injection a month. The injections cost $500 each. His insurance company policy said they were fully covered. But when the HMO changed administrators, the man was told he would have to pay $180 a month out of his own pocket. He didn't have $180 a month, so he had to go with the only other treatment his doctor said could control his cancer. He was castrated. The day he returned from the hospital, he got a letter from his HMO saying they had made a mistake; the HMO would now pay the $500 after all.

Three different people, three different parts of the country, but they all have one thing in common: They were all powerless against their insurance companies.

Unfortunately, I could go on and on.

Two years ago, 130 million Americans said they or someone they knew had a problem with a health insurance company. Last year, that number had grown to 154 million Americans.

When we first introduced our bill, nearly 2 years ago, a lot of our Republican friends said we didn't need a Patients' Bill of Rights. Today, they have a bill of their own. We consider that progress. But we still have big differences of opinion about what a Patients' Bill of Rights should do.

Our bill covers 161 million Americans. Their bill covers 48 million people; it leaves out more than 100 million Americans.

Our bill lets health care professionals make medical decisions about your health. Their bill lets insurance company accountants make those decisions.

Our bill guarantees you the right to see a qualified medical specialist, including pediatric specialists for your children. The Republican bill doesn't guarantee that either you or your children will be able to see qualified medical specialists.

If your HMO refuses to pay for care your doctor says you need, our bill allows you to appeal that decision to an independent review board. Their bill contains an appeal process, too—except they let the HMO decide what decisions can be appealed. They also let HMOs handpick and pay the people who hear the cases.

Finally, our Patients' Bill of Rights is enforceable. Theirs isn't.

CBO estimates that the most our Patients' Bill of Rights would increase premiums is 4.8 percent over 5 years—less than 1 percent a year. That comes out to less than $2 per beneficiary—less than $2 a month to guarantee that your health insurance will be there when you need it.

Last month, when we offered our Patients' Bill of Rights, a Republican colleagues voted to kill it, without discussing its specific pieces. Yet, they claim they support nearly all the protections in our plan.

So this week, we intend to offer our plan again, piece by piece. Let's debate each of the protections in our plan. Maybe when our colleagues really look at our proposals, they will decide they can support some of the protections in our bill. The American people deserve to know exactly where each of us stands on each of these protections.

Let me just say a word at this point about the kind of debate we expect this week. By agreeing to this debate, we are assuming our Republican colleagues intend to allow a real, honest debate. That means debating and voting on each of the major protections in our Patients' Bill of Rights. If we have that sort of debate, then, whether we win or lose, we will certainly agree not to bring the Patients' Bill of Rights up again this year. Up or down, win or lose, if the debate this week is fair and honest, we will not offer our Patients' Bill of Rights again this year.

But, if we are not able to do that, if we don't have a real debate, if we are not permitted to offer our protections as amendments so that the Senate can discuss and vote on each of them, if there are those who try to prevent an honest debate by using parliamentary tricks, we are putting them on notice now: This debate will certainly not end on Thursday. We will continue to offer the protections in our plan as amendments for as long as we have to until we finally have that honest debate.

We know from experience that we can pass bills that protect the health of American families when we want. Together, Republicans and Democrats passed a bill allowing people to take their health care with them when they change jobs. Together, we passed a bill to help working parents purchase private, affordable health insurance for their kids. Together we can pass a real, meaningful Patients' Bill of Rights this week.

AMENDMENT NO. 1232

(Purpose: To provide the text of Senate Bill 326 (106th Congress), as reported by the Committee on Health, Education, Labor, and Pensions of the Senate, as a complete substitute)

Mr. DASCHLE. 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 South Dakota (Mr. DASCHLE) proposes an amendment numbered 1232.

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

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

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

Mr. DASCHLE. Mr. President, let me explain the amendment I have just offered. This amendment is the Republican HMO reform bill. We are offering it as a substitute to the Democratic bill for one reason.

Senator LOTT has been very candid and open about his intentions. His intention, of course, is to offer at the end of this debate a Republican bill that has not been debated or amended or scrutinized in any way.

By offering as our first amendment the Republican substitute, we now lay down a dual track for the week—their bill and our bill. Both bills are subject to amendments. Both are subject to consideration. Both are subject to the debate that we had anticipated when we reached this agreement.

We will be offering amendments to the Republican bill. We would love nothing more than for our bill to pass without amendment. But certainly, if that is not to be, we will at least do what we can to make sure the Senate deals honestly with this issue.

By offering the Republican bill, we hope to make sure the Senate at least has an honest debate, and we have the opportunity to try to make the Republican bill what it should have been in

the first place—a good bill that deals with each of the issues and offers real protections.

I retain the remainder of our time both under the amendment as well as the general debate.

The PRESIDING OFFICER (Mr. VOINOVICH). The Senator from Texas.

Mr. GRAMM. Mr. President, let me begin by explaining how we came to be here. Then I want to take a little walk down memory lane, as Ronald Reagan used to say, and talk about the real Democrat health care bill—the bill offered in 1993. I then want to talk about the difference between the two bills—the Democratic Kennedy bill, and our bill—and why that difference is relevant to every working American family.

Then I would like to conclude by explaining why our bill is a good bill and why I am confident that if Senator KENNEDY and I could go into every house in America and sit down with people at their kitchen table, and if he could explain his bill and what he is trying to do, and if I could explain our bill and what we are trying to do, I am confident that 90 percent of the people in America would choose our bill.

We are going to have 4 days of debate. But the outcome of the debate, I think, is clear. We are going to win when the votes are cast, and we are going to win this debate because we have a better program. Our program benefits the people who do the work and pay the taxes and pull the wagon in America.

I think when the week is over that we will have discredited the approach of this bill as we discredited the bill in 1993. But, of greater importance, we will have passed a real bill that gives Americans real freedoms.

Our colleagues have lamented that we have waited this long to deal with this issue. I want to remind everyone that last year throughout the year the majority leader offered to bring this bill up, and he offered to bring it up in two different forms.

I thought the most reasonable offer was to let the Democrats write the best bill they could write that does the most that they can provide to help people with health insurance and to impose whatever restrictions they want to write. Then let Republicans put together the best bill they can put together, and bring the two bills to the floor of the Senate and let the Senate choose between one. We could then choose one or the other. That was rejected by the minority.

We then offered them the ability to bring the two bills up and each side have five amendments. That was rejected by the minority.

Not to waste a lot of time to get into a debate with the minority leader, or with other Democrats, I simply submit that we have been 2 years getting to this point because the Democrats have wanted it to be 2 years getting to this point. We could have brought up bills and voted under an orderly process 2 years ago. But, in reality, the Democrats thought they had a political issue. That is why we are only getting to this bill now. I think we are going to prove this week they don't have much of a political issue, and I think when the debate is over they are going to be glad it is over. And I think the American people are going to be glad it is over.

Let me remind my colleagues, and anybody who is watching this debate in America, that this is not the first time Bill Clinton and TED KENNEDY have wanted to rewrite the health care system of this country. I have here on this desk the Clinton health care bills, and the version of it that was sponsored by Senator KENNEDY.

Let me remind those who followed that debate in 1993—their memories might have gotten a little clouded—what this bill did. This bill said that the problem in America was that we had 43 million Americans who didn't have health insurance, and that in trying to deal with health insurance and make it available, we needed to get rid of the current health care system, and we needed to set up on a regional basis in America health care collectives that people would be forced to join. And these collectives would be run by the Government. The whole idea behind the Kennedy bill in 1993 was give up freedom to control cost.

Obviously, I wouldn't have enough time in the day or the week to go through all of these provisions. But let me just remind you of a couple of them.

In 1993, Senator KENNEDY, Senator DASCHLE, and President Clinton said: We are going to have the Government take over the health care system in your hometown—in Phoenix, AZ. There would be one health care collective run by the Government, and if you refused to join that collective, you would be fined $5,000.

That is what they wanted in 1993. That was their concept of freedom when they last asked us to let them run the health care system in America.

Then they said, if this plan did not provide the kind of health care you needed and you sought to get that health care through your physician and the health care was not allowed under this plan, the physician could be fined $50,000.

If you needed health care for your child, their concept of freedom, in 1993, in the Clinton-Kennedy health care bill, was: We know what kind of health care you need. They said: We are going to provide it in this bill, and, if you want health care outside this bill and a physician provides it for you, we are going to fine them $50,000.

That was their concept of freedom in 1993. In 1993 they said, What about the circumstance where your baby is really sick? So you go to a doctor and say, I need health care, and they, under the Clinton-Kennedy plan, say, We are not allowed to provide this kind of treatment. You say, forget about the plan, I'll pay for it out of my own pocket. In 1993, Senator KENNEDY and Senator DASCHLE and President Clinton thought so much of freedom that they said, If you pay the doctor out of your pocket for a treatment that we do not provide for, and the doctor takes the money, he can be sent to prison for 15 years. That was their concept of patients' rights in 1993. That is what they thought freedom consisted of in 1993.

I submit, this is what they still want. The bill that is before us, their bill, is step 1 toward government running the health care system, so when my mama needs to go see a doctor, she first has to talk to a government bureaucrat. We defeated that in 1993, and we are going to defeat it this week in the Senate.

What is the plan today? Unlike 1993, when our colleagues were very concerned about the cost of health care, now they are not concerned about health care cost, they are concerned about rights. So all of a sudden they have put together a bill that imposes a whole lot of government restrictions, that expands liability, so 60 percent of the premiums that go to provide insurance against medical liability will end up going to lawyers instead of to doctors and hospitals and clinics.

They have put together a bill that the Congressional Budget Office has said, when you take into account all the bureaucracy and all the legal liability, will drive up the cost of health care by 6.1 percent. That is equivalent to taking 6.1 percent right out of the paycheck of working Americans in order for them to be able to keep their insurance. Only a lot of Americans will not be able to keep their insurance. In fact, a study funded by the AFL–CIO has concluded, if you take the increase in health care costs under the Kennedy plan, 1.8 million Americans will lose their health insurance.

Mr. President, 1.8 million Americans will lose their health insurance if we should adopt the bill that the Democrats have proposed. For those who are lucky enough not to be one of the 1.8 million people who would lose their health insurance, they would pay $72.7 billion over a 5-year period more for health insurance and health costs than they are paying now.

This is not just about dollars, this is about real people and real health care. By 1.8 million people losing their health insurance, that means you would have 188,595 fewer breast examinations every year for Americans, because the Kennedy bill would take away their health insurance. It means 52,973 American women would not have mammograms who would have them under current law, because the increase in cost under this bill would take away their health insurance. It means that 135,122 Pap tests would not be undertaken, because people would have lost their health insurance and therefore lost access to that coverage. Mr. President, 23,135 American men, mostly elderly men, would lose their prostate

screening exam as a result of the health care cost increase that would be dictated by the Kennedy plan.

So what do they offer us in the name of health care rights? They offer us a bill that would drive up health insurance costs by 6.1 percent, costing 1.8 million Americans their health insurance, and for those who are lucky enough to be able to afford to keep their health insurance, they would pay $72.7 billion more for their health insurance over a 5-year period.

In return for all of these costs, what do people get? Rather than going into the details, I am going to reduce it down to a very simple example. I want to define the problem Senator KENNEDY sees—and we agree on the problem. Then I am going to explain what he provides in the name of rights that drives up costs by 6.1 percent, costs 1.8 million people their health insurance, and those who keep their health insurance pay $72.7 billion more for it.

Here is the problem. The innovation—which, by the way, has been championed by the people who are offering this amendment—is HMOs. They thought so much of them they wanted to force everybody in America into a government-run HMO. But, under HMO, there is a problem. The problem is that people lose the control they want and need over their health care. Let me reduce it down to a simple example.

When people with an HMO go into the examining room, too often, in addition to their doctor in the examining room, they have, either literally or figuratively, the HMO gatekeeper in the examining room. So they are going into the examining room—obviously, that often entails taking your clothes off. People are often a little nervous about that. They want privacy. They like to be in the examining room with their doctor, but with an HMO they find themselves with this gatekeeper virtually looking over the doctor's shoulder. They would like to be in the examining room alone with the doctor. We agree. We think they should have the right to make that choice.

But how does Senator KENNEDY fix the problem? How Senator KENNEDY fixes the problem—and you will be able to tell why it is so expensive when you look at it—the way Senator KENNEDY fixes the problem is demonstrated by this stethoscope. What people want is the doctor in the examining room with the stethoscope up against their heart, but right now they have an HMO listening in, double-checking their doctor. They would like to get this HMO gatekeeper out of the examining room. So what does Senator KENNEDY do? He says: We can fix your problem. It will cost 1.8 million of you your health insurance; those who keep the health insurance, it will cost $72.7 billion more. But look at what you get.

What you get under Senator KENNEDY's plan is this. He doesn't get rid of the HMO, that guy is still there listening in, but he brings a government bureaucrat into the examining room who will be there to keep an eye on the HMO, and to keep an eye on the doctor, and to regulate. Then, in addition to the bureaucrat, he brings the lawyer into the examining room who will be there keeping an eye on the bureaucrat and HMO and the doctor, so that he can be there to sue the doctor or the HMO.

The reason Senator KENNEDY's plan drives up health care costs by 6.1 percent and costs 1.8 million Americans their health insurance and drives up the cost for those who can afford to keep it by $72.7 billion is it costs a lot of money to bring all these bureaucrats and all these lawyers into the process.

But the point is, what people are unhappy about is the HMO gatekeepers being in the examining room. They wanted to get them out of the examining room. They do not want to bring the bureaucrats in and bring lawyers in. What they want is a health care system that looks like this: They want a health care system where you have two people in the examining room and one of them is you. You are on this end of the stethoscope, and your doctor is on the other end of the stethoscope, and there is nobody else in the room. That is what they want.

The difference between the Kennedy bill and our bill is, under his bill, he brings in the bureaucrat and the lawyer. So now you have four people in the examining room. What we do is we get rid of the HMO gatekeeper and give people real freedom.

This is such a critically important point. Our Democrat colleagues have gotten caught up in this deal about how they are going to give people rights. I think it is wonderful that it is so easy for somebody to see what they mean by ''rights'' and what we mean by ''freedom'' are two totally different things.

Under the Democrat bill, you are not free to fire the HMO your boss picks for you, but you are free to have the Government regulate it.

Under the Kennedy plan, you are not free to fire your doctor, but you can sue him.

Under the Kennedy plan, you are not free to control your health care cost, but you can share that control with a lawyer and with the Government.

What we do is give people freedom. It is an interesting paradox that the Kennedy bill debases the very term ''choice.'' It debases the very term of ''rights'' because it contains no rights; that is, no rights that are really meaningful to somebody who has a child who is sick or whose mama is ill.

We give people real rights. We give people the right to fire their HMO by guaranteeing them an alternative, which I will talk about in a minute.

We give people the right to fire their doctor.

We give people the right to take their health care money and spend it as they choose on their own family.

We give people the right to pick the protections they believe are important to their family, not those basic benefits the Government might decide in Washington would be useful.

And finally, we give people the right to control their own health care, something the Democrats do not do.

The Democrat plan means more Government, more lawyers, more rules, more uninsured and more Government control, but the one thing it does not mean, the one thing it does not provide is more freedom. Our bill provides more freedom. Let me explain two ways it does.

First of all, under the current tax system, we have a terrible inequity. If General Motors buys your health insurance for you as their employee, it is tax deductible. But if you buy it for yourself as either a small businessperson who does not have health insurance or a self-employed who does not have health insurance or somebody who works for a company that does not provide health insurance, or if you would rather buy your own health insurance rather than General Motors choosing for you, it is not fully tax deductible. The first thing our bill does is it treats you as well as current tax law treats General Motors. Under our bill, if you buy your own health insurance—let's say you are self-employed. You will get the right to the same tax treatment that General Motors does, so your health insurance is tax free.

The second and most important choice we give to people is a totally new program, a new choice. We do not force anybody to take it, but we give people the ability to buy, in addition to all the choices we provide with everything from an HMO to private practice of medicine through a medical savings account, we expand people's freedom. One of the choices we provide, which I am very excited about, is the right to buy a medical savings account. Here is how it would work.

A medical savings account is a device that really is aimed at helping people who want health care coverage but who often do not have a lot of money. The way it would work is, in addition to joining the health plan your company might try to impose on you, you have the right to take your money and buy a high-deductible insurance policy and then join with your company in setting aside money to pay the deductibles in what we call the medical savings account. Those medical savings accounts are fully tax free, just like conventional health insurance. Here is basically how it would work.

You might buy a health insurance policy with a $3,000 deductible. Normally, that policy would cost less than half as much as a first-dollar-coverage policy. Then you and your employer would begin to build up a savings account up to $3,000, which would belong to you, to cover the deductible.

Then how it works is you make the decision, when your child needs to see a doctor, which doctor your child needs to see. You are empowered to make the decision.

It is true that under the Kennedy plan, if your baby has a 104-degree fever, you could get out the phonebook and you could look under the blue pages for the U.S. Government and you could find the Health Care Financing Administration, or HCFA as they are called, and at 2 o'clock in the morning you could call up HCFA. You would, in all probability, get an answering machine if you were lucky. Maybe you would not. I do not think you are going to find the Director of HCFA at work at 2 o'clock in the morning. You can call up and leave a message, and then they, under the Kennedy plan, will set up a meeting. Maybe next Tuesday at 4:52 in the afternoon they might meet with you or talk to you on the phone.

You also could call up a lawyer. You could look under ''attorney'' in the phone page and you can pick—one thing about Senator KENNEDY's health care rights bill is it gives you no freedom with regard to doctors, but it gives you complete freedom with regard to attorneys.

Senator KENNEDY's bill is unlike the bill he put together in 1993 with President Clinton. Remember, their health care bill in 1993 did not let you sue. They have had a change in heart, it seems, so now he says you can pick up the Yellow Pages and you can look under ''attorney'' and you can pick any attorney. You have your car wrecks. Maybe you want another attorney. This one deals with car wrecks. You have injury. You have family law, criminal law, jail release, traffic tickets, bankruptcy, will and trust, personal injury, board-certified personal attorney. Anyway, you find the one who suits you. You hire that attorney, and you go to court. Eighteen months from now, you might be able to collect some money from some doctor or from some HMO.

Our bill does not work that way. Under our bill, if your baby has a temperature, you pick up the Yellow Pages. I have the Yellow Pages from Arlington and Mansfield, TX. This Yellow Pages lists all the physicians who practice medicine in that area.

Under our plan, you pick up the phone and you call up the physician you might pick. Let's say I pick Louis W. Adams, pediatric ophthalmologist, and I call him up. Under the Kennedy bill, I would have to ask him some questions. I would have to say: Are you a preferred provider? In fact, we did an experiment on that in Washington, DC. Let me show it to you.

In Washington, DC, we took a page out of the phonebook. It was page 1017. These are the physicians who were listed. The first one is Ginsberg, Susan M., M.D., and the last one is Robert O. Gordon.

Let's say you are in an HMO or you are in a PPO, and you call up—let's say you pick Philip W. Gold. You call him up and say: Dr. Gold, I need health care. I have a child who has a 103-degree temperature. Are you in the Kaiser HMO, or are you part of the Blue Cross PPO?

We found that out of the 28 doctors, 10 accepted the Kaiser HMO, 17 accepted the Blue Cross PPO. But let me tell you the amazing revelation we made. With a medical savings account, which any American could set up, under the Republican plan, you would get a checking account. This is from Golden Rule Insurance Company in Indiana. This is a medical savings account checking account. Then this is for a medical savings account that is operated by Mellon Bank, and this is a MasterCard. Then this is an American Health Value medical savings account, and this is operated through Visa.

Under the Republican plan, you would have the right to opt for a medical savings account where you would make the decision about health care for your family. We empower you—not some lawyer, not some bureaucrat—but we empower you as a parent.

So then we called up everybody on page 1017 of the Yellow Pages and we asked them three questions:

Do you take a check?

Yes. Every one of them took a check.

Do you take Visa?

Every one of them took Visa.

Do you take MasterCard?

Every one of them, all 28 of them, took MasterCard.

So the real freedom in the Republican bill is the right for you to choose—not to choose a lawyer to sue somebody 18 months from now, not to call up a government bureaucrat and fill out a form and register a protest. What kind of freedom is that? The freedom we give is the freedom to act, the freedom to hire, the freedom to fire, the freedom to say yes, the freedom to say no. That is what freedom is about.

Our Democrat colleagues believe freedom is about being able to talk to a bureaucrat. They think freedom is about the right to sue.

Under the Republican plan, freedom is the right to say to your HMO: You're fired. I don't like the way I'm being treated here. I'm leaving your HMO. I'm opting for another option. The example I gave is a medical savings account.

Freedom, under the Republican plan, is the freedom to pick up the phonebook and let your fingers do the walking. You pick the doctor: I want John V. Golding, Jr. I don't want anybody else. He is the doctor I want. I got his telephone number. I called him up and said: My mama is sick, Dr. Golding, and I would like her to come see you. Do you take a check or MasterCard or Visa? He says: Yes. I am in.

As this debate goes on, you are going to hear Senator KENNEDY, and others, say: The world will come to an end if you have medical savings accounts. They are going to use the interesting charge they use any time they are against something, and that is it is for rich people. If Democrats are not for something, they claim it is for rich people. Tax cuts are for rich people. Choice, freedom, is for rich people. They are going to say: Oh, the medical savings accounts, rich people will get medical savings accounts and poor people will not have them; it will just be terrible.

The facts are that even though we have a limited number of medical savings accounts that can be sold, even though in the year 2000 they lose this option and have to go back into the old system unless we change the law, the people who are buying medical savings accounts are primarily modest-income people. But we are going to repeal those limitations and we are going to do it this week. Uninsured people are buying medical savings accounts because it allows them to buy an affordable high-deductible policy that covers them against terrible things happening and then lets them build up savings accounts with their employer to pay the deductible.

So those who are going to criticize medical savings accounts are going to say it is for rich people, but they really do not like it because it is freedom. What they want is this. They want the old Clinton health care bill. They know that if we ever give people the right to choose, they will never nationalize health care. So medical savings accounts are, to our dear colleague from Massachusetts, like a crucifix is to a vampire. They cower, they are struck with fear at the idea that some parent would actually have the ability to fire an HMO and do it without having to call a bureaucrat or without having to hire a lawyer.

Why do they fear freedom? Because they are not for it. They want the Government to take over and run the health care system—always have, always will.

The basic question is, Who should manage care? Should it be an insurance company? Should it be the Government? Or should it be you? We believe it ought to be you. We believe that parents ought to be empowered to control health care. We believe that parents can make better decisions.

That is what this debate is about. This debate is about whether freedom means getting access to a bureaucrat or firing your HMO, whether freedom in health care means hiring a lawyer or being able to hire your own doctor. That is what the debate is about.

A final point I would like to make—and I think it is a significant point; some people would say it is a reach, but I do not think so—why, all of a sudden, are our same colleagues who in 1993 wanted the Government to take over and run the health care system and make everybody be in one big Government-run HMO—why, all of a sudden, do they want to drive up costs in the name of expanding bureaucracy and lawsuits?

Part of it is, they like bureaucracy and they like lawsuits. But that is not, in my opinion, the real story. The real story is, if, God forbid—and He is going to forbid, because we clearly have the votes to stop him but if, God forbid,

the Kennedy plan should be adopted, and health insurance went up by 6.1 percent and 1.8 million people lost their health insurance, does anybody doubt that next year Senator KENNEDY would be back with the Clinton health care bill saying: Now 1.8 million people have lost their health insurance, and we have no choice except to let the Government take over the health care system? I think that is what he would say. In fact, I think that is basically what we are debating here: Destroy the private health care system so the only alternative would be Government.

Our answer is: Let's make the current health care system better; let's have a meaningful, timely internal and external appeal if you want to stay in an HMO; let's empower people to fire HMOs and go to the private practice of medicine again if they choose; let's expand freedom as a solution to making our current system work better to make it more efficient and to empower families to make more choices.

The alternative the Democrats have is: Destroy the current system and then let's let Government take over and run the health care system.

Our answer is: Expand freedom and choice within the current system, empower families to decide, and let's forever and ever keep Government out of health care.

That is really the choice. Our Democrat colleagues believe that somehow they are going to benefit by Americans knowing they are unhappy about HMOs and they want to expand your access to bureaucrats and lawyers. We do not think that solves the problem. We think what solves the problem is to make HMOs give you an effective internal and external appeal; but we go one step further, and that is, we empower people to fire the HMO and to hire their own doctor.

We believe in freedom. We believe freedom works. It built America in every other era. Can you imagine if we had a Clinton-Kennedy car insurance bill or car repair bill so that if you are unhappy with your assigned repairman to fix your car, and if you are unhappy with what he does, you contact a bureaucrat and then, if you are unhappy with what he does, you contact a lawyer? I submit that the cost of repairing our cars would be astronomical.

We have a different system. It is one we would like in health care. That is, you pick where you go to get your car repaired, and if you do not like the work they are doing, you say to them, in a traditional American fashion: You are not doing a good job. You have not lived up to our trust. You have not done what you said you would do. And you're fired.

That is freedom. That is freedom. That is what we want. We want the right of people to choose. We don't want this substitute for the right to choose, the right to pile up costs in lawsuits or the right to deal with bureaucrats. What kind of right is that? How many wrongs do bureaucrats right? About one-tenth as many as they create.

We give you freedom. The Democrats give you bureaucracy. We help lower the cost of health care by expanding choices and expanding tax deductibility. They drive up the cost of health care by 6.1 percent. Their bill would deny health insurance to 1.8 million Americans. Their bill would drive up health care costs by $72.7 billion. Senator KENNEDY likes to claim, well, it is just a hamburger a day for however long. Well, with $72.7 billion, you could buy every McDonald's franchise in America for the 5-year cost that this will drive up health insurance.

Senator KENNEDY doesn't understand that if the company you are working for is paying your health insurance and the cost is driven up, you are still paying it. It is part of your wages. What is going to happen, according to estimates that were undertaken by the AFL-CIO—in support of this bill, by the way—is that 1.8 million people will lose their health insurance. We don't want that to happen, and we are going to stop it from happening.

This is going to be a very meaningful debate. I look forward to it. I think people will learn from it. I think in the end they are going to have two different choices about what freedom is.

If freedom to you is access to a bureaucrat and a lawyer, then you are with Senator KENNEDY. If freedom to you is the right to choose your own health care, your own doctor, the right to hire and the right to fire, the right to say what you want and people either do it or you get somebody else, if that is what freedom means in your hometown, if you would rather be able to pick up the Arlington-Mansfield phonebook when your baby is sick and look up ''physician'' rather than look up ''attorney'' or, rather than look in the Blue Pages for HCFA, if that is what you would like to have, you are with us. On the other hand, if you think your answer is at HCFA in the Blue Pages or with an attorney, then you want to be with Senator KENNEDY. It is about as clear a choice as you could possibly have.

When the debate is over this week, not only will we have won the vote, but I think, more importantly, we will have won the debate. We will have ended, hopefully forever, any dream of ever getting back to the Clinton health care bill, where every American is forced into a health care collective and, when your momma gets sick, she talks to a bureaucrat instead of a doctor. They tried that in 1993. Eighty-two percent of the American people thought this might be a good idea. Finally, when a few of us stood up and fought it, it was like sticking a great big inflated balloon with a pin. Suddenly, once people understood it, they were against it. They understood that what was at stake wasn't just health care, but what was at stake was freedom.

That is what this is about—the right to choose. Don't get confused about it, as we go through the debate.

I thank the Chair for its indulgence. I yield the floor and reserve the remainder of our time.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I am very hopeful we will be able to get into the substance of the differences between the approaches taken in the two bills. We heard a great deal of rhetoric, of course, earlier in the afternoon. We have had a brief presentation by the Democratic leader, Senator DASCHLE.

At the outset, one point worth highlighting, as we begin this debate, is that there isn't a single health or medical organization in the United States that supports the position being advanced by that side of the aisle—not one.

This really isn't or shouldn't be a Democratic or Republican debate. Republicans are members of HMOs as well as Democrats. Children are Republicans as well as Democrats. Women who need clinical trials are Republicans and Democrats. Those who have been in the vanguard of protecting women's health issues have been Republicans as well as Democrats. On children's issues, disabled issues, there have been Republicans as well as Democrats.

I cannot remember a single piece of legislation that has been considered on the floor of the Senate in the time that I have been here where you have such overwhelming support for one side and virtually no support for the opposition side—in this case, the Republicans—not a single instance. I made that statement during one of the brief times we had a chance to talk about the Patients' Bill of Rights debate and discussion. It has never been rebutted.

We heard earlier, in the course of the afternoon, about how the Republican proposal is really going to provide for necessary specialty care. Why is it then that every specialty organization in the country supports our bill? We heard over on the other side: Look, we are really giving the consumers a great deal of protection in our bill. Why is it that every consumer organization in the country supports our bill and opposes theirs? Every one, make no mistake about it.

We are in a situation where, as so many of us have seen, special interest groups can pay for and buy just about any statistic they want to buy, and they have done so. They have put out misrepresentations and distortions about our bill. These misrepresentations and distortions about cost are all over the airwaves. We will have a chance later in the course of this debate to address the issue of costs. We will have a chance to make a presentation about what independent studies have concluded about the cost of our particular proposal. Despite the fact that we will introduce and present

these independent studies, do you think that will than alter and change people's minds? Absolutely not. You are going to hear distortions and misrepresentations. You have already heard them over the course of this afternoon.

I was sitting here when our good friend from the State of Maine was speaking about the importance of the types of protections included in their Patients' Bill of Rights. The interesting fact is, their proposal doesn't cover any members of HMOs. Isn't that amazing? Listen to this: It doesn't cover any of the patients of HMOs. That is what brought about all of this concern. We can ask ourselves: Is there a concern today? The answer is yes, and not just because we say so.

I heard talk about the importance of the State insurance commissioners. I ask our colleagues on the other side of the aisle to call their State commissioners and hear about the complaints that we are hearing. Call them this afternoon; call them tomorrow. Call them before we finish this debate and find out: There are two and three and four times more complaints today than there were a year ago or 2 years ago. Those are the facts. You would not know these facts from the earlier debate.

This is a very interesting chart. We know there are 160 million Americans who are covered by private health insurance. On this particular chart, the ''Republican Plan Excludes More Than 100 Million People,'' there are 48 million people covered through self-funded employer plans. That is the total group that is covered by the Republican plan.

There are 75 million people whose employers provide coverage through insurance policies or an HMO—that is what I thought this debate was really all about. They are not protected in the Republican plan. We listened this afternoon to assertions about all the protections included in the Republican plan. But these 75 million people are not protected under the Republican plan. They are not phased in next year or in 2 years. They are out; the Republican bill doesn't apply to them.

State and local government workers, they are left out of the Republican bill. People buying individual policies, some 15 million, are left out. Who are they, Mr. President? They are the small shopkeepers.

They are the farmers and the mom-and-pop stores that have to go out and buy these health plans. They are the one of the most vulnerable groups in our society.

Do you know what was missing in the other side's presentation? The fact that the top 10 HMOs in this country, last year, made $1.5 billion. Isn't that interesting? We see crocodile tears coming from the other side of the aisle about the cost of protecting patients. Then we find out the profits of the major HMOs and the multimillion dollar salaries paid to their CEOs. We hear about the $100 million being spent by the insurance companies to defeat our proposal.

How much is that going to add? Why don't you address that, I say to our friends on the other side. Over $100 million. You know, generally around here—and the American people understand it—you can look at who is for a piece of legislation and who is against it in terms of who will benefit and who will lose out. It is not a bad way of looking at it. Sometimes issues are so complex that the balance is not completely clear. But on this issue, all the health care groups that favor adequate protections are in favor of our Patients' Bill of Rights. On the other side is the insurance industry—one industry, the insurance industry. That is it.

Can we have some explanation by the other side, as we start this debate, about how they justify that? That is the bottom line. It is one industry. The Republican program is the profit protection program for the insurance industry. It is a bill of goods. It is a bill of wrongs. The Democratic proposal is the Patients' Bill of Rights.

So as we start off on this issue, it is our hope, as we have mentioned before, to review for this body and the American people exactly what we intend to do. We have commonsense protections which have been developed over the last decade. What we want to ensure is that any bill passed will at least provide these commonsense protections. Perhaps legislation isn't going to be so all-inclusive as to include every commonsense protection. I hope it will.

These are commonsense protections. You can ask where they all come from? Where did these patient protections that are included in the DASCHLE proposal come from? That is a fair question. We say they come from at least one of four different evolutions. You have the insurance commissioner's recommendations; Insurance commissioners, representing Republicans and Democrats, making recommendations. The President's bipartisan commission made what they call, not majority recommendations but unanimous recommendations. Do we understand that? Unanimously, Republicans and Democrats have said: Here are five or six protections we recommend, and we have included those recommendations.

The only difference is that the bipartisan commission recommended that the protections be voluntary. Well, if every one of the companies complied with that recommendation, we would probably not be here today. They have not complied, and they will not comply. We also include protections included in Medicare and Medicaid, and protections recommendations by the health plans themselves. Those four groups have made the recommendations that are included in our proposal. That is why our bill has the unanimous support of the health professions.

I will not take further time this afternoon. But I will point out, as we start this debate, that no health care debate this year is more important to every family. Yes, Medicare is enormously important. Yes, the issue of medical records privacy is important. Yes, home health care for our elderly is enormously important. There are other important issues concerning basic medical research.

But the issue of health care quality is most important. The issue of whether your child, your wife, your loved one, your family member, receives the kind of health care that well-trained, committed medical professionals, doctors and nurses, who are trained and dedicated to try to provide the best in health care, want to provide, is most important.

This legislation belongs to the nurses of this country, the doctors of this Nation, the cancer researchers, the children's advocates, and to the disabled organizations. Every one of those organizations supports our bill. Over the course of this week we will have an opportunity to address each and every one of these items. Hopefully, the American people will speak through their representatives and the result will be sound patients' protection legislation.

Mr. WELLSTONE addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I will be very brief because we are anxious to get on with this debate. I want to add to the words of Senator KENNEDY.

This debate is a very personal debate for many of us, for both Democrats and Republicans. It is really heartbreaking to sit down with a family and talk to a father whose son was denied experimental treatment for cancer and wonders whether or not his son might have lived if he had been able to obtain that treatment. It is really disheartening to meet with a railroad worker whose wife talks to you about her husband and how he is fighting cancer but how every day she is on the phone battling these insurance companies to find out whether or not they will provide coverage for the treatment.

That is what this debate is really all about. I think that, by the end of the week, it is going to be really clear what the differences are between the two proposals. This Republican bill that is on the floor—the Daschle amendment—altogether covers 48 million people. But for those citizens who aren't working for a Fortune 500 company, who are small businesspeople, family farmers, and others, there is no patient protection. That is a huge difference. There is a huge difference between the 2 proposals of 115 million Americans. The Republican plan doesn't cover the 115 million Americans that the Democratic plan does. Quite often, I don't talk in terms of Democrat or Republican, but here it makes a difference.

Second of all, people are so desperate to make sure that if their child needs to see a pediatric oncologist, or a parent with Parkinson's needs to see a

neurologist, they will have access to that specialty care. The Republican plan does not guarantee that that will be the case. The Democratic plan makes it crystal clear to these managed care plans: Make sure you have those specialists available for people, and make sure that if it is not in your network, they will have access to whoever can provide the best care for their child or their parent.

Third is the question of consumer choice and continuity of care.

This Republican bill on the floor of the Senate, does not guarantee the continuity of care and doesn't give you the right, really even if you have to pay a little bit more in premium, to go outside the network of the managed care plan and take your child or your parents to the best expert or make sure your family members see the best specialist. This is called the point-of-service option.

I will have an amendment that deals with that.

Fourth, I heard my colleague from Maine speak about the appeals process. But, in all due respect, if people are not able to go to an independent, external appeal from these managed care plans dominated by these insurance companies and make sure that those independent panels are not picked by the companies, I don't call that independence.

The Republican plan has the external appeals process controlled and dominated by the very companies that you have a grievance against.

The Democratic plan provides for an independent appeals process backed by an ombudsman program that can help families.

I will conclude because there are other Senators who want to speak.

I think that this debate is all about representative democracy.

I think this debate goes far beyond the issues at hand, although I agree with my colleague from Massachusetts; I think this is the most important debate of our session.

This debate is all about whether or not the Senate belongs to the insurance companies of America or belongs to the people of Minnesota or Nevada or Massachusetts or North Dakota—the people around the country. That is what this debate is all about.

I look forward to debating into these specific amendments. I hope that people in the country will be engaged.

I say to all of my colleagues that I believe people will hold us accountable.

This is an opportunity to do well for people. This is an opportunity to provide families with some protection. This is an opportunity to be willing to stand up against some powerful economic interests—the insurance companies of America that dominate so many of these managed care plans—and be advocates for the people we represent back in our States.

Republicans, no matter what you call your plan—no matter what the acronym is—it is swiss cheese. You have too many loopholes in this plan. You don't provide protection for consumers. The people in Minnesota are not going to be in favor of an insurance company protection plan. They want it to be a Minnesota family protection plan.

That is what I am going to fight for all week.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I yield 5 minutes to the Senator from North Dakota on the substitute.

The PRESIDING OFFICER. The Senator from North Dakota is recognized for 5 minutes.

Mr. DORGAN. Mr. President, we are finally going to have a debate on the issue of the Patients' Bill of Rights. It will not be a debate about theory. It will not be a debate about past proposals for health care reform. It will be a debate about real protections for real people in this country.

We have two plans before us.

One is a patients' protection act that we have offered that has the support of virtually every health care organization in this country.

The other is a piece of paper with a name—just a name, just an empty vessel—that pretends that it provides protection but in fact it doesn't.

Let me describe, if I might, some of the details of these plans. I want to be very brief, but I want to do it by talking about protections for people.

This young boy's name is Ethan. Ethan was born in 1992 after a difficult birth. During his delivery, oxygen was cut off from Ethan, so he was born with significant problems that required special therapy. But the HMO denied the special therapy for Ethan because they said the probability of him being able to walk by age 5—a 50-percent potential of being able to walk by age 5—was insignificant. They called a 50-percent chance of being able to walk insignificant.

So corporate profits take precedence over patients' protection, and Ethan does not get the therapy he needs.

Or let me show you another example. Dr. GANSKE, a Republican in the U.S. House, used this chart to show a young child with a serious facial birth defect, a cleft lip. No one looking into the face of that young child could say that correcting this birth defect should not be done.

Yet Dr. GANSKE did a survey of reconstructive surgeons and found that 50 percent of the doctors who had patients like this have had the corrective surgery denied by HMOs. These HMOs said this procedure was not ''medically necessary.''

Would any parent in the world believe that this is not ''medically necessary''?

Dr. GANSKE, a Republican Congressman from the U.S. House, certainly doesn't believe that. He has been a champion for this kind of patients' protection act.

Here is an example of what a young child with that deformity can look like after reconstructive surgery.

Isn't that wonderful? Is that a ''medical necessity''? You bet it is. Of course, it is. But health insurance only works if patients get what they pay for.

Dr. GANSKE sent something around the other day that I pulled out in preparation for this debate. I want to describe this just briefly because I think it illustrates the difference between an empty vessel with the same title and a patients' protection bill that gives real protection to real people.

At 3:30 in the morning, Lamona Adams found her six-month infant boy, Jimmy, panting, sweaty, and moaning. He had a temperature of 104. So she phoned her HMO to ask for permission to go to the emergency room.

You have to do that, by the way—get permission to go.

The voice at the other end of the 1–800 number told her to go to Scottish Rite Hospital. ''Where is it?'' asked Lamona. ''I don't know—find a map,'' came the reply. It turns out that the Adams family lived south of Atlanta, Georgia, and Scottish Rite was an hour away on the other side of the Atlanta metro area.

Lamona held little Jimmy while his dad drove as fast as he could. Twenty miles into the trip while driving through Atlanta, they passed Emory University Hospital's ER, then Georgia Baptist's ER, then Grady Memorial's ER. But they pushed on to Scottish Rite Medical Center—still 22 miles away, because they knew that if they stopped at an unauthorized hospital, their HMO would deny treatment and they would be left with the bill.

They knew Jimmy was sick, but they didn't know how sick. After all, they weren't trained professionals.

They pushed on to where the HMO said they could stop.

With miles yet to go, Jimmy's eyes fell shut and wouldn't open.

Lamona frantically called out to him. But he didn't awaken. His heart had stopped.

Imagine Jimmy's dad driving as fast as he could to the ER while his mother is desperately trying to keep him alive.

They finally pulled into the emergency room entrance. Jimmy's mother leaped out of the car and raced into the ER with Jimmy in her arms calling, ''Help my baby! Help my baby!''

They gave him mouth-to-mouth resuscitation while a pediatric ''crash cart'' was rushed to the room. Doctors and nurses raced to see if the miracles of modern medicine could save his life.

He was intubated and intravenous medicines were given and he was cardiopulmonary resuscitated again. He was a tough little guy. He survived despite the delay in treatment by his HMO. But he didn't survive whole.

He ended up with gangrene in both his hands and feet, and the doctors had to amputate both of Jimmy's hands and feet.

This is a picture of little Jimmy before his illness, and then afterward. His folks drove past three hospital emergency rooms because the HMO said he had to go to the fourth one miles and miles and miles away. And this young boy has no hands and no feet now because of that.

We have two plans on the floor.

One of the plans, our bill, says that families have a right to the emergency care they need at the nearest hospital.

The other plan says they offer such a right—until you read the fine print. The other side will tell you they have a good plan, but they have an empty vessel.

On the issue of emergency care, little Jimmy, his parents, and others across this country will understand that it doesn't improve care when HMOs are allowed to determine which emergency rooms they will allow patients to stop at to get emergency treatment for these children.

My point is this: We are going to debate theory all week. But it is not theory that is important. What is important is children like Jimmy, children like Ethan, or children like this little boy who has a severe birth defect of the face and was told by an HMO that this deformity need not be fixed.

We know that is not right.

This debate is about profits, patient care, insurance companies, and the rights of patients who are sick.

I think at the end of the day and at the end of this week all of us will see that there are two plans. One is supported by virtually every medical and consumer group in the country because they know it allows real protections to allow doctors to practice medicine—not an insurance accountant thousands of miles away making decisions about patients' health care.

The PRESIDING OFFICER (Ms. COLLINS). The Senator from Oklahoma is recognized.

Mr. NICKLES. Madam President, what is the time situation on the amendment?

The PRESIDING OFFICER. On the amendment, there are 10 minutes remaining for the Senator from Oklahoma and 23 minutes for the Senator from Massachusetts.

Mr. NICKLES. What about the remaining time on the bill?

The PRESIDING OFFICER. On the underlying bill, there are 63 minutes for the Senator from Oklahoma and 80 minutes for the minority.

Mr. NICKLES. I yield to my colleague from Wyoming 10 minutes on the amendment, and if he desires additional time on the bill, I will yield that as well.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. ENZI. Madam President, during the last few months I have patiently watched the minority come to the Senate floor and threaten to hold up the legislative process until they received a full debate and amendment process on the President's Patients' Bill of Rights. On May 25, leaders of the minority put that request in writing by sending a letter to the distinguished majority leader asking for a debate on their bill. That time has arrived. No tricks, no gimmicks. This debate will allow us to determine if the President's bill is everything they say it is.

Last Friday, the President, while in Los Angeles, suggested that by debating his bill the Republicans are trying to hide their plan from the voters. This comment begs the question: Why wouldn't the Democrats want to debate their own bill? Aren't they getting exactly what they asked for?

They asked for it by holding up the agriculture bill. They asked for it by holding up appropriations. Now they have what they asked for. Perhaps they would rather have an issue to talk about—not legislation.

Our presence today and throughout this week clearly illustrates we are not hiding anything from the voters. Who is hiding? My mom can watch this on her television in Sheridan, WY—and she probably is.

We have every intention of offering our bill during this debate. Be assured, the Senate will vote on our bill. We are not interested in hiding. We are interested in showing that we have a better bill. If anyone should be nervous, it is the President. If I had to defend his bill, I would be pretty nervous too.

I am glad we are debating his legislation. Perhaps all the rhetoric we have heard during the last few weeks, and even today, will be replaced with some substance. Sound policy conquers rhetoric. We are confident of this as the debate unfolds. The bill left standing will be our Patients' Bill of Rights Plus.

I commend our leadership for the work they have done to put together our Patients' Bill of Rights. On January 13, 1998, the majority leader created the Republican health care task force, pouring the foundation for a comprehensive piece of legislation to enhance quality of care without increasing the number of uninsured Americans. During the last 18 months, the task force in the Senate Committee on Health, Education, Labor, and Pensions has worked together to make our bill live up to its title—a Patients' Bill of Rights our Nation's consumers and patients can be proud of.

Aside from the title, the scope of the President's bill and our bill is quite different. I agree it is important we explain the difference between the two measures. The amendments Senators offer this week will clearly show those differences. I am proud of our bill's scope. It respects State's jurisdiction. The President's would apply across the board—a nationalized bureaucracy, budget busting, a one-size-fits-all national approach.

I remember the last time this administration pushed a health care package of this size and scope. It was back in 1993 when the President and Mrs. Clinton launched an aggressive campaign to nationalize the delivery of health care under the guise of ''modest reform.'' The sales pitch back then wasn't any different from what it is now, backed with scores of anecdotes illustrated from Presidential podiums across the country. These stories will pull on the heart strings of all Americans and are intentionally aimed at injecting fear and paranoia into all persons covered or not covered by private health insurance.

I am in Wyoming almost every weekend. I am quick to ask my constituency interested in the President's bill to look at the fine print. It is no surprise to me that most of them already have. The American people aren't easily fooled. They haven't forgotten the last time the President and Mrs. Clinton tried to slip nationalized health care past their noses. Anyone can put lipstick on a pig, give it a Hollywood-style debate, and hope for a political slam dunk. Expecting the public to close its eye and kiss this pig, however, is an entirely different matter.

I remember the reaction Wyoming residents had to the 1993 ''Clinton Care'' plan. I was a State senator at the time. I recall how the President and Mrs. Clinton rode a bus across America, promoting their plan to federalize our Nation's health care system. The people of Wyoming also remember the detour they took when they got to the Wyoming border. Instead of entering our home State, they chose a more populated route through Colorado. That was an unfortunate choice. They missed their chance to receive an education on what rural health care is about. Had they driven all 400 miles across southern Wyoming, they would have seen for themselves why federalized national bureaucracy, one-size-fits-all legislation doesn't work in rural, underserved States.

Wyoming has 480,000 people scattered over 98,000 square miles. My hometown of Gillette has 22,000 people—fourth largest in the State. It is 145 miles to another town of equal or greater size, and it isn't even in our State. Many of the people in my State have to drive up to 125 miles one way just to receive basic health care. More important is the difficulty we face in enticing doctors and health care professionals to live and practice medicine in rural areas. I am very proud of Wyoming's health care professionals. They practice with their hearts, not with their wallets.

In a rural, underserved State such as Wyoming, only three managed care health plans are available, and that covers just six counties of our State. Once again, this is partly due to my State's small population. Managed care plans generally profit from high enrollment, and, as a result, the majority of plans in Wyoming are traditional indemnity plans commonly known as fee-for-service. In fact, the vast majority of regulated health insurance in Wyoming is handled by the State.

Some folks might wonder why I am so concerned about the scope of the President's bill if it doesn't affect Wyoming that much. I am worried because a number of Wyoming insurers offer managed care plans elsewhere. Any premium hike spurred by a federalized bureaucracy, national one-size-fits-all bill would be distributed across the board. We would get an increase when

we didn't receive a benefit, thereby causing increases in the fee-for-service premiums in Wyoming. Simply put, my constituents could easily end up paying for services they will never get.

Expecting my constituents to pay more dues to the President's national health care system poses a potential threat to exclude them from health insurance coverage altogether. That is entirely unacceptable. Moreover, it further hinders our ability to keep physicians in Wyoming. If the President's bill passes, it will actually drive down the number of health care professionals we have in our State.

Our Patients' Bill of Rights is not a federalized, national health care system. It stays within the traditional, regulatory boundaries established and already built in by the Employee Retirement Income Security Act, ERISA, of 1974. ERISA applies to self-insured plans, meaning employers who fund their own insurance plans for their own employees—all 48 million. These plans lie outside the regulatory jurisdiction of the States. Since it is the responsibility of the federal government to regulate ERISA plans, our bill stays within that scope.

The President and the Senate minority, however, argue that our bill should apply to all plans and all persons—including those already regulated by the states. Our bill's goal is to improve health care quality through better information and improved procedures as well as rights for consumers and patients, without significantly increasing the cost of health coverage and the number of uninsured Americans. By legislating within the federal jurisdiction of ERISA only—and not usurping state jurisdiction—we accomplish our goal.

Unfortunately, that hasn't silenced the claims made by the President and the Senate minority. These claims are no different than those made by the President and Mrs. Clinton back in 1993. He wants nationalized healthcare—plain and simple. Americans have been down this road before. The states, however, have been in the business of regulating the health insurance industry far longer than Congress or any President. The President wants all regulatory decisions about a person's health insurance plan to be made from Washington. The reason this won't work is that it fails to take into account the unique type of health care provided in states like Wyoming.

While serving in the Wyoming Legislature for 10 years, I gained tremendous respect for our state insurance commissioner's ability to administer quality guidelines and insurance regulations that cater to our state's consumers and patients. State regulation and respect for their jurisdiction is absolutely, unequivocally essential. I firmly believe that decisions which impact my constituents' state regulated health insurance should continue to be made in Cheyenne—not Washington.

You can call Cheyenne and talk to the same person each day, if you need to. But since you can talk to the same person, you do not have to make as many calls. Here you have to spend half of your time explaining to the person the problem that didn't get followed-up on the last time you called. The President and the Senate minority want to crate that all up and ship those decisions back here to Washington.

By advocating federalized, national one-size-fits-all health care, done through a bureaucracy, the President's bill would increase the number of uninsured. Perhaps that's something he wants. We know that the President and Mrs. Clinton prefer a national, Federal health care system in lieu of private health insurance. Their 1993 plan is evidence of that. By increasing the number of uninsured, maybe he hopes that these folks will join him in his campaign for a Washington-based health care system. I sure hope that is not the case, but as long as the President continues to dodge that issue, I am forced to assume that this is his position.

By keeping the scope of this bill in perspective, we also control that cost which directly impacts access. Affordable access to health care is an even higher priority than quality. If it is not affordable, quality does not exist. By issuing federalized, national one-size-fits-all mandates and setting the stage for endless litigation, the President's bill could dramatically raise the price of premiums—barring people from purchasing insurance. That is the bottom line for American families—the cost. We all want as much consumer and patient protection as the system can support. There is not a member in the Senate who does not support consumer and patient protection. But if Americans are expected to pay for the premium hikes spurred by the President's bill, they'll most often go without insurance. That is why we must keep the scope of this bill in perspective.

The President has repeatedly accused the Senate majority of being in the pocket of the insurance industry. I take great offense to that charge. That same blanket claim was also made during the tobacco debate last summer, even though I never took a dime from the tobacco industry. Just last Friday, the President said that we are being captive to the ''raw political interest of health insurers'' and said that our party's leaders had resorted to delaying debate on his plan for cynical political reasons. How does the President respond to claims that his plan was written on behalf of special interests like organized labor and trial lawyers? I'd sure like to get his thoughts on that.

The President's bill would allow a patient to sue their own health plan and tie up state courts with litigation for months or years. The only people that benefit from this would be trial lawyers. The patient, however, would be lucky to get a decision about their plan before their ailment advanced or even took their life. A big settlement does not do you much good if you win because you died while the trial lawyers fiddled with the facts. Folks are not interested in suing their health plan. They watch enough court-TV shows to know how expensive that process is and how long it takes to get a decision made. This is not L.A. Law—it is reality. Our Patients' Bill of Rights avoids all this by incorporating an expedited external appeals process that does not exceed 72 hours. Getting quick decisions saves lives. We insist on a decision before the patient dies!

The President apparently has no problem expanding the scope of federal jurisdiction, but he is silent when it comes to increasing access for the uninsured. Our Patients' Bill of Rights delivers on access. It would increase access to coverage by removing the 750,000 cap on medical savings accounts (MSA's). MSA's are a success and should be made available to anyone who wishes to control his or her own health care costs. Moreover, persons who pay for their own health insurance would be able to deduct 100 percent of the cost if our bill becomes law—equalizing the taxes, making coverage more affordable. This would have a dramatic impact on folks in Wyoming. These provisions would, without a doubt, pave the way for quality health care to millions of Americans without dismantling access and affordability due to federally captured state jurisdiction.

While the President's bill has been pitched as being essential to enhancing the quality of care Americans receive, I hope that my colleagues will carefully evaluate the impact that any federalized, national one-size-fits-all approach would have on our nation's health care system. As I have encouraged my constituents to read the fine print, I also ask them to listen carefully to this week's debate. I hope they'll see for themselves how the President's legislation effects their home state. Rural states deserve a voice, too. Only our Patients' Bill of Rights would provide them that podium from which they can be heard.

Madam President, I yield the floor and reserve the remainder of our time.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I yield 5 minutes to the Senator from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico is recognized.

PRIVILEGE OF THE FLOOR

Mr. BINGAMAN. Madam President, I ask unanimous consent that Robert Mendoza, a fellow on my staff, and Matt Maddox on my staff be granted the privilege of the floor during the pendency of this bill, and also that same privilege be granted to Ellen Gadbois and Arlan Fuller, fellows from Senator KENNEDY's office.

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

Mr. BINGAMAN. Madam President, I rise to discuss managed care reform, an extremely important issue which we are finally getting to a debate this week. We have an opportunity this week to substantially improve the

quality of life for 161 million Americans, including 900,000 New Mexicans, many of whom have contacted me through letters and phone calls and faxes, telling about their desire for some reform of the managed care system.

Our goal this week seems to me very clear. The American people—and I believe every family who spends their hard-earned dollars on health insurance—need to receive nothing less than the finest of medical care available. We are trying to ensure that through this legislation. That is the task we have set, to guarantee the people of this country critical patient protections.

It is clear the reasons are valid, why we should do this. First, survey after survey reports the American people are demanding the passage of patient protections such as those contained in the Democratic bill that I supported, which Senator KENNEDY offered in the committee. In my State, there are 350,000 New Mexicans who will not have critical patient protections if the bill we pass at the end of this week leaves medical decisions up to non-medical insurance personnel. There are 200 patient groups and health care provider organizations, physicians, workers' unions, and employee groups, that stand behind the need for these patient protections. There are 30 million Americans who have had trouble seeing a specialist, women and children with special needs who either had critical care delayed or, worse, had that care denied. I heard my colleague from Wyoming just now say providing this access to specialized care will dramatically increase premiums.

The statistics are clear. The Congressional Budget Office did an analysis and determined that the increase in premium costs would be, at the most, 4.8 percent over a 10-year period. Providing this specialized care or access to specialists would be a one-tenth-of-1-percent increase in cost, less than $2 per patient per month for the entire array of patient protections about which we are talking. This is a very modest amount which Americans are willing to pay.

Americans who live in rural areas, such as my State and the Senator from Wyoming was talking about his State, have to travel an hour or more to get to a doctor when there is an appropriate health care provider just down the road. We are trying to ensure those other appropriate health care providers also be made available to those patients.

Even if you put aside all of these particular reasons for passing the bill, clearly the main reason we should pass it is that it is the fair thing to do.

There was a very good editorial in this morning's Washington Post which I believe all Members should read. Let me refer to it for a moment. It talks about the managed care debate coming up in the Senate this week. It says:

> The objective is, or ought to be, to legitimize the containment of these costs by giving the public a greater guarantee that the process will be fair. Republicans resist the increased regulation this would entail. In the past they have tried to deflect the bill; now they offer weak legislation that is mainly a shell.

My colleague from North Dakota said the Republican proposal is an empty vessel. The Washington Post says it is ''mainly a shell.''

It goes on to say:

> The stronger Democratic bill is itself fairly modest. Much of it is ordinary consumer protection. Patients would have to be fully informed about the costs and limits of coverage, including any arrangements a plan might have with physicians or other providers that might give them an economic incentive to cut costs. No gag orders could be imposed on physicians to keep them from disclosing the range of possible treatment, without regard to cost. A plan would be required to have enough doctors to meet the likely needs of the enrollees. Patients could not be unfairly denied access to emergency care or specialists. . . .

It goes on:

> The Republican bill professes to provide many of the same protections, but the fine print often belies the claim.

Madam President, the debate is going to be very constructive this week. The distinctions between the Democratic bill, which contains real protections, and the Republican bill, which the Washington Post refers to as ''mainly a shell,'' will be made clear to the American people. I hope very much we will step up to the challenge and pass something that contains some substantive protections for the people of my State. We will have other opportunities to debate specific amendments in the future.

I see the Democratic leader is ready to speak. I yield the floor, and I appreciate the chance to speak.

The PRESIDING OFFICER. Who yields time? The minority leader is recognized.

Mr. DASCHLE. Madam President, I commend the distinguished Senator from New Mexico for his excellent statement and for his leadership on this issue. He has been very much a part of the effort from the very beginning and has lent the caucus and the Senate an extraordinary amount of his expertise on this issue, and we are deeply grateful to him.

AMENDMENT NO. 1233 TO AMENDMENT NO. 1232

(Purpose: To ensure that the protections provided for in the Patient's Bill of Rights apply to all patients with private health insurance)

Mr. DASCHLE. Madam President, we yield back the remainder of the time on the substitute, and I send an amendment to the desk on behalf of the distinguished Senator from Massachusetts, Mr. KENNEDY.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

> The Senator from South Dakota [Mr. DASCHLE], for Mr. KENNEDY, for himself, Mr. REID, Mr. DURBIN, Mr. WELLSTONE, Mr. WYDEN, Mr. REED, Mrs. MURRAY, Mr. DASCHLE, and Mr. CHAFEE, proposes an amendment numbered 1233 to amendment No. 1232.

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

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

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

Mr. DASCHLE. Madam President, I yield the floor.

The PRESIDING OFFICER. Who yields time? Does the Democratic leader yield time?

Mr. DASCHLE. Madam President, I yield the remainder of the time to the distinguished Senator from Massachusetts for him to manage.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Madam President, there are several of my colleagues on the floor. As I understand, we have 50 minutes; is that correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. KENNEDY. I yield myself 7 minutes.

PRIVILEGE OF THE FLOOR

Madam President, I ask unanimous consent that David Doleski from Senator WELLSTONE's office and Steven Snortland from Senator DORGAN's office be granted the privilege of the floor.

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

Mr. KENNEDY. Madam President, as we start this debate, there are a series of issues before us. One of the most important and most significant is who is covered under the two different approaches before the Senate. One approach has been advanced by Senator DASCHLE, of which many of us are cosponsors, and the other approach on the other side has been reported out of the Health, Education, Labor, and Pensions Committee. Senator FRIST and the Republican leadership are cosponsors.

In our proposal, we provide that virtually every individual who has health insurance will have the protections included in our bill. Under the Republican proposal, we are finding out that the total numbers covered are only those in what they call ERISA plans. There are 163 million total individuals who have health insurance covered under our bill. The other side covers only 48 million, and excludes 113 million. They are only covering a third of all Americans.

We can ask ourselves: If their proposal is so solid and makes so much sense, why don't they cover all Americans? We heard the principal advocates for the Republicans go on about what good things their particular proposal is going to do. Then why not cover all the people in the country instead of only a third?

They will find out that under their proposed legislation, they do not cover anyone who receives their health care through health maintenance organizations. Isn't it extraordinary that this

whole development, the need for patient protections, is a result of insurance companies making medical decisions in the interest of the company profitability rather than the health interests of the patient? That is the basic reason this whole issue has developed.

Their solution is to advance a program that does not even cover all Americans. I am still waiting to hear why. If their program is so wonderful, as has been stated in the Senate, I still wonder why they are not covering everyone. Can they explain how they justify to people, living side by side, that one will be covered and the other one will not be covered under the Republican plan? They certainly are not covering the 15 million people who are buying individual policies. These are generally small business men and women, farmers, and individuals who are buying individual policies. They are excluded under the Republican plan. State and local government workers are excluded, and the 75 million whose employer provides fully funded coverage, the largest category, are all excluded. Only 48 million are covered under the Republican plan.

I tried to read through every explanation to understand. Then I started to read the proposals advanced in the House of Representatives.

There are five different Republican House proposals. But all the Republican proposals in the House of Representatives cover all Americans. Why is it that the Republican bills in the House of Representatives cover all Americans and over here in the Senate the Republicans only cover a third of Americans? I thought there might be some explanation.

The Democrats cover all Americans. When we say ''all,'' we mean all. When we say ''protections,'' we mean protections. That is what this legislation is all about. We want to make sure we will have the opportunity, over the course of this week, when we are talking about protections for the type of specialty care that a child might need—such as a child who has cancer—that they are guaranteed they will be covered by the protections we have included in our bill.

We want to ensure that all women are going to be guaranteed the protections we have included. We want to make sure that all of those with some type of physical or mental challenge are going to be guaranteed the protections we have included—not just a quarter, not just a third, not just a half, not just three-quarters but all of them.

So I find that on the most basic and fundamental issue, the plans differ greatly. We are all asked: Well, look, Senator, the Republican proposal has emergency protections and you have emergency protections. Can you tell us what the differences are?

The fact is that virtually two-thirds are excluded from the Republican proposal, before we even discuss the loopholes they have written so that their legislation does not provide adequate protections that have the support of the emergency room physicians.

We heard this afternoon how the Republican bill provides protections for emergency room care and specialty care. The fact is that none of those professional groups that are dealing with children every single day and none of the specialists that are dealing with the most complicated cases are supporting their plan. All are supporting our plan.

It is for this reason I would have thought we would be able to bring Republicans and Democrats together. Let's decide whether we really want to deal with the issue. Let's start off this debate on the first day, on Monday, and say: OK, let's go ahead and make sure whatever we are going to do is all inclusive in protecting the children, not only those covered by self-funded employer plans. I do not know how many children in this country know whether they are getting their health care as a result of a self-funded employer plan or whether it is the employer providing the services through insurance programs.

I say, let's deal with children. Let's deal with all the children. That is what our bill does. And that, I believe, is fundamental.

The PRESIDING OFFICER. The time has expired.

Mr. REID. I ask the Senator from Massachusetts to yield me 10 minutes from the bill.

Mr. KENNEDY. I yield that time.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I can remember the first time I went to New York as a young man. My wife and I, of course, traveled the streets of New York. We walked, and there were a lot of fascinating things. But one of the things I will never forget is the people on the streets who were involved in shell games. I did not participate in any of them, but they would try to get people to come. They would move these little markers around. You could never win. No one ever won. None of the people they got to participate in these shell games ever won. I had had enough experience from going to carnivals as a young man not to participate in those games because there are certain games you can never win.

What is happening with the majority is they have a shell game going on. They are here today pronouncing what is so good about their bill. But the fact of the matter is, it is a shell game. Because you pick it up, and what they talk about is never there. The important part of what they are talking about is never there. Pick it up, and it is gone.

What am I talking about? The Senator from Massachusetts has talked about the bill of the Republicans covering only about one-fourth, about 25 to 30 percent, of the people that our bill covers. That is part of the shell game. You pick it up and 75 percent of it is missing.

We are talking about passing a real patient protection act, a bill that covers 161 million Americans, not 25 percent of 161 million Americans who receive health care through some form of managed care.

Our bill is not a bill that omits 113 million Americans. Our bill ensures access to the closest emergency room without prior authorization and without higher costs.

There have been lots of stories told about people wanting to go to an emergency room but having to check first. I participated in an event this afternoon where an emergency room physician talked about what is happening with managed care and how an emergency room physician never has the opportunity, under managed care, to really do what they need to do because of: How did that patient get there? Did they come on their own? Did they get prior approval?

Our bill is not a shell game. As to emergency care, you pick up the shell and under it the Republicans give you nothing. Our bill ensures access to qualified specialists, including pediatric specialists, unlike the Republican bill, a bill that limits access to specialists and does not guarantee that children may see a pediatric specialist.

We live in a world of specialization. When your child is sick, you want your child to go to someone who is a pediatric specialist. Whether it is a pediatric oncologist specialist, whether it is a pediatric orthopedic specialist, you need to be able to take your child to the person who can render the best care. But when you pick up this Republican shell where they talk about ''they get everything,'' and you want a pediatric specialist, it is empty; you cannot get it.

Our bill, the minority bill, guarantees that women may designate their obstetrician/gynecologist as a primary care provider. Why is that? Because that is, in fact, the reality in America. Women go to their gynecologists. That person treats them when they have a cold, when they are sick from something dealing with whatever the cause might be. They look to their gynecologist as their primary care physician.

Under our legislation, it guarantees that women may designate their OB/GYN as a primary care provider. But what happens under the Republican bill? It makes no guarantees and limits this to only a few select women.

Again, you look up and you see this shell game and you see all these promises. You think you are going to score big. You pick up this shell, and there is nothing there for women that guarantees their OB/GYN as a primary care provider.

The junior Senator from Wyoming came to the floor and again tried to move this shell around. What was his shell game? The junior Senator from Wyoming said that this was national health insurance—those bad words: national health insurance. Of course, this

has nothing to do with national health insurance, absolutely nothing. But, of course, this is part of the shell game: We want to frighten people; we want to frighten and confuse people, as the health insurance industry is doing as we speak by spending millions of dollars with false and misleading advertisements.

The insurance industry, as the Senator from Massachusetts pointed out, opposes this legislation. Hundreds of groups support this legislation—hundreds of groups.

I ask unanimous consent to have printed in the RECORD a partial list of those organizations that support this legislation.

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

GROUPS SUPPORTING THE DEMOCRATIC PATIENTS' BILL OF RIGHTS

ABC for Health, Inc.
Access Living.
AIDS Action.
AIDS Law Project of Pennsylvania.
Alamo Breast Cancer Foundation and Coalition.
Alcohol/Drug Council of North Carolina.
Alliance for Lung Cancer Advocacy, Support, and Education (ALCASE).
Alliance for Rehabilitation Counseling.
Alzheimer's Association—Greater Richmond Chapter.
Alzheimer's Association—New York City Chapter.
American Academy of Child and Adolescent Psychiatry.
American Academy of Emergency Medicine.
American Academy of Neurology (AAN).
American Academy of Pediatrics.
American Academy of Physical Medicine and Rehabilitation.
American Association for Marriage and Family Therapy.
American Association for Psychosocial Rehabilitation.
American Association for Respiratory Care.
American Association of Children's Residential Centers.
American Association of Nurse Anesthetists.
American Association of Pastoral Counselors.
American Association of Private Practice Psychiatrists.
American Association of University Women (AAUW).
American Association on Mental Retardation (AAMR).
American Autoimmune Related Diseases Association (AARDA).
American Board of Examiners in Clinical Social Work.
American Cancer Society.
American Chiropractic Association.
American College of Emergency Physicians (ACEP).
American College of Obstetricians and Gynecologists (ACOG).
American College of Physicians (ACP).
American Counseling Association.
American Federation for Medical Research.
American Federation of Home Health Agencies.
American Federation of Labor & Congress of Industrial Organizations (AFL–CIO).
American Federation of State, County and Municipal Employees (AFSCME).
American Federation of Teachers.
American Gastroenterological Association.
American Group Psychotherapy Association.
American Heart Association.
American Lung Association.
American Medical Association (AMA).
American Medical Rehabilitation Providers Association.
American Music Therapy Association.
American Network of Community Options and Resources.
American Nurses Association (ANA).
American Occupational Therapy Association.
American Optometric Association.
American Orthopsychiatric Association.
American Physical Therapy Association.
American Podiatric Medical Association.
American Psychiatric Nurses Association.
American Psychoanalytic Association.
American Psychological Association (APA).
American Public Health Association.
American Society of Clinical Oncology.
American Speech-Language-Hearing Association.
American Therapeutic Recreation Association.
Anxiety Disorders Association of America.
The Arc.
Arc of Washington State.
Asian and Pacific Islander American Health Forum.
Association for the Advancement of Psychology.
Association for Ambulatory Behavioral Healthcare.
Association of Behavioral Healthcare Management.
Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN).
Bazelon Center for Mental Health Law.
Brain Injury Association.
California Advocates for Nursing Home Reform.
California Breast Cancer Organizations.
Cancer Care, Inc.
Candlelighters Childhood Cancer Foundation.
Catholic Charities of the Southern Tier.
Center for Patient Advocacy.
Center for Women Policy Studies.
Center on Disability and Health.
Children and Adults with Attention Deficit Disorder.
Child Welfare League of America.
Children's Defense Fund.
Clinical Social Work Federation.
Coalition of Wisconsin Aging Groups.
Colorado Ombudsman Program—The Legal Center.
Communication Workers of America—Local 1039.
Consortium for Citizens with Disabilities Health Task Force.
Consumer Federation of America (CFA).
Consumers Union.
Corporation for the Advancement of Psychiatry.
Crater District Area Agency on Aging.
Council of Vermont Elders.
Dekalb Development Disabilities Council.
Delta Center for Independent Living.
Disabled Rights Action Committee.
Eastern Shore Area Agency on Aging/Community Action Agency.
Epilepsy Foundation.
Families USA Foundation.
Family Service America.
Family Voices.
Federation for Children with Special Needs.
Florida Breast Cancer Coalition.
Friends Committee on National Legislation.
Friends of Cancer Research.
Gay Men's Health Crisis.
Gazette International Networking Institute (GINI).
General Clinical Research Center Program Directors Association.
Genzyme.
Glaucoma Research Foundation.
Goddard Riverside Community Center.
Health and Medicine Policy Research Group.
Human Rights Campaign.
Independent Chiropractic Physicians.
International Association of Psychosocial Rehabilitation Services.
League of Women Voters.
Lukemia Society of America.
Managed Care Liability Project.
Mary Mahoney Memorial Health Center.
Massachusetts Association of Older Americans.
Massachusetts Breast Cancer Coalition.
Meals on Wheels of Lexington, Inc.
Mental Health Association in Illinois.
Mental Health Net.
Minnesota Breast Cancer Coalition.
NAACP.
National Abortion and Reproductive Rights Action League.
National Alliance for the Mentally Ill (NAMI).
National Alliance of Breast Cancer Organizations.
National Association for Rural Mental Health.
National Association for the Advancement of Orthotics and Prosthetics.
National Association of Childrens Hospitals (NACH).
National Association of Developmental Disabilities Councils.
National Association of Homes and Services for Children.
National Association of Nurse Practitioners in Reproductive Health.
National Association of People With AIDS (NAPWA).
National Association of Protection and Advocacy Systems.
National Association of Psychiatric Treatment Centers for Children.
National Association of Public Hospitals.
National Association of School Psychologists.
National Association of Social Workers.
National Black Women's Health Project.
National Breast Cancer Coalition (NBCC).
National Caucus and Center on Black Aged, Inc.
National Coalition for Cancer Survivorship.
National Community Pharmacists Association.
National Consumers League.
National Council for Community Behavioral Healthcare.
National Council of Senior Citizens.
National Hispanic Council on Aging.
National Marfan Foundation (NMF).
National Mental Health Association (NMHA).
National Multiple Sclerosis Society.
National Parent Network on Disabilities.
National Partnership for Women & Families.
National Patient Advocate Foundation.
National Therapeutic Recreation Society.
NETWORK: A National Catholic Social Justice Lobby.
Nevada Council on Developmental Disabilities.
Nevada Council on Independent Living.
Nevada Forum on Disability.
Nevada Health Care Reform Project.
New York City Coalition Against Hunger.
New York Immigration Coalition.
New York State Nurses Association.
North American Brain Tumor Coalition.
North Carolina State AFL–CIO.
North Dakota Public Employees Association—AFT 4660.
Oklahomans for Improvement of Nursing Care Homes.

Older Women's League (OWL).
Ombudservice.
Opticians Association of America.
Oregon Advocacy Center.
Paralyzed Veterans of America.
Pregnancy Planning Services, Inc.
Physicians for Reproductive Choice and Health.
President Clinton.
Reform Organization of Welfare (ROWEL).
RESOLVE.
Rhode Island Breast Cancer Coalition.
Rockland County Senior Health Care Coalition.
San Diego Federation of Retired Union Members (FORUM).
San Francisco Peakers Senior Citizens.
Service Employees International Union (SEIU).
Service Employees International Union (SEIU)—Local 205.
Service Employees International Union (SEIU)—Local 585, AFL–CO CLC.
South Central Connecticut Agency on Aging.
Southern Neighborhoods Network.
Susan G. Koman Breast Cancer Foundation.
Tourette Syndrome Association, Inc.
United Automobile, Aerospace and Agricultural Implement Workers of America (UAW).
United Cerebral Palsy Association.
United Church of Christ, Office for Church in Society.
United Senior Action of Indiana.
University Health Professionals Union—Local 3837, CFEPE/AFT/AFL–CIO.
US TOO International.
Vermont Public Interest Research Group.
Voice of Seniors.
Voluntary Action Center.
Volunteer Trustees of Not-For-Profit Hospitals.
West Side Chapter NCSC.
Western Kansas Association on Concerns of the Disabled.
Women in Touch.
Y–ME National Breast Cancer Organization.

Mr. REID. This isn't national health insurance. This is something that the junior Senator from Wyoming and others would like you to think is. You can follow these shells. You pick one up, and, of course, again it is misleading. Our legislation ensures access to needed drugs and clinical trials. It is not a bill that imposes financial penalties for needed drugs. Of course, their bill does not guarantee access to clinical trials for cancer patients, among others.

What does this mean? Again, not speculation but facts. We were at an event at 2 o'clock today, and there was a man there whose 12-year-old son last August got cancer. It was a rare form of cancer. During his chemotherapy, the managed care entity suddenly said: We don't cover you. What was he going to do? He wrote numerous letters and called numerous people. In short, by the time the managed care entity finally agreed to cover it and that it was certainly something which was necessary, and by the time his family and friends gathered together to help pay for this, the boy was almost dead, and he died in February, just a few months ago.

Our bill ensures access to needed drugs and clinical trials, not this shell game where you say: Here, my 12-year-old son is sick; I have been told this will cover me. You pick up the shell. It is empty. There is nothing under there. You lose again.

Our legislation prohibits arbitrary interference of HMO bureaucrats. What does that mean? It means that insurers cannot overrule doctors' medical decisions. What we need is a bill that reestablishes the patient-doctor relationship, not one that allows clerks in Minneapolis or Baltimore or Sacramento to make decisions for my friends, relatives, and constituents in the State of Nevada. We want the doctors making those decisions. Our legislation does that. The Republican version does not do that. It is a part of the shell game that shuffles these shells around. People think they have won, but they pick up the shell and, again, they have lost.

The minority legislation prohibits gag clauses and improper financial incentives to withhold care. What does this mean? There are many organizations around the country that give incentives to keep people out of hospitals, incentives to keep people from having certain types of care rendered. Why? Because if they do that, they get bonuses.

Our legislation also prevents HMOs from prohibiting doctors and other medical care specialists from telling patients what is really wrong. They can't be fired if they do so. Again, our legislation is not a shell game. It is not a shell game, as the majority legislation is a shell game. The majority would like you to believe that under every one of those shells you have a winner, but the fact of the matter is, every shell you pick up under the Republican version is empty; you lose again.

The minority bill holds HMOs accountable when their decisions lead to injury or death. There have been people who have talked about how this bill is going to be overtaken by the lawyers. Let me give you a little statistic about medical malpractice cases. In the State of Nevada, since we have become a State, there have been fewer than 40 medical malpractice cases tried by a jury. We became a State in 1864.

I say that HMOs should be treated like everyone else. I went to dinner in Reno a couple weeks ago with a woman who is a manager of a managed care entity. She said: HARRY, I like your bill except for the lawyers. I said: Why should you be any different from anybody else in America? We all have to deal with lawyers. You should, too.

This legislation will not increase costs more than the cost of a cheeseburger and a very small order of fries every month. We can go through a list of people who have indicated that that, in fact, is the case, contrary to what the junior Senator from Wyoming and others have said today.

Madam President, I ask unanimous consent for 3 additional minutes, since the manager is not here. I will take that off the bill.

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

Mr. REID. Madam President, the fact that lawyers are involved will make managed care entities do better work. The history of this is certainly adequate. In the State of Texas, as an example, where they have a Patients' Bill of Rights, it doesn't cover enough people, but it covers some people. By the way, it is a Patients' Bill of Rights that George W. Bush vetoed. They came back and passed another one, and he refused to sign that. He is going around talking, in his Presidential run, about what a great Patients' Bill of Rights they have in Texas. Everyone should understand, he vetoed the bill and refused to sign the second one. The fact of the matter is, the Texas experience indicates that it doesn't increase cost; it just makes the health care entity, the managed care entity, do a better job.

Our bill holds HMOs accountable when the decisions lead to injury or death. This is not a bill, as the Republican bill, that maintains protections for HMOs that injure or kill patients. I was startled today to hear one of the majority talk about how their bill would reimburse costs for somebody who has been aggrieved, whatever the medical care would have been. That is what happens now under HMOs. That is why it makes it so bad.

We want a bill that takes care of patients, a bill that takes care of patients based on doctors' decisions, not clerks' decisions. We want a bill that is more concerned about patients than about profits.

I yield the floor.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. NICKLES. Madam President, I will speak in general on the bill, but I am on amendment time.

Mr. REID. Will the Senator yield for a unanimous consent request?

Mr. NICKLES. Surely.

Mr. REID. On behalf of Senator KENNEDY, the manager of the bill, I ask unanimous consent that the time I used, so there is no misunderstanding, be charged to the amendment and not the underlying bill.

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

Mr. REID. I express my appreciation to the Senator from Oklahoma.

PRIVILEGE OF THE FLOOR

Mr. NICKLES. Madam President, I ask unanimous consent that the list of staff I now send to the desk be granted the privilege of the floor during consideration of S. 1344, the Kennedy-Daschle health care bill.

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

The list is as follows:

HEALTH CARE TASK FORCE

Senate office	Staffer
Brownback	Rob Wassinger
Collins	Priscilla Hanley
DeWine	Helen Rhee
Enzi	Chris Spear
	Raissa Geary

HEALTH CARE TASK FORCE—Continued

Senate office	Staffer
Frist	Anne Phelps
	Sue Ramthun
Gramm	Don Dempsey
	Mike Solon
Gregg	Alan Gilbert
Hagel	Steve Irizarry
Hutchinson	Kate Hull
Jeffords	Paul Harrington
	Kim Monk
	Tom Valuck (fellow)
	Carole Vannier (fellow)
Lott	Sharon Soderstrom
	Keith Hennessy
Nickles	Stacey Hughes
	Meg Hauck
Mack	Mark Smith
RPC/Craig	Michael Cannon
Roth	Kathy Means
	Bill Sweetnam
	Dede Spitznagel
Santorum	Peter Stein
Sessions	Libby Rolfe

Mr. NICKLES. Madam President, I will speak in general about the bill and maybe correct some statements that I believe are factually incorrect. I think it is important to deal with facts.

I have heard a lot of opinions. I heard that the Republican bill that many of us worked together on was a shell. I am kind of offended by that, I mention to my colleague.

First, let me say, when we are considering health care, we should make sure we don't do any damage. We should do no harm. Maybe we should repeat the physicians' Hippocratic oath: Do no harm.

When I look at the proposal of Senator KENNEDY, the Democrats' bill, I see it doing a lot of harm. If that bill was enacted, a lot of people would become uninsured. That is harm. As a matter of fact, it is estimated as many as 1.8 million, almost 2 million, people would become uninsured if we passed his bill. We already have 43 million uninsured Americans. Let's not add to it. Let's not make it worse. Unfortunately, I think that is what would happen.

We shouldn't be dramatically increasing health care costs. That is not going to help solve the problem. Cost is a big problem. We had a little press conference today. We had several self-employed people who said: I can't afford health insurance. One said they didn't have it. One said they barely had it and, if the cost went way up, they would lose it. They would have to cancel it for themselves and their employees. We don't want to do that. That is doing harm. That is doing damage. That is doing damage, frankly, to the best health care system in the world. I am not saying the health care system we have in the country today is perfect. Does it make mistakes? You bet. Can we make it better? Sure we can. Let's do that.

But I don't think we make it better by coming up with a whole laundry list of Federal mandates stacked on top, duplicating State mandates, saying: The Federal Government knows best. Yes, this is going to cost you a lot of money. Oh, yes, Mr. Employer, you can be sued. The employer saying: Thank you very much, but I don't have to provide this benefit in the first place and, if you are going to sue me for it, I will just drop it. I hope my employees take care of their health care needs on their own. I will give them a little money. I hope they do it.

You and I know, in many cases they won't do it. We shouldn't do harm; we shouldn't do damage to the system.

I heard my colleagues, from Massachusetts and from Nevada, say: Well, our bill doesn't cost much. It costs about the cost of a cheeseburger, maybe a cheeseburger and fries.

Let's look at the reality. The Congressional Budget Office says the Kennedy bill would increase health care costs by 6.1 percent. I understand they may amend it to make it 4.8 percent. What people haven't caught onto is, that is in addition to health care inflation that is already in the system. The cost of health care is going up. It is estimated to go up 9 percent, by a national survey of plans by William Mercer. So health care costs are going up 8 or 9 percent. You add another 5 or 6 percent on top of it, that means if we pass the Kennedy bill, health care costs will be up by 15 percent. What if it is 14 percent? I think that is too high. I think if health care costs go up that percentage, you are going to have a lot more people uninsured.

Then what about: Well, it only costs as much as a Big Mac. I have the greatest respect for Senator KENNEDY, but I do not know how good his math is. Let me use some people who are pretty good at math, the Congressional Budget Office. They are not Democrats. They are not Republicans. They're not people who say: Let's come up with some bad information on the Kennedy bill.

They said, Senate bill 6, the Kennedy Patients' Bill of Rights, will increase health care premiums by 6.1 percent, resulting in an $8 billion reduction in Social Security payroll taxes over the next 10 years, an $8 billion reduction in Social Security payroll taxes. The total reduction in payroll over that period of time is $64 billion over the next 10 years. Now, $64 billion in lost wages is a lot more than a Big Mac. As a matter of fact, I think it equates to $355 more per family per year. That is not a Big Mac. That is about $30 a month. That is not $3 a month, or $2 a month, as Senator KENNEDY alluded to. That is about $30 a month. That is a big hit. That means that is $30 less that an employer will have to compensate his employees. Where does that money come from? That is real money. According to CBO, $64 billion over the next 10 years is the cost of the Kennedy bill. Where does that come from? From lost wages of employees. A whole lot of employees say: Thank you very much, Senator KENNEDY, but I want the money. Thank you, but I want to keep my health insurance. Don't price it out.

So I think it is funny, in a way, that I hear it will only cost $2 a month. That is not accurate. CBO says it would cost $355 per year per family. So I mention that, and I think it is important that we use facts. I think everybody is entitled to their own opinion, but they are not entitled to their own facts. The fact is that the Kennedy bill would cost families hundreds of dollars per year and would increase the number of uninsured in the millions.

Right now, there are 43 million uninsured Americans. That equals the population of 9 States—the population of the States that I have in yellow on the chart. If we pass the Kennedy bill, we can add 3 more States, North Dakota, South Dakota, and Wyoming. The entire population of those States would be uninsured. We should not be doing that. Democrats and Republicans, from the outset, should not do any harm and we should not increase the number of uninsured.

Another thing we should not do is increase the complexity of plans. My friend and colleague, Senator DASCHLE sent that to the desk for Senator KENNEDY. He said we need to expand the scope, that the Republican plan only covers 48 million Americans, and we cover 161 million Americans, and those other 100 million Americans have no protections whatsoever.

Well, this chart, compliments of Senator GREGG from New Hampshire, shows you the complexity of the Kennedy plan. Now, this is very graphic, and I am sure anybody looking at it closely would say that looks like a mess. And it is, because what it does it, it says: States, we don't care what you have done. We know better. The Federal Government knows best.

Again, I have great affection and admiration for my colleague, Senator KENNEDY. He has always thought the Federal Government knows best when it comes to health care. He has always supported national health care and thought the Federal Government should write the plan and insist on the benefits. We know best, so States get out of the way. The Federal Government will tell you how to run your health care business. We don't care if you have had experience over the last 50 years in administering insurance, health care, having insurance commissioners, and having quality inspectors. We don't care if you have that. We know better. The Federal Government, HCFA, Health Care Finance Administration, knows better and should be making these decisions.

Under the Kennedy bill, we are going to overlay on top of all the State regulations a Federal-Government-knows-best plan. We are going to dictate that you have all these things. This little chart kind of shows the complexity of it. Health care is fairly complex anyway with State administrations. But this says we are going to overlay, on top of what the States do, complex Federal mandates. States, you must do as the Federal Government decided.

What if there is competition? What if the State has an emergency room provision for their State-regulated plans? We are going to say: We are sorry, but we know better, so you have to comply

with ours. The State says: We think ours is better. But we are going to have to have a Government bureaucrat who knows best. Senator KENNEDY knows best, HCFA know best, the Government knows best.

That is the problem with the Kennedy bill. Unfortunately, in many cases, the Government doesn't know best. There are lots and lots of State mandates, and I pulled out a few on this chart. Forty-two States have a Bill of Rights. My colleague from Nevada said the Texas Governor vetoed a Bill of Rights. I see on the list that Texas has a Bill of Rights. I happen to see that Texas has a total of 42 mandates. Probably many of them—the Senator from Texas says it may be too many. It is probably increasing the cost of health care, but the State of Texas is doing it.

Maybe we are the source of all wisdom. I don't know what the State of Texas has, but is it really in our prerogative and our right to say: Texas, you don't know what you are doing; we know what is best. So whatever you have in your mandates, we are going to mandate something more, something more expensive. We are going to dictate to you. I think that is a mistake.

There is a basic difference in philosophy between Senator KENNEDY and Dr. FRIST, who will be here shortly to discuss this. I might mention, I think the plan we proposed, as far as scope is concerned—we said, let's regulate the unregulated and protect the unprotected. There were a lot of plans that aren't covered by State insurance, and we said those plans should have some basic protections, so we put them in. Those plans weren't covered by the State mandates. That is the reason we put them in there. My Democrat colleagues said they are unprotected, out of luck, as if the States have no role whatsoever. The States don't know what they are doing. HCFA knows better. HCFA is not a cure-all for health care.

Here is an example. On a bill that we passed last year, I have a couple comments. This was in a bill we passed:

> HCFA, as a regulatory authority to enforce consumer protections, stands by the Health Insurance Portability and Accounting Act of 1996. In States that failed to enact these provisions, according to the General Accounting Office, HCFA admits that it has ''pursued a Band-Aid or minimalist approach'' to enforcing these consumer protections. The General Accounting Office also found that HCFA lacks ''appropriate experience'' in regulating private health insurance.

So GAO said HCFA is not doing a very good job. The Kennedy bill says turn it all over to HCFA. We don't think the States are good enough. We are going to turn it over to HCFA and let them do it better. GAO also said that HCFA is doing a crummy job. They should not be trying to regulate insurance throughout the country. They have a big job. What about the health insurance portability bill, the Kennedy–Kassebaum bill? People have been bragging on it. It is interesting to find out that the State of Massachusetts has not yet complied. Five States have not complied. I doubt that that means the State of Massachusetts doesn't care about insurance portability. My guess is that it is probably just as portable in Massachusetts as it is in other States. But they have not met congressional criteria. Therefore, HCFA is supposed to administer their plans. Guess what? They are not doing it. They have not done it. I don't want them to do it; I will be frank. Even though that is a law we have already passed, I don't think Federal regulation of health care in Massachusetts is going to make it any better. As a matter of fact, it might make it worse. I think that might be a mistake.

Look at the number of health care mandates on this chart. My State of Oklahoma has 26. The State of Texas has 42. Florida has 44. States have an average, I think, of 30-some or 40. Again, is it really necessary for us to come in and say: States, thank you very much, we are sure you are well-intended, but we know better. We have decided this, and we have had hearings. Our emergency room provision has to be better than yours. Our access to specialists has to be better than yours. We don't know what yours is, but we know ours is better. A colleague showed pictures and said: Look at this child; he was denied the health care. The plan said it was not medically necessary; therefore, the child didn't get the health care. So we are going to change all the laws of all the States because somebody finds some horror stories.

I have said in the past that there have been mistakes. There always will be. There will be some mistakes. We have to decide what is the best way to solve the problem. Is the solution to the problem coming up with more Government mandates—a Federal Government takeover of health care, which is really, in effect, what the Kennedy Patients' Bill of Rights is. Is that the solution? Or will it make it worse? Look at other countries that have really tried socialized medicine, government-controlled medicine, government dictates from A to Z. Is their health care better or worse than in the United States? It is worse. It is much worse. All you need for evidence of that is people in their states continue to come to the United States for quality health care, including their leaders, and including their top officials. They want to have health care in the United States because we have the best quality health care system in the world.

We need to make sure that we do no harm to that system. We absolutely need to make sure that if we can make improvements on the system, let's do so, but let's not make it worse.

Let's not pass this government-knows-best, one-size-fits-all, Washington, DC, HCFA, you are going to run it, and that we have confidence in the government bureaucrats that we are going to hire, and solve all the problems.

Mr. GRAMM. Will the Senator yield before he gets off this point?

Mr. NICKLES. I am happy to yield to my friend from Texas.

Mr. GRAMM. This is very important.

Senator KENNEDY keeps standing up and really setting up the straw man and knocking him down, it seems to me.

I want to pose this as a question.

He is saying this bill covers 160 million people, whereas our bill covers only 48 million people.

But isn't it true that under our bill we cover those that are in self-funded plans where the Federal Government has jurisdiction and where the States don't have the freedom to legislate patients' rights? So we deal with the Federal jurisdiction and allow the individual States to set up their own program. But Senator KENNEDY wants to do the same thing that he did in the Clinton-Kennedy health bill of 1993, and that is to have the Federal Government set mandates even though 43 States have passed their own laws.

Is that not the distinction we are talking about? Senator KENNEDY believes that only he knows anything about this and that the State legislature in Texas does not know anything about health care and doesn't care anything about Texas. But Senator KENNEDY knows about it. In fact, he helped President Clinton do the 1993 bill, which would have put everybody into a health care collective run by the Federal Government—one big HMO very much similar to and with all the compassion of the IRS. But now he says that States aren't competent, even though 43 of them have passed patients' bills of rights. He is trying to preempt those States, whereas I understand our bill simply goes to the people who can't, because of Federal law, be covered by State patients' rights.

Is that correct?

Mr. NICKLES. That is correct. I appreciate my colleague making that distinction.

I have a list of all of the mandates that the State of Texas has. I have a list that says 42 States have a State bill of rights.

I might say that those States might have a more far-reaching bill of rights than the proposal that Senator KENNEDY offers. They may; I don't know. But I happen to think they are probably a lot closer to the people in that State. I happen to think if there are complaints, they are more likely to be resolved favorably by the State regulators than they would be by bureaucrats in HCFA that have no idea of how to regulate health care plans.

That quote that I just read from GAO said that HCFA pursued a Band-Aid or minimus approach to enforcing consumer protections, and that HCFA lacks appropriate experience in regulating private health insurance.

The GAO has already studied HCFA's results, and they have failed. Yet Senator KENNEDY's bill says to States: We want HCFA to regulate their insurance.

I just disagree with that. I disagree with that very strongly.

When I see the pictures of the health care catastrophes where somebody was denied care, or somebody didn't get care, I am very sympathetic to the families. But I don't think they are going to get more protection by turning it over to the Federal Government. I think, frankly, they get less.

Mr. GRAMM. If the Senator will yield further, does the Senator believe that HCFA cares more about the people of Oklahoma than the State representatives—the State senator and the Governor—who may not know the Oklahoma needs the way Senator KENNEDY and HCFA know them?

Mr. NICKLES. I will answer the Senator's question. No, I don't. I don't think HCFA knows the State of Oklahoma. I think HCFA is an organization that has a lot of responsibilities, and most of which are not doing a very good job—most of which haven't done a very good job, frankly, regulating Medicare. They have caused a lot of problems, as the Senator from Maine can attest to, whether you are talking about home health care, or whether you are talking about information to seniors. I know for a fact they haven't given information to seniors which was mandated by law under the Medicare changes in 1997.

I am looking at HCFA. I am sure there are some very good quality people who are very concerned about health care in general. But I don't want to turn over all insurance regulation to them, because GAO says they don't have appropriate experience. Frankly, I don't think they can do it as well. I know they shouldn't be doing it. I think that is a responsibility that can and should be left to the States. The States may make mistakes. Individuals may make mistakes. I want to make sure that I point this out before we see—I am sure—dozens more charts of somebody who was denied care.

Ms. COLLINS. Mr. President, will the Senator yield for a question?

Mr. NICKLES. Let me finish this point. I haven't made this point just yet. It is important.

We will have countless charts showing somebody who needs a cleft pallet replaced, or somebody who has lost an arm by mistake, or somebody was not treated. Obviously, any lay person would say, Why didn't that person get health care?

If you pass our plan, we were going to see them and make sure they get health care.

The distinction that I want to make is that the bill that we have before us on the Republican proposal is that every health care plan in America has an internal appeal done by a doctor. The internal appeal is done by a doctor. It is done by a physician. If for some reason that physician still determines that it wasn't medical necessary, that physician can appeal it to an outside, independent expert to make the determination of whether or not it was medically necessary, or whether or not the treatment should go forward.

Hopefully that would solve the pictures, or the horror stores that we have seen.

It wouldn't be decided by politicians. It would be decided by an independent expert in that field who has no financial incentive whatsoever and no connection to the health insurance industry—as I heard one of my colleagues say, Oh. Yes. They are bought and paid for. That is not correct.

What we are offering instead of a lot of litigation and the probability that people will be dropping plans like crazy is the chance for people who need health care to get. If they are denied health care coverage, they get an appeal. If their life is threatened, or if it is dangerous, they can get it immediately, and they can get it done by an independent review board. So they get the health care they need—not get a lot of litigation, and not in the process uninsured millions of Americans.

Ms. COLLINS. Will the Senator yield for a question?

Mr. NICKLES. Sure.

Ms. COLLINS. Will the Senator agree that it is absolutely irresponsible to be proposing a vast expansion of HCFA's authority in regulating the private insurance market given HCFA's record, which includes missing 25 percent of the implementation deadlines in the balanced budget amendment of 1997; of taking 10 years to implement a 1987 law establishing nursing home standards; of yet to have updated 1985 fire safety standards for hospitals; when it is utilizing 1976 health and safety standards for the treatment of end-stage kidney disease; when it is shown that it has been unable to handle the responsibilities that Congress gave it under the Health Insurance Portability and Accountability Act?

Is that part of the Senator's concern about taking away the authority from State governments that are doing an excellent job in providing patient protections, and instead relying on the Federal Government and the agency of HCFA to do that job?

Mr. NICKLES. I certain concur with my colleague from Maine that turning the responsibility over to HCFA won't make any improvement. It will make it worse.

I might qualify part of the Senator's statement. I am not sure that States are doing an excellent job in every area. I think they will do a much better job than they would be if it is turned it over to the Federal Government. I think they would be much closer to fixing the problem, and they could fix the problem of the absence of quality. I think they can fix that much, much better than we can by dictating it from Washington, DC.

Ms. COLLINS. If the Senator will yield on one further point for a question, would the Senator agree that the health committee legislation is an attempt to protect the unprotected consumers, to reach out to those health care consumers that the States are prohibited from protecting, and that, indeed, the assertions we are hearing from Senator KENNEDY, our colleague, and others, and that we are leaving more than 100 million Americans completely unprotected is absolutely false because they are protected under State laws that the States enacted without any prompt from Washington, without any encouragement from Washington, and in fact the States are far ahead of Washington in this debate?

Mr. NICKLES. To answer my colleague from Maine, the Senator is exactly right—although I say we protect the unprotected. Even in the State-regulated plans, we make sure all those plans have an appeals process.

ERISA, which is a national law that does deal with fiduciary standards, deals with reporting standards. We make sure there is also an appeals process that covers 124 million people. Maybe our colleagues on the other side forget that. That is a basic process which we think is much better than saying, let's go to court; you were denied coverage, let's go to court and sue. It may be 3 or 4 years and the plaintiff may eventually get something—or the trial lawyer may get most of the money. We say, instead of going that way, let's go through an appeals process. We formulate an excellent internal and external appeals process for 124 million Americans, broad based, for any employer-based plan.

That is a fundamental asset in our plan that will improve quality health care throughout the country.

Ms. COLLINS. I thank the Senator. I certainly agree with his analysis.

Mr. NICKLES. I yield the floor.

Mr. KENNEDY. Mr. President, how much time do we have?

The PRESIDING OFFICER (Mr. HUTCHINSON). The Democrats have half an hour on the amendment.

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

Mr. DURBIN. There was a historic event that just occurred on the floor of the Senate. Those who look through the CONGRESSIONAL RECORD are going to find something truly amazing has just occurred. This debate on health insurance reform started at 1:10 p.m. It wasn't until 3:59 p.m., almost 3 hours later, that the first Republican Senator referred to our amendment as ''socialized'' medicine. Almost 3 hours passed on the Senate floor before the Republicans turned to that old, beat up shibboleth—socialized medicine. That may show there has been some progress. In years gone by, that would have been raised in the first 5 minutes.

However, I think it is important my friends on the Republican side of the aisle, who were supporting the approach favored by the insurance industry, stop and consider for a moment that the world has changed dramatically since we used to simplify debate into terms of socialized medicine and the medical practice that most Americans want.

I say to Senators on the floor for the Republican side, do the Senators not consider it odd, if State regulation—which you are lauding—is so effective, that the American Medical Association is suggesting they may have to unionize across America to deal with these health insurance companies? Isn't it strange, if State regulation and State bills of right for patients are so effective, that over 200 medical organizations and others support the Democratic approach for a national standard of protection for all American citizens? If the States are doing such a great job protecting so many people, why are so many medical professionals unhappy? Why are so many families across America calling our office, writing letters, telling these horror stories which we have recounted on the floor of the Senate and will recount during the course of this week?

There may not be a more important debate on the floor of the Senate this year for America's families. We are going to decide this week whether or not you can count on your health insurance. A lot of people across America can't count on it. When it comes down to the tough time, a 12-year-old boy with cancer, as Mr. and Mrs. Ray Cerniglia discussed this afternoon, they had to fight their HMO. A couple, facing the tragedy of a 12-year-old with a rare, dangerous cancer, summons the courage to deal with it. They go for the best medical help they can find. That isn't enough. Now they have to worry about fighting the insurance company.

The Republican approach is: So what. That's business. That is the way things are.

We on this side of the aisle disagree. We believe, along with the medical professionals in America, that American families deserve better. The Republican approach is an approach supported by one group: the insurance industry. The insurance industry is spending millions of dollars on television ads distorting what this debate is all about.

I heard my Republican colleagues talk about States rights; we should leave it to the States to decide whether or not America's families should have good health insurance protection.

Take a look at what the States have already done:

Twelve States haven't done a thing about access to emergency services. If you have a serious accident in your backyard, you can take that little boy who fell out of the tree and broke his arm to the nearest emergency room and not fumble around looking at your insurance policy, wondering if you will be covered.

Thirty-one States have not enacted laws for independent appeals. If an insurance company denies coverage, you have an opportunity for an independent appeal. The Republican approach is an in-house appeal by the insurance company.

Thirty-eight States have not protected families that want to make certain they have access to the right medical specialists. But the Republican bill is one that doesn't guarantee that right to literally over 100 million Americans.

The list goes on and on.

Many of the Republicans who oppose this plan to protect America's families and their health insurance argue ''States rights.'' It is an old argument.

Senator KENNEDY, Senator DASCHLE, and others have said: Yes, if you bring these new protections into law, as we would like to have for every American regardless of where they live, the cost of health insurance will go up—$2 a month.

I see crocodile tears on the floor of the Senate as they bemoan the increased costs of health insurance policies if we pass our bill—$2 a month. Isn't it worth $2 a month to have access to a specialist when you need it? Isn't it worth $2 a month to know your doctor is giving you the best medical advice and his decision is not being overridden by some health insurance clerk? I think it is worth that and more.

They on the other side argue that our approach is too much government. It isn't empowering government. We are empowering families across America to have negotiable rights with the insurance companies, that they can stand up and say these are our rights, this is for what we stand.

This isn't a right for government. It is a right for families—families in the most precarious situations in their lives, facing the most serious illnesses. That is what we are doing here. We are empowering families and individuals to stand up to these health insurance companies.

We have seen from the letters—I have seen them from Illinois; every Senator has—how helpless people feel when they have someone in their family who is near death and they are sitting there fighting with some faceless clerk at an insurance company, begging for the care their doctor says their little boy or their little girl needs.

We give these families power with this Patients' Bill of Rights. Why the Republicans oppose this, I don't know. I can understand why the insurance industry opposes it. They have a pretty good thing going on. They make the decisions and they can't even be sued when they are wrong. You can't even take them to court.

I had an interview the other day in Chicago. One of the reporters afterwards said: Let me get this straight. We can't sue these health insurance companies when they make the wrong decision? I said: That is right. It is the only business in America that can't be held accountable for its wrongdoing.

Think about their wrongdoing. It is a matter of life and death. A health insurance company denies a basic treatment and someone can die as a result and they wouldn't be held accountable.

The thing that troubles me, too, is the Republicans leave so many people behind. What they call ''our Patients' Bill of Rights'' is an empty promise. Mr. President, 113 million Americans without health insurance—no protection in the Republican bill; no protection in a bill supported by the insurance industry.

Look what it means in some of the States of the Senators who have been on the floor today. I say to the Senator from Oklahoma, 1,574,000 people in Oklahoma are not protected by the Republican bill; 79 percent of privately insured are not protected under the Republican plan. Who are these people? They are farmers. They are self-employed people, wheat growers in Oklahoma.

Look at the State of Maine, the potato growers. Farmers there, 557,000 of them, are not protected by the Republican bill; 70 percent of the privately insured are not protected by the Republican bill. State of Texas: We have heard a lot about big government there, haven't we? Over 6 million residents of Texas are not protected by the Republican bill, 59 percent of them.

Yes, it is true. There is a State Bill of Rights in Texas. Governor George W. Bush vetoed it, and it was overridden by the State legislature. It is on the books. But basically we say everybody in America—Texas, Illinois, you name it—deserves the same kind of protection. If the Republicans had their way, in my home State of Illinois, almost 5 million people would not be protected, would not receive the benefit of the reforms we are talking about in health insurance; 59 percent of those privately insured not protected by the Republican plan.

Who are those folks? Let me show you a picture of some of them. This is my home State, farmers left unprotected by the Republican ''Patients' Bill of Wrongs.'' This is a gentleman I know by the name of Tom Logsdon. His 24-year-old daughter was diagnosed with breast cancer. She has gone through a lot. The Republicans would not protect her, would not protect her family because they are self-employed people. They are farmers. They do not believe there should be this kind of protection for those folks. I disagree. I think these families and families across America deserve the same continuity of care, the same protection. I think, frankly, when you look at the choice in this bill, you can understand why the insurance companies support the Republican bill and oppose the Democratic bill.

Here is the only way we are going to get this bill passed. We have to hope that five or six Republican Senators will break ranks and decide to join us in a bipartisan effort to really provide coverage and protection for people across America. If that does not happen, if this breaks down along partisan lines, we will spend a week in debate and the American people will say: What happened? Nothing will have happened. I hope before this debate is concluded we have that bipartisan support.

I yield the remainder of my time.

The PRESIDING OFFICER. Who yields time?

The Senator from Nevada.

Mr. REID. On behalf of Senator KENNEDY, I yield the Senator from North Dakota 5 minutes.

The PRESIDING OFFICER. The Senator from North Dakota is recognized for 5 minutes.

Mr. DORGAN. Mr. President, I have sat and listened quietly and patiently to the debate over this amendment. I was thinking to myself that, if ever there were an Olympic sport for sidestepping, I surely have seen some gold medal winners this afternoon. The issue in this amendment is, whom does this piece of legislation protect? Whom does the Patients' Bill of Rights protect?

Some people view this debate as a debate between a bunch of wind generators in blue suits, and they do not know whom to believe. So here is an editorial from USA Today—not from Republicans, not from Democrats. The headline of this USA Today editorial reads: ''100 Million Reasons GOP's Health Plan Fails. That's How Many People Proposal Will Leave Unprotected.'' Let me read what it says:

Judging from the health insurance reform package announced this week by Senate Republicans, at least the title is correct. The proposal is called the Patients' Bill of Rights. If you are waiting for this perfunctory plan to protect you, you'll need to be patient indeed, many of the plan's key protections are restricted to the 51 million Americans who get their insurance through self-insured employer-sponsored plans subject to direct Federal regulation. But another 100 million or so whose health plans are subject to state regulation are excluded.

Again, USA Today says this plan is an empty shell. This plan does not match the needs the American people ought to expect will be met.

I have heard debate this afternoon I would have expected 100 years ago in this Chamber. Back in the years when suspenders and spittoons adorned this Chamber, you would have heard exactly the same debate on every issue. Meat inspection? Let the States do it. The Federal Government should not be involved. Pollution control? Let the States do it. Nursing home regulation? Let the States do it. Minimum wage? The Federal Government should not be involved. That is a debate a century old, and it is old and tired.

The question here is, What kind of legislation are we going to pass that protects American families? Are we going to pass a bill that includes the 100 million people their side leaves out? You were told to be careful of stories about children who tug at your heart because somehow that is not reflective of the whole issue. Jimmy, here, is never going to stroke his mother's face, may never be able to shoot a basket. He has no arms and no legs. Why? Because in the middle of the night when 6-month-old Jimmy was desperately ill, his dad had to drive past the first hospital, drive past the second hospital, drive past the third hospital, in order to get to the hospital they approved for this little boy to get emergency treatment. As a result, he lost his hands and his feet. Our opponents bill does not provide a guarantee that this young boy would have gotten emergency treatment at the first, second, or third hospital. No such guarantee exists in their plan. If it did, it would not apply to 100 million Americans.

They say don't let these stories affect you. That is what this is about. It is about patient care. It is about real people. It is about Jimmy, it is about Ethan, it is about the people I have talked about on the floor of the Senate.

Let me conclude just by pointing out the differences in titles. They brought a bill to the floor of the Senate with the title the Patients' Bill of Rights. That is the same name as the piece of legislation we authored. Ours contains real protections; theirs does not.

Abe Lincoln was debating Douglas, and he could not get Douglas to understand his point. Finally he said to Douglas: Let me ask it this way. He said:

Tell me, how many legs does a horse have?

And Douglas said,

Four, of course.

Abe said,

Now if a horse's tail were called a leg, how many legs would a horse have?

And Douglas said,

Five.

And Abe Lincoln said,

No, that's where you are wrong. Simply calling a tail a leg doesn't make it a leg at all.

You can call this proposal that has been offered by the majority party whatever you like, but it does not make it a patients' protection act. As USA Today says in its editorial, if you think you are going to get protection from the Republican patient protection plan, you had better be patient, because it leaves out 100 million Americans. There is a lot of misinformation that has been given on the floor of the Senate today and a lot of sidestepping on the important issues. But I say when this debate is over, do not, as the Senator from Oklahoma suggests, dismiss the concerns and stories that are raised about individual people. After all, the only question really important in this debate is how it affects the individual patients, the men, women, and children who seek treatment in our health care system.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Several Senators addressed the Chair.

Mr. NICKLES. I yield to the Senator from Maine such time as she desires.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, we have heard it again. Once again we have heard the myth that is being perpetrated on the other side of the aisle that the bill approved by the health committee leaves millions of Americans unprotected, completely unprotected. You heard it again. That is simply not true. These Americans live in States that have enacted patient protections very similar to the ones included in the health committee bill to apply to those plans where people truly are unprotected. Those are the ERISA plans, the self-funded plans that the States cannot regulate because of a Federal preemption.

According to the CBO, 80 percent of the U.S. population lives in States with laws guaranteeing access to emergency care; 77 percent of Americans work in organizations offering employee health plans with a point-of-service option. The Kennedy mandates, with direct access to OB/GYN, already exist in States containing almost 70 percent of the population. We know that 47 States have enacted laws to prohibit gag clauses, something we all agree need to be prohibited. Why do we need to duplicate and preempt the good work of the States? Why not build on the good work of the States?

The State of Maine has enacted 35 mandates—35 patient protections. Now, who is to say the emergency access protection of the State of Maine is somehow inferior to the one in Senator KENNEDY's bill, just because it differs from Senator KENNEDY's bill? Who is going to make these determinations? Are they going to end up in court? Is HCFA, by the Federal Government, by fiat, going to decide that Maine's was not quite right, that it should be knocked out, replaced by the Kennedy standard, because Washington knows best? Washington is the source of all wisdom in this?

The opponents of our legislation contend that the Federal Government should preempt the States' patient protection laws unless they are identical to the ones in Senator KENNEDY's legislation. However, the States' approaches to the same types of patient protection can vary widely.

States may have emergency requirements but not the exact same standards as in the Kennedy bill. That is the case with the State of Maine.

Moreover, what if the State has made an affirmative decision not to act in one of these areas because the market in their State does not require it and they are concerned about costs? What if the bill has failed in the legislature or has been vetoed by the Governor? Let me give a recent example from my home State of Maine.

Maine law requires insurance plans to allow direct access to OB/GYN care without a referral from a primary care physician but only for an annual visit. Maine's law also requires plans to allow OB/GYNs to serve as the primary care provider.

Our State legislature recently decided that those current laws, which Maine was the head of the Nation in enacting, provided sufficient access, that they corrected a problem in the

marketplace. The legislature rejected a bill that would have expanded the direct access provision primarily out of concern that it would drive up premium costs.

I note for my colleague from Massachusetts, this decision was made by a legislature controlled by the Democratic Party. This was not some Republican legislature that made this decision, but rather the legislators in Maine were satisfied with the current law and decided not to expand it because they were concerned about the additional costs that would be incurred.

In cases such as this, the Kennedy proposal for a one-size-fits-all model would just simply preempt the decision made by the State legislature. That is why the National Association of Insurance Commissioners supports the approach that was taken in the legislation reported by the Health Committee.

In a March letter to the committee, the NAIC pointed out:

> The states have already adopted statutory and regulatory protections for consumers in fully insured plans and have tailored these protections to fit the needs of their states' consumers and health care marketplaces. In addition, many states are supplementing their existing protections during the current legislative session based upon particular circumstances within their own states. We do not want states to be preempted by Congressional . . . actions.

The letter continues:

> It is our belief that states should and will continue the efforts to develop creative, flexible, market-sensitive protections for health care consumers in fully insured plans, and Congress should focus attention on those consumers who have no protections in self-funded ERISA plans.

That is exactly what our plan would do. I ask unanimous consent that the letter from the National Association of Insurance Commissioners be printed in the RECORD at the conclusion of my remarks.

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

(See Exhibit 1.)

Ms. COLLINS. Mr. President, current Federal law prohibits the States from regulating the self-funded, employer-sponsored health plans that cover 48 million Americans. Our legislation, which is intended to protect the unprotected, to reach those consumers in self-funded plans that the States are prohibited from regulating, would extend many of the same rights and protections to the Americans covered by these plans that are already enjoyed by Americans who are under the State-regulated plans.

The States have been ahead of the Federal Government in this area. They have acted over the past 10 years to correct problems in the managed care marketplace by enacting specific consumer protections. Our bill extends those kinds of protections to those plans that the States cannot reach. We go beyond that, though, when it comes to the procedural protections, the all-important internal and external appeal procedures that are in our legislation. We provide that to all plans across the board. Again, another myth perpetuated by those on the other side of the aisle that somehow our appeals process does not cover these Americans.

We have produced a good bill. It builds on, but does not preempt, the good work of the States. It provides protections to those 48 million Americans whom the States cannot protect. It balances carefully the need to have reforms that ensure that essential care is provided, that no one is denied care that an HMO has promised. It holds HMOs accountable for their decisions. It puts decisions in the hands of physicians, not insurance company executives or accountants and not trial lawyers. It carefully strikes a balance of providing important consumer protections without driving up the costs, as the Kennedy bill would do, in a way that would jeopardize, that would undermine health insurance coverage for millions of Americans.

Mr. President, I reserve the remainder of our time.

EXHIBIT 1

NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS,
Washington, DC, March 16, 1999.

Hon. JAMES JEFFORDS,
Chair, Senate Health, Education, Labor, and Pensions Committee, Washington, DC.

DEAR SENATOR JEFFORDS: We are writing this letter in response to some concerns raised by your office regarding the testimony of the National Association of Insurance Commissioners (NAIC) Special Committee on Health Insurance (''Special Committee'') before the Senate Health, Education, Labor, and Pensions (HELP) Committee on March 11, 1999. The hearing focused on the rule of the states and the federal government in enacting patient protections for consumers in group health plans. Specifically, concerns have been raised over the Special Committee's testimony and whether the Special Committee now supports a federal floor.

We understand why the members of the Senate HELP Committee would get the impression from our oral testimony that the members of the Special Committee are supportive of a federal floor. During our testimony we may have implied that the members of the Special Committee would accept a federal floor in any federal patient protection legislation. The members of the Special Committee have not made a determination that a federal floor is acceptable. It is our belief that states should and will continue the efforts to develop creative, flexible, market-sensitive protections for health consumers in fully insured plans, and Congress should focus attention on those consumers who have no protections in self-funded ERISA plans.

Rather, the members of the Special Committee are interested in strengthening the distinction between self-funded ERISA plans, which are clearly outside the purview of state law, and fully insured plans. State insurance departments want to ensure that citizens in their states who are covered by fully insured ERISA plans can still rely on the state to address their questions, complaints and grievances and can still expect the same level of protections already established by the states. The states have already adopted statutory and regulatory protections for consumers in fully insured plans and have tailored these protections to fit the needs of their states' consumers and health care marketplaces. In addition, many states are supplementing their existing protections during the current legislative session based upon particular circumstances within their own states. We do not want states to be preempted by Congressional or administrative actions.

During our testimony, we highlighted our Statement of Principles on Patient Protections (''Statement of Principles''), which were created to assist Congress in developing patient protection legislation. The Statement of Principles highlights the elements that we believe must be included in any patient protection legislation and reflects the NAIC's commitment to consumer protection. We suggested that these principles be used as guidelines in drafting any federal legislation.

The principles are as follows:

Principle 1: Federal legislation establishing patient protection laws should reinforce the ERISA saving clause and not preempt existing state health care consumer protection laws, particularly as these protections apply to fully insured health plans.

Principle 2: Federal legislation establishing patient protection laws should ensure a basic level of protections for all health care consumers, focusing particular attention on those consumers in self-funded ERISA plans who do not currently have such protections.

Principle 3: Federal legislation establishing patient protection laws should preserve the state infrastructure already in place.

Principle 4: Federal legislation establishing patient protection laws should ensure that all health care consumers, whether under fully insured or self-funded plans, have access to an appropriate regulatory body for answers to their questions, complaints and grievances.

Principle 5: Federal legislation establishing patient protection laws should establish an appeals process to resolve disputes and enforce decisions for those consumers, such as those in self-funded plans, without access to such a process.

The members of the Special Committee appreciate the efforts of Congress to provide patient protections to all consumers, and we offer the above principles as guidelines in developing such legislation. In doing so, we urge Congress to focus its legislative activity on consumers in self-funded ERISA plans, which are under the federal government's exclusive jurisdiction, and to preserve the state protections that already exist for consumers in fully insured ERISA plans. Again, we have not endorsed the concept of a federal floor with regard to patient protections.

On behalf of the members of the Special Committee, we would like to thank you for the opportunity to testify before the Senate HELP Committee and for the opportunity to clarify our position. If any members of the NAIC can be of further assistance, please feel free to contact Jon Lawniczak at (202) 624–7790.

Sincerely,

GEORGE REIDER, Jr.
President, NAIC.
KATHLEEN SEBELIUS,
Secretary-Treasurer, NAIC.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, we have 15 minutes left; is that true?

The PRESIDING OFFICER. The Senator is correct.

Mr. REID. I yield 7½ minutes to the junior Senator from North Carolina and 7½ minutes to the senior Senator from Rhode Island.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. I thank the Chair.

Mr. President, I will briefly respond to the remarks by Senator COLLINS from Maine, for whom I have tremendous respect. She and I have worked together on a number of issues. I know she believes deeply in the cause she advocates this afternoon. I have great professional and personal respect for her. This is an issue on which I happen to disagree with her for a number of reasons.

First, she suggests their plan—the plan she is referring to I assume is the Republican plan—is one that adequately protects patients' rights because of laws enacted in States across the country. If that is so, why is there such an enormous public outcry for reform? The American people believe deeply that patient protection legislation is desperately needed across this country. If these laws already exist and are already in place and are working, why in the world does anybody need to do anything? The reality is that these laws are not in place and they are not working. Let me give a few examples.

For example, access to clinical trials, which is a critical component of our bill: 47 States of the 50 have no provision for access to clinical trials.

External appeals, which are absolutely essential: 32 States have no provision for independent external appeals.

Access to specialists: 39 States have no provision allowing people to designate a specialist as their primary care provider, and 36 States have no provision for standing referrals to specialists.

Continuity of care: 30 States have no continuity of care provisions.

This list goes on and on.

The reality is, No. 1, that the majority of States have none of the protections we are talking about in the Democratic Patients' Bill of Rights. That is the reason there is an enormous public outcry. That is the reason we have a health care crisis in this country today, and it is the reason I respectfully disagree with my colleague, the Senator from Maine.

The second reason is, to the extent a State has passed any kind of patient protection legislation and that legislation conflicts in any way with ERISA, it is preempted. It is absolutely preempted, under existing law, if we never pass anything. Even the laws that have been passed, to the extent those laws conflict in any way with the existing ERISA statutes, are preempted by ERISA.

The bottom line is this: No. 1, if State laws adequately dealt with this problem, we would not have the public outcry, the horror stories which we have heard and will continue to hear in this Senate over the course of the next week.

No. 2, the fact of the matter is, to the extent those laws exist—and they do not exist in the majority of States on the critical issues—to the extent they do exist, they are preempted by ERISA.

I do want to mention one other thing on the issue of cost because there has been a lot of discussion about cost from the Senator from Oklahoma and the Senator from Maine.

First of all, it is critically important to recognize that to the extent we get a patient to a specialist soon, and we do that in our bill, to the extent we allow women to go directly to an OB/GYN as their primary care provider, to the extent we allow patients who are in a critical emergency to go the nearest hospital and be seen by an emergency room department or physician and thereby save that patient's life or reduce the amount of long-term care that patient receives—in every one of those instances we are reducing long-term health care costs in this country.

So I want us to recognize, first, that to the extent we are talking about increased costs, they are only talking about short-term costs, not long-term costs. The truth of the matter is that long-term costs will be reduced by passage of the Patients' Bill of Rights for the very same reason that preventive medicine reduces health care costs in this country, because we are going to get folks to the doctor they need to see sooner; they are going to get the care they need quicker.

The net result of that is that they do not need the ongoing, chronic, long-term care that many patients, unfortunately, have to get because they do not see the physician they need to see as quickly as they need to see them. That is what the external review process does. That is what the internal review process does.

I might add, those two things work in concert with the fact that, under our bill, an HMO can be held accountable in court for what they do. I want the American people to recognize what happens when an HMO cannot be held accountable, when they are treated as a privileged entity. And under existing law they are a privileged entity. They, among all the businesses and corporations and individuals in this country, get special treatment, treatment that none of our families or our children or our small businesses get. They are all held completely responsible. But HMOs, for some reason, are above the rest of us. They are a cut above the rest of us. They get special treatment. They cannot be held accountable in court.

So what happens when an HMO makes an arbitrary and capricious decision and a child suffers a serious injury as a result and has a lifetime of medical care in front of them—for example, a 7-year-old child? If the HMO can be held responsible, the HMO bears that cost, as well they should bear that cost because they are responsible for it.

But what happens if the HMO does not bear the cost? We know where the cost goes. It goes to us. It goes to the American taxpayer. Because those kids do not have the money to pay for chronic, long-term care over the course of their lives. They are paid out of Medicaid. They are paid with taxpayer dollars. The net result of that is that the cost an HMO or a health insurance company would bear has been shifted to the American taxpayer. That is wrong. We know it is wrong. That is one of the things we are trying to do something about in this bill.

I have to add one other thing. The Senator from Oklahoma said over and over during the course of his argument that what our bill proposes is that the Government knows the answer, that the Government has the solution. My response to that, with all due respect, is existing law and the bill of the other side would say the HMO has the answer, the health insurance company has the answer.

I say to the American people, and to my colleagues, we have tried that. We have tried leaving this in the hands of the HMO. We have tried leaving it in the hands of the health insurance industry. And it has not worked.

With that, I conclude by saying I think it is critically important that we cover all Americans, that all Americans are covered by health insurance plans. That is done under the Democratic bill.

The PRESIDING OFFICER. The time has expired.

Mr. EDWARDS. Thank you, Mr. President.

Mr. CHAFEE addressed the Chair.

The PRESIDING OFFICER. The Senator from Rhode Island is recognized.

Mr. CHAFEE. Mr. President, one of the key issues in this debate is the scope of the provisions; that is, should patient protections we are debating apply solely to those 48 million Americans enrolled in the self-insured ERISA plans or should they apply to all privately insured Americans? Obviously, there can be varied views on this subject, as we heard from the Senator from Maine, the Senator from Oklahoma, and otherwise on the floor today.

In 1996, through the Kassebaum-Kennedy law, Congress passed reforms to the private health insurance marketplace with respect to portability. In my opinion, we should use the same framework used then with respect to scope and effect on State law. Thus, we should establish, I believe, a minimum floor of Federal protection for all 164 million privately insured Americans, not just those 48 million enrolled in self-insured ERISA plans.

I see no reason for narrowing the scope of the patient protections in this next and far more consequential area of reform. Protections as critical to patients as the right to a specialist when needed should apply to all Americans, I believe.

Some of my colleagues argue that it is the individuals only in the self-insured plans—those completely out of State reach—who should benefit from these Federal protections. While it is true that States do have the authority

to legislate patient protections for these other plans, that alone, I believe, is insufficient reason to deny these basic quality improvements and safeguards to all 164 million Americans in privately insured plans. Such a system would, in my judgment, create many unnecessary and inequitable circumstances for consumers and exacerbate the already unlevel playing field which exists in the health insurance marketplace.

Congress has recognized the need for minimal Federal guarantees regarding health insurance in several instances. I think this is very important to note. For example, in addition to the portability protections included in the Kassebaum-Kennedy bill, all Americans have been granted protections for continuation of care under the so-called COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985. They have been given this protection in mental health parity. They have been given this protection in maternity lengths of stay. They have been given this protection just last fall when we passed the breast reconstructive surgery protections. And we extended that to all Americans; we did not restrict it just to the self-insured under the ERISA plans.

Republicans and Democrats alike continue to recognize the need for Federal protections that apply to the entire health insurance market. The generic nondiscrimination provisions of S. 326 would apply to plans beyond the self-insured ERISA plans.

Where is the logic in creating Federal protections applying to the entire health insurance market regarding these aspects of health insurance but not patient protections as fundamental as access to external appeal or emergency services?

Furthermore, as with many other limited preemption laws on the books, this approach would not preempt equal or stronger patient protections which have been adopted by the States.

Look at this list. These are not health matters. These are environmental matters. They are consumer and other statutes. They start with the Clean Air Act. All of these statutes provide a floor of Federal protections that the States can and, in some instances, do go beyond.

The Federal Government has come in, in all these instances, and said: This is a floor—Toxic Substances Control Act, Safe Drinking Water Act. If you in the State want to go further, fine, go ahead, but these are the minimals you have to do. That is what we are suggesting presents a real problem in the legislation that has been reported and then discussed by the Senator from Maine and the Senator from Oklahoma.

It is critical that the protections we adopt this week in the Senate apply to all Americans, including those with plans regulated by the States because State protection is extremely spotty. One justification for applying privacy protections to the entire health insurance market is that there is not a complete body of State law on privacy. For example, it is likewise true with respect to patient protections. Considering only a few of the most important patient protections, only 15 States have adopted an external review procedure and only 13 States have adopted standing referrals to specialists.

It is important to note that by not covering all Americans, many of the most vulnerable insurance customers will be left with no protection. You go out to buy a policy. You do not have employee benefit managers; you do not have somebody to look after you like that; and you are at the mercy of the insurers making decisions based solely or primarily on cost considerations.

To summarize, all Americans, I believe, should have these basic protections regardless of whether the plan they are in is regulated at the State or Federal level. In fact, most Americans probably do not know who is responsible for regulating their plan and should not have to worry when they are sick as to who is the regulator and what protections they have as a result. They should have the assurance that however their plan is regulated, it will provide them the care they need according to the most basic and commonsense principles.

I thank the Chair.

Mr. FRIST addressed the Chair.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Mr. President, how much time do we have on this side?

The PRESIDING OFFICER. Fifteen and a half minutes.

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

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

Mr. FRIST. Let me just say at the outset that I, for one, am very glad that we are on this bill, the Patients' Bill of Rights. It is a bill that is terribly important to the American people. All of us know, as we conduct our town meetings around our various States, that we have a real problem today in that today's problem is reflected in the feeling of helplessness by patients, helplessness by physicians, helplessness by other providers when it comes to managed care. There are reasons for that.

As my colleagues know, I am a physician and was involved in the practice of medicine and training for about 20 years where every day—before coming to this body—I took care of many patients, thousands of patients, well over 10,000 patients, and the changes have been tremendous over the last 20 years as we look at how health care is delivered and the reasons for it.

Right now our society, our country is caught up in a rapidly changing health care system. In all those changes and in that evolution, many challenges have been introduced. Part of our responsibility as Senators, as trustees to the American people, is to make sure that we very gently, but in many ways very firmly, make sure these challenges are faced in a systematic way, such that a patient—again, I come back to patients. We are going to hear about cost and about managed care companies and health maintenance organizations and trial lawyers and costs going up and big budgets. I hope throughout this week we will come back again and again to patients. Patients have to be at the center of this debate.

When we talk about patients, we are talking about a Patients' Bill of Rights, a bill of rights that patients can expect when they are dealing with the health care system and with managed care and with HMOs. We also need to be talking about the quality of care that is delivered. We need to be talking about access and not ever forget about the 43 million people who don't have health insurance.

For the most part, people say: Well, let's deal with the people who have insurance, group health insurance with managed care plans. Let's make sure their rights are protected. In doing that, let's not forget that there is a whole group of people over here, 43 million people—too many people, inexcusable, I feel—who don't have any health insurance at all, making sure that when we fight for the rights of the people who do have health insurance, we don't want to drive more people to the ranks of the uninsured, who don't even have insurance in the first place.

When we talk about the Patients' Bill of Rights, whether it is the gag clause or access to specialists or scope of the plan, let's not forget that we are talking about individual patients. In trying to get rights to one segment, let's not go so far or too far in all the anger that we feel against managed care that it drives up the ranks of the uninsured.

Why is this access issue important? We know—studies document it again and again—that in America, if you have some health care insurance, the health care system does open up to you broadly. If you have no health care insurance at all, it is less likely that that health care system will open up to you broadly. So the last thing I think we want to do in this body is take rights to such an extreme that we drive up the number of uninsured, recognizing that access is a huge problem, a huge challenge for our country.

When I first started 20 years ago in the field of medicine, it was very different. The practice of medicine was basically straight out fee for service. Very few physicians were in groups. They were practicing by themselves. They had full autonomy. They were making a very good living, basically went to medical school and worked very hard. They had professional ethics of ''do no harm,'' all of which continues today, except the system around them has changed dramatically. Managed care 20 years ago was tiny. Today, managed care, coordinated care, health maintenance organizations, if you look

at the overall, nongovernment coverage is the majority of care that we give. And as a product of that, we have this pendulum which has swung back and forth over time. It is true—that is why we are debating this bill today—there is no question that that pendulum has swung way over towards managed care and away from individual patients, individual people who need that care, who will go to bed tonight worried that if they have a heart attack tomorrow, will they be taken care of appropriately, will they have access to the emergency room, will they have access to the appropriate specialist. That is where this whole Patients' Bill of Rights comes in because over the last 5 years or 10 years that pendulum has swung way in the favor of managed care.

Now, I believe we are going to hear a discussion over the next week of how we can best get that pendulum back to the middle and have that balance between patients and physicians on the one hand and managed care on the other.

One of the objectives I would like to see as we go forward in a very rational way, after we cut away all the rhetoric, going at each other and the hot debate, is to come back and say: Let's keep our eye on the ball. The ball is the patient who is in this system of managed care, and not physicians and trial lawyers and lawsuits, and make sure we say that they are going to get the very best care. If anything is going to happen to them, they know they will have certain rights in this evolving, changing world.

It has gotten to the point that it is not just anecdotal, but some managed care, some health maintenance organizations have garnered so much power, so much control that they have abused the system. The whole accusation that some HMOs are in the business of practicing medicine is hard to argue against. I think one of our objectives needs to be to make sure that we don't have insurance companies or managed care companies or HMOs practicing medicine. In other words, get that pendulum back to that patient, to that decisionmaking through that doctor-patient relationship.

On the other hand, I think it is irrational to assume that we will go back 20 years and not have managed care, not have coordinated care, not have health maintenance organizations. That being the reality, we want to have a strong Patients' Bill of Rights that looks to those patient protections that empower the patient, empower the American citizen, empower the physician and bring that pendulum back over to that doctor-patient relationship, to keep the patient in charge.

We have on the floor now a Democratic bill, a Republican leadership bill, and we have one amendment talking about the scope. We will need to come back to talk a little bit more about scope because it is one of the important issues where there is a sharp dividing line. We will hear words like ''medical necessity,'' the issue of scope, of medical specialists, but amidst all of that, let's come back to the patient.

Let me speak to what is in the Bill of Rights Plus Act, which is the Republican bill which is now on the floor, in terms of scope. Scope really means who is being covered. Does this bill cover just a targeted population, the whole population, a part of the population? You can almost look at it as a pie chart in your mind.

There are a number of provisions in each of these bills. You have to go through each of the provisions when you are talking about scope.

When we talk about the issue of comparative information in the Republican leadership bill, all group health plans would be required to provide a wide range of comparative information about health insurance coverage so that the individual patient knows what is covered and what is not covered, what that relationship is, what they have actually signed, what that contract is about, what the network descriptions are, what the cost-sharing information is. The scope is complete, all 124 million people in the Republican bill are covered by that particular provision, the information.

When we look at what I think is fundamentally the most important mechanism by which we are fixing the system, getting that pendulum back over in the middle between managed care and the patients and the physicians, it is the whole process of accountability, the grievance and appeals process, the internal review process, the external review process. Over the next 4 days, we will be talking a lot about how these appeal processes work.

If you look at the way health care is delivered, I do believe this is one of most important provisions in the Patients' Bill of Rights. Both bills address grievance and appeals, but I want to make it very clear, in terms of the Republican bill, that the scope is complete, with all 124 million Americans covered. The scope is complete. All group health plans would be required to have written grievance procedures and have an internal review process. So if you have a patient who disagrees with the coverage from the plan, or a doctor and a patient who disagree with a plan, they will have someplace to go in an internal review process. If they don't like what the internal review process says, if there is disagreement on coverage between the doctor, the patient, and the plan, they can go outside the system to an external review process.

Now, what I like very much about our plan, which I think is very important, is that our external review process has a physician in charge. It is not an insurance company; it is not a trial lawyer; it is not a bureaucrat. It is a medical—I will use the word—''specialist,'' if necessary, in that field who is independent of the doctor, the patient, and the plan.

Remember, that external appeals process all started with a disagreement on coverage; you have gone through the internal appeals process, and now you are outside. You go through an external appeals process and that person also is independent.

So we have an internal appeals process, and then we have an external appeals process, where you have an independent physician reviewing the coverage and making the decision. In addition, that independent medical expert makes the final decision on coverage—not a trial lawyer somewhere, not a court, not a lawsuit, but an independent medical specialist makes the final decision on coverage. That decision is binding; it is binding on the plan.

Therefore, we aim at the heart of what I think is broken today; that is, if there is some sort of disagreement, if the managed care is taking advantage in some shape or form of an individual patient or individual physician, we have an independent medical expert making the final decision, not some statute written here in the Congress, not some definition that we try to give it if we try to define ''medical necessity'' in statute, but somebody who is independent and outside of the system.

I mention that because when we are talking about scope, all 124 million people in plans are covered, not a segment. It has nothing to do with ERISA, and non-ERISA, and State-regulated, and Federal-regulated. All 124 million Americans are covered by both self-insured and fully insured group health plans. All 124 million Americans are in there.

Again, when we talk of scope and about the information components of our bill, everybody is covered. What I think is much of the heart and guts of this bill is the accountability provisions, the accountability of managed care, the accountability of coordinated care. Everybody is covered, all 124 million people.

Now, in our bill, we also have an important component on genetic information. As we all know, the human genome project has been tremendously successful. We have 2 billion bits of information coming out in the next several years and, with that, we raise the potential for insurance companies, or managed care companies, to use that information to discriminate against a patient. In other words, if a patient had a test, and there was an 80-percent chance that a patient would develop cancer, and that information were to get out, an insurance company might say: We are not going to insure you. That is interesting information so we are going to raise your rates.

We are not going to let that happen. That provision in our bill—which is not in the Democrats' bill—basically covers everybody. Scope is complete.

Now, the one area where scope is targeted in a particular area is what we call the consumer protections, patient protections. That is the gag clause, the access to specialists, the prudent layperson access to emergency rooms, and the continuity of care.

Mr. President, do we have 1 minute remaining?

The PRESIDING OFFICER (Mr. BROWNBACK). That is correct.

Mr. FRIST. Mr. President, I will yield 30 seconds to my colleague, Senator ENZI. Let me notify my colleague that he will have more time than that. Instead of yielding now, I will yield to him in about a minute.

Mr. President, do we have 30 seconds left on the amendment?

The PRESIDING OFFICER. The chairman will be recognized for 30 seconds.

Mr. FRIST. Mr. President, the last area, in terms of focus, where the scope narrows down, is that for the specific patient protections we cover the 48 million people. Why? Because they are not covered. They are not regulated by the States, and that is why we target that population.

The PRESIDING OFFICER. The Senator from Tennessee has 30 seconds remaining.

Mr. FRIST. Mr. President, I yield the floor.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, I yield myself 3 minutes on the bill.

The PRESIDING OFFICER. The Senator is recognized for 3 minutes on the bill.

Mr. KENNEDY. Mr. President, I am not going to take the time right now. I was waiting for my good friend, Dr. FRIST, to be able to get into the questions of scope. I was waiting for Dr. FRIST to and answer why the protections included in our legislation—for example, the guarantees for emergency room care, the access to specialists who might be necessary to care for a sick child, the formulary protections that were included in our legislation, should not apply to all Americans. I was waiting to ask Dr. FRIST why the Republican House of Representatives bills protect 124 million Americans, while the Senate Republican legislation falls woefully short on those particular protections.

I hope in these next few days we come back to what this whole debate is about, the commonsense protections that are included in this bill. That is what is important. Are we really going to have the protections necessary to guarantee the prudent layperson's judgment is used in determining whether emergency room treatment is covered? Are we going to have that? Are there going to be real protections, or are we going to have in the fine print something that effectively creates a loophole? Let's get to addressing that issue.

Let's start talking about guaranteeing access to clinical trials, which are so important to women who have cancer. Clinical trials may be the only option for saving their lives—yet their medical doctor says this is in your best interest but the HMO says no. That is what this legislation is about.

The information that the Senator talked about is all very valuable, but what this is about is clinical trials. Their particular proposal requires a study of this particular provision. There isn't a clinical researcher out there, or I daresay a member of the National Cancer Institute at the NIH, who does not support the importance of clinical trials. That is what is at the heart of this. Those are the kinds of protections we are talking about here. Are we going to make sure we will finally have the accountability that is so important to assure that plans are really going to be serious in guaranteeing good quality health care?

Mr. President, on behalf of my colleagues, Senators GRAHAM and others, is it in order for me to send an amendment to the desk?

The PRESIDING OFFICER. Until the time has been used or yielded back on the first-degree amendment, a second-degree amendment is not in order.

Mr. KENNEDY. Mr. President, how much time remains on the first-degree amendment?

The PRESIDING OFFICER. There are 30 seconds on the Republican side and a minute and a half on the Democrat side.

Mr. KENNEDY. Mr. President, I yield our time.

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

The PRESIDING OFFICER. There is not sufficient time to suggest the absence of a quorum.

Mr. FRIST. Mr. President, I yield 10 minutes to Senator ENZI to speak on the general debate time.

The PRESIDING OFFICER. The Senator from Wyoming is recognized for 10 minutes on the general debate time.

Mr. ENZI. Mr. President, I am sorry that in my absence from the floor for a few minutes there was some exception taken to the comments that I made about the Democrats' proposal for this one-size-fits-all, budget-busting Federal bureaucracy bill.

I am pleased now to return to be able to talk a little bit more about States rights and to support the scope of the Republican amendment.

Among the handful of principles that are fundamental to any true protection for health care consumers, probably the most important one is allowing States to continue in their role as the primary regulator of health insurance—not a Federal bureaucracy.

This is a principle which has been recognized—and respected—for more than 50 years. In 1945, Congress passed the McCarran-Ferguson Act, a clear acknowledgment by the federal government that states are indeed the most appropriate regulators of health insurance. It was acknowledged that states are better able to understand their consumers' needs and concerns. It was determined that states are more responsive, more effective enforcers of consumer protections. And, as if we need to re-learn this lesson yet again, it is usually for the best when we let each state respond to the needs of its own consumers.

As recently as this year, this matter of fact was reaffirmed by the General Accounting Office. GAO testified before the Health, Education, Labor, and Pensions Committee, saying, ''In brief, we found that many states have responded to managed care consumers' concerns about access to health care and information disclosure. However, they often differ in their specific approaches, in scope and in form.''

Wyoming has its own unique set of health care needs and concerns. But, despite our elevation, we don't need the mandate regarding skin cancer that Florida has on the books. My favorite illustration of just how crazy a nationalized system of health care mandates would be comes from my own time in the Wyoming Legislature. It's about a mandate that I voted for and still support today. You see, unlike in Massachusetts or California, for example, in Wyoming we have few health care providers; and their numbers virtually dry up as you head out of town. So, we passed an any willing provider law that requires health plans to contract with any provider in Wyoming who's willing to do so. While that idea may sound strange to my ears in any other context, it was the right thing to do for Wyoming. But I know it's not the right thing to do for Massachusetts or California, so I wouldn't dream of asking them to shoulder that kind of mandate for our sake when we can simply, responsibly, apply it within our borders.

An extra, unnecessary layer of mandates, whether they be for certain kinds of coverage or for a protection that not everybody needs or wants, are so-called ''protections'' we simply shouldn't force people to pay for. If we were all paying for skin cancer screenings that only a few of us need or want, or if we were all paying for any willing provider mandates that only some of us need to assure access, then we'd all be one of two things—either over-charged, not-so-savvy consumers, or we'd be uninsured.

As consumers, we should be downright angry at how some of our elected officials are responding to our concerns about the quality of our health care and the alarming problem of the uninsured in this country. It is being suggested that all of our local needs will be magically met by stomping on the good work of the states through the imposition of an expanded, unenforceable federal bureaucracy. It is being suggested that the American consumer would prefer to dial a 1–800–number to nowhere versus calling their State Insurance Commissioner, a real person whom they're likely to see in the grocery store after church on Sundays.

As for the uninsured population in this country, carelessly slapping down a massive new bureaucracy on our states does nothing more than squelch their efforts to create innovative and flexible ways to get more people insured. We should be doing everything

we can to encourage and support these efforts by states. We certainly shouldn't be throwing up roadblocks.

And how about enforcement of the minority's proposal?

One of the findings of the amendment reads as follows, ''It would be inappropriate to set federal health insurance standards that not only duplicate the responsibility of the 50 State insurance departments but that also would have to be enforced by the Health Care Financing Administration (HCFA) if a State fails to enact the standard.'' In other words, not only is it being suggested that we trample the traditional, overwhelmingly appropriate authority of the states with a three-fold expansion of the federal reach into our nation's health care, they want HCFA to be in charge. HCFA, the agency that leaves patients screaming, has doctors quitting Medicare, and, lest we not forget, is the agency in charge as the Medicare program plunges towards bankruptcy.

I could go on at length about the very real dangers of empowering HCFA to swoop into the private market with its embarrassing record of patient protection and enforcement of quality standards. For example, it took ten years for HCFA to implement a 1987 law establishing new nursing home standards intended to improve the quality of care for some of our most vulnerable patients. According to the General Accounting Office, HCFA missed 25 percent of its implementation deadlines for the consumer and quality improvements to the Medicare program which were required under the Balanced Budget Act of 1977—10 years.

Even more alarming is that HCFA is still using health and safety standards for the treatment of end-stage kidney disease that are 23 years old! Equally astonishing is that HCFA has yet to update its 1985 fire safety standards for hospitals. HCFA is a federal bureaucracy at its worst, making it the last place to which we want our consumer protection responsibilities to revert.

The message is pretty clear to me. Expanding the role of the federal government well beyond its lawful authority would be a big mistake. The scope of federal authority under the Employee Retirement Income Security Act (ERISA) with regard to the regulation of health care is well understood. Duplicating, complicating and ultimately unraveling 50 years of state experience and subsequent action makes no sense. For those of my colleagues who think no one is bothered by that, I, and the 117 million Americans currently protected by State health insurance standards, beg to differ.

Our federal responsibility lies with the 48 million consumers who fall outside the jurisdiction of state regulation. That's our scope; that's our charge. That's what the states are politely reminding us of right now.

In March of this year, the National Association of Insurance Commissioners implored us not to make a mess of what they've done for health care consumers, saying, ''The states have already adopted statutory and regulatory protections for consumers in fully insured plans and have tailored these protections to fit the needs of their states' consumers and health care marketplaces. In addition, many states are supplementing their existing protections during the current legislative session based upon particular circumstances with their own states. We do not want states to be preempted by Congressional or administrative actions.'' I'm stunned that their plea is so easy for some to ignore.

I will not undo what's good in Wyoming only to offer my constituents what's good for Washington. That's my mandate from them.

When we balk at the minority's ''one-size-fits-all'' proposal, it sounds like such a cliche, but the health care needs and wants in this country are a living, breathing example of why a singular approach is a bad prescription for American consumers. No one should be forced to swallow this poison pill.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

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

The PRESIDING OFFICER. On whose time?

Mr. NICKLES. On my time equally divided.

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

The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. NICKLES. 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. NICKLES. Mr. President, I ask unanimous consent to yield back the remainder of our time on the last amendment.

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

AMENDMENT NO. 1234 TO AMENDMENT NO. 1233

(Purpose: To do no harm to Americans' Health Care Coverage and expand health care coverage in America)

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

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Oklahoma [Mr. NICKLES], for Mr. SANTORUM for himself, Mr. BOND, Mr. NICKLES, Mr. HUTCHINSON, and Mr. CRAIG, proposes an amendment numbered 1234 to Amendment No. 1233.

Mr. NICKLES. 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:

Strike all after the first word in line three and insert the following:

SENSE OF THE SENATE CONCERNING THE SCOPE OF A PATIENTS' BILL OF RIGHTS.

(a) FINDINGS.—The Senate makes the following findings:

(1) Congress agreed that States should have primary responsibility for the regulation of health insurance when it passed the McCarran-Ferguson Act in 1945.

(2) The States have done a good job in responding to the consumer concerns associated with a rapidly evolving health care delivery system and have already adopted statutory and regulatory protections for consumers in fully-insured health plans and have tailored these protections to fit the needs of their States' consumers and health care marketplaces.

(3) 117,000,000 Americans who are enrolled in fully insured plans, governmental plans and individual policies are protected by State patient protections.

(4) Forty-two States have already enacted a Patient's Bill of Rights.

(5) Forty-seven States already enforce consumer protections regarding gag clauses on doctor-patient communications.

(6) Forty States already enforce consumer protections for access to emergency care services.

(7) Thirty-one States already enforce consumer protections requiring a prudent layperson standard for emergency care.

(8) The Employee Retirement Income Security Act of 1974 (referred to in this section as ''ERISA'') expressly prohibits States from regulating the self-funded employer sponsored plans that currently cover 48,000,000 Americans.

(9) The National Association of Insurance Commissioners has recommended that Congress should focus its legislative activities on consumers in self-funded ERISA plans, which are under the Federal Government's exclusive jurisdiction, and preserve the State protections that already exist for consumers in fully insured ERISA plans.

(10) The National Association of Insurance Commissioners has expressly stated that they do not endorse the concept of a Federal floor with regard to patient protections.

(11) Senate bill 6 (106th Congress) would greatly expand the Federal regulatory role over private health insurance.

(12) It would be inappropriate to set Federal health insurance standards that not only duplicate the responsibility of the 50 State insurance departments but that also would have to be enforced by the Health Care Financing Administration if a State fails to enact the standard.

(13) One size does not fit all, and what may be appropriate for one State may not be necessary in another.

(14) It is irresponsible to propose vastly expanding the Federal Government's role in regulating private health insurance at a time when the Health Care Financing Administration is having such a difficult time fulfilling its current and primary responsibilities for Medicare.

(15) In August, 1998, the United States Court of Appeals affirmed a district court ruling that the Health Care Financing Administration failed to enforce due process requirements and monitor health maintenance organization denials of medical service to medicare beneficiaries.

(16) On April 13, 1999, the General Accounting Office testified that the Health Care Financing Administration failed to use its authority to ensure that medicare beneficiaries were informed of their appeals rights under managed care plans.

(17) The General Accounting Office testified at a July, 1998 hearing in the Ways and Means Committee of the House of Representatives that the Health Care Financing Administration missed 25 percent of the implementation deadlines for the consumer and quality improvements to the Medicare program under the Balanced Budget Act of 1997.

(18) The Health Care Financing Administration should not be given new, broad regulatory authority as they have not adequately met their current responsibilities.

(19) The Health Care Financing Administration took 10 years to implement a 1987 law establishing new nursing home standards.

(20) The Health Care Financing Administration has yet to update its 1985 fire safety standards for hospitals.

(21) The Health Care Financing Administration is utilizing 1976 health and safety standards for the treatment of end-stage kidney disease.

(22) ERISA preempts State requirements relating to coverage determinations, grievances and appeals, and requirements relating to independent external review.

(23) In a recent judicial decision in Texas (*Corporate Health Insurance, Inc. V. The Texas Department of Insurance*), the lower court held that ERISA does preempt the State's external review law as it relates to group health plans.

(b) DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS INCREASED.—IN GENERAL.—Section 162(l)(1) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended to read as follows:

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

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

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

Mr. NICKLES. Mr. President, for the information of our colleagues, let me outline where we are procedurally. We notified Members under the unanimous consent request that we would lay down S. 6, the so-called Kennedy bill, to mark up. The Democrats offered a substitute to that, the Republican bill that passed out of the Labor Committee, S. 326.

The Democrats then offered a first-degree perfecting amendment to the substitute, to the Republican bill. Their amendment dealt with scope. Their amendment says: We want the Federal Government to have far-ranging scope to overrule all State plans. All State plans must do such and such under their first-degree amendment.

I am offering a second-degree amendment on behalf of my colleagues. The amendment would do two things. One, it is the sense of the Senate that the States are the primary providers of health care, for good reasons. States have hundreds of mandates. We don't think the Federal Government should come in and say: We know best; Senator KENNEDY knows what is best; HCFA knows what is best; the Health Care Financing Administration should regulate all health care plans.

We think that would be a mistake. We don't think that, many times, the Federal Government knows best. That doesn't mean all State plans are administered perfectly. It doesn't mean that they are not without problems. We just don't think HCFA—the Health Care Financing Administration—overruling States, dictating to the States, or this Congress, or Senator KENNEDY, should be saying: States, here is what we know should be in your plan.

We state that in the sense of the Senate.

We also state some other things that come not just from Republicans but from the GAO. The Health Care Financing Administration has, in paragraph 16, stated:

On April 13, 1999, the GAO office testified the Health Care Financing Administration failed to use its authority to ensure that Medicare beneficiaries were informed of their appeals rights under managed care plans.

HCFA failed, according to the GAO. Yet Senator KENNEDY's bill says: We want to give HCFA more power.

Section 17 says the GAO testified in a July 1998 hearing in the Ways and Means Committee, House of Representatives, that the Health Care Financing Administration missed 25 percent of the implementation deadlines for consumer and quality improvements to the Medicare Program under the Balanced Budget Amendment of 1997.

Senator COLLINS alluded to that earlier.

Section 18 states the Health Care Financing Administration should not be given new, broad authority as they have not adequately met their current responsibilities.

I could go on.

Section 1 of this amendment states the States should maintain primary regulatory authority over health care.

Section 2 states that self-employed individuals should be able to deduct 100 percent of their health care premiums.

It is ironic that when we talk about health care we have such inadequate, inequitable treatment under the present Tax Code. Corporations deduct 100 percent of their health care costs; self-employed individuals deduct 45 percent. I personally am offended by that provision. I used to be self-employed, and I used to run a corporation. I wanted health care for my family in both circumstances. When I was self-employed, you could deduct almost nothing. Any person self-employed today can deduct 45 percent. Under the present Tax Code, in another 8 years they finally get to deduct 100 percent. That is a mistake. It needs to be remedied. We remedy it in this amendment. We provide 100 percent deductibility, beginning December 31, 1998—it would be effective immediately—100 percent deductibility for the self-employed.

I want my colleagues to understand that under this provision we are correcting the fact that the self-employed can only deduct 45 percent of their health care costs. We are expanding access. We are making it possible for more people to buy health insurance. I hope we will have strong bipartisan support for this provision.

This amendment is a second-degree amendment to the underlying amendment offered by Senator KENNEDY and Senator DASCHLE that tries to expand the scope that says the Federal Government knows best. We say no, the States should be the primary regulator over health insurance, and self-employed individuals should be entitled to deduct 100 percent of their health care premium.

I yield to my colleague from Arkansas such time as he desires.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, I rise in very strong support of the second-degree amendment of the Senator from Oklahoma, the sense of the Senate regarding the State being the primary regulator of health insurance plans, as well as the provision supporting 100 percent deductibility for the self-employed.

We talk about scope. We talk about increasing the number of people in this country who have health insurance. This is one of the most important steps we could possibly take.

Over the next 3 days, the Senate will debate legislation that will impact the lives of every American in terms of health care benefits they receive. The Kennedy bill that we will talk a lot about in the next few days, while called the Patients' Bill of Rights, is certainly not as simple as it sounds. It involves decreased access; it involves higher costs; and it involves the quality of our Nation's health care.

In 1997, the percentage of uninsured individuals under the age of 65 in my home State of Arkansas was 28.2 percent. Arkansas ranks the lowest in the country in terms of the percentage of individuals covered by private insurance and is second to dead last in terms of the percentage of workers covered by employment-based health insurance.

An even more alarming figure is that Arkansas has the highest rate of uninsured children in the Nation. I applaud the efforts of our Governor in Arkansas and the State legislature in trying to change that, but still it is a very alarming figure.

Any legislation this body passes will have a direct impact on Arkansas workers and families. The bill introduced by Senator KENNEDY and his colleagues would increase premiums by as much as 6.1 percent according to the Congressional Budget Office. If we pass the Kennedy bill and were it signed into law, over 1.8 million people would lose their health insurance coverage.

We see heartrending portrayals of those who have been denied care under managed care plans, and we ought to be concerned about that. That is why we have a bill that is going to provide protections for 48 million Americans

under self-insured ERISA plans. But as Senator FRIST from Tennessee well pointed out, let's not forget the millions, over 40 million Americans, who are without any health insurance at all and whose numbers are going up by the day.

The Kennedy bill, by increasing premiums over 6 percent, will result in over 1 million, nearly 2 million more Americans being added to the ranks of the uninsured. Let's not forget those. Those are the ones who are most vulnerable. If we could only put up their portraits, portrayals of those millions of Americans who, day in and day out, are living without the protection that most Americans take for granted in their health insurance plans, I think we would see the Kennedy bill, the so-called Bill of Rights, in a different light altogether.

If we pass the Kennedy bill, 1.8 million people will lose health insurance coverage they now have. That is demonstrated by a Lewin study commissioned by the AFL–CIO which shows that for every 1 percent increase in premiums an additional 300,000 people will become uninsured.

My colleague, Senator KENNEDY, during the markup of the Republicans' Patients' Bill of Rights Plus Act, stated that this premium increase would be spread out over several years; therefore somehow that made it acceptable. I suspect that the 6-plus percent increase in premiums being spread out over several years and the additional 1.8 million people added to the ranks of the uninsured which occurs over several years is of little comfort to those who will lose their insurance as a result of this bill. No matter how you slice it, the total number of people impacted, the 1.8 million people impacted, remains the same. That is simply unacceptable.

Last year, 98 Members of the Senate voted for an amendment expressing their belief that Congress should not increase the number of uninsured. Clearly, the Kennedy health care bill violates this statement of belief. The uninsured population in the United States grew from 32 million to, most recently, 43 million in 1997. It is certain the Kennedy legislation will only make this growing problem even worse.

The result of passing the Kennedy health care bill is more hard-working Arkansas families, more American families will go without health care insurance. The Kennedy bill gives quality health care only to those who can afford it. On average, the Kennedy bill would cost employees an additional $183 per year according to the Congressional Budget Office, and the cost for families under the Kennedy bill is estimated to be an additional $275 per year. Whether it is $183 or $275 per year, the Kennedy bill places a huge additional expense on American families which many simply cannot afford. What the Democrats give with one hand, they take away with the other. How can you say you are protecting people when you are taking their insurance away from them?

By contrast, the Republican Patients' Bill of Rights Plus Act, I believe, is both rational and responsible. It protects those who are not covered by State regulations. It ensures that health insurance premiums will not rise more than a fraction of a percent according to CBO. It also provides important tax incentives to increase access to health insurance for the current uninsured population, including the 100 percent deductibility of health insurance premiums for the self-employed and the expansion of medical savings accounts.

There are few more effective things we could do in the area of patients' rights to expand access than to include the self-employed and give them that 100-percent deductibility that they so deserve. According to one recent poll by Public Opinion Strategies, 82 percent of the public want Congress to make health care more affordable. The Republican Patients' Bill of Rights Plus Act responds to that need and that overwhelming desire of the American people.

Does the Kennedy bill do anything for the 43 million uninsured Americans in this country? The answer to that is very simple, it is very plain, and I think it is absolutely undisputed. The Kennedy bill does nothing to assist 43 million Americans who do not currently have health insurance get that insurance they so desperately need. It does nothing. So while we hear from bleeding hearts, while we hear emotional stories, I ask my colleagues to remember, I ask the American people to remember, the 43 million who currently do not have insurance need to have it more accessible. The Republican bill does that while providing greatly enhanced protections for the 43 million Americans who are in self-insured plans under ERISA. Not only does the Kennedy bill increase cost and decrease access, it creates a whole new system of Government-run health care. The Kennedy bill would create 359 new Federal mandates, 59 new sets of Federal regulations, and would require 3,828 new Federal bureaucrats to enforce the legislation at a cost to taxpayers of $155 million per year. The question begs to be asked: Who will benefit from this new bureaucracy and maze of Government regulation? Patients? Or the bureaucrats? I think we know the answer.

It is illustrated by a chart we have already seen today. The bottom of this chart, a summary of the effects of the Kennedy bill, are all of the new mandates that would be imposed as a result of the Kennedy legislation. Flowing from these mandates are the arrows and all of the various bureaucratic agencies required to enforce the Kennedy health care bill.

It is simply a one-size-fits-all approach to regulating health care in this country. It disregards the good work that has already been done by the States in this area, as opposed to what the Republican bill does, building upon the good works the States have already done in patient protections.

Mr. President, 42 States have already enacted a Patients' Bill of Rights; 47 States already enforce consumer protections regarding gag clauses on doctor-patient communications; 40 States already enforce consumer protections for access to emergency care services; 50 States, every State already has requirements for grievance procedures; and 36 States already require direct access to an OB/GYN.

The Kennedy bill imposes a blanket of heavy-handed Federal mandates on States and throws away the States' hard work to tailor patient protections for their populations' specific needs. One size does not fit all. What may be appropriate for California may not be appropriate for a rural State such as Arkansas.

When the Congress passed the McCarran-Ferguson Act in 1945, it agreed that States should have primary responsibility for the regulation of insurance. The National Association of Insurance Commissioners has also spoken on this issue. We have heard about this on the floor of the Senate today. In a March 16, 1999, letter to members of the Health and Education Committee, the commissioners stated their concern. They said:

> It is our belief that states should and will continue the efforts to develop creative, flexible, market-sensitive protections for health consumers in fully insured plans, and Congress should focus attention on those consumers who have no protections in self-funded ERISA plans.

That is precisely what the Republican bill does. Congress needs to act to protect the 48 million Americans covered by self-insured ERISA plans. It should not override the States in the area that they have primary responsibility.

My colleague, Mr. KENNEDY, says the Republican bill leaves millions of Americans without any protection. That is false. If you are not covered by an ERISA self-insured plan, you fall under the protections enacted by your State legislature, a group in which most Americans have greater confidence, I daresay, than in their Federal officials hundreds of miles away. This is why the Republican bill applies patient protections to the 48 million Americans who currently do not have any protections. It is sound policy and it makes good sense.

The Republican bill also creates new rights for millions more Americans. For instance, all 124 million Americans in employer-sponsored health plans will have an improved internal appeals process available to them as well as a new, independent, external review process. These 124 million Americans will also be entitled to clear and complete information about their health plan, about what their health plan does

and what it does not cover, about copayments, and about other plan procedures and policies. Our bill also improves existing Federal law on insurance underwriting with regard to preexisting conditions by ensuring that all 140 million Americans' group and individual plans will not be discriminated against by health insurers on the basis of predicted genetic information. Ironically, Senator KENNEDY's bill includes several provisions that were specifically rejected by the President's Advisory Commission on health care quality.

For example, State-run ombudsman programs were rejected by the Commission. Yet they are included in the Kennedy bill. This is the President's Advisory Commission on health care quality.

The Kennedy bill also includes 12 other Federal mandates that were not specifically recommended by the President's Advisory Commission.

In its report, the Commission states that it sought to ''balance the need for stronger consumer rights with the need to keep coverage affordable.''

That is the balance we have sought to maintain in our Republican bill. It is rejected by the Democrats in the Kennedy bill; it is embodied in the Republican Patients' Bill of Rights Plus Act.

The bottom line is that cost does matter because cost is directly related to access and the number of uninsured in our country. If cost was not such a factor, why have the Democrats tried to reduce CBO's scoring of their own bill? It is a factor. It is a big factor. It is an important factor because it affects who can buy insurance and how many millions of Americans are going to go without insurance protection.

Guess how the Democrats thought about trying to reduce that CBO scoring. They sought to reduce the CBO scoring by taking away legal remedies currently available to those in ERISA health plans.

A Patients' Bill of Rights should not be about taking away existing rights. The fact of the matter is, the Kennedy bill would put health care out of reach for close to 2 million Americans. It is not in this country's best interest to pass the kind of legislation that will make insurance less affordable and less accessible to those who need it most.

I thank the Chair, and I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I rise to address the amendment.

Mr. REID. Mr. President, if the Senator will yield, I yield the Senator 3 minutes on the amendment.

Mr. DURBIN. Mr. President, the amendment proposed in the second-degree amendment by the Republican side states a principle which is universally popular in the Senate. It is this: If you are a self-employed person buying health insurance, you should be able to deduct the cost of that health insurance from your taxes like other Americans do.

I introduced legislation along these lines more than 10 years ago in the House. I introduced it in the Senate with Senator BOND of Missouri and Senator COLLINS of Maine. It is bipartisan. It is universal. It will easily pass. And it is a diversion from the debate. It is a diversion.

The Republicans want to talk about access to health insurance, which is important; the Democrats believe it is equally important to talk about the quality of the health insurance that you are buying.

It is ironic as well that the Republicans offer this amendment so that the self-employed people in America can buy insurance. When I take a look at their underlying bill, which you might find surprising, it says those same people who will now be able to buy insurance will enjoy none of the protections of the Republican bill. On the one hand they say: Buy the insurance. But on the other hand they say: We can't guarantee that it is worth buying.

The Democratic approach is consistent: Help families buy insurance, make sure the insurance policy is worth owning, make sure that in time of family crisis you are protected.

The Republican approach is: We will help you buy it, but we cannot tell you whether it is worth buying or not.

They argue it is a matter of States rights. This is such a weak argument when you consider the 200 different organizations—the American Nurses Association, the American Medical Association, all of the different groups for medical professionals—have said that State regulation is not enough; we do not have a consistent national standard of protection for American families. That is what the Democratic side is offering: a consistent national standard.

It bothers those on the Republican side. They do not want to see this consistency. They think people who live in Oklahoma deserve perhaps more rights than those who live in Maine. They think people who live in Nevada should be treated differently than people in Illinois. I disagree. Wherever you live in America, if you buy health insurance, you ought to know that it protects your family. To leave it to State legislatures and to leave over 113 million Americans behind, as the Republicans have done with their approach, is not fair.

This second-degree amendment, which allows self-employed people like farmers and businesspeople to buy health insurance, is so universally popular we can accept it with a voice vote. But let it not divert us from our mission at hand: to make sure the insurance that every American buys is worth owning.

I yield back the remainder of my time.

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

Mr. NICKLES. Mr. President, I was a little disappointed when I heard my colleague say the Republican amendment is a diversion. The Republican amendment is an effort to increase access to quality health care for the self-employed. We have 43 million Americans who are uninsured today. We want to help them get insurance.

A large number of the people who are uninsured are self-employed. They are in small businesses. Small businesspeople who are just starting their businesses sometimes have a hard time getting quality fringe benefit packages. Almost all of the larger corporations have health insurance and pension benefits. But most job growth is in small businesses, and a lot of small businesses have not had time yet to develop and expand a fringe benefit program, including access to quality health care.

When they find out they can deduct 100 percent of their wages but they cannot deduct but 45 percent of their health insurance cost, what do you think most self-employed people are going to do? They might tell their employees: I will just give you the money and you buy the insurance yourself; I cannot deduct it so why spend it? I want to spend my money in my business operations. Everything I spend should be deductible.

It is not. We are trying to remedy that.

I am glad my colleague from Illinois says we have bipartisan support. I know we passed a provision a year or two ago that phased it in gradually, but that is too long. We want to make it effective now. We want to make it where the self-employed get to deduct 100 percent of their health care costs just like corporations. Why not do it now? That is not a diversion.

When we promote our bill, we say Patients' Bill of Rights Plus. What is the plus? We want to increase access. That is in stark contrast to the Kennedy bill which will decrease access. Their bill dramatically increases health care costs, and when you increase health care costs, you are going to be driving a lot of people into the ranks of the uninsured. We do not want to do that. That is not a diversion. It just happens to be a fact.

We want to make health insurance more affordable. The people who cannot afford it, in many cases, are self-employed, and they get the short end of the stick in the Tax Code. They are not treated fairly in the Tax Code. We are trying to remedy that. That is what we have in our amendment.

Also, we have in our amendment a finding of the Senate that, frankly, HCFA does not do a very good job in many cases. Despite what our colleagues say—we want all these people to have assurances and we want them to have all these guarantees. They are basically saying: We want the Health Care Financing Administration of the Federal Government to regulate insurance—we are saying no, that really

should not be the prerogative of the Federal Government to duplicate, override, overrule State regulation of insurance plans.

There is a difference. I am amazed that people keep making the comment: The Republican plan leaves all these people unprotected, as if the States are not doing anything. Every State has a regulatory regimen set up to regulate health insurance under their plans, and our colleagues evidently on Senator KENNEDY's side seem to think whatever the States are doing is not good enough; we know better, in spite of the fact, if you look at HIPAA, the Health Insurance Portability and Accountability Act that Congress passed in 1996, there are five States that are not complying. HCFA is supposed to be regulating those plans, and they are not. They are not complying with the law that we passed 3 years ago. The State of Massachusetts is one of the States that is not complying. Maybe I have too much faith in the States, but I cannot help but think the State of Massachusetts is still interested in making sure employees have portability and continuity of coverage, so I am not really faulting the State. I just find it ironic that some people seem to think: Whatever the States are doing, it's not good enough. We know better. And HCFA, this grand almighty bureaucracy of the Federal Government, can do better than the States. I disagree with that.

So the second-degree amendment that we have states two things: One, findings that the primary regulatory authority of insurance should be done and handled by the States, not the Federal Government; and, two, we should help the self-insured be able to have equitable tax treatment comparable to corporations; they should be able to deduct 100 percent of their health care costs.

I just hope that our colleagues, if they agree in the primacy of States, if they believe in State regulation, if they believe in the 10th amendment to the Constitution that says all other rights and powers are reserved to the States and to the people, respectively, will adopt this amendment. I hope we will when we vote on this. For the information of our colleagues, I expect the vote will occur sometime tomorrow, most likely after the policy lunches.

Mr. President, I yield the floor.

Mr. GRAHAM addressed the Chair.

The PRESIDING OFFICER. The Senator from Florida.

Who yields time?

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. GRAHAM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded for purposes of a parliamentary inquiry.

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

Mr. GRAHAM. Mr. President, I had thought that the Senator from Oklahoma was yielding back the remainder of the time on that amendment.

Mr. NICKLES. No.

Mr. GRAHAM. Therefore, I was going to offer the next in order second-degree amendment.

Mr. NICKLES. To clarify, I did not yield back the remainder of the time. I yielded the floor, just for the information of my colleagues.

Mr. GRAHAM. Mr. President, parliamentary inquiry. How much time is remaining on this amendment?

The PRESIDING OFFICER. The Democrat side controls 47 minutes; the Republican side controls 26 minutes.

Mr. GRAHAM. Is the time running during the quorum call?

The PRESIDING OFFICER. It was.

Mr. GRAHAM. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

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

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

Ms. COLLINS. Mr. President, I yield myself such time as I may consume on the amendment.

The PRESIDING OFFICER. The Senator from Maine is recognized for such time as she may consume.

Ms. COLLINS. Mr. President, I regret that my colleague and friend from Illinois, Senator DURBIN, has temporarily left the floor because I wanted him to hear my comments.

I want to start by commending the Senator from Illinois who has, indeed, been a leader in the effort to provide 100 percent tax-deductibility for health insurance purchased by self-employed individuals. I have been proud to be a cosponsor of the legislation he has introduced, as well as an identical bill introduced by Senator BOND, the chairman of the Senate Small Business Committee.

This issue has been an important one to me. I believe it will help many of our small business men and women throughout this Nation, including the 82,000 Mainers who are self-employed. They include, as you might suspect, many of our farmers, our fishermen, our lobstermen, our hairdressers, our electricians, our plumbers, our small shop owners. They are the ones who find it very difficult to afford the costs of health insurance.

Indeed, the part of Maine's population that has the most difficulty in affording health insurance is our self-employed individuals. By providing 100 percent deductibility for health insurance, we can assist these individuals in affording health insurance coverage. We thus will be taking a very important step toward reducing the number, the growing number, of uninsured Americans.

But this provision is important for another reason. It is important as a matter of equity. Right now a multinational corporation can deduct 100 percent of the cost of health insurance premiums for its employees, and yet the Tax Code discriminates against self-employed individuals. It allows self-employed individuals to deduct only 45 percent of the cost of the health insurance they purchase. That is simply unfair. So this corrects an inequity in our Tax Code, and it is important in terms of expanding access to health insurance.

I disagree with those on the other side of the aisle who contend, however, that somehow this very important provision does not belong on this bill, that it is a diversion of some sort. That statement tells me that my friends on the other side of the aisle still do not understand the crux of this debate. The crux of this debate is, are we going to pass legislation which will drive up the cost of health insurance to the point where we jeopardize coverage for 1.8 million Americans? That is the crux of this debate.

This debate is not only about holding HMOs accountable for the care that they promise; it is not only about improving the quality of care; it is not only about ensuring that people who are denied care that they need have the remedies to give them that care to ensure that care is provided before harm is done, but also this debate is about ensuring access to health insurance.

The single most important determining factor about whether or not people have health insurance is its cost. We face a growing problem with uninsured Americans in this country. It has gone to a record high 43 million Americans who lack health insurance. That is a terrible situation.

We should not be passing any legislation that is going to exacerbate that problem. Yet that is exactly what the Kennedy bill would do, by driving up the cost of health insurance to the point where it would jeopardize coverage for 1.8 million Americans. That is more than the population of the entire State of Maine. The last thing we need to do is to increase the pressure to drive up the cost and jeopardize insurance for working Americans.

The second part of Senator NICKLES' amendment is also important. It affirms the Federal policy that was passed back in the 1940s when Congress passed the McCarran-Ferguson Act giving the States primary responsibility for insurance regulation. Some on this side of the aisle apparently believe that we need a debate on the McCarran-Ferguson Act. Fine. Let's have a debate on that. But we should recognize that until we repeal or change the McCarran-Ferguson Act, it is the policy of this country and the law of the land that the States, not the Federal Government, have the primary responsibility for the regulation of insurance. It is a system that has worked well for more than 50 years.

As someone who was responsible for the Bureau of Insurance in the State of

Maine for 5 years, I know firsthand what a good job our State regulators do and how seriously they take their responsibility of protecting consumers. Indeed, in my capacity as commissioner of the Department of Professional and Financial Regulation, I worked hard to strengthen the consumer division of our Bureau of Insurance. We took enforcement actions against insurance companies that did not live up to the letter and the spirit of Maine's law. I can tell you that I know the people of Maine would much rather make a phone call to Augusta to the Bureau of Insurance and to ask for help—it has actually moved to Gardiner now—but to ask for help from the Bureau of Insurance's Consumer Division than to try to figure out the maze of Federal regulation and call the ERISA office in Boston for assistance. I don't think that is serving our consumers well.

I urge my colleagues to support Senator NICKLES' amendment. It is an important amendment that will help expand access to health care while reaffirming the wisdom of the policy adopted more than 50 years ago when the Federal Government gave responsibility to the States to be the primary regulator of insurance.

Mr. President, I yield the floor and reserve the remainder of the time on our side.

The PRESIDING OFFICER. The Senator from Florida.

PRIVILEGE OF THE FLOOR

Mr. GRAHAM. Mr. President, I ask unanimous consent that two members of my staff, Mr. Matt Barry and Ms. Melanie Nathanson, be granted the privilege of the floor for the balance of consideration of this legislation.

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

Mr. NICKLES. Mr. President, will the Senator mind repeating the request?

The PRESIDING OFFICER. It was floor privileges.

Mr. NICKLES. No objection.

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

Mr. NICKLES. Mr. President, how much time remains on both sides on the amendment?

The PRESIDING OFFICER. The Republican side holds 19 minutes, and the Democrat side controls 47 minutes.

Mr. NICKLES. I yield 5 minutes to our colleague from Alabama, Senator SESSIONS.

The PRESIDING OFFICER. The Senator from Alabama is recognized for 5 minutes on the amendment.

Mr. SESSIONS. I thank the Chair.

Mr. President, I appreciate very much the outstanding remarks of the distinguished Senator from Maine on her experiences dealing with insurance issues in that State.

I served as attorney general of the State of Alabama until a little over 2 years ago. I worked with the State insurance commissioner on a number of important issues. Each State in our Nation has an insurance commissioner. They have for many years worked to develop specific regulations of insurance plans within their own States.

The reason we are here—and, in my opinion, it is for a legitimate reason—is because under the Federal law known as ERISA, certain state policies are preempted. That is what this Congress should concern itself with: the kind of health care plans that cannot be regulated by the States. States have set up policies regarding health care. They have passed regulations. The insurance departments have promulgated their own regulations to address managed care concerns in their own states, and I think it is healthy that that happens.

Therefore, it is appropriate that we in Congress focus only on the policies and insurance programs that fall under the federal law ERISA.

Many have attempted to create an aura of fear by saying that health care in America is failing and in great danger, and that people can't count on their health care anymore. That is not what the people of America are saying. I am not hearing them say that to me when I travel my State. When I have town hall meetings, they are not lining up and complaining about that issue. They are, in most instances, well satisfied. We can, and we will, help and improve health care in certain areas, but I am just not hearing really outrageous cries of widespread abuse.

In fact, in March of this year, March 14 to be exact, the Mobile Press Register-University of South Alabama reported a poll of Alabamians concerning their views of health care. This is the question that was asked:

> I would like to ask you a few questions about health care. Which of the following statements best describes your family's health insurance coverage?

A number of potential answers was listed. The one that received the highest vote: We have sufficient health insurance coverage. Sixty-nine percent of the people in Alabama said: We have sufficient health insurance coverage for our family.

The second answer, which was the second highest vote getter at 7 percent, was: We probably have more coverage than we need: We have insurance, but we don't have sufficient coverage: 16 percent. We do not have health insurance at all: 6 percent.

Therefore, I suggest that what we in Congress need to do is recognize the fact that we have a good health care system in the United States. The first thing we should want to do is do no harm and not destroy it. When you have 76 percent of the people satisfied with their health care, then you have to conclude the system is doing well. In fact, we have the greatest health care system in the world.

I will make one more point. I know the Senator from Missouri would like to make some comments, and I would like to yield the floor to him.

The National Association of Insurance Commissioners has testified before our Health, Education, Labor, and Pensions Committee and on March 16, 1999, they sent a letter stating the official position of their association on the matter as to whether or not the federal government ought to have control over every plan in America.

They said this:

> It is our belief that states should and will continue efforts to develop creative, flexible, market-sensitive protections for health consumers in fully-insured plans. Those are the plans that the States can regulate and do regulate data.
>
> Congress should focus attention on those consumers who have no protections under the self-funded ERISA plans.

Now, that is exactly what this bill does. It focuses on those plans.

My time is up, and I yield the floor. I believe the legislation as proposed is precisely the course we should take.

The PRESIDING OFFICER. Who yields time?

Mr. NICKLES. Mr. President, I yield to the Senator from Missouri, who has been one of the principal sponsors of deductibility for the self-employed in the Senate. How much time do we have remaining?

The PRESIDING OFFICER. The majority side controls 14 minutes.

Mr. NICKLES. I yield the Senator 13 minutes and 30 seconds, reserving 30 seconds for myself.

The PRESIDING OFFICER. The Senator from Missouri is recognized for 13 minutes 30 seconds.

Mr. BOND. Mr. President, I thank the Chair and I thank my distinguished colleague from Oklahoma. In a gesture of goodwill, I ask that the Chair notify me when 13 minutes is up because I would like to hear a full minute from the Senator from Oklahoma. I very much appreciate the opportunity to discuss the amendment that the Senator from Oklahoma has addressed and sent to the floor.

First, let me put into context some of my views about the competing Patients' Bill of Rights. I happen to be very proud to be a supporter of the majority or Republican Patients' Bill of Rights Plus. I am proud to be one of 50 Senators who cosponsored the majority bill, and I will be proud to vote for the legislation.

As with anything we do up here, there are probably some ways you could say it is not perfect. But I believe it is the best approach we have before us that places reasonable controls on managed care companies, while also helping rather than hurting access and coverage problems.

That is something that is extremely important to many Americans—having access and getting the coverage they need.

When we look at the competing proposals, I think it is good to drop back to the first rule of medicine, which is do no harm. I am stunned that with the bill offered on the other side, described as helping patients, we are faced with the fact, according to the Congressional Budget Office and others, that

over a million people who have health insurance today probably can't afford it tomorrow, and that thousands more who were thinking they would be able to get insurance would see that opportunity snatched away if their bill, which would drive up costs, were to pass.

I wonder how anyone can support such a backwards proposition that we are willing to price people out of health care in the name of helping them. That is a fatal flaw, as I see it, in the Kennedy plan: too much cost; too little gain.

In contrast, our Patients' Bill of Rights Plus contains basic, reasonable, commonsense patient protections; access to emergency room care for which their health plan will pay. Americans shouldn't have to worry that their insurance won't pay for necessary emergency room care. Our bill guarantees that patients have information on treatment options. Doctors and patients need to be able to discuss openly all possible treatment options without gag rules.

Our bill provides access to a quick, independent, expert appeals process. Patients should get the care they need when they need it. There has been a lot of talk on the other side about how we need to open up the courts for more costly litigation. Well, frankly, we don't want to see widows or orphans having to sue because their breadwinner did not get the health care he or she needed. We want to make sure they get that care promptly, efficiently, and effectively.

I am very pleased that the Patients' Bill of Rights Plus contains important pediatric and maternal health care protections, which I introduced earlier this year in what we call the Healthy Kids 2000 legislation, which had broad support from major health care supporters, including children's hospitals and pediatricians, who are concerned about care for children.

The Patients' Bill of Rights Plus gives the right for a child to go see a pediatrician without going through a gatekeeper. It gives the right for a child to see a specialist with pediatric expertise, including going to children's hospitals when necessary. It gives the right to a woman to have direct access to an obstetrician or gynecologist without having to go through some gatekeeper. It gives the right to have a pediatric expert review a child's case when appealing an HMO decision. In other words, somebody who treats kids will be the one who will oversee the decision and be able to participate in the external review as to whether the kind of care the HMO proposes for a child is appropriate for that child.

But just as important as what is in our Republican bill, the Patients' Bill of Rights Plus, is what isn't in it. It doesn't contain the same costly bureaucratic provisions the Democratic bill has. One would have thought they would have learned something when we had the health care debates of 1993 and 1994, the Clinton plan, which had the Federal Government and its bureaucracy controlling health care. When people took a look at that dog and found out how mangy it was, it failed, not because the Republicans beat it, but because nobody was willing to get out and support it—and with good reason. The more people looked at it, the worse it looked.

Well, the Congressional Budget Office has given estimates that the Democratic bill could raise health care premiums anywhere from 5 to 6 percent, depending on which version of the bill we are discussing. I have heard people on talk shows saying that is one Big Mac a month. Five percent of basic family health insurance at $3,600 a year—my math suggests that is a whole lot more than a Big Mac a month. We are talking in the neighborhood of $180 a year.

CBO and others have told us that for every 1 percent increase in costs, a couple hundred thousand people will lose health care insurance. Under this bill, that means, under the Democratic version, over a million Americans or more could lose their health care coverage.

I speak as chairman of the Committee on Small Business because cost increases for small businesses and small business employees is a No. 1 concern. We have listened to small businesses, and we have heard from small businesses. They say: Please don't do us any more favors. Don't burden us with more costly health care plans. Small businesses are fighting to try to get economical, caring, compassionate, effective health care for their employees and for the business owners themselves. Small business owners are particularly sensitive to the issue of cost. Small businesses—the owners and their families, the employees and their families—would be the ones who would pay for an extravagant bill.

Nearly 40 years ago, President Kennedy told the Nation that a rising tide would lift all boats. Unfortunately, the bill before us turns that concept on its head, and perhaps a new doctrine is that rising costs will sink health care hopes. To me, that is a major concern.

As an alternative to this heavy-handed bureaucratic approach, the Patients' Bill of Rights Plus, offered by the Republicans, tries to increase access and coverage. Now, it is extraordinary and unconscionable that the bill we are debating, the Democratic bill, doesn't do anything to improve access to health care. It seems that the only thing our colleagues on the other side of the aisle can think of to improve access is to have Government-run care, like the Clinton health care plan of 1993 and 1994. Since that fell on its face a few years ago, they seem not to have had any good ideas about how to get more people health insurance.

We need to increase access. Perhaps the most important part of our bill is the acceleration of the full deduction of insurance costs for the self-employed. I am very pleased that our distinguished majority whip, the Senator from Oklahoma, has introduced an amendment that achieves, for this year, full deductibility of health care costs. That means there is hope that the health care premiums paid this year will be fully deductible.

Now, my colleagues, the Senator from Maine and the Senator from Alabama, have already discussed the importance of keeping insurance regulation at the State level. As a former Governor, I can tell you that government insurance regulation, run at the State level, is readily accessible, it is more professional, and it is more responsive to the needs of the citizens. That is why I agree with the portion of the amendment introduced by Senator NICKLES which talks about moving away from Federal Government takeover of health care regulation.

But I am particularly pleased that Senator NICKLES has introduced full deductibility based on the Self-Employed Health Insurance Fairness Act of 1999, which I introduced on February 3 of this year. I am very proud to have 30 bipartisan cosponsors. We are making progress when we work on a bipartisan basis to assure full deductibility of health care costs for the self-employed. I am proud to work with my colleagues on both sides of the aisle.

According to the Employment Benefit Research Institute's estimates of the March 1998 current population survey, there are 21.3 million Americans in families headed by a self-employed entrepreneur. Nearly a quarter—23.9 percent—of them have no health insurance. That is 5.1 million uninsured Americans. Even more troubling, that means that the 21.1 percent of the children in self-employed American families are uninsured; 1.3 million children have no coverage for annual checkups, let alone any major health care needs.

This amendment would address these alarming statistics by providing an immediate—I mean right now, in real time—100 percent deductibility in order to make health insurance more affordable and accessible to hard-working entrepreneurs and their families.

Let me add an additional perspective on the importance of this amendment. Today, one of the fastest growing segments of the small business community is the woman-owned business. Women are opening businesses at a very rapid rate. They are the ones with the entrepreneurial spirit. They may be operating out of their homes, they may be moving from another full-time job, or they may just have a good idea. But women are now seeing an opportunity to start up their own businesses, and we are very proud of the significant contributions they are making to our economy.

According to statistics from the National Foundation for Women Businessowners, there are now 9.1 million women-owned businesses in the United States, which compromise almost 38 percent of all U.S. businesses.

In addition, between 1987 and 1999, the number of women-owned firms increased by 103 percent nationwide—more than double. The reasons for this explosive growth are manifold. Topping the list is greater flexibility in meeting the demands of family life, and the ability to spend more time with children.

Even more impressive, the National Foundation for Women Business Owners reports that women-owned businesses employ more than 27½ million people, and that employment rate has increased by 320 percent over the past 12 years.

Today, while self-employed woman business owners can deduct 60 percent of their health care costs thanks to the strides that we made in previous years, that is still not on a level playing field with a large business which can deduct 100 percent. While the self-employed are slated to have full deductibility in 2003, what woman business owner or her family members can wait 4 more years to get sick?

By making health-care insurance fully deductible now, the added tax savings will enable many women business owners to cover their health-care needs and those of their children. In addition, it will encourage these women entrepreneurs to provide health insurance for their employees and their families.

And we're not talking about a tax break for ''the rich'' when it comes to the health-insurance deduction for the self-employed. Recent estimates based on the March 1998 Current Population Survey indicate that 68.7 percent of families headed by a self-employed individual with no health insurance earn less than $50,000 per year.

These are the people who we are trying to get health coverage. These are the people who need the benefit of full deductibility.

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

Currently, S. 343, from which my amendment is derived, has the bipartisan support of 30 cosponsors. It also enjoys overwhelming support of small business organizations including the National Association for the Self-Employed, the National Federation of Independent Business, the Small Business Legislative Council, the National Small Business United, and the Health Tax Deduction Alliance, to name just a few.

I have also added a provision to the amendment to correct a disparity under current law that bars a self-employed individual from deducting any of her health-insurance costs if she is eligible to participate in another health-insurance plan. This provision unfairly affects entrepreneurs who are eligible for, but do not participate in, a health-insurance plan offered through a second job or through a spouse's employer. The bill ends this disparity by clarifying that a self-employed person loses the deduction only if she actually participates in another health-insurance plan.

It has long been my goal that the self-employed have immediate 100 percent deductibility of health-insurance costs. I have sought every opportunity to achieve that goal, and I will keep coming back until we get this job done. I commend the Senator from Oklahoma for pushing for this amendment on the bill so that we can have bipartisan, unanimous support for the effort to ensure that all Americans who are self-employed will have the same kind of benefits in terms of taxes that a large corporation or its employees do; and that is 100 percent deductibility.

I am very proud to be a cosponsor of this amendment. I ask all of my colleagues to join in supporting a very forward-looking amendment which deals with some of the significant problems in the underlying bill offered by our colleagues on the other side and makes significant changes to assure access to fair and equitable health care insurance for all Americans.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I thank Senator BOND for cosponsoring this amendment, in addition to Senator SANTORUM, who is also a principal sponsor of this amendment, and Senators HUTCHINSON, CRAIG, and myself who are original sponsors.

Mr. President, I inquire of my colleague from Nevada, is he prepared to yield the remainder of time on this amendment?

Mr. REID. Yes. We are.

Mr. NICKLES. Mr. President, if my colleague from Nevada is yielding back the remainder of time on the amendment, we likewise yield the remainder of time on the amendment.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. NICKLES. 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. NICKLES. Mr. President, I ask unanimous consent that the Republican manager of the bill be allotted an additional 40 minutes on the bill itself.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Reserving the right to object, on second thought, I tell my friend, the majority whip, we also want 40 minutes.

Mr. NICKLES. Mr. President, I ask unanimous consent that both sides be allotted an additional 40 minutes on the underlying bill.

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

Mr. NICKLES. Mr. President, I ask unanimous consent that the second-degree amendment proposed by myself and Senator BOND and others be temporarily set aside.

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

The PRESIDING OFFICER. The Senator from Florida.

AMENDMENT NO. 1235 TO AMENDMENT NO. 1233

(Purpose: To provide for coverage of emergency medical care)

Mr. GRAHAM. I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Florida (Mr. GRAHAM), for himself, Mr. REID, Mr. CHAFEE, Mrs. MURRAY, Mr. DURBIN, Ms. MIKULSKI, Mr. SCHUMER, Mr. KENNEDY, Mr. DASCHLE, Mr. BAUCUS, Mr. FEINGOLD, and Mr. DORGAN, proposes an amendment numbered 1235.

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

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

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

Mr. GRAHAM. Mr. President, on behalf of the Senators listed, I offer an amendment relative to emergency care services.

This is a particularly critical issue because so many of the conflicts between beneficiaries and their health maintenance organizations occur in an emergency room setting.

When the Senate in 1997 adopted provisions that extended to Medicare and Medicaid beneficiaries—the same rights that this amendment will now provide to all Americans—we discussed the fact that 40 percent—40 percent—of the conflicts between Medicare beneficiaries and HMOs occurred in an emergency room setting.

Questions of coverage, type of coverage, and what would happen after the patient was stabilized was the cauldron in which many of the disagreements between HMOs and beneficiaries were fought out.

Just as the Medicare and Medicaid provisions which were adopted by the Congress and signed into law by the President have helped to relieve that tension for 70 million Americans, this amendment will attempt to do the same for the rest of Americans.

This amendment also raises a couple of other important issues.

One of those is what I call the ''big monster argument''—that anything that we do is going to inevitably lead to an escalation of cost and an escalation of Federal regulation and bureaucracy and an overwhelming of the patients' ability to get affordable health care.

I would like to point out the first sentence of this amendment. The first sentence is essentially, if the health care plan offers emergency services, then these are the standards that will have to be met.

The clear implication of that is that no HMO under this amendment is required to offer emergency room services. If the HMO wishes to go to its beneficiaries and say, Now, look, you are not covered if you go to the emergency room—you understand that—and the fee that you are going to pay for your HMO contract is predicated on the fact that emergency room services are not covered, the HMO has the prerogative of so doing. If the HMO gives the appearance that it is offering emergency room services, then it is required to offer credible emergency room services that comport to what the average American thinks they are going to get in an emergency room.

So the ''big monster argument'' that this is going to have all of these adverse effects is irrelevant as long as the HMO plays by the rules. It cannot offer emergency room services at all. But once it purports to do so, it can't bait and switch and say, Yes, you thought you were getting comprehensive emergency room coverage, but in fact you are getting something much, much less.

The second argument is what I call the ''checking off the boxes'' argument. We have heard it already. We will say, well, the plan of the Republicans offers an external appeal provision, and the Democratic plan offers an external appeal provision. So we check both of them with an equally large mark. We have an emergency room provision. You have an emergency room provision. Check, check—both get the same large mark.

The problem is that it is not just a matter of checking off the boxes. It is a matter of seeing what inside the box. What are the actual words? What is the detail? Words make a difference. Details matter. We are not talking about semantics or legalisms. We are talking about whether in the final analysis the beneficiary—the American family—gets the kind of protection that they think they paid for.

There will be other colleagues who will discuss important distinctions between the two bills. I want to focus on two of those differences.

I look forward to a debate with my Republican colleagues on these two differences, whether they are meaningful, and whether they have properly stated what the Republican provisions are. The first of those distinctions is hidden in the Republican bill in language which effectively eviscerates the ''prudent layperson standard'' that is at the heart of the emergency care provision.

What is the prudent layperson standard? This is a standard which is now in the Medicare law and the Medicaid law by action of Congress. It essentially says if a prudent layperson—a layperson of normal intelligence and knowledge of health and medical matters—thinks symptoms occurring require urgent attention, that prudent layperson can then seek the attention of the most available emergency room, and the HMO will be responsible for paying the costs of that emergency room service.

How does the Republican bill eviscerate that basic principle, which now protects 70 million Americans on Medicare and Medicaid? The Republican bill allows for the imposition of ''any form of cost-sharing applicable to any participant or beneficiary (including copayments, deductibles, and any other [form of] charges . . . if such form of cost-sharing is uniformly applied under such plan with respect to similarly situated beneficiaries.''

Now, what does that mean? It means that a patient who goes to a hospital that is not part of the network of the HMO will have to pay, according to the HMO's plans, for additional deductibles, coinsurance, and other charges, while a person who is in the same position of an emergency medical crisis, who goes to the in-network hospital will not be required to pay those additional out-of-network charges.

The practical effect of that distinction is to create a strong economic incentive for the prudent layperson who thinks they have symptoms requiring emergency attention. If they understand they could go to the emergency room which is 5 minutes away but which is not part of their HMO's network or they could go to the emergency room that is 30 minutes away and be within the network of the HMO, and that there will be a significant economic differential as to what that choice is, then you have a prudent layperson making a critical decision. Will I go to the emergency room that offers the most immediate attention to my condition, or will I go to the emergency room where the cost will be less?

How do we know this is what was meant in the Republican version of the emergency room provisions in the Patients' Bill of Rights? Because they said it in very clear language in the committee's report of this section, which appears on page 29. I will read from that report:

> The Committee believes that it would be acceptable to have a differential cost-sharing for in-network emergency coverage and out-of-network emergency coverage, so long as such cost-sharing is uniformly applied across a category (i.e. [across all] in-network, out-of-network). . .[beneficiaries and providers.]

I suggest there goes the prudent layperson definition, or the rationale for the prudent layperson definition, right out the window.

The Democratic plan provides explicitly that there will be parity payment between in-network and out-of-network emergency room services; that is, the prudent layperson would have the right to go to what is the most prudently accessible emergency room to get that service.

I suggest what is good for 70 million Medicare and Medicaid beneficiaries should be good for all Americans. Patients should not be required to call an insurance bureaucrat to see if they can get emergency room care approved before they go to the emergency room. They shouldn't have to call their HMO before they call 911. That is the very thing we are trying to prevent. Patients should be able to seek the treatment wherever it can be provided—inside or outside the network—and not be subject to economic compulsion.

That is one important differential between the Republican and the Democratic bill. That little devil was in the details.

Another provision called poststabilization is a crucial component of emergency room care. This provision relates to what happens after a person has gone to the emergency room, had that immediate treatment, and their condition is now stabilized; what happens next?

Let me give an example. A person goes to an emergency room on a Friday night with shortness of breath, high fever, pain in the left side of their chest. They are diagnosed by the emergency room as having not a heart attack but acute pneumonia. The emergency room treats the patient with intravenous antibiotics and oxygen. The emergency department then calls the HMO to request one of two things be done: that the plan take responsibility for the patient by having the patient transferred to one of their in-network hospitals, or the plan authorize the admission of the patient to the treating hospital.

Unfortunately, this is a Friday night, about 10 or 11 o'clock, and no one picks up the phone at the other end of the line. The hospital is stuck; the party is stuck. The hospital cannot transfer the patient to another facility but it can't get authorization to admit the patient to its own facility. As a result, the emergency room does admit the individual for treatment. On Monday, the patient goes home.

The health care plan has not authorized the treatment. It now denies the claim, retroactively, after the hospital services have been provided. Under the Republican bill, the patient is responsible for the noncovered hospital bill, potentially for several thousand dollars for that weekend institutionalization.

Under our amendment, the nonresponsive HMO would be financially responsible for that bill. Better yet, we see a different scenario. Under our amendment, we see the health plan with a positive incentive to coordinate the patient's care with the emergency department. The patient was transferred to a network facility, which in turn has saved all overall health costs both for the patient and the health plan—a win-win scenario.

Let me give an example of this coordination. A parent brings their young child into an emergency room with a high fever. The emergency physician rules out a life-threatening illness. She brings the fever under control, thereby stabilizing the patient. However, follow-up care is necessary to determine the cause of the high fever and the extent and nature of the illness. The emergency room calls the

plan to get the plan to refer the child to a primary care doctor. The plan doesn't call back. What is the result? The child is admitted to the hospital overnight, potentially costing the family thousands of dollars of unnecessary hospitalization and emotionally traumatizing the child.

Under the Republican proposal, the plan gets a double windfall. First, the plan saves the money of having to staff ''response capability,'' particularly on the weekend, and by not having personnel to respond to that emergency room call and to make treatment decisions. That is not all. The HMO also saves; when the emergency room treats the patient without prior authorization, the health plan can then go back and claim the care was unnecessary and refuse to pay.

What the Democratic poststabilization provision is all about is simply requiring the health plan to take responsibility for the patient by answering the phone when the emergency room calls, and then either authorizing treatment, referring followup primary care, or transferring the individual.

There are those who say this provision places an unwarranted burden on the HMO. But let's give an example of one of the Nation's oldest and largest health maintenance organizations, Kaiser-Permanente. Kaiser-Permanente endorses this position and has implemented the poststabilization requirement voluntarily. Guess what. After all the discussion about cost and the desire to maintain affordable and accessible health care, this provision has saved Kaiser-Permanente money. How could it do that? Because Kaiser has found that by coordinating care with the emergency room, it has been able to avoid unnecessary admissions through providing followup care at an outpatient facility.

I will quote from a letter signed by Mr. Don Parsons, the associate executive director for health policy development for Kaiser-Permanente. I ask unanimous consent the entire letter be printed in the RECORD immediately after my remarks.

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

(See Exhibit 1.)

Mr. GRAHAM. Mr. Parsons states:

By assuring immediate response to telephone inquiries from non-participating emergency facilities, we have been able to provide substantial assistance to the emergency doctor who otherwise is practicing in an isolated environment without access to the patient's medical record.

Our own emergency physicians on the telephone have offered peer consultations, personally approved coverage for urgently needed tests and treatment, arranged for the coordination of follow up care, and implemented critical care transportation of patients back to our own facilities. Of over 2,000 patients transported in this fashion, one third have been discharged to their homes. Without this coordination of care, these patients would have been hospitalized at needless expense.

For example, to go back to my hypothetical of the child with the high fever without signs of a bacterial infection, they could have been sent home if there were arrangements made for the child to see a doctor the next day. But absent the communication between the plan and the emergency room, the emergency room admits the child. If the insurance company plays by the rules, as Kaiser-Permanente, it will now be only out the $50 for a routine primary care visit rather than the $1,000 or more that it might be out if the child is admitted to the hospital.

So why are companies such as Kaiser coordinating poststabilization care with emergency departments? They are doing it because it is good health care and it is good business. I point out again, this is the same provision that the Congress passed in 1997 as it relates to Medicare and Medicaid beneficiaries who currently have this poststabilization coordination of care coverage.

So how the amendment is drafted, what the amendment says, what the details are, makes all the difference. This is not just a matter of checking off the box. It is a matter of looking inside that box to see if the prudent layperson provision, which both versions purport to offer—is it meaningful? The person who exercises prudence by going to the nearest emergency room, not necessarily the nearest emergency room that happens to be part of the network of the HMO, will they be financially protected?

The person who has been stabilized—and now the question is what needs to be done to deal with the underlying cause of their symptoms—will they be financially protected when the HMO fails to respond to the request for specific authorization? Those are the types of real differences that make the difference between the two alternative versions of emergency room care that are before the Senate.

I urge my colleagues to study these differences and to be mindful of the other differences that will be articulated by the other cosponsors of this amendment. I urge their support for this amendment that makes emergency room care real for the families of America.

I ask unanimous consent that two letters be printed in the RECORD: One from the American College of Emergency Physicians supporting the amendment that has been offered, and the letter from the American Heart Association supporting the emergency room provision that I and colleagues have offered.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

AMERICAN COLLEGE
OF EMERGENCY PHYSICIANS,
Washington, DC, July 12, 1999.

Hon. BOB GRAHAM,
Hon. JOHN H. CHAFEE,
U.S. Senate,
Washington, DC.

DEAR SENATORS GRAHAM AND CHAFEE: The American College of Emergency Physicians (ACEP), on behalf of its more than 20,000 physicians and the patients we serve, is pleased to support your amendment, which will protect people with health insurance who make reasonable decisions to seek emergency care from claims denials by managed care plans. Today's health care market warrants establishment of basic consumer protections to ensure coverage for emergency services, and ACEP believes that your amendment would provide such safeguards.

As emergency physicians, we applaud your efforts to prevent health plans from denying patients coverage for emergency services. Prior authorizations requirement for emergency care and ''after-the-fact'' claims denials create barriers that can place a patient's health at serious risk. Your amendment provides those covered by private managed care plans with the same ''prudent layperson'' standard that Congress provided Medicare and Medicaid patients as a part of the ''Balanced Budget Act of 1997.''

Again, ACEP is pleased to offer its support of your amendment, and we commend your leadership in proposing a bipartisan solution.

Sincerely,

JOHN C. MOORHEAD, MD, FACEP,
President.

AMERICAN HEART ASSOCIATION, OFFICE OF COMMUNICATIONS AND ADVOCACY,
Washington, DC, July 13, 1999.

Hon. BOB GRAHAM,
Washington, DC.

DEAR SENATOR GRAHAM: The American Heart Association strongly supports your amendment, to be offered today to the patient protection legislation, which will ensure prompt emergency room access. This important amendment is essential to our mission of reducing death and disability from cardiovascular diseases, the leading cause of death in America.

To reduce the devastation caused by cardiovascular diseases, the American Heart Association is committed to educating the public about the warning signs and the symptoms of heart attack and stroke. Acting on this knowledge is often the key to survival. In fact, every minute that passes before returning the heart to a normal rhythm after a cardiac arrest causes the chance of survival to fall by as much as 10 percent. Our consistent message to the public, therefore, is both to know the signs and symptoms of heart attack and stroke and to get emergency care as quickly as possible.

However, unnecessary and burdensome obstacles often stand between the patient and the emergency room door. Insurer ''pre-approval'' processes for emergency care can impede prompt treatment of heart attack and stroke. Delays in treatment can significantly increase mortality and morbidity. Our efforts to educate the public about the importance of getting prompt treatment are severely hindered by these ''pre-approval'' barriers.

The American Heart Association applauds your efforts to address these obstacles by ensuring the ''prudent layperson'' definition of emergency. Any managed care reform proposal that seeks to protect patients' rights must include this prudent layperson standard.

Thank you for your leadership on this important issue.

Sincerely,

DIANE CANOVA, ESQ.,
Vice President, Advocacy.

Mr. GRAHAM. And so, Mr. President, as I stated early in my remarks, how the amendment is drafted, and what the amendment says, makes all the difference.

It's not good enough just to check off the boxes. That's why I urge the adoption of our amendment.

EXHIBIT 1

KAISER PERMANENTE,
Washington, DC, July 7, 1999.

Hon. BOB GRAHAM,
U.S. Senate,
Washington, DC.

DEAR SENATOR GRAHAM: Since 1996, Kaiser Permanente has supported the passage of federal legislation embracing the Prudent Lay Person concept, which requires insurance coverage of emergency services provided to people who reasonably expect they have a life or limb threatening emergency. In connection with this, we support a requirement that the emergency physician or provider communicate with the health plan at the point where the patient becomes stabilized. This will allow for coordination of post-stabilization care for the patient, including further tests and necessary follow-up care. These concepts are contained in several bills currently pending before Congress. I should note, however, that our favoring of this language should not imply endorsement in its entirety of any specific bill that deals with other issues.

As a result of the Balanced Budget Act of 1997 with its ensuing regulations applicable to Medicare + Choice and Medicaid enrollees and the Executive Order applying the President's Advisory Commission's Bill of Rights to all federal employees, approximately 30 million Americans are now the beneficiaries of a financial incentive to emergency departments to communicate with the patient's health plan after the patient is stabilized. This helps to ensure that the patient's care is appropriate, coordinated and continuous. It is important that emergency departments have the same incentive to coordinate post-stabilization and follow up care for patients who are not federal employees or beneficiaries of Medicare or Medicaid. We have heard of minimal problems implementing this standard in those health plans participating in FEHBP and Medicare + Choice programs. Since a federal standard is in place and working, it is good policy to extend that standard to the general population.

For the past ten years, we have implemented on a voluntary basis a program that embraces these concepts of honoring payment for the care our members receive in non-participating hospital emergency departments up to the point of stabilization. Our Emergency Prospective Review Program has encouraged the treating physicians in such settings to contact our physicians at the earliest opportunity to discuss the need for further care. This has allowed us to make available elements of the patient's medical record pertinent to the problem at hand and to coordinate on-going care as well as the transfer of the patient back to his/her own medical team at one of our facilities. We have found this program to be considerate of the patients' needs, emphasizing both the urgency of treatment for the immediate problem as well as the continuity of high quality care.

This has been a cost-effective practice, affording the patient the highest quality of care in the most appropriate setting. By assuring immediate response to telephone inquiries from non-participating emergency facilities, we have been able to provide substantial assistance to the emergency doctor who otherwise is practicing in an isolated environment without access to the patient's medical record. Our own emergency physicians on the telephone have offered peer consultations, provisionally approved coverage for urgently needed tests and treatment, arranged for the coordination of follow up care, and implemented critical care transport of patients back to our own facilities. Of over two thousand patients transported in this fashion, one third have been discharged to their homes. Without this coordination of care, these patients would have been hospitalized at needless expense.

In summary, this program has served the needs of our patients, the treating emergency physicians, and our own medical care teams, while providing substantial savings in both clinical expense and in administrative hassle over retrospective approval of payment for services provisionally approved through the telephone call. We are strongly in favor of the post-stabilization coordination provision as an essential element of the emergency access provision of the Patients Bill of Rights.

Sincerely,

DONALD W. PARSONS, MD,
Associate Executive Director.

The PRESIDING OFFICER. Who yields time?

Mr. REID. Mr. President, I yield myself such time as I may consume on the amendment.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, just briefly, the Senator from Alabama stated the State of Alabama had this great health insurance by some poll that he had conducted by, I think, South Alabama University.

First of all, regarding coverage of emergency care, the State of Alabama is one of 12 States that does not use the prudent layperson or similar standard for emergency room treatment. In addition to that, with drug formularies, 36 States have no procedures for obtaining nonformulary drugs; Alabama is one of those. Access to clinical trials, 47 States have no access to clinical trials; Alabama is one of those. Continuity of care, 29 States have no continuity of care provisions; Alabama is one of those. Bans on financial incentives, 28 States have no ban on financial incentives to providers; Alabama is one of those. Provider protections, 21 States have no protections for providers who are terminated; Alabama is one of those. Point-of-service options, 30 States do not require that point-of-service plans be offered; Alabama is one of those. Coverage of emergency care, I have already stated 12 States do not use a prudent layperson or similar standard; Alabama is one of those.

The State of Alabama has 1,617,000 State residents who are not protected under the Republican plan; 62 percent of privately insured in Alabama are not protected under the Republican plan. So I do not know about the poll in South Alabama, but I know what the facts are. The facts are that State is similar to many States. That is why groups support our Democratic Patients' Bill of Rights.

Why do I say groups? Hundreds of groups. They are already on the record, the groups that support us, a listing of some of the groups that support us. Alliance for Lung Cancer Advocacy, Alzheimer Association, American Academy of Child and Adolescent Psychiatry, American Academy of Emergency Medicine, American Academy of Neurologists, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation—over 200 groups support this legislation, over 200.

In addition to that, we have a unique situation. The doctors and the nurses have joined with the lawyers to support this legislation. It is a unique day in American legislation when we can say not only do the doctors support this—the American Medical Association does, all the specialty groups—but in addition to that the lawyers support it.

I suggest people coming in, bragging about the other bill, the majority's bill, they are talking about—the junior Senator from Maine said all we want to do is ensure access. I respectfully submit they want to ensure the insurance companies continue to rip off the American public. That is what that legislation is about. That is what they are trying to ensure, and this legislation is meant to stop that.

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

Mr. FRIST. Mr. President, I yield myself 10 minutes on the amendment.

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

Mr. FRIST. Mr. President, we have a number of issues on the floor today—the underlying bill that has been introduced and a substitute bill. We have talked some about scope today. Now we are talking about emergency services. I think it is important that people understand that both of the underlying bills do have parts which address this access to emergency medical care. It is absolutely critical that over the course of today and on future amendments on emergency care we appropriately address a bill of rights that does have a real impact because there is no way we can responsibly leave this debate without addressing the fear, the fear which is supported by anecdote—I do not know how big of a problem it is, but it is a fear and that means we have to deal with it and we should deal with it—of having a heart attack or chest pain or laceration or broken arm or a sick child and going to an emergency room, and in some way, for some reason, having that care denied or be channeled to emergency rooms that are across town, all of the sorts of things that are truly frightening and are really unconscionable. Therefore, it needs to be addressed and needs to be addressed well.

The amendment today brings up an issue of poststabilization, which I think needs to be addressed, and I will carefully look at the amendment.

Poststabilization is a point after which you have gone to the emergency room, gone through screening, and gone through treatment. Then what happens? Again, it looks at a more complete picture, and we need to make sure what we ultimately pass several days from now addresses that adequately and appropriately, given the

realities of the managed care, coordinated care, and fee-for-service system.

Let me briefly comment on what is in our Republican bill. This was discussed in the Health, Education, Labor, and Pensions Committee. We talked about emergency access, and we talked about some of the other issues as it went through the committee.

What passed out of committee, and is before this body, is as follows: We require group health plans that are covered by the scope of the bill—and the issue of scope has come forward—to pay, without any sort of prior authorization, for an emergency medical screening exam. If you go to the emergency room, that exam, using a prudent layperson standard, which has just been discussed—meaning, if you are at a restaurant and you have chest pain, you think it might be a heart attack, you know it is an emergency or you feel it is an emergency, and you go to the emergency room. They say it is indigestion, not a heart attack; therefore, they are not going to cover it. The prudent layperson —that is, the average person in terms of medical knowledge in America today—says there is no way I am going to know if it is an emergency or not, if it is serious or not. We reach out, using the prudent layperson standard, and cover that individual.

You would not have to have prior authorization. That would be for an emergency medical screening exam and any additional emergency care that is required to stabilize that condition.

Stabilization is difficult. As a physician, when I think of stabilization, because I am a heart surgeon, I think of heart failure and blood pressure, going into shock, and all sorts of bad things happening overall. Stabilization might also mean if you have a broken arm or if you have a laceration. The definitions are important as we go forward.

Mr. GRAHAM. Mr. President, will the Senator from Tennessee yield for a question?

Mr. FRIST. Let me finish walking through what is in the Republican proposal first.

The stabilization end of it is important. I mention that because we are talking about a period of poststabilization—after you are stabilized. Again, the Republican bill covers, through the screening and stabilization process, using that prudent layperson standard.

We define in our bill what a prudent layperson is, and that is an individual who possesses an average knowledge of health and medicine. I think that is as good a definition as one can generate, and the concept of prudent layperson I believe is accepted by both sides.

As to the cost-sharing aspect, again looking at what is in the Republican bill which was introduced earlier today, plans may impose cost sharing on emergency services, but the cost-sharing requirement cannot be greater for out-of-network or out-of-plan emergency services than for in-network services. That is very important, because I have heard several people allege, no, you can charge anything, you can charge much higher than what in-network cost sharing is, and that is simply not true in the Republican bill.

An individual who has sought emergency services from a nonparticipating provider or nonparticipating hospital or nonparticipating emergency physician cannot be held liable for charges beyond that which the individual would have had to pay if that physician were a member of that particular coordinated care plan or managed care plan or health maintenance organization.

The important points are basically that you do not need prior authorization. It does not matter whether or not that facility is part of that plan or that HMO's network itself. So you can go to the nearest hospital if, using that prudent layperson standard, you have a concern that you have something that does need to be treated and treated very quickly.

The prudent layperson would expect the absence of immediate medical attention to result in some sort of jeopardy to the individual's health or serious impairment—again referring back to that standard—or serious dysfunction of their body. Again, it is very difficult in terms of covering the overall realm.

The poststabilization period: What happens after you go to the nearest emergency room, using that prudent layperson standard, not having to pay anything beyond what you would have to pay if you had gone to a facility in that network, you have had the screening exam and you have had that stabilization or that initial treatment.

Poststabilization introduces: What if you are there and you had this chest pain and you found out it was just indigestion, but while you were there in that poststabilization period, the physicians find a spot on the chest x-ray that you need to rule out as lung cancer, or you have cholecystitis or right quadrant pain, and with a quick exam it is pretty clear another medical problem has been picked up. Does that fall into that poststabilization period? And, if so, does that treatment continue over time?

Those are the questions we need to debate, we need to look at. We need to make sure we do not open the door so broadly that somebody basically goes to an emergency room with a complaint and it is taken care of, but 10 other complaints are found and that is an excuse to get all your care outside of that network simply because that might potentially circumvent the whole point of having care coordinated and to have a management aspect of coordinated care.

Over the debate, as it continues tonight and in the morning, the poststabilization period is an important period we need to address. We do not want to create any huge loopholes through which people can slide. I am going to keep coming back to again and again that we have to do what is best for the individual patient, and we have to keep our focus on the patient, and we do not want to do anything that exorbitantly increases cost if it is unnecessary, if it is wasteful, because if we do that, we increasingly, by an increase in premiums—somebody is going to have to pay for it—drive people to the ranks of the uninsured.

I reserve the remainder of my time.

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

Mr. FRIST. I will be happy to yield.

Mr. GRAHAM. First, on the question of prudent layperson, you are correct; both bills have essentially the same language on a prudent layperson, but there is a very sharp difference in terms of the economic exposure of that prudent layperson, whether they are in a hospital as part of the HMO's network or in a hospital that is not part of the network.

The Democratic plan clearly states there must be parity of treatment; that is, if you are in an out-of-network hospital, you cannot be charged more than if you are in an in-network hospital.

The Republican bill—and I will quote from the committee report, which is on our desks, on page 29. This is the committee that reported the Republican bill, the Labor Committee. The first full paragraph states:

> The committee believes that it would be acceptable to have a differential cost-sharing for in-network emergency coverage and out-of-network emergency coverage, so long as such cost-sharing is applied consistently across a category (i.e., in-network, out-of-network) and uniformly to similarly situated individuals and communicated in advance to participants and beneficiaries. . . .

What that language seems to say to me is that under the Republican proposal, if you have a standard copay, let's say, of 20 percent if you are inside the HMO network but it is a 50-percent copay if you are out of the network, and you end up in the emergency room that is out of the network because it was the one closest to where you were when you had that chest pain, you may end up having to pay 50 percent of the emergency room bill rather than 20 percent that you would have had to pay in your in-network emergency room, which is what the Democratic bill would provide, that you would pay whatever emergency room from which you ended up receiving that emergency service.

Mr. FRIST. The question is, in essence, what I said earlier about the differential cost sharing; if you go back and look at the committee report, if you go to an emergency room, you can be charged out-of-network rates instead of in-network cost sharing. I do not have that report language before me right now, but if that is what is in the committee report, that is unacceptable to me. That is something that I am willing to work on in terms of the amendment process over the next several days because there is no question

in my mind as to the cost-sharing requirement, when you go into an emergency room, that you have to remove all barriers, that you can go to the closest emergency room, and that that cost-sharing requirement cannot be exaggerated or elevated to an out-of-network rate as we go forward.

I will work with you in terms of this whole issue that the cost-sharing requirement cannot be greater for out-of-network emergency services than for in-network services. That is a barrier that should not be there.

Mr. GRAHAM. Mr. President, that response was so satisfactory and indicated the kind of spirit which I hope this debate over the next 3½ days will sustain; that we are all trying to do what is best for patients and that we will work together to get to that end.

I have no further questions.

Mr. FRIST. Mr. President, let me just respond that I hope in my earlier comments in what I was saying about poststa-bilization—although I have not seen the wording of the amendment, but I know from committee that the Senator is committed to this—in the poststabilization end of things, in terms of how far in the process of prudent layperson recognition, the presentation to the emergency room of your choice, the cost-sharing arrangement we talked about, the medical screening, the stabilization, the poststabilization period, I, again, want to work with the Senator as we go forward.

I have to say it is a very complex issue as to how you trade back into the network, how you do that notification process. I worked in emergency rooms. I have been there. I worked for years in emergency rooms.

When somebody comes in, the last thing you want to be thinking about is a lot of phone calls and calling networks—should we or should we not take care of that individual patient? On the other hand, after things settle down and you take care of the emergency in the emergency room, you have the heart going, you have resuscitated them, then at some point in time they have to make their entrance back into the coordinated care plan.

So we have to be careful about poststabilization—at an appropriate time—but, again, doing what is right for the patient. So those two issues—the cost sharing and the poststabilization—I am committed to working with the Senator over the next several days.

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

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I say to my friend from Florida that was an excellent question. It does appear the Senator from Tennessee has indicated that the Republican version of the emergency care aspect of that bill is lacking and that he would support the provisions you have indicated, having parity in charging from one emergency room to the other. It was an excellent question.

Mr. President, I yield 5 minutes to the Senator from Montana.

Mr. BAUCUS addressed the Chair.

The PRESIDING OFFICER. The Senator from Montana.

PRIVILEGE OF THE FLOOR

Mr. BAUCUS. I first ask unanimous consent that my assistant, Brent Asplin, be allowed floor privileges during the remainder of this bill.

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

Mr. BAUCUS. Mr. President, I want to follow up on the dialogue we had between Senator GRAHAM from Florida and Senator FRIST from Tennessee. I think we are finally getting to the heart of the matter as to on why the amendment offered by the Senator from Florida really does make sense and why it saves money and at the same time helps the patients.

I point out that this amendment contains identical language that this Senate has already passed 2 years ago with respect to Medicare and Medicaid—the same language. I frankly think it would not be wise—in fact, I think it would be a mistake—if the Senate were now to turn around and adopt a lower standard of care for Americans with private health insurance plans. It just does not make any sense.

I must also say that both bills appear to provide coverage for emergency services using the prudent layperson standard. At least that is how it appears on the surface. The prudent layperson standard is the standard that guarantees emergency care without prior authorization in any case that a prudent layperson would regard as an emergency. Both bills appear to have that same standard.

The question here is something that is a little bit different. The difference comes down to poststabilization services. The amendment before us today does offer coverage for poststabilization services. The Republican bill does not.

What are poststabilization services? They are those services needed when a patient has been stabilized after a medical emergency. That is afterwards.

Really, the debate about poststabilization comes down to two basic questions: First, is poststabilization care going to be coordinated with the patient's health plan or is it going to be uncoordinated and therefore inefficient?

The second question is: Are decisions about poststabilization care going to be made in a timely fashion; that is, when they are needed, or are we going to allow delays in the decisionmaking process that will compromise patient care and also lead to overcrowding in our Nation's emergency rooms?

Those are the two basic questions. Again, are the poststabilization services going to be coordinated with the health care plan or not; and, second, are these decisions going to be made in a timely fashion?

We have heard a lot of rhetoric about how poststabilization services amount to nothing more than a ''blank check'' for providers. That is the major argument against this amendment. Is it going to provide for a ''blank check'' for doctors, for hospitals, and for emergency care providers? If these provisions are a ''blank check,'' I might ask, then, why did one of the oldest, largest, and most successful managed care organizations in the country, Kaiser-Permanente, help create them in the first place?

Kaiser-Permanente likes this because it knows it makes sense. It helps patient care and it helps reduce costs. Kaiser-Permanente is a strong supporter of the poststabilization provisions in our bill; that is, the provisions offered by the Senator from Florida.

Why does Kaiser-Permanente support this? One simple reason. They realize that coordinating care after a patient is stabilized not only leads to better patient care but—guess what—it also saves money.

Let me give you an example of how the poststabilization services in this amendment can actually save money.

Just last week, while the Senate was in recess, I learned of a 40-year-old woman who went to an emergency room complaining of numbness on the right side of her body. The symptoms began to improve in the emergency room, and she was diagnosed with what her physicians referred to as a ''mini-stroke'' or a ''TIA.'' This condition is a warning sign for the possibility of a more serious, debilitating stroke.

The patient was stabilized in the emergency room, and the emergency physician attempted to contact the patient's physician but was unable to do so. The emergency doc tried to contact the patient's physician but could not. If the poststabilization provisions in our bill had been in place, it may have been possible to send this woman home to continue her tests as an outpatient. It would have been possible. It would have been probable because of the way she was stabilized.

But because the plan and the private physician were not available to provide coordinated and timely followup care, the emergency physician had to admit the patient to the hospital. Now, I am confused. Why don't some of my colleagues support this provision? Why don't they support a provision that provides a pathway to more efficient medical care?

Mr. President, I ask consent to speak for an additional 3 minutes.

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

Mr. BAUCUS. In this case, the outcome is very simple. A patient could have been discharged to home with follow-up care as an outpatient. Instead, she was admitted to the hospital because timely follow-up care couldn't be guaranteed through the health plan. Her hospitalization costs were much higher than the care she would have received as an outpatient.

Now, I must say, too, we have heard many stories about the retrospective denial of coverage for poststabilization services. These services are not optional medical care. That is not what we are talking about. That is a red herring. We are not talking about optional medical care. We are talking about the situation where the emergency doc has time only to make sure the patient is taken care of, either admitted to a hospital poststabilization or coordinate a plan with the patient's doctor, some similar thing, not unrelated or just tangentially related optional medical care. That is a red herring. That is not what we are talking about.

If my colleagues support the Graham-Chafee amendment, it is clear they will be voting for more efficient and more timely medical care. I hope the Republicans will join us to pass the real prudent layperson standard for emergencies. This standard has bipartisan support. It is endorsed by many professional organizations and consumer groups throughout the country.

For example, just this afternoon I received an endorsement by the American Heart Association of the prudent layperson amendment offered by Senators GRAHAM and CHAFEE. The American Heart Association states that the prudent layperson standard is ''essential to their mission of reducing death and disability from cardiovascular disease, the leading cause of death in America.''

The American Heart Association wants this amendment because they know it is right. Kaiser-Permanente wants this amendment because they know it is right. There is no reason why this amendment should not pass, particularly when the same standard applies today because of a law passed by this Congress 2 years ago, to Medicare and Medicaid.

I think it is common sense. I can't believe the objections to this amendment. I hope that after the other side thinks about it a little bit, they will realize that it does make sense and support it.

Mr. President, I ask unanimous consent to have printed in the RECORD a letter to me from the American Heart Association endorsing this amendment.

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

AMERICAN HEART ASSOCIATION,
Washington, DC, July 13, 1999.

Hon. MAX BAUCUS,
U.S. Senate,
Washington, DC.

DEAR SENATOR BAUCUS: On behalf of the 4.2 million volunteers of the American Heart Association, I urge you to support Senator Bob Graham's amendment, to be offered today to the patient protection legislation, which will ensure prompt emergency room access. This amendment is essential to our mission of reducing death and disability from cardiovascular diseases, the leading cause of death in America.

To reduce the devastation caused by cardiovascular diseases, the American Heart Association is committed to educating the public about the warning signs and the symptoms of heart attack and stroke. Acting on this knowledge is often the key to survival. In fact, every minute that passes before returning the heart to a normal rhythm after a cardiac arrest causes the chance of survival to fall by as much as 10 percent. Our consistent message to the public, therefore, is both to know the signs and symptoms of heart attack and stroke and to get emergency care as quickly as possible.

However, unnecessary and burdensome obstacles often stand between the patient and the emergency room door. Insurer ''pre-approval'' processes for emergency care can impede prompt treatment of heart attack and stroke. Delays in treatment can significantly increase mortality and morbidity. Our efforts to educate the public about the importance of getting prompt treatment are severely hindered by these ''pre-approval'' barriers.

The American Heart Association strongly supports Senator Graham's efforts to address these obstacles by ensuring the ''prudent layperson'' definition of emergency.

Thank you for your consideration of this issue. We look forward to your strong support for the Graham amendment.

Sincerely,

DIANE CANOVA, Esq.,
Vice President, Advocacy.

Mr. KENNEDY. Mr. President, HMO's across the country are denying coverage for emergency care, and patients are suffering.

A child has a severe fever, but his parents are forced to drive past the nearest emergency room to a distant facility that participates in the HMO's network. The child's hands and feet are amputated as a result of the delay in getting care.

A middle-aged man has severe chest pain and believes he is having a heart attack, but finds out at the emergency room that it was merely indigestion. His HMO denies payment for the visit, leaving him with an expensive bill for tests to rule out his symptoms.

A woman fractures her skull and is knocked out during a 40-foot fall while hiking. She is airlifted to a local hospital, but her HMO later denies coverage because she did not seek ''pre-authorization'' for emergency treatment.

A teenager dislocates his shoulder in an after-school sports program in Massachusetts. Another student's mother—who happens to be a physician—saves his arm by performing an emergency procedure while waiting for his HMO to send an ambulance to take him to the hospital.

Each case is unique, but all share a common theme. Patients are injured or stuck with the bill because their HMO tries to avoid responsibility for care that should be covered. According to a September, 1998, survey by Harvard University and the Kaiser Family Foundation, one in seven HMO patients report that their plan refused to pay for an emergency room visit, and one in ten say they have difficulty getting emergency care.

Two years ago, Congress passed legislation with strong bipartisan support in the Balanced Budget Act that put a stop to these abuses for Medicare and Medicaid patients. As a result, America's elderly, disabled and low-income citizens can seek care at the nearest hospital—without financial penalty—when they believe they are facing a medical emergency.

The Graham amendment and the Democratic Patients' Bill of Rights, which are strongly supported by the American College of Emergency Physicians, would extend those protections to all 161 million Americans with private health insurance.

The Republican leadership claims to do the same in their proposal, but their so-called protections are missing key parts or are riddled with loopholes. They apply to fewer than one-third of privately insured Americans. According to the American College of Emergency Physicians in a letter dated June 22, 1999, S. 326, as reported out of Committee, ''fails to achieve the promise of its section name. As drafted, [it] calls into serious question the underlying intent of the provision.''

First, the prudent layperson standard applies only if the HMO happens to define emergency medical care exactly as the act does. Thus, plans may be able to avoid the standard simply by changing their definition of emergency care.

Second, even if the prudent layperson standard were to apply, the Republican bill allows plans to charge patients more for going to the nearest emergency department, instead of the HMO's hospital. An amendment was offered in the committee to try to limit cost-sharing for patients who seek care at an out-of-network provider, but conflicting language in the legislation and accompanying Committee Report calls into question the true effect and intent of the amendment. The American College of Emergency Physicians calls the situation ''vague and confusing.'' Clearly, without this assurance, the protections offered by using a prudent layperson standard and removing prior authorization restrictions are moot. Patients will still feel pressured to seek care only at network hospitals—even if it means risking life or limb to get there—because they will fear the financial repercussions that may occur if they go to the nearest emergency room.

Third, the Republican leadership bill does not ensure coverage and coordination of the care that is provided after a patient is stabilized in the emergency room. This is a critically important gap, and an area in which coverage can be confusing and disputes frequent. That is why Congress included coverage for post-stabilization care in the Balanced Budget Act's protections for Medicare patients. Senator HUTCHINSON included it in the legislation he cosponsored with Senator GRAHAM last year. This year, however, Republican support for this important protection has disappeared, leaving millions of patients out in the cold.

Coverage of post-stabilization care will not significally undermine an

HMO's relationships with particular facilities or become a vehicle for a hospital or patient to manipulate the system after care is provided at a non-participating hospital. It simply ensures that patients receive all necessary care before being transferred or discharged, and that they are not left with the bill simply because the HMO turns off its phones at 5 p.m. or refuses to coordinate with the hospital.

Our plan would create a system to ensure that the treating provider and the plan begin a conversation to coordinate care as soon as practical once the patient arrives at the emergency room.

I have heard my Republican colleagues argue that this protection is unnecessary because no hospital will discharge a patient until that patient is sufficiently stabilized. That may be true, but the problem we seek to address here deals with coverage, not treatment. Thanks to the anti-dumping Emergency Medical Treatment and Labor Act, under current law patients should received the care they need when they present with symptoms in an emergency room.

But HMOs do not need to abide by this act—hospitals and doctors do. So, when the hospitals and doctors do their job and provide the care they think is necessary, the insurance company can later deny coverage for the care and patients are stuck with the bill.

The Graham amendment, which I strongly support, would put a stop to this abuse by ensuring that all parties begin discussing proper treatment and coverage options at the earliest possible moment. This amendment is based on Medicare's provisions. It says that insurance companies must use a prudent layperson standard if they cover emergency services. It says patients should not be charged more for going to the closest, but non-participating hospital. And it says that coverage should extend for necessary post-stabilization care, too. Millions of families deserve this protection, and they are waiting for its passage.

Mr. CHAFEE. Mr. President, today I urge my colleagues to join me in supporting meaningful emergency services protection for patients in managed care plans. I am happy to cosponsor this amendment with my good friend, Senator BOB GRAHAM.

This is one area where we should have little difficulty in coming to agreement—we have already extended this critical protection to Medicare and Medicaid beneficiaries as part of the Balanced Budget Act of 1997. Now it is time for the federal government to finish the job and provide all Americans with a single and consistent standard for emergency room coverage. What's good for our Medicare and Medicaid patients should be good for patients in private plans; there is no earthly justification for not extending this basic protection to all Americans. If a plan says it covers emergency medical services, then it ought to do just that—cover legitimate emergencies.

Simply put, this provision establishes reasonable standards to guarantee that patients will have their emergency services covered by their insurance company—regardless of when or where they happen to be faced with the emergency. This question of where the emergency occurs is an important one—the very nature of an emergency situation suggests that the patient will not always have the luxury of going to an emergency room that is part of the plan's network. It is important for patients who reasonably believe they need emergency medical care to receive it without delay.

There are several aspects to this provision that must be included to make it a meaningful protection for patients. I will quickly run through just a few of the most important:

First, protection from higher cost-sharing must apply to emergency services received without prior authorization. When time is of the essence, the patient should not be held to prior authorization requirements.

Second, if the patient is faced with an emergency, he or she should not be charged higher cost-sharing for going to an out-of-network hospital.

Third, the patient must have the assurance that his or her plan will arrange for necessary post-stabilization care—either at the facility where the patient is being treated for the emergency, or at an in-network facility—in a timely fashion. The best way to achieve this is through a reference to the post-stabilization guidelines already established in the Social Security Act.

This so-called ''post-stabilization'' requirement has been widely mischaracterized as requiring plans to pay for a whole host of services unrelated to the emergency condition at hand. However, I want to make clear that the requirement is really one for coordination—that is, the plan must simply communicate with the emergency facility in order to coordinate the patient's post-stabilization care. If the plan fails to communicate with the treating emergency facility, then, and only then, could the plan be held responsible for payment of post-stabilization services. Furthermore, the services must be related to the emergency condition.

Lest anyone doubt the importance of this coordination requirement—for patients and plans alike—all we have to do is look at the experience of Kaiser-Permanente, one of our nation's largest and oldest health insurers. They have found the provision easy to implement, and a money-saver. In a letter to Senator BAUCUS dated June 24, 1999 they write ''Of over two thousand patients transported in this fashion, one third have been discharged to their homes. Without this coordination of care, these patients would have been hospitalized at needless expense.''

All of these features are a part of the current law for Medicare and Medicaid beneficiaries, and have been extended to Federal employees by Executive Order. Patients in private health insurance plans deserve no less protection.

In sum, with passage of this provision, patients will no longer be in the unreasonable position of fearing that payment for emergency room visits will be denied even when these emergency conditions appear to both the patient and emergency room personnel to require urgent treatment. Patients will be assured prompt access to emergency care regardless of whether the emergency happens to occur out of range of an in-network provider.

I thank the Chair.

Mr. GRAHAM. Mr. President, how much time remains on this amendment?

The PRESIDING OFFICER. The Senator from Florida has 17 minutes 11 seconds.

Mr. GRAHAM. Mr. President, I yield myself such time as is necessary and ask to be notified when there are 5 minutes remaining for the proponents of the amendment.

When I spoke earlier, I said the devil was in the details, and I took some time to talk about two of those details, which were the question of cost sharing, whether you went to an emergency room that was inside the HMO's network or outside the network and, therefore, created an economic incentive under the Republican plan to not go to the emergency room that might be closest and most appropriate and, in instances, the life-saving emergency room. Then we talked about poststabilization care, whether the HMO could, by just not answering the telephone, not giving authorization, put the hospital and the patient in the situation where they had to take either a medical risk or an economic risk.

Let me mention two other specific areas which I think deserve the attention of the Senate where there are differences between the Republican and the Democratic proposal.

First is the issue of what is the kind of initial care that one will receive when they go into the emergency room as a prudent layperson. That is, they have exercised common sense as a layperson, that they have a symptom that could be emergent in character and, therefore, they should go to an emergency room.

In the Democratic plan, the definition of the services that will be provided are: A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition. That is the definition of the services to which you are entitled.

In the Republican bill, here is the definition: The plan shall provide coverage for benefits without requiring prior preauthorization for appropriate emergency medical screening examinations.

Now, are we going to get into the situation a week, a month, a year after

the emergency services have been provided that there will be a raging debate between the emergency room physician and the HMO as to whether the services that were provided were appropriate? Or should we not use the language that is in the Democratic provision which clearly states that it will be those services that are within the capability of the emergency department of the hospital?

The second concern is: What is the responsibility of the prudent layperson while you are lying there on the gurney having emergency diagnosis? Under the Republican plan, it states that to the extent that a prudent layperson who possesses an average knowledge of health and medicine would determine such examinations to be necessary to determine whether emergency medical care is necessary.

Do they really mean to say that here is this person who is having symptoms of a heart attack, is stretched out, is attached to all kinds of medical equipment, is obviously in a very distressed physical condition and probably in a very distressed emotional condition, that now this prudent layperson has to be so prudent as to second-guess whether the examinations that the emergency room physician is providing are the kind of examinations that should be provided? Presumably, if the prudent layperson in that almost comatose state doesn't make the right judgment as to what examination the emergency room physician should be rendering, those services won't be covered by the HMO.

That provision is so extreme as to shock the conscience of a prudent layperson who is just reading the language in the Republican bill. I am hopeful that the kind of spirit of common sense that our colleague, Dr. FRIST, the Senator from Tennessee, expressed would apply to focusing on these provisions.

The fortunate aspect of this proposal is that we don't have to totally operate in an environment of hope and guess. As the Senator from Montana stated, it has now been almost 3 years since this Senate and our colleagues in the House of Representatives, and the President of the United States, joined hands to adopt an emergency room provision for Medicare and for Medicaid covering almost 70 million Americans. We have had 3 years of experience under virtually the identical language that is now in the amendment before us.

My exploration with emergency room physicians, who strongly support this amendment, with HCFA, the Federal agency with the responsibility for the administration of the Medicare program in conjunction with the States, of the Medicaid program, have not pointed out that there have been this parade of horribles as a result of that legislation. If someone has other evidence they would like to offer, I urge them to do so.

I do not believe such testimony was given before the Labor Committee, when it considered this legislation, that indicated there had been a cratering of health care services in the emergency room for Medicare or Medicaid beneficiaries, or an escalation of cost as a result of the actions of the Congress and the President just some 3 years ago.

So I suggest that the prudent senatorial course of action on this matter would be to adopt the amendment that is before us. It is an amendment that we have already voted on in previous years as it relates to Medicare and Medicaid. We have a positive track record. We don't need to take chances with the emergency room treatment of the other almost 190 million Americans who are not under Medicare or Medicaid.

So in the spirit of the good will expressed by our colleague from Tennessee, I look forward to a close examination, and I hope that at the conclusion of that examination we will support and reaffirm the wisdom and judgment that we made in 1997.

The PRESIDING OFFICER. Who yields time?

Mr. GRAHAM. Mr. President, I suggest the absence of a quorum and ask unanimous consent that the time be charged to the opponents of the amendment.

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

The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. REID. Mr. President, I ask unanimous consent that the time during the quorum call run against both sides.

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

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. REID. Mr. President, I ask unanimous consent that the time not be charged against either side on this quorum call that I am going to suggest.

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

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. NICKLES. 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. HARKIN. Mr. President, today I stand in support of a strong Patients' Bill of Rights. S. 6, the Democratic leadership bill, is of immense importance to the American people.

Some may ask, is such a bill necessary? Without question, it is. Currently, over 160 million of our family, friends, neighbors and children, are paying good money for health care with no guarantee of proper and appropriate treatment.

We don't have to look too hard to see that there are too many cases where appropriate care is not being provided. We have all heard horror stories of individuals unable to see their doctor in a timely manner * * * of patients unable to access the specialist they need * * * of individuals unable to get coverage for the type of care they believed and expected was covered under their plan.

It's very simple. Insurance either fulfills its promises or it doesn't. And we've heard enough to know that in too many cases it doesn't. Employers and patients pay good money for health care coverage, only to find that they're not getting the coverage they expected. In too many cases, the coverage they expected disappears when the need arises. I didn't have to look very hard to find such situations in my own state of Iowa.

Let me tell you a story about Eric, from Cedar Falls, Iowa, who has health insurance through his employer. Eric is 28 years old, with a wife and two children. He suffered cardiac arrest while helping out at a wrestling clinic. He was rushed to the hospital, where he was resuscitated.

Tragically, while in cardiac arrest, Eric's brain was deprived of oxygen. He fell into a coma and was placed on life support. The neurosurgeon on call recommended that Eric's parents get Eric into rehab.

It was then the problems began. Although Eric's policy covered rehabilitation, his insurance company refused to cover his care at a facility that specialized in patients with brain injury.

Thankfully, Eric's parents were able to find another rehab facility in Iowa. And Eric began to improve. His heart pump was removed, his respirator was removed, and his lungs are now working fine.

But, even with this progress, Eric's family received a call from his insurance company saying they would no longer cover the cost of his rehab, because he is not progressing fast enough.

Eric's mother wrote to me, saying, ''This is when we found out we had absolutely no recourse. They can deny any treatment and even cause death, and they are not responsible.''

This week, here on the Senate floor, we have a critical choice before us. A choice for Eric and his family. A choice between real or illusionary protections. A choice between ensuring care for millions of Americans or for perpetuating the already burgeoning profit margins of the Managed Care industry.

The Republicans have offered a bill that leaves out 115 million people because most of the patient protections in the plan apply only to self-funded employer plans. This would protect only 48 million of the 161 million with private insurance.

Our bill establishes a minimum level of patient protections by which managed care plans must abide. States can—and it's my hope that states will—provide even greater protections, as necessary, for the individuals in such plans in their states. As a starting point, however, we need to pass a strong and substantive managed care reform bill.

The American people want real patient protections.

Our bill, the real Patients' Bill of Rights Act, delivers on what Americans want and need, real protection against insurance company abuse. The bill provides basic protections for Americans, such as:

Access to needed specialists, including access to pediatric specialists;

the guarantee that a patient can see a doctor who is not on their HMO's list if the list does not include a provider qualified to treat their illness;

access to the closest emergency room and coverage of needed emergency care;

the guarantee that patients with ongoing serious conditions like cancer, arthritis, or heart disease can see their oncologist, rheumatologist, or cardiologist without asking permission from their HMO or primary care doctor each time;

the guarantee that patients can continue to see their doctor through a course of treatment or a pregnancy, even if their HMO drops their doctor from its list or their employer changes HMOs;

the guarantee that patients can get the prescription drug their doctor says they need, not an inferior substitute the HMO chooses because it's cheaper;

access to quality clinical trials for those with no other hope;

the ability to appeal an HMO's decision to deny or delay care to an independent entity and receive timely, binding decisions;

and, finally, the right to hold HMOs accountable when their decisions to deny or delay care lead to injury or death. Most situations will be resolved through our appeals mechanism. However, I believe that HMOs and insurers should not have special immunity when they harm patients.

No one can argue with the need to ensure access and quality of care for Americans. Over 200 organizations representing patients, consumers, doctors, nurses, women, children, people with disabilities, small businesses, and people of faith support the Democrats' Patients' Bill of Rights.

The Majority pretends that their bill offers real patient protections, but when you read everything below the title, it reads more like an insurers' bill of rights.

We have a chance to pass real and responsible legislation. The time for real reform is now. The American people have been in the waiting room for too long.

TRIBUTE TO JEANMARIE HICKS

Mr. DASCHLE. Mr. President, today I would like to take a moment to acknowledge a remarkable young woman from Rapid City, South Dakota, Jeanmarie Hicks, who was recently selected as the National Winner in the 1999 National Peace Essay Contest sponsored by the United States Institute of Peace.

This year more than 2,500 high school students from all 50 states were asked to express their thoughts on the topic of preventing international violent conflict. Winners from each state were awarded a $1,000 college scholarship and invited to participate in a week of special activities here in Washington. The National Winner receives an additional $10,000 college scholarship.

Jeanmarie Hicks, who recently graduated as valedictorian from St. Thomas More High School in Rapid City, wrote an eloquent essay entitled ''Preventive Diplomacy in the Iraq-Kuwait Dispute and in the Venezuela Border Dispute.'' In addition to her writing skills, Jeanmarie recently took first place in South Dakota in both the National French Contest and the National Spanish Contest, and will attend the College of St. Benedict in Minnesota this fall.

I know my colleagues join me in congratulating Jeanmarie on all of her accomplishments, and I ask unanimous consent that her essay be printed in the RECORD.

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

PREVENTIVE DIPLOMACY IN THE IRAQ-KUWAIT DISPUTE AND IN THE VENEZUELAN BORDER DISPUTE

(By Jeanmarie Hicks, St. Thomas More High School, January 22, 1999)

''Too little, too late'' often in the prevention of violent conflicts holds true (Peck). When the roots of the problem are not identified in time, violence becomes the solution. Preventive diplomacy, one way of avoiding conflicts, can be defined as ''action to prevent disputes from arising among parties to prevent existing disputes from escalating into conflicts, and to limit the spread of the latter when they occur'' (Boutros-Ghali 45).

Preventive diplomacy protects peace and ultimately people, who suffer greatly in armed conflicts. Preventive diplomacy has been used in many disputes, including the border dispute in Venezuela with Great Britain in the 1890s and in this decade's Iraq-Kuwait dispute. Conflict was prevented in Venezuela. However, preventive action was not effective in Kuwait; and civilians suffered as a result.

The United States' intervention in the border dispute in Venezuela is one example of preventive diplomacy. Unfortunately, the border between Guyana and Venezuela was never clearly defined; and colonial maps were inaccurate (Lombardi 29). From the 1840s until the 1880s, Britain pushed into Venezuela over Guyana's western border by claiming the area's gold (Lombardi 29), and by asserting that the land from the Rio Essequibo to the Orinoco was part of Guyana (Schomburgk Line) according to colonial maps (Daly 2). Britain was vehement about its right to the land, and Venezuela appealed to the U.S. for aid. Under the Monroe Doctrine, the U.S. states that it will act as a police force to protect Latin America from European influence. The U.S. viewed Britain's occupation of a portion of Venezuela as a breech of the doctrine (Cleveland 93).

Conflict was imminent, as Britain began to prepare its navy for war (Boutwell 4). A solution appeared in 1895 in the person of Secretary of State Richard Olney, Enthusiastic to attempt preventive diplomacy, Olney sent a dispatch to Britain stressing the importance of the Monroe Doctrine. Lord Salisbury of Britain responded, saying that the Monroe Doctrine was not applicable in the Venezuela situation, as no system of government was being forced upon the country (Cleveland 100–101). In addition, Salisbury pointed out that the conflict was not the result of the acquisition of new territory: Guyana owned the territory in question (Boutwell 10).

Olney stressed that the issue was pertinent to American stability, and remained steadfast in his demands (Cleveland 109). When Britain refused to submit, Congress authorized the president's appointment of an investigative committee. Meanwhile, Salisbury and Olney organized a meeting for November 10, 1896. At the meeting, a treaty was written; and the U.S. threatened to use its military to remove Britain from Venezuela's border if necessary. Britain and Venezuela signed the treaty on February 2, 1897, giving Venezuela control of the Rio Orinocco and much of the land behind the Schomburgk Line (Cleveland 117–118). Thus preventive diplomacy on the part of the U.S. was successful, and war was avoided.

The use of preventive diplomacy in the recent Iraq-Kuwait dispute was less successful. Iraq had been part of the Ottoman Empire from the 1700s until 1899, when Britain granted it autonomy (Darwish and Alexander 6). When in 1961, Britain gave Kuwait independence, Iraq claimed that, historically, Kuwait was part of Iraq (Sasson 9). Iraq begrudgingly recognized Kuwait's independence in 1963.

For awhile, relations between the two countries improved as Kuwait aided Iraq monetarily in the Iran-Iraq War (1980 until 1988) (Sasson 11). After the war, however, Iraq demanded money from Kuwait for reconstruction. Then Iraq accused Kuwait of drilling oil from the border without sharing and of taking more oil than the Organization of Petroleum Exporting Countries (OPEC) quota permitted (Sasson 12). Iraq began to threaten Kuwait borders, beginning a conflict that would take thousands of soldiers away from their homes, harm civilians, and detrimentally affect the environment.

In 1990, Iraq began to mobilize near the Kuwait border (Darwish and Alexander 6). Arab nations made unsuccessful attempts at preventive diplomacy (U.S. News & World Report 99). Surrounding nations attempted unsuccessfully to meet with Saddam Hussein. Iraq invaded Kuwait, took control of its capital on August 2, 1990, and installed a puppet government under Hussein's command. Iraqi soldiers brutally raped Kuwaiti women, and killed any civilian who was considered an obstruction (Sasson 76). At this point, the United Nations Security Council and the Arab League placed an embargo on Iraqi oil as punishment. Iraq, in response, annexed Kuwait (U.S. News & World Report 95–96).

War was imminent. On November 29, 1990, Iraq showed no signs that it would retreat. The United Nations Security Council declared that the coalition should use all

means to expel Iraq from Kuwait if Iraq remained there after January 15, 1991 (Gordon and Trainor 195). In a final attempt at preventive diplomacy on January 9, James Baker of the U.S. met with Iraq's foreign minister, Tariq Aziz. Baker stressed that the coalition was willing to fight, and encouraged Iraq to leave Kuwait (U.S. News & World Report 199). Iraq, however, refused to retreat; and Hussein declared that Iraq would fight a ''holy war'' for Kuwait. The world realized that war was the only means of solving the problem (Gordon and Trainor 197–198).

Air assaults began on January 17, and land war began on February 24 (U.S. News & World Report). Iraqi civilian casualties were heavy. The land war lasted only 100 hours, but numerous oil wells were set afire, causing the emission of dangerous gases. Peace was never truly made. Hussein resisted the requirements for peace, including frequent United Nations inspections and the prohibition of possession of nuclear weapons (U.S. New & World Report 447).

The consequences of the Iraq-Kuwait conflict are grave. Civilians of both Iraq and Kuwait suffered. Fires in oil wells caused dangerous air pollution. American soldiers suffer from the so-called Gulf War Syndrome, which has caused a number of afflictions and death. The Syndrome is believed to have resulted from the biological and chemical weapons and the gases emitted by the oil wells (Eddington 1–2).

As illustrated, preventive diplomacy can affect the outcome of imminent disputes. Various factors affect its success. In the Venezuela border dispute, preventive diplomacy was effective for several reasons. First, the problem was recognized early; and neither side was truly battle-ready. Second, the problem was contained, in that only four nations (Venezuela, Britain, Guyana, and the U.S.) were involved. Finally, both sides were willing to cooperate: the U.S. supported the Monroe Doctrine, and Britain decided that the border area was not worth war.

Preventive diplomacy was not effective in the Iraq-Kuwait dispute. First, the problem was not recognized and acted upon until Iraq had mobilized in Kuwait. Second, many nations were involved in the conflict, putting Iraq on the defensive. Problem solving was made a worldwide effort rather than an isolated effort concerning Iraq, Kuwait, and a few mediators. Finally, Hussein and the Iraqis were and remain unwilling to cooperate for peace, as illustrated by the recent problems with weapons' inspections.

With increasingly powerful weapons of mass destruction, preventive diplomacy is particularly important. Moreover, preventing crises is more effective than dealing with the consequences of armed conflict (USIA Electronic Journals). Consequently, some factors could be initiated to make preventive diplomacy more effective in the future. First, nations must learn about other nations' cultures in order to learn respect for the people (''Stopping War Before It Starts''). Children should be taught about the other countries' histories and cultures in school; and current information about events abroad should be readily available to the public. Secondly, acceptable political behavior must be explicitly defined by an international council that all nations will be aware of the consequences of their actions (Kennan 83). The ownership of nuclear weapons, for example, should be limited. An international council would deal with breaches of the rule by inspections, reprimands, and military action, if necessary.

Preventive diplomacy centers must be established in all regions (Peck). Each center would have professional peacemakers and staffs, and report to the previously mentioned international council, for international cooperation is important in the prevention of war in that all nations must cooperate to maintain good relations, and thus peace (''Preventive Diplomacy in Action''). The centers would watch for signs of conflict, study causes, and train diplomats. With centers in all regions, conflicts could be dealt with immediately. The involved nations would not need to feel threatened, unless preventive diplomacy is refused, in which case, the nations in the council would unite militarily to maintain peace. If a potential conflict was identified, the center would react by gathering representatives from each party (Peck). The center's diplomats would facilitate negotiation by suggesting ways to make concessions; and hopefully, war would be prevented.

Preventive diplomacy, when used effectively as in Venezuela, aids in the avoiding of armed conflict. However, as apparent in the tragedy in the Iraq-Kuwait dispute, when preventive diplomacy is not effective, people on both sides of the conflict and resources suffer. Certain measures, including regional centers, the consolidation of the problem, and cooperation, should be taken for optimum effectiveness. Preventive diplomacy can make the difference between bloodshed and peace, which is necessary for survival in these times of technological advances in weaponry. As Abraham Lincoln said in his second inaugural address, ''Let us strive . . . to do all which may achieve a just and lasting peace among ourselves and all nations'' (qtd. in Boutwell 16).

INTELLECTUAL PROPERTY BILLS

Mr. LEAHY. Mr. President, on July 1, 1999, just before last week's recess, the Senate passed four bills which Senator HATCH and I had joined in introducing and which the Judiciary Committee had unanimously reported on the same day as Senate passage. These four bills would reauthorize the Patent and Trademark Office, update the statutory damages available under the Copyright Act, make technical corrections to two new copyright laws enacted last year, and prevent trademark dilution. Each of these bills makes important improvements to our intellectual property laws, and I congratulate Senator HATCH for his leadership in moving these bills promptly through the Committee and the Senate.

Passage of these four bills is a good start, but we must not lose sight of the other copyright and patent issues requiring our attention before the end of this Congress. The Senate Judiciary Committee has a full slate of intellectual property matters to consider and I am pleased to work on a bipartisan basis with the chairman on an agenda to provide the creators and inventors of copyrighted and patented works with the protection they may need in our global economy, while at the same time providing libraries, educational institutions and other users with the clarity they need as to what constitutes a fair use of such works.

Among the other important intellectual property matters for us to consider are the following:

Distance education. The Senate Judiciary Committee held a hearing in May on the Copyright Office's thorough and balanced report on copyright and digital distance education. We need to address the legislative recommendations outlined in that report to ensure that our laws permit the appropriate use of copyrighted works in valid distance learning activities.

Patent reform. A critical matter on the intellectual property agenda, important to the nation's economic future, is reform of our patent laws. I worked on a bipartisan basis in the last Congress to get the Omnibus Patent Act, S. 507, reported by the Judiciary Committee to the Senate by a vote of 17 to one, and then tried to have this bill considered and passed by the Senate. Unfortunately, the bill became stalled due to resistance by some in the majority. We should consider and pass this important legislation.

Madrid Protocol Implementation Act. I introduced this legislation, S. 671, to help American businesses, and especially small and medium-sized companies, protect their trademarks as they expand into international markets by conforming American trademark application procedures to the terms of the Protocol in anticipation of the U.S.'s eventual ratification of the treaty. Ratification by the United States of this treaty would help create a ''one stop'' international trademark registration process, which would be an enormous benefit for American businesses.

Database protection. I noted upon passage of the Digital Millennium Copyright Act last year that there was not enough time before the end of that Congress to give due consideration to the issue of database protection, and that I hoped the Senate Judiciary Committee would hold hearings and consider database protection legislation in this Congress, with a commitment to make more progress. I support legal protection against commercial misappropriation of collections of information, but am sensitive to the concerns raised by the Administration, the libraries, certain educational institutions, and the scientific community. This is a complex and important matter that I look forward to considering in this Congress.

Tampering with product identification codes. Product identification codes provide a means for manufacturers to track their goods, which can be important to protect consumers in cases of defective, tainted or harmful products and to implement product recalls. Defacing, removing or tampering with product identification codes can thwart these tracking efforts, with potential safety consequences for American consumers. We should examine the scope of, and legislative solutions to remedy, this problem.

Online trademark protection or ''cybersquatting.'' I have long been concerned with protection online of registered trademarks. Indeed, when the Congress passed the Federal Trademark Dilution Act of 1995, I noted that:

[A]lthough no one else has yet considered this application, it is my hope that this

antidilution statute can help stem the use of deceptive Internet addresses taken by those who are choosing marks that are associated with the products and reputations of others. (CONGRESSIONAL RECORD, December 29, 1995, page S19312).

Last year, my amendment authorizing a study by the National Research Council of the National Academy of Sciences of the effects on trademark holders of adding new top-level domain names and requesting recommendations on related dispute resolution procedures, was enacted as part of the Next Generation Internet Research Act. We have not yet seen the results of that study, and I understand that the Internet Corporation for Assigned Names and Numbers (I–CANN) and World Intellectual Property Organization (WIPO) are considering mechanisms for resolving trademark and other disputes over assignments of domain names in an expeditious and inexpensive manner.

This is an important issue both for trademark holders and for the future of the global Internet. While I share the concerns of trademark holders over what WIPO has characterized as ''predatory and parasitical practices by a minority of domain registrants acting in bad faith'' to register famous or well-known marks of others—which can lead to consumer confusion or downright fraud—the Congress should tread carefully to ensure that any remedies do not impede or stifle the free flow of information on the Internet. I know that the Chairman shares my concerns and that working together we can find legislative solutions which make sense.

As detailed below, the four intellectual property bills by the Senate will help foster the growth of America's creative industries.

S. 1257, THE DIGITAL THEFT DETERRENCE AND COPYRIGHT DAMAGES IMPROVEMENT ACT OF 1999

I have long been concerned about reducing the levels of software piracy in this country and around the world. The theft of digital copyrighted works and, in particular, of software results in lost jobs to American workers, lost taxes to Federal and State governments, and lost revenue to American companies. A recent report released by the Business Software Alliance estimates that worldwide theft of copyrighted software in 1998 amounted to nearly $11 billion. According to the report, if this ''pirated software had instead been legally purchased, the industry would have been able to employ 32,700 more people. In 2008, if software piracy remains at its current rate, 52,700 jobs will be lost in the core software industry.'' This theft also reflects losses of $991 million in tax revenue in the United States.

These statistics about the harm done to our economy by theft of copyrighted software alone, prompted me to introduce the ''Criminal Copyright Improvement Act'' in both the 104th and 105th Congresses, and work over those two Congresses for passage of this legislation, which was finally enacted as the ''No Electronic Theft Act.'' The current rates of software piracy show that we need to do better to combat this theft, both with enforcement of our current copyright laws and with strengthened copyright laws to deter potential infringes.

The Hatch-Leahy-Schumer ''Digital Theft Deterrence and Copyright Damages Improvement Act'' would help provide additional deterrence by amending the Copyright Act, 17 U.S.C. §504(c), to increase the amounts of statutory damages recoverable for copyright infringements. These amounts were last increased in 1988 when the United States acceded to the Berne Convention. Specifically, the bill would increase the cap on statutory damages by 50 percent, raising the minimum from $500 to $750 and raising the maximum from $20,000 to $30,000. In addition, the bill would raise from $100,000 to $150,000 the amount of statutory damages for willful infringements.

Courts determining the amount of statutory damages in any given case would have discretion to impose damages within these statutory ranges at just and appropriate levels, depending on the harm caused, ill-gotten profits obtained and the gravity of the offense. The bill preserves provisions of the current law allowing the court to reduce the award of statutory damages to as little as $200 in cases of innocent infringement and requiring the court to remit damages in certain cases involving nonprofit educational institutions, libraries, archives, or public broadcasting entities.

In addition, the bill would create a new tier of statutory damages allowing a court to award damages in the amount of $250,000 per infringed work where the infringement is part of a willful and repeated pattern or practice of infringement. I note that the House version of this legislation, H.R. 1761, omits any scienter requirement for the new proposed enhanced penalty for infringers who engage in a repeated pattern of infringement. I share the concerns raised by the Copyright Office that this provision, absent a willfulness scienter requirement, would permit imposition of the enhanced penalty even against a person who negligently, albeit repeatedly, engaged in acts of infringement. The Hatch-Leahy-Schumer bill avoids casting such a wide net, which could chill legitimate fair uses of copyrighted works.

S. 1258, THE PATENT FEE INTEGRITY AND INNOVATION PROTECTION ACT OF 1999

The Patent Fee Integrity and Innovation Protection Act would reauthorize the Patent and Trademark Office for fiscal year 2000, on terms that ensure the fees collected from users will be used to operate the Patent and Trademark Office and not diverted to other uses.

The PTO is fully funded and operated through the payment of application and user fees. Indeed, taxpayer support for the operations of the PTO was eliminated in the Omnibus Budget Reconciliation Act of 1990, which imposed a large fee increase (referred to as a ''surcharge'') on those who use the PTO, namely businesses and inventors applying for or seeking to protect patents on trademarks.

The fees accumulated from the surcharge were held in a surcharge account, for use by the PTO to support the patent and trademark systems. Unfortunately, however, the funds in the surcharge account were also diverted to fund other, unrelated government programs. By fiscal year 1997, almost $54 million from the surcharge account was diverted from PTO operations.

Last year, Congress responded to this diversion of PTO fees by enacting H.R. 3723/S. 507, which the chairman and I had introduced on March 20, 1997. That legislation authorized a schedule of fees to fund the PTO, but no other government program, and resulted in the first decrease in patent application fees in at least 50 years.

This PTO reauthorization bill would make $116,000,000 available to the Patent and Trademark Office, a self-sustaining agency, to pay for salaries and necessary expenses in FY 2000. This money reflects the amount in carryover funds from FY99 that PTO expects to receive from fees collected, pursuant to the Patent Act and the Trademark Act. By authorizing the money to go to PTO, the bill would avoid diversion of these fees to other government agencies and programs. Inventors and the business community who rely on the patent and trademark systems do not want the fees they pay to be diverted but would rather see this money spent on PTO upgraded equipment, additional examiners and expert personnel or other items to make the systems more efficient. This bill would ensure those fees are not diverted from important PTO operations.

S. 1260, COPYRIGHT ACT TECHNICAL CORRECTIONS ACT

In the last Congress, Senator HATCH and I worked together for passage of the Digital Millennium Copyright Act (DMCA) and the Sonny Bono Copyright Term Extension Act. This significant legislation is intended to encourage copyright owners to make their works available online by updating the copyright laws with additional protections for digital works, and conforming copyright terms available to American authors to those available overseas. The Hatch-Leahy substitute amendment to this bill adopted by the Judiciary Committee and passed by the Senate, makes only technical and conforming changes to those new laws and the Copyright Act.

S. 1259, THE TRADE AMENDMENTS ACT OF 1999

The Hatch-Leahy Trademark Amendments Act is significant legislation to enhance protection for trademark owners and consumers by making it possible to prevent trademark dilution before it occurs, by clarifying the remedies available under the Federal trademark dilution statute when it does occur, by providing recourse

against the Federal Government for its infringement of others' trademarks, and by creating greater certainty and uniformity in the area of trade dress protection.

Current law provides for injunctive relief after an identical or similar mark has been in use and has caused actual dilution of a famous mark, but provides no means to oppose an application for a mark or to cancel a registered mark that will result in dilution of the holder's famous mark. In *Babson Bros. Co. v. Surge Power Corp.*, 39 USPQ 2d. 1953 (TTAB 1996), the Trademark Trial and Appeals Board (TTAB) held that it was not authorized by the ''Federal Trademark Dilution Act'' to consider dilution as grounds for opposition or cancellation of a registration. The bill remedies this situation by authorizing the TTAB to consider dilution as grounds for refusal to register a mark or for cancellation of a registered mark. This would permit the trademark owner to oppose registration or to petition for cancellation of a diluting mark, and thereby prevent needless harm to the good will and distinctiveness of many trademarks and make enforcing the Federal dilution statute less costly and time consuming for all involved.

Second, the bill clarifies the trademark remedies available in dilution cases, including injunctive relief, defendant's profits, damages, costs, and, in exceptional cases, reasonably attorney fees, and the destruction of articles containing the diluting mark.

Third, the bill amends the Lanham Act to allow for private citizens and corporate entities to sue the Federal Government for trademark infringement and dilution. Currently, the Federal Government may not be sued for trademark infringement, even though the Federal Government competes in some areas with private business and may sue others for infringement. This bill would level the playing field, and make the Federal Government subject to suit for trademark infringement and dilution. I note that the Lanham Act also subjects the States to suit, but that provision has now been held unconstitutional. Last week, the Supreme Court held in *College Savings Bank versus Florida Prepaid Postsecondary Education Expense Board* that federal courts were without authority to entertain these suits for false and misleading advertising, absent the State's waiver of sovereign immunity. This case (as well as the other two Supreme Court cases decided the same day), raise a number of important copyright, federalism and other issues, but do not effect the provision in the bill that waives Federal government immunity from suit.

Fouirth, the bill provides a limited amendment to the Lanham Act to provide that in an action for trade dress infringement, where the matter sought to be protected is not registered with the PTO, the plaintiff has the burden of proving that the trade dress is not functional. This will help promote fair competition and provide an incentive for registration.

Finally, this bill makes a number of technical ''clean-up'' amendments relating to the ''Trademark Law Treaty Implementation Act,'' which was enacted at the end of the last Congress.

These bills represent a good start on the work before the Senate Judiciary Committee to update American intellectual property law to ensure that it serves to advance and protect American interests both here and abroad. I began, however, with the list of copyright, patent and trademark issues that we should also address. We have a lot more work to do.

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business Friday, July 9, 1999, the Federal debt stood at $5,623,337,708,599.03 (Five trillion, six hundred twenty-three billion, three hundred thirty-seven million, seven hundred eight thousand, five hundred ninety-nine dollars and three cents).

One year ago, July 9, 1998, the Federal debt stood at $5,526,093,000,000 (Five trillion, five hundred twenty-six billion, ninety-three million).

Fifteen years ago, July 9, 1984, the Federal debt stood at $1,535,474,000,000 (One trillion, five hundred thirty-five billion, four hundred seventy-four million).

Twenty-five years ago, July 9, 1974, the Federal debt stood at $471,954,000,000 (Four hundred seventy-one billion, nine hundred fifty-four million) which reflects a debt increase of more than $5 trillion—$5,151,383,708,599.03 (Five trillion, one hundred fifty-one billion, three hundred eighty-three million, seven hundred eight thousand, five hundred ninety-nine dollars and three cents) during the past 25 years.

PRESIDENT BUSH'S 75TH BIRTHDAY

Mr. LUGAR. Mr. President, it would be remarkable for any American to celebrate his or her 75th birthday by skydiving, but it is even more remarkable when that person is the former President of the United States. I would expect no less however, of former president George Bush.

From the South Pacific to China to the White House, he has been as brave and bold in honorably serving his country as he has been in his private life. His leadership in holding together the international coalition during the Gulf War seems even more remarkable in recent years, as other attempts to hold together a Persian Gulf alliance have failed.

Mr. President, I am pleased to join the Senator from Connecticut, Mr. LIEBERMAN, in bringing attention to a wonderful story by the indefatigable White House Correspondent, Trude Feldman. Few people could provide such insight in profiling President George Bush on the occasion of his 75th birthday.

Mr. LIEBERMAN. Mr. President, I rise today on behalf of Senator LUGAR and myself to note the passing of another milestone for former President George Bush, a man the State of Connecticut considers a native son. President Bush recently celebrated his 75th birthday in his typically exuberant fashion, by jumping out of an airplane, just as he did on his 70th birthday.

After such a long and distinguished career of public service—which started in the South Pacific, where he put his life on the line for the cause of freedom, and which culminated in the Persian Gulf, where he put his Presidency on the line to stand up to the brutal aggression of Saddam Hussein—it's hard for some to believe that President Bush would have the interest, let alone the energy, to pursue his sky-diving habit as a septuagenarian.

But no one has ever accused the man who assembled and led the Gulf War coalition to victory of taking the easy way out. And today, much as we have grown to appreciate the fortitude and unobtrusive dignity he brought to the Presidency, so too can we admire the vitality and vigor he has brought to his life outside the Oval Office. He has shown himself to be a man for all seasons, not to mention all altitudes.

Those estimable characteristics were vividly captured in a profile recently penned by White House correspondent Trude B. Feldman to commemorate President's Bush's birthday. To pay tribute to President Bush on the passing of this important milestone, and in the spirit of bipartisanship, I would join with Senator LUGAR in asking unanimous consent to print the full text of Ms. Feldman's article in the RECORD.

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

[From the Los Angeles Times International]

GEORGE BUSH AT 75

(By Trude B. Feldman)

George Bush, the former President of the United States, just turned 75 years old, and says, ''It doesn't hurt a bit.''

In an interview to mark the milestone, he adds: ''I am blessed with good health—very good health. Oh, one hip might need replacing and the other might need a little shot of something, but I still fast-walk—13 minutes per mile—enough to get the aerobic effect going, yet not enough to pound the old joints into agony.''

Nonetheless, prior to his birthday, he took another parachute jump on the grounds of his presidential library at Texas A & M University in College Station, Texas. The next day, he participated in a fund-raising event for his Number One cause—the fight against cancer—that will highlight the role the Houston-based M.D. Anderson Cancer Center has played in that fight. (It was leukemia that took the life of the Bushes' daughter, Robin, in 1953 before her 4th birthday. George Bush's father, Prescott S. Bush, a U.S. senator from Connecticut (1953–62), also died of cancer—of the lung—on Oct. 8, 1972, at age 77.)

The father of five children—two of whom are the governors of America's second and fourth largest states—George Bush told me: ''Last November, when George W. was re-elected governor of Texas and Jeb (John Ellis Bush) was elected governor of Florida, I was happier than when I was elected President of the United States 10 years before.''

After his Inauguration as the 41st President on Jan. 20, 1989, George Bush went to the Oval Office in the White House. In the top drawer of the presidential desk, he found a handwritten note from President Ronald Reagan. On stationery headed ''Don't Let the Turkeys Get You Down,'' the note read ''Dear George, You will have moments when you want to use this stationery. Well, go to it. I treasure the memories we share and wish you the very best. You will be in my prayers. God bless you and Barbara. I will miss our Thursday lunches . . . Ron.''

As President and Vice President (from 1981 to 1989), the two men ate lunch together every Thursday in the Oval Office and shared each others' views on domestic issues and foreign affairs as well as personal sentiments. To this day, neither one has revealed those conversations. Despite their fierce competition in the presidential primaries in 1980, Mr. Bush had been genuinely loyal to Mr. Reagan in eight years as Vice President.

Five years ago, while preparing a feature for George Bush's 70th birthday, I asked Ronald Reagan about those private lunches. While not disclosing much of the substance of their sessions, he did tell me that Mr. Bush was much more than a silent partner and that his solid advice was always valued.

''From those luncheons and from our constant interaction, I got to know him well,'' Ronald Reagan told me. ''He was always informed, understanding and decent. He was also wise, honest and capable.''

Mr. Reagan added: ''No American Vice President should sit on the sidelines, waiting; he should be like an executive vice president of a corporation—active—and George was all that. He was a part of all we did—during times of crises and times of historic triumphs and achievements.''

In our interview, Mr. Reagan also recalled: ''As Vice President, George led the task force to cut away excess regulation, saving Americans 600 million man-hours of paperwork a year and making possible millions of new jobs. He also worked with our allies to strengthen NATO; and he helped make possible the new INF (Intermediate-Range Nuclear Forces) Treaty. I'd say he helped to make our world much safer.''

Ronald Reagan noted that Mr. Bush also had launched a successful major offensive against drug smuggling that succeeded in blocking a record 70 tons of cocaine from ever reaching our communities. ''In addition, he handled our Task Force on Terrorism that advised me on policy,'' Mr. Reagan said. ''He was the architect of the plans we put into effect.''

In defending Mr. Bush's role in the Iran-Contra affair—the crisis that engulfed and threatened his presidency—Mr. Reagan emphasized: ''George had been completely honest. He was supportive of our policy—to establish communication with the pragmatic leadership in Iran with the goal of eventually renewing U.S.-Iranian relations. Yes, he had some reservations, but that often happened with other issues. For example, when we discussed and debated any policy at our Cabinet meetings—some Cabinet members still had reservations after I made a decision. But once the decision was made, they supported it. That's what George did—he supported my decision.''

According to George Bush, who visited with Ronald Reagan two years ago, it was President Reagan who had set the stage for the world to change. ''President Reagan contributed by building a foundation of principles that is solid,'' Mr. Bush remembers, ''and I was proud to build upon that.''

Born in June 1924, in Milton, Mass., George Herbert Walker Bush was named for his mother's father. George Bush's mother, Dorothy, died of a stroke at age 91. ''Even at 90 she was the moral leader of our family and the idol of our children and grandchildren,'' he recalls. ''I often think of her advice on the fundamentals—to be tolerant, to turn the other cheek, to stand against discrimination and for fair play.'' He credits her with instilling in him a respect for principles and values that motivate him to this day. ''She was the personification of everything that is good, everything that is for our family—the Christian ethic,'' he adds. ''She set examples. She would discipline us, then put her arms around us and love us.''

The Rev. Billy Graham, who first met George Bush through his relationship with the senior Bushes, describes Dorothy Bush as a ''woman of God, a wonderful Bible student, who constantly emphasized spirituality, honesty and integrity.''

In an interview, Rev. Graham also told me that George Bush is ''one of the best and most loyal friends I ever had. I admire him for the way he loves his family and friends; for the way he handled his near-death experience in World War II when his plane was shot down; and for his courageous speeches on controversial issues.''

Describing George Bush as ''one of America's greatest presidents who provided excellent leadership and brought to the office close family ties and strong religious faith,'' Rev. Graham adds that Mr. Bush had also put the presidency on a high level and maintained the dignity of the office that Ronald Reagan bequeathed to him.

Rev. Graham led the prayers at George Bush's Inauguration for President in 1989 as well as for the swearing-in ceremonies for Gov. George W. Bush in 1995 and Gov. Jeb Bush in 1999.

While George Bush was the leader of the Free World, his five children knew him as their loving, attentive father—a constant, guiding influence on their lives. They, in turn, have proven to be loving children who did their part to give him a lasting place in history as well as to sustain his pride in them. In addition to the two governor sons—there are Marvin and Neil, both businessmen, and Dorothy (Doro), still the apple of her father's eye.

At the time of Doro's birth, in August 1959, in Houston, Texas, her father was in the offshore oil-drilling business. Since then, he has been a two-term congressman from Texas (1967–71); U.S. Ambassador to the United Nations (1971–73); chairman of the Republican National Committee (1973–74); chief of the U.S. Liaison office in Beijing (1974); director of the Central Intelligence Agency (1976); Vice President of the United States (1981–89), and President of the United States (1989–93).

Rather than complain about the demands on her peripatetic father's time over the years, Doro expresses pride in his achievements and reflects on their relationship. She says her father has given her a strong sense of security and has enhanced her life. ''No matter how hard he worked in his various jobs, he took time for family, friends and small kindnesses, which really meant so much,'' she adds. ''I'm now the mother of four children, and I try to instill my dad's teachings in them.''

She says that his high positions did not change him as a father—that he has always had a gentle, personal touch and, to this day, continues to care about the details in each of his children's lives. ''He still writes us special notes,'' she says, ''and his sense of humor and optimistic outlook haven't changed. And now, even on his 75th birthday, he isn't comfortable focusing attention on himself.''

George Bush says that he has allowed his children to do their own thing. ''Barbara and I decided that they were strong enough to chart their own course, to lead their own lives,'' he says. ''They do not often need fine-tuning advice from their parents.''

As for Marvin, Neil and Doro, he says, they are good children and happy out of politics. ''George and Jeb, in spite of the ugliness of the times, have decided to get into politics,'' he told me. ''Having two sons as governors is a blessing that I cannot describe. I am proud of them and I don't want to see them hurt in what, unfortunately, has become a mean, intrusive political climate. They are honest and honorable men with wonderful families of their own and with nothing to be ashamed of. But some in the press have literally gone well beyond the bounds of just plain common decency. And, as you know, I have disdain for the policies of destruction.''

Why, then, I asked, in view of today's destructive atmosphere, does George Bush want his two sons in the political arena?

''Because,'' he responds, ''I believe if good and competent people are unwilling to get involved, our whole system of democracy is diminished.''

When contemplating his legacy, does he think in terms of his two governor sons as being an extension of him?

''Regarding George W. and Jeb, I do not think in terms of legacy,'' he replies. ''I just take great pride in two extraordinarily able and strong men who, on their own—without their father's help—have already gone a long way.''

He adds that marrying the mother of his five kids was the best decision he made in his personal life. ''That was 54½ years ago,'' George Bush reminisces. ''I first met Barbara Pierce at a Christmas party, just after Pearl Harbor was attacked. I was 17 and she was 16. The U.S. was at war, so ours was a wartime romance. Ever since, to me, it has been a classic love story.

''We found we had much in common, even our sense of humor. When I graduated from Phillips Exeter Academy (a preparatory school in Andover, Mass., on June 4, 1942), I took Barbara to the senior prom.''

Eight days, later, his 18th birthday, he enlisted in the U.S. Navy as a Seaman Second Class. In 1943, he earned his wings and was commissioned as the youngest naval aviator, assigned to USS San Jacinto in the Pacific.

At the time of his marriage, on Jan. 6, 1945, a man under 21 years of age needed parental consent to marry; a woman over 18 did not. Mr. Bush's brother, Prescott, remembers that 19½-year-old Barbara was ''really ticked'' that her 20½-year-old fiancé—a war hero with a Distinguished Flying Cross—had to get his parents' permission to marry. And despite teasing suggestions that two Geminis are usually not compatible—the ''warnings'' still amuse the Bushes. (Mrs. Bush was also born in June—on the 8th.) She recalls that the timing of their wedding was determined by world events, because had it not been for the war, she believes neither family would have consented to their marrying at that young age.

Today, Mr. Bush admits to many disappointments—personally and in politics, even in the Oval Office—''but none that have shaken our happy marriage.''

As a boy, George Bush often went to Yankee Stadium (in New York) with his father and had youthful hopes of one day playing first base there. Years later, when baseball great Babe Ruth came to Yale University to present his papers at a ceremony at the stadium, George Bush, as captain of the

baseball team, was chosen to receive the papers in behalf of the university. (Mr. Bush graduated Phi Beta Kappa with a degree in economics from Yale in 1948—the year Babe Ruth died.)

''Meeting Babe Ruth,'' he recalls, ''was one of the most memorable days of my young life.''

While George Bush did not go on to a career in baseball, he is, today, one senior citizen who is the personification of the premise that there is life after 40—even after 75. He is in great demand the world over for speaking engagements on all subjects and issues. Since leaving the White House, he has visited some 55 foreign countries. Last week, he was in Korea and Thailand, as well as in Hong Kong, where he spoke at The International Bank of Asia.

On the lecture circuit, he recently addressed organizations such as the American Medical Association and the American Hotel & Motel Association.

To what does he attribute his long, happy and healthy life?

''Possibly because I was so active,'' he says. ''And I've always been involved in competitive sports.''

He still revels in fresh-air sports—fishing, swimming, high-speed boating, camping, golf and horseshoes. His passion for pitching horseshoes was once so strong that he built a horseshoe court with two pits on the grounds of the White House when he was its occupant.

''Physically, I'm still in good shape and feel young at heart,'' he says, ''but there are things I cannot do anymore, like jogging and tennis (he has played with tennis champs Billie Jean King and Chris Evert). I travel a lot and have tons of energy. Oh, once in a while, I get really tired, but I'm lucky with my physical condition.''

Does aging bother him?

''Not in the least,'' he says. ''I haven't lost interest in events, nor have my body and health deserted me. The only thing about aging that does bother me is that I want to be here on Earth long enough to see my grandkids—all 14 of them—grow up and be happily married, raising their own kids. That would be the best things that could happen to me after a full and happy and lucky life.''

He says he worries about the decline and disintegration of today's American family. ''I'm convinced that this decline leads to the many social and cultural problems facing our nation,'' he adds. ''Thank God, we have mentors and 'other points of light' willing to help the neglected kids, to read to them, to love them. But so many slip through the cracks. When the parents go AWOL, the kids are hurt and our society suffers.''

Turning to his years in the White House, Mr. Bush says that, as President, one of his best decisions was selecting Colin L. Powell as the Chairman of the Joint Chiefs of Staff. (During his years in the highest military position in the Department of Defense, Gen. Powell oversaw 28 crises, including Operation Desert Storm in the 1991 Persian Gulf War.) ''Another important decision, once it became clear we had to fight in Desert Storm, was to put full confidence in the military and not try to second-guess them or change the mission,'' Mr. Bush told me. ''My team and I did the diplomacy, and then, when we had to go to war, we let the military, under the leadership of Gen. Powell; Dick Cheney (Secretary of Defense) and Norman Schwarzkopf (commanding general of the U.S. forces in the Gulf) and others, fight and win.''

Gen. Powell, also a National Security Advisor in the Reagan White House and now chairman of ''America's Promises—The Alliance for Youth,'' told me: ''I considered George Bush a tremendous Commander in Chief. And as President of the U.S., he brought class, character and dignity to the office.''

George Bush emphasizes that the decision to commit troops to battles is the most onerous a Chief Executive can make. His most difficult moment in the Oval Office, he recalls, was when he had to decide whether or not to send someone's son or daughter to war. ''To commit one to fight—to put one in harms' way,'' he stresses, ''is the toughest of all calls.'' I did this in Panama, in the Gulf and Somalia, but I did it knowing we were going to give them full support—to enable them to complete their mission, to win and come home.

''This we did. I regret that the mission in Somalia changed after I left the White House. I do not like mission creep (an evolution of the mission away from its originally stated purpose). I was proud of our military in all three actions.''

He adds, ''You know, I miss dealing with our military because I believe in 'duty, honor, country.' My own military experience in WW II well equipped me to wrestle with the problems of military action. That also instilled in me a respect for those who do their duty for our country. I was proud to wear our uniform in WW II, and when I was Commander in Chief I took pride in my support of the military.''

Two years ago, when George Bush jumped from an altitude of 12,5000 feet and opened his parachute canopy at 4,000 feet above the Yuma Proving Ground in Arizona, he called that feat a great thrill. ''I was alone, at peace,'' he recalls. ''I was floating into the tranquil sands of Yuma.''

That jump was in keeping with a personal vow to ''some day, do it right'' (jumping from a plane) he made after Sept. 2, 1944, when he bailed out of his flaming torpedo bomber near Japanese-held Chichi Jima Island, some 150 miles from Iwo Jima. After five hours in the water, he was rescued by a submarine.

I asked George Bush if the pilot—recently downed over Serbia in the former Republic of Yugoslavia—brought back memories of when he was shot down as a Navy pilot 55 years ago.

''To some degree, yes, it did, because, like this pilot, I was shot down near the enemy,'' he remembers. ''I wasn't sure that I would be rescued. Neither was this pilot sure he would be found. I knew the Navy would go all out to find me. This pilot felt sure his comrades in arms would go the extra mile to rescue him. He prayed, and so did I—so, yes, there are some similarities.''

If George Bush could have had his life to live again, what would he have done differently?

''I would not do anything differently,'' he answers with an air of finality. ''My life has been a good one—satisfying and rewarding. I did not set a grand design for my career. I just tried to do well in each of my jobs and lead a meaningful life.

''I also tried to make a difference in the lives of others. I have always cared about the welfare of others.''

Attesting to Mr. Bush's self-assessment, former Attorney General Dick Thornburgh told me that throughout his presidency, George Bush exhibited an extraordinary sensitivity to questions of law and justice and the protection of the civil rights and civil liberties of all Americans. ''Nowhere,'' Mr. Thornburgh states, ''was this more evident than in President Bush's support for the Americans With Disabilities Act—which he signed into law on July 26, 1990.''

Mr. Thornburgh, a former governor of Pennsylvania, adds, ''This important civil rights legislation—strongly championed by the President during its considerations by Congress—provides a significant vehicle to secure access to the mainstream of American society for those 54 million Americans with physical, mental and sensory disabilities. (Thornburgh's son, Peter, now 39, was the victim of a car accident in 1960 when he was 4 months old. He suffered serious brain injuries, causing mental retardation.)

''In this, as in other endeavors, George Bush's compassion and commitment to justice for all was an inspiration to those of us privileged to serve in his administration.''

Manifesting his concern for human rights, Mr. Bush visited the infamous Nazi concentration camp at Auschwitz in Poland in 1987 when he was Vice President of the United States. He then told me that that visit made him determined not just to remember the Holocaust, but, more important, to strengthen his resolve to renew America's commitment to human rights the world over.

He quoted Nobel Peace Laureate Elie Wiesel, a Holocaust survivor who this week is in Macedonia, visiting refugees from Kosovo: ''In extreme situations, when human lives and dignity are at stake, neutrality is a sin.''

Elie Wiesel, now a professor at Boston University, spoke at a recent Millennium Evening at the White House on ''The Perils of Indifference: Lessons Learned From a Violent Century.'' He later told me that in the years he has know George Bush, he always found him to be sensitive to issues related to human rights.

''As Vice President, he directed the rescue mission that brought the surviving remnant of Ethiopian Jews to Israel,'' he adds, ''and he was instrumental in enabling a group of Nobel laureates to go to Poland, still under the dictatorship of Gen. Jaruzelski.''

If he had his presidency to live over, what would George Bush have done differently?

''I would like to have been a better communicator so I could have convinced the American people in 1992 that we were not in a depression, that the economy had recovered,'' he says. ''We handed the Clinton Administration a fast-growing economy, but I could not convince the people or the media that this was so.''

He describes as ''wonderful'' his 12 years in the White House as Vice President and President, but he continues to feel a sense of ''sadness'' that he was not given another four years ''to finish what I had begun.''

In Rev. Graham's view, George Bush lost that election ''mainly because his campaign people did not work hard enough, and some of his advisors gave him wrong advice. There was also an element of over-confidence due to the favorable polls.''

Gen. Brent Scowcroft, Mr. Bush's National Security Advisor, still considers it a ''tragedy'' that George Bush lost the 1992 election and did not have four more years ''to build the sense of closeness with other foreign leaders—which could have done so much to promote a closer world community.''

For his part, Mr. Bush continues, that if he had had his way, he would have won the election ''because I would have done a better job of getting out the facts and the benefit of our programs, and I would have gotten more legislation through Congress.

''For instance, the economy was better than it had been reported,'' he recalls, ''but the media pounded me on how bad things were. When I said we were not in recession, the press ridiculed me. It turned out that the recession ended in the spring of 1991.''

If he could turn back the clock, what decisions would he have changed?

''Given the way history worked out, raising taxes was not good because it got at my word,'' he recalls. ''People said that I broke

my word, and that is a regret. Raising taxes was my worst desision. I lost the election because of the economy. Yet, what I was saying—at the time—about the economy was true.''

On other decisions, Mr. Bush believes that his wisest was having ''mobilized the world to stand up against aggression'' in the Persian Gulf.

He describes the start of Iraq's invasion of Kuwait as ''a critical moment in world history.''

On that night—Jan. 16, 1991—he invited Rev. Billy Graham to the White House for private prayers. The next morning, Rev. Graham conducted a prayer service for the Bush Cabinet, congressional leaders and Marines at a chapel in Ft. Myer, a military compound in Virginia. ''Our prayers were for a short war,'' Rev. Graham says, ''and one that would be followed by a long period of peace in the Mideast.''

He also told me that George Bush will be remembered in history for having put together a coalition of nations in the Gulf War, and that much of that was due to his own relationship with world leaders. ''He got along well with them,'' he adds, ''and that means a great deal during crises.''

For his accomplishments, Mr. Bush cites his housing initiatives, his education program—America 2000—and his national energy strategy. He says he was more successful when he was able to work with state governors on issues such as his welfare reform programs, his crime-prevention initiative and the Americans With Disabilities Act. ''MY Administration deserved credit for those initiatives,'' he recalls, ''and we received none.''

In foreign affairs, Mr. Bush considers among his most significant achievements the START II Treaty, which he signed in Moscow (Jan. 3, 1993) during his last foreign trip as President. He also singles out Desert Storm, the U.N. coalition in 1991 to liberate Kuwait from Iraqi domination.

He says he was satisfied with START II, and, in terms of history Desert Storm led to many things, like people talking peace in the Midwest and the U.S. being the sole country to which people turn to solidify their democracies. He notes that his secretary of State, James A. Baker III, initiated the Mideast peace process that began with multilateral talks in Madrid in October 1991. ''We made dramatic strides, which history will record,'' he states. ''You would never believe that Arabs and Israelis would be talking to each other. No one thought we could get that done. Well, at least we got it started, and that happened largely because of Desert Storm.''

Mr. Bush recalls that he learned much from the courage of Russian President Boris Yeltsin, when, in August 1991, he climbed on a tank to talk to the crowd supporting him against the hard-line Communists. ''I was appreciative of what Mr. Yeltsin said about me being his first and most stalwart supporter.''

With all of his accomplishments, what continues to trouble George Bush and his associates is the perception that he was a ''wimp.'' In retrospect, how does he view that image?

''I never convinced the Washington press corps of what my real heartbeat was about,'' he says. ''I don't think I came through as a caring person, and one with a sense of humor. And the press felt I was posturing to get away from my Ivy League background when I played horseshoes or listened to country music. Some, like Newsweek (in 1988), had me down as 'wimp.' Some said I wasn't tough enough. I believe my record in life entitled me to a better assessment than that, but I couldn't get around their misperceptions.''

According to Rev. Billy Graham, George Bush is ''anything but a wimp—look how he handled the Gulf War. Everyone has faults, but he has fewer than almost any leader I have known.''

Gen. Scowcroft—co-author with Mr. Bush of ''A World Transformed'' (Knopf, 1998)—puts it this way. ''One misperception is what became known as the 'wimp factor.' That was the view that he was unwilling to make tough decisions or stand up for his beliefs. That was a total misperception because he fully demonstrated his decisive manner in the way he, as President, conducted the foreign and military policy of the United States. By the time he became President, he was not only a true foreign policy professional but he knew the leaders of virtually every country. That enabled him to establish a personal diplomacy that I believe is without parallel in the presidency. He communicated directly with an enormous number of foreign leaders. He listened to their problems, explained his views, discussed what U.S. policy was, or should be, thus adding a new and invaluable dimension to America's ability to act and be received as the leader of the world.

''Another misperception is that he is a patrician or a blue blood with an aristocratic approach. But that's not so. He is warm, friendly and outgoing. I never saw him, even as President, put on airs or any kind of imperial manner.''

Further describing George Bush, the man, Gen. Scowcroft says that in the years he has known him, he has ''developed and become broad and deeper, because he is wiling and eager to learn. He was, and is, a patient listener and has a good way of eliciting the views of others on all issues.''

He adds that, as President, George Bush's judgment was basically instinctive rather than analytical, but that it was based on extensive probing discussions with principal advisors before he made decisions.

Today, George Bush—looking younger than his age—presents a picture of a man full of vitality and brimming with confidence. He still possesses an innate sense of decency but is a complex personality. He is as tenacious as he is unassuming.

He singles out two of many turning points in his life: joining the Navy in 1942 and moving from the East Coast to Texas after graduating from Yale. ''These two moves really changed my life in many ways,'' he recalls. ''My move to Texas changed my life because I learned a lot about entrepreneurship and risk-taking.''

His first job was as a clerk in an oil-equipment company in Odessa, Texas, and he soon rose to become co-founder and president of an oil-drilling company.

Twenty years ago, as a Republican Presidential candidate, George Bush appeared on the NBC news program 'MEET THE PRESS' to explain why he should be elected President of the United States; and how he would make a difference in American life—from the Oval Office.

''I believe a man can make a difference,'' he pointed out. ''I'd like to re-awaken our sense of pride in ourselves as it applies to our relationships abroad.'' People abroad are wondering, 'Does the United States want to lead the free world anymore?'

He also told the Christian Science Monitor's Godfrey Sperling: ''I want to demonstrate, and help Americans demonstrate—given our strengths—that we can cope and solve problems, particularly our domestic economy. Once we solve these problems, I believe we can offer a better life to everybody in America. So I am motivated by that.

''I also want to re-awaken a sense of pride by putting stars in the eyes of our children.''

How has his philosophy changed over the years?

''I am not sure there has been a fundamental change,'' he told me. ''I hope I have become more tolerant of the different opinions of others. I feel even more convinced that the United States of America must stay involved in the world and be the leader.

''You know, there was a time during the Cold War days when I had only disdain for Russia and China. That has changed a lot. We must stay engaged with both nations. We must look at the big picture and work closely with both of these powers—not doing it their way, but not always bashing them, either.''

I asked George Bush for his views on the current crisis in Kosovo.

His response: ''I will not criticize President Clinton and, thus, will say nothing more.''

Concerning the revelations of surreptitious Chinese espionage allegedly involving four American administrations, Gen. Scowcroft, speaking for the Bush Administration, told me: ''In the four years as President Bush's National Security Advisor, I do not recall an issue of Chinese espionage at the nuclear labs being brought to my attention.''

Dr. Condoleezza Rice, director of Soviet and East European Affairs, national Security Council in the Bush Administration (1989–91), told me that there is no one who is more deserving of the title 'public servant' than George Bush.

''I most appreciated his integrity and his devotion to America,'' She adds. ''And I'm especially grateful to him for the way that he handled the end of the Cold War.''

Dr. Rice, now provost at Stanford University, notes that in the former president's book, ''A World Transformed,'' Mr. Bush describes his final phone conversation with Mikhail Gorbachev only moments before the Soviet president resigned and brought to an end 75 years of Soviet communism.

''Mr. Gorbachev was clearly looking for affirmation that this fateful decision would be good for the word.'' Dr. Rice points out. ''Why, might you ask, would the Soviet president call the President of the U.S. at that moment? It speaks volumes about how President Bush had managed difficult issues. He was tough, vigorously pursuing America's interests and skillful in his diplomacy.

''His leadership was quite and persistent. But he was also compassionate and humane. He found a way to treat this great, defeated, but still dangerous adversary with respect and dignity. That, more than anything, allowed the Soviet Union to slip quietly into the night—to collapse with a whimper, not a bang. We all owe President Bush a great debt for that.''

As George Bush's secretary of State, James A. Baker III traveled to 90 foreign countries as the U.S. confronted the unprecedented challenges and opportunities of the post-Cold War era. ''I think history will treat George Bush very, very well,'' Mr. Baker told me. ''He was president at a time of remarkable global changes. The world, as he and I had known it all our adult lives, changed fundamentally with the collapse of communism, the end of the Cold War and the implosion of the Soviet Union.

''In addition, during his presidency, America successfully fought the Gulf War and Panama. Through his leadership, Germany was reunified as a member of NATO and Israel and all of her Arab neighbors negotiated face to face for the first time at the Madrid peace conference.

''President Bush managed all of this with skill and dexterity. As a result, America was respected by our allies and feared by our adversaries—the way it should be.''

Secretary Baker adds: ''Another accomplishment was to make the national security apparatus of our nation work the way it should—without the usual rivalries, backbiting and counterproductive leaking to the

press. That enabled us to manage properly the historic changes that occurred around the world from 1989 to 1992.''

Baker, an intimate Bush friend of 40 years, also served in 1997 as the personal envoy of U.N. Secretary General Kofi Annan to mediate direct talks between the parties to the dispute over Western Sahara.

''Friendships mean a lot to George,'' Jim Baker writes in his book ''The Politics of Diplomacy'' (Putman, 1995). ''Indeed, his loyalty to friends is one of his defining personal strengths. Yet some have suggested it became one of his greatest political weaknesses and that out of concern for their friendship, he stayed loyal for too long to people who hurt his presidency.''

Gen Scowcroft concurs: ''If I observed any faults, it was perhaps that George Bush was too loyal in that he would support colleagues and associates even after it had become apparent that they were not adequately suited to the jobs they held or were about to hold.''

In 1974, when Mr. Bush was head of the liaison office in China, it was a restricted period as far as contact with the Chinese leaders was concerned. Nonetheless, he set out to learn about the people and the country. He even studied Chinese. He and Mr. Bush bicycled around Beijing, asked questions, invited the people to their home and developed a real feel for them and their culture.

In 1976, when Mr. Bush was appointed by President Ford to be director of the Central Intelligence Agency, Gen. Scowcroft was his (Ford's) National Security Advisor. ''I saw how George Bush was learning more and more about foreign policy,'' Gen. Scowcroft says.

''It was not so much his foreign policy expertise, although he was well versed as a result of his U.N. and China positions, but what he did in restoring the morale and self-respect of the CIA. The morale at CIA was at rock bottom after the congressional investigations of the Pike and Church committees. Even today, Mr. Bush is considered to be the agency's most revered CIA director.''

One birthday gift George Bush considers especially significant is the 258-acre complex named after him in the Central Intelligence Agency's headquarters in Langley, Va.—the first Washington, D.C.-area tribute to him.

Last October, President Clinton signed legislation authorizing the designation of the George Bush Center for Intelligence, and, in a letter, read by CIA Director George Tenet at the recent dedication ceremony, Mr. Clinton noted that when George Bush assumed his duties as director of the CIA (1976), the Vietnam War had just ended, the Watergate scandal was still an unhealed national wound, and government investigations had exposed abuses of power in connection with intelligence activities.

''Many Americans had lost faith in government and asked whether the CIA should continue to exist,'' President Clinton noted. ''George Bush restored morale and discipline to the Agency while publicly emphasizing the value of intelligence to the nation's security, and he also restored America's trust in the CIA and the rest of the intelligence community.

''I have been well served by the talented and dedicated men and women who make up the intelligence community that George Bush did so much to preserve and strengthen.''

The ceremony was attended by former CIA Directors Richard Helms, James Schlessinger, Robert Gates and William Webster. Mr. Tenet hailed George Bush—the only director to have become President of the United States—as a war hero and said that every component of the Agency ''feels indebted to him in some way—because his belief in the fundamental importance of its work never faltered.

''He was a staunch defender of the need for human intelligence—for espionage—at a tough time when it really counted.''

Mr. Tenet also pointed out that each day, the men and women of the CIA provide the President of the United States and other decision-makers the critical intelligence they need to protect American lives and advance American interests around the globe. ''Thanks in great measure to George Bush's leadership, the U.S. no longer confronts the worldwide threat from a rival superpower that we did during the Cold War,'' he stated. ''But, as the 21st century approaches, we must contend with a host of other dangerous challenges—challenges of unprecedented complexity and scope.

''The U.S. remains the indispensable country in this uncertain and chaotic world. And time and again, the CIA has proven itself to be the indispensable intelligence organization, helping America build a more secure world for people everywhere.''

Accepting a model of the sign bearing the name of the compound, George Bush—in his remarks—observed: ''My stay here had a major impact on me. The CIA became part of my heartbeat some 22 years ago, and it has never gone away. I hope it will be said that in my time here, and in the White House, I kept the trust and treated my office with respect.''

And to the assembled CIA employees, Mr. Bush added: ''Your mission is different now from what it was in my time. The Soviet Union is no more. Some people think, 'What do we need intelligence for?'

''My answer is that plenty of enemies abound . . . unpredictable leaders willing to export instability or to commit crimes against humanity. Proliferation of weapons of mass destruction, terrorism, narco-trafficking, people killing each other, fundamentalists killing one another in the name of God, and many more.

''To combat them, we need more intelligence, not less. We need more human intelligence and more protection for the methods we use to gather intelligence and more protection for our sources, particularly our human sources who risk their lives for their country.''

Mr. Bush went on to say that even though he is now a ''tranquil guy,'' he has ''contempt and anger for those who betray the trust'' be exposing the names of our (intelligence) sources.

''They are, in my view, the most insidious of traitors,'' he asserted. ''George Tenet is exactly right when it comes to the mission of the CIA and the intelligence community. 'Give the President and the policy-makers the best possible intelligence product and stay out of the policymaking or policy implementing—except as specifically decreed in the law.''

George Bush has always been hesitant to talk about himself—even as to how he made a difference as President. ''You ask others,'' he tells me, ''I am not good at talking about myself. That is part of my make-up. Some people say it is lack of character, but I can't blow my own horn. My mother taught me not to brag and she is still watching me.''

Respecting his penchant for modesty, I did ask others—including former American presidents, as well as the current one—for their reflections and comments on George Bush's milestone.

Former President Gerald R. Ford said: ''President Bush, at 75, has earned the highest compliments for his strong and effective military and diplomatic leadership in the Gulf War with Iraq.''

Former President Jimmy Carter says: ''From one septuagenarian to another, I, of course, wish George Bush a wonderful birthday and many more years of good health and much happiness.

''He is a man of integrity who served America with honor. We had a very good relationship while he was in the White House, and even though we did not agree on every issue, he treated me with respect and kindness.

''I always shared my invitations to foreign countries with him or with Secretary of State James Baker, and they were supportive of our work at the Carter Center (in Atlanta, Ga).''

Jimmy Carter adds that he and his wife, Rosalynn ''thoroughly enjoyed'' attending the opening of the Bush Presidential Library. (On Nov. 6, 1997, the library and museum, together with the George Bush School of Government and Public Service, were opened.)

President William Jefferson Clinton recalls with gratitude his wide-ranging conversations with George Bush four months ago as they flew on Air Force One to and from Jordan for King Hussein's funeral. (Former Presidents Ford and Carter were also aboard.)

''George Bush embodies the spirit of public service,'' Mr. Clinton told me. ''For me, he has also been a trusted advisor. While there are many who advise me, at times the greatest counsel comes from one who has shared the pressures and unique experience of serving in the Oval Office—one who knows exactly what you're up against and one who will tell you the truth.

''George has often done that, and while I have been the immediate beneficiary of his counsel, people here and abroad have ultimately benefited most of all.''

Richard Fairbanks, President of the Center for Strategic & International Studies (CSIS), advised Mr. Bush on policy during his 1980 presidential bid. Later, as chief U.S. negotiator for the Mideast peace process, he worked closely with Vice President Bush. Ambassador Fairbanks recalls that George Bush was seen as a pragmatic problem-solver rather than a conceptualizer, ''which is one of the reasons he encountered trouble with his famous statement that he was not comfortable with 'the vision thing.'''

Mr. Fairbanks, a member of the Council of American Ambassadors, adds that George Bush is a natural leader with real intellectual depth, but he is also a private man, who is ''not comfortable flaunting his thought processes in a public forum.''

Edwin Meese, counselor to President Reagan (1981–85) and U.S. Attorney General (1985–88), who is now The Ronald Reagan Fellow in Public Policy at The Heritage Foundation, says that he ''thoroughly appreciated the opportunity to work with George Bush as Vice President because he was an invaluable asset to President Reagan and to all of us in the Cabinet.''

In his 12 years as Vice President and President, George Bush witnessed a number of scandals, including Watergate, Irangate, Iran-Contra and the Savings and Loan bust.

On his last day in the Oval Office as president I asked him how he would advise incoming President Bill Clinton to prevent similar scandals.

''If Governor Clinton asks me, I would tell him to be very conscious of how he works with his staff; and to be sure there are no loose cannons running around the White House,'' Mr. Bush told me during that interview. ''People around a President or Vice President or any high official can make or break his image. So we each need to surround ourselves with competent and caring individuals—men and women of integrity who respect the presidency and live their own lives accordingly.''

He adds: ''There is a need for revival of ethical behavior, and exemplary conduct must come from officials and leaders. It cannot be legislated.

''What mattered to me most in the White House was integrity and responsibility. Public service has been damaged by people who don't have the judgment to place the public's business above their own self interest, and unethical conduct should not be tolerated at any level of government.''

Mr. Bush went on to say that he was determined—at all times—to treat the office of the presidency with respect and not do anything that would cheapen or diminish it.

''I still take pride in the fact that my administration was clean and free of scandal,'' he says. ''We had not been hounded by people using government jobs for personal gain. We came to the White House with high ethical standards and we left with heads high in that regard.''

And what did George Bush learn from his years in the White House that has made a lasting impact on him?

''I learned that the power to get things done is less than some people believe,'' he remembers. ''Yes, the presidency is magnified out of proportion. You can get some things done, but you can't wave a wand to have everything work the way you want it. The presidency is too complicated.

''I also learned that the White House is surrounded by history, and I left there with even more respect for America's principles, more respect for the institution of the presidency, and more respect for the civil servants, including the staff of the executive residence and the uniformed Secret Service officers, who make that magnificent museum of a place into a real home for whoever is President of the U.S. as well as for his family and guests.''

And since he departed the White House, in 1993, how, in his view, has the presidency evolved?

''Like many Americans, I have worried about the recent happenings in and around the White House,'' George Bush told me. ''But the presidency is a vital and strong and resilient institution. Just as (former President) Jerry Ford instantly restored honor to the Executive Mansion—after Watergate—so will whoever is elected President in the year 2000.

''Respect for the office is important and character and behavior in that office do count. The office is not too big for any individual, provided he or she can make tough decisions and give credit to bright and experienced people who should surround the Chief Executive.''

If George Bush could leave but one legacy, he wants it to be a return to the moral compass that must guide America through the next century.

''And,'' he adds, ''I hope historians will say that I and my Administration left the world a little more peaceful by the way we handled the unification of Germany, the liberation of Eastern Europe and the Baltics, as well as the way we worked with the Soviet leaders to bring about change there, and to get their support when we had to fight the Gulf War.''

''I also hope my legacy will include the Madrid peace conference (1992); our key role in NAFTA, the Brady Plan (plan for debt relief for Latin America), and the way we handled China after Tiananmen Square 10 years ago.

''On a personal level, I hope my legacy will be that 'George Bush did his best and served America with honor.' ''

If he could have one wish on this birthday, what would it be?

''I am not sentimental,'' he says, ''but, yes, there is a certain special quality to this milestone. For myself, I have no wishes for my birthday. I have everything a man could want. But, for the world, I would wish more peace; and for America, I wish for stronger families and better values.''

And George Bush's vision for the next century?

''I am optimistic about the 21st century,'' he told me. ''With no superpower confrontation on the horizon, I believe the next century can be one of peace—though there will always be regional conflicts. But I, for one, am still hopeful.''

And to share that hope, he likes to recount the time that his wife, Barbara, was planting a flowering bush. She was instructed to dig a deep bed, fill it with fertilizer and firmly plant the bush by covering it with water and soil.

''We were told that the plant would not bloom right away, but that it would, after a year or so, and then for a long time to come,'' he mused. ''Soon, we realized that she was planting that flowering bush for our kids and grandkids and great-grandkids.

''So despite the vicissitudes we face now, and will face in the future, I believe that that planting was not in vain. Sure, we have problems in the U.S. and overseas, and the world has the weapons to blow itself up. Yet my inner self tells me that our great-grandkids will be around to enjoy those flowers.''

AID FOR RUSSIAN AND ROMANIAN ORPHANS

Ms. LANDRIEU. Mr. President, before the recess, with the help and support of my colleagues Mr. HELMS, Mr. LEAHY, and Mr. MCCONNELL, I offered an amendment to Senate Bill 1234, which would provide some relief for the hundreds of thousands of orphans who find themselves confined to institutions and have no one to provide the love, affection and guidance that they so desperately need. Sadly, the disruption and extreme poverty which followed the end of the Cold War Era has had a devastating impact on the lives of the children in the Eastern block. In both Russia and Romania, it is the children, the future of democracy, who are struggling to survive. It is my hope that the funds designated by this amendment will allow the governments in each of these two countries to protect the health, safety and well being of their children and in doing so, build for a stronger and brighter tomorrow.

Specifically, this amendment ensures that $2,000,000 of the funding appropriated for aid to Russia and the Independent States is used to further the innovative efforts of nongovernmental organizations, such as Christian World Adoption Agency, to provide vocational and professional training for those children who are about to ''age out'' of orphanages. When this body created Independent Living, it recognized that such training and support is essential to the future of the young adults who have, for whatever reason, grown up in an institution rather than in a family. With the help of help organizations like Christian World, these children can be given the tools they need to become confident and successful adults.

Further, my amendment provides that $4,400,000 of the funds provided for aid to Eastern Europe and the Baltic States will be used to support the Romanian Department of Child Protection and their work to save the lives and improve health of the more than 100,000 Romanian children in orphanages. Just the other day, myself and several of my colleagues met with the present Secretary of the Department of Child Protection, Dr. Cristian Tabacaru. With great passion, Dr. Tabacaru painted for me a picture of the dire circumstances faced by his country's children. At present, Romania has the highest infant mortality rate in Europe. What is worse, is that 60% of these deaths are from preventable causes such as malnutrition and premature births.

The Romanian Department of Child Protection is working desperately to save their most precious resource, their children. They have instituted programs that provide nutritional supplements to these children, they have developed their first ever in-home foster care program and are working to improve the services available for those with special needs. While they have made a great deal of progress in very little time, they need and deserve our help. This small amount of money will help them out of their present crisis and to build a child welfare system of which they can be proud.

In closing, I want to again thank Mr. HELMS, Mr. LEAHY, and Mr. MCCONNELL for their support of my amendment. As we continue to aid the children of this world, we can be confident that we are building the hope of a bright and wonderful future, a future in which few children will grow up without a family to call their own.

REPORT OF THE DISTRICT OF COLUMBIA'S FISCAL YEAR 2000 BUDGET REQUEST ACT—MESSAGE FROM THE PRESIDENT—PM 46

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Governmental Affairs.

To the Congress of the United States:

In accordance with section 202(c) of the District of Columbia Financial Management and Responsibility Assistance Act of 1995 and section 446 of the District of Columbia Self-Governmental Reorganization Act, as amended, I am transmitting the District of Columbia's Fiscal Year 2000 Budget Request Act.

This proposed Fiscal Year 2000 Budget represents the major programmatic objectives of the Mayor, the Council of the District of Columbia, and the District of Columbia Financial Responsibility and Management Assistance Authority. For Fiscal Year 2000, the District estimates revenue of $5.482 billion and total expenditures of $5.482 billion, resulting in a budget surplus of $47,000.

My transmittal of the District of Columbia's budget, as required by law, does not represent an endorsement of its contents.

WILLIAM J. CLINTON.

THE WHITE HOUSE, *July 12, 1999.*

MESSAGES FROM THE HOUSE

At 1:05 p.m., a message from the House of Representatives, delivered by Mr. Hanrahan, one of its reading clerks, announced that the House has agreed to the following concurrent resolution, without amendment:

S. Con. Res. 43. Concurrent resolution providing for a conditional adjournment or recess of the Senate and a conditional adjournment of the House of Representatives.

The message also announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 10. An act to enhance competition in the financial services industry by providing a prudential framework for the affiliation of banks, securities firms, and other financial service providers, and for other purposes.

At 3:03 p.m., a message from the House of Representatives, delivered by Mr. Hanrahan, one of its reading clerks, announced that the House agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 144. Concurrent resolution urging the United States Government and the United Nations to undertake urgent and strenuous efforts to secure the release of Branko Jelen, Steve Pratt, and Peter Wallace, 3 humanitarian workers employed in the Federal Republic of Yugoslavia by CARE International, who are being unjustly held as prisoners by the Government of the Federal Republic of Yugoslavia.

A message from the House of Representatives was received announcing the Speaker signed the following enrolled bill on Tuesday, June 29, 1999:

H.R. 4. An act to declare it to be the policy of the United States to deploy a national missile defense.

MEASURE PLACED ON THE CALENDAR ON JULY 8, 1999

Pursuant to the order of June 29, 1999, the following bill was read twice and placed on the calendar:

S. 1244. A bill to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

MEASURES PLACED ON THE CALENDAR ON JULY 12, 1999

The following bill was read the second time and placed on the calendar:

H.R. 1218. An act to amend title, United States Code, to prohibit taking minors across State lines in circumvention of laws requiring the involvement of parents in abortion decisions.

The following bill was read twice and placed on the calendar:

H.R. 10. An act enhance competition in the financial services industry by providing a prudential framework for the affiliation of banks, securities firms, and other financial service providers, and other purposes.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC–4051. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to the Jerusalem Embassy Act of 1995, the report of Presidential Determination Number 99–29 relative to the suspension of the limitation of the obligation of FY 1999 State Department Appropriations; to the Committee on Appropriations.

EC–4052. A communication from the Director, National Institute of Environmental Health Sciences, Department of Health and Human Services, transmitting, pursuant to law, a report entitled ''Health Effects From Exposure to Power-Line Frequency Electric and Magnetic Fields''; to the Committee on Health, Education, Labor, and Pensions.

EC–4053. A communication from the Secretary of Transportation, transmitting, pursuant to law, the Department's report entitled ''Transportation Research and Development Plan''; to the Committee on Commerce, Science, and Transportation.

EC–4054. A communication from the Assistant Attorney General for Administration, Justice Management Division, Department of Justice, transmitting, pursuant to law, the report of a rule entitled ''Justice Acquisition Circular 99–1'' (RIN1105–AA68), received June 30, 1999; to the Committee on the Judiciary.

EC–4055. A communication from the Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Qualified Zone Academy Bond Credit Rate'' (RIN1545–AX23), received June 30, 1999; to the Committee on the Finance.

EC–4056. A communication from the Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Qualified Zone Academy Bond Credit Rate'' (Notice 99–35, 1999–27 I.R.B.—, Jul 5, 1995), received June 30,. 1999; to the Committee on Finance.

EC–4057. A communication from the Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Rev. Rul. 99–30, BLS–LIFO Department Store Inventory Price Indexes-May 1999'' (Rev. Rul 99–30), received June 24 1999; to the Committee on Finance.

EC–4058. A communication from the Director, Acquisition Policy and Programs, Office of the Secretary, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Solicitation Provisions and Contract Clauses; Women-Owned Small Business Sources'' (RIN0605–AA13), received June 29, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4059. A communication from the Special Assistant to the Chief, Mass Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.202(b), Table of Allotments; FM Broadcast Stations'' (MM Docket No. 98–133; RM–9314 Zapata, Texas), received June 25, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4060. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Texas; Revised Format for Materials Being Incorporated by Reference'' (FRL # 6342–9), received June 30, 1999; to the Committee on Environment and Public Works.

EC–4061. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval of Hospital/Medical/Infectious Waste Incinerator State Plan for Designated Facilities and Pollutants: Illinois'' (FRL # 6371–5), received June 30, 1999; to the Committee on Environment and Public Works.

EC–4062. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Lead; Requirements for Disclosure of Known Lead-Based Paint and/or Lead-Based Paint hazards in Housing, Technical Corrections to Reflect OMB Approval of the Information Collection Requirements'' (FRL # 6053–9), received June 30, 1999; to the Committee on Environment and Public Works.

EC–4063. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Hazardous Air Pollutants: Regulations Governing Constructed or Reconstructed Major Sources'' (FRL # 6369–6), received June 25, 1999; to the Committee on Environment and Public Works.

EC–4064. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''National Emission Standards for Hazardous Air Pollutants: Group I Polymers and Resins and Group IV Polymers and Resins'' (FRL # 6369–9), received June 25, 1999; to the Committee on Environment and Public Works.

EC–4065. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''State of Alaska Petition for Exemption from Diesel Fuel Sulfur Requirement'' (FRL # 6367–1), received June 25, 1999; to the Committee on Environment and Public Works.

EC–4066. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Toxic Substances Control Act Test Guidelines'' (FRL #6067–4), received June 25, 1999; to the Committee on Environment and Public Works.

EC–4067. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Amendment to the Effluent Limitations Guidelines and Standards for the Bleached Papergrade Kraft and Soda Subcategory of the Pulp, Paper, and Paperback Point Source Category: Final Rule; OMB Approvals Under the Paperwork Reduction Act: Technical Amendments'' (FRL #6372–9), received July 1, 1999; to the Committee on Environment and Public Works.

EC–4068. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report

of a rule entitled ''Approval and Promulgation of Implementation Plan for New Mexico—Albuquerque/Bernalillo County; Transportation Conformity Rule'' (FRL #6372–7), received July 1, 1999; to the Committee on Environment and Public Works.

EC–4069. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plan for Texas: Transportation Conformity Rule'' (FRL #6372–6), received July 1, 1999; to the Committee on Environment and Public Works.

EC–4070. A communication from the Administrator, National Aeronautics and Space Administration, transmitting, pursuant to law, a report relative to the NASA Industrial Plant in Downey, California; to the Committee on Commerce, Science, and Transportation.

EC–4071. A communication from the Secretary to the Commission, Premerger Notification Office, Federal Trade Commission, transmitting, pursuant to law, the report of a rule entitled ''Hart-Scott-Rodino Act Amended Formal Interpretation 15: Limited Liability Companies,'' received July 1, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4072 A communication from the Special Assistant to the Chief, Mass Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Manzanita, Cannon Beach and Bay City, Oregon)'' (MM Docket No. 98–189, RM–9377, RM–9475), received June 25, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4073. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Class E Airspace; Sanford, NC: Docket No. 99–ASO–7 (6–30/7–1)'' (RIN2120–AA66) (1999–0215), received July 1, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4074. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Amendment to Class D and Class E Airspace; San Juan, PR; Docket No. 99–ASO–6 (6–30/7–1)'' (RIN2120–AA66) (1999–0216), received July 1, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4075. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Boeing Model 737–700 and –800 Series Airplanes; Request for Comments; Docket No. 99–NM–133 (6–30/7–1)'' (RIN2120–AA66) (1999–0263), received July 1, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4076. A communication from the Program Analyst, Office of the Chief Counsel, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives: Boeing Model 777–200 Series Airplanes; Docket No. 99–NM–243 (6–30/7–1)'' (RIN2120–AA64) (1999–0264), received July 1, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4077. A communication from the Attorney, Research and Special Programs Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Hazardous Materials: Revision to Regulations Governing Transportation and Unloading of Liquified Compressed Gases (Chlorine)'' (RIN2137–AD07) (1999–0002), received July 1, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4078. A communication from the Senior Regulations Analyst, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Disadvantaged Business Enterprise (DBE) Regulation; General Update (Correction)'' (RIN2105–AB92) (1999–0002), received July 1, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4079. A communication from the Acting Executive Director, Commodity Futures Trading Commission, transmitting, pursuant to law, the report of a rule entitled ''Chicago Board of Trade Petition for Exemption from the Statutory Dual Trading Prohibition in the Ten-Year U.S. Treasury Notes Futures Contract Traded on the Project A Electronic Trading System,'' received June 29, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4080. A communication from the Manager, Federal Crop Insurance Corporation, Farm and Foreign Agricultural Services Risk Management Agency, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Group Risk Plan of Insurance; Final Rule'' (RIN0563–AB06), received July 1, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4081. A communication from the Secretary of Agriculture, transmitting, pursuant to law, the annual ''Animal Welfare Enforcement'' report for fiscal year 1998; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4082. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Bifenthrin; Pesticide Tolerance'' (FRL #6089–9), received June 25, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4083. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Fludioxinil; Pesticide Tolerance'' (FRL #6085–3), received June 25, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4084. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Paraquat; Extension of Tolerance for Emergency Exemptions'' (FRL #6084–3), received June 25, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4085. A communication from the Director, Office of Congressional Affairs, Office of Nuclear Material Safety and Safeguards, Nuclear Regulatory Commission, transmitting, pursuant to law, the report of a rule entitled ''10 CFR Part 72, Miscellaneous Changes to Licensing Requirements for the Independent Storage of Spent Nuclear Fuel and High-Level Radioactive Waste'' (RIN3150–AF80), received July 1, 1999; to the Committee on Environment and Public Works.

EC–4086. A communication from the Director, Regulations Policy and Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Listing of Color Additives for Coloring Meniscal Tacks; D & C Violet No. 2'' (Docket No. 98C–0158), received June 25, 1999; to the Committee on Health, Education, Labor, and Pensions.

EC–4087. A communication from the Chairman, President's Committee on Employment of People with Disabilities, transmitting the annual report for fiscal year 1998, received July 1, 1999; to the Committee on Health, Education, Labor, and Pensions.

EC–4088. A communication from the Assistant General Counsel for Regulations, Special Education and Rehabilitative Services, Department of Education, transmitting, pursuant to law, the report of a rule entitled ''NIDRR—Assistive Technology Act Technical Assistance Program'' (84.224), received July 1, 1999; to the Committee on Health, Education, Labor, and Pensions.

EC–4089. A communication from the General Counsel, Federal Emergency Management Agency, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' (64 FR 32817) (06/18/99), received June 30, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4090. A communication from the Chief Counsel, Office of Foreign Assets Control, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Blocked Persons, Specially Designated Nationals, Specially Designated Terrorists, Foreign Terrorist Organizations, and Specially Designated Narcotics Traffickers: Additional Sudanese Government Designations and Supplementary Information, and Removal of One Individual'' (Appendix A to 31 CFR Chapter V), received June 25, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4091. A communication from the Chief Counsel, Office of Foreign Assets Control, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Blocked Persons, Specially Designated Nationals, Specially Designated Terrorists, Foreign Terrorist Organizations, and Specially Designated Narcotics Traffickers: Additional Designations'' (Appendix A to 31 CFR Chapter V), received June 24, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4092. A communication from the Chief Counsel, Office of Foreign Assets Control, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Blocked Persons, Specially Designated Nationals, Specially Designated Terrorists, Foreign Terrorist Organizations, and Specially Designated Narcotics Traffickers: Additional Designations and Removals and Supplementary Information on Specially Designated Narcotics Traffickers; Removal of Appendix B; Redesignation of Appendix C'' (Appendices A to 31 CFR Chapter V), received June 24, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4093. A communication from the Acting Director, Office of Federal Housing Enterprise Oversight, transmitting, pursuant to law, the report of a rule entitled ''Debt Collection'' (RIN2550–AA07), received June 25, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4094. A communication from the Chairman, Board of Governors of the Federal Reserve System, transmitting, pursuant to law, the annual report for fiscal year 1998, received July 1, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4095. A communication from the President and Chairman, Export-Import Bank of the United States, transmitting, pursuant to law, a report relative to a transaction involving U.S. exports to Russia; to the Committee on Banking, Housing, and Urban Affairs.

EC–4096. A communication from the President and Chairman, Export-Import Bank of the United States, transmitting, pursuant to law, a report relative to a transaction involving U.S. exports to Bulgaria; to the Committee on Banking, Housing, and Urban Affairs.

EC–4097. A communication from the Secretary of Housing and Urban Development, transmitting, pursuant to law, the report of the Department's Five Year Plan for Energy Efficiency, received July 1, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4098. A communication from the Chairman, Federal Election Commission, transmitting, pursuant to law, the report of a rule entitled ''Treatment of Limited Liability Companies Under the Federal Election Campaign Act,'' received June 25, 1999; to the Committee on Rules and Administration.

EC–4099. A communication from the Director, Office of Surface Mining, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Maryland Regulatory Program'' (SPATS # MD–043–FOR), received July 1, 1999; to the Committee on Energy and Natural Resources.

EC–4100. A communication from the Attorney, General and Administrative Law, Office of the General Counsel, Federal Energy Regulatory Commission, Department of Energy, transmitting, pursuant to law, the report of a rule entitled ''Standards for Business Practices of Interstate Natural Gas Pipelines'' (RM96–1–012), received June 22, 1999; to the Committee on Energy and Natural Resources.

EC–4101. A communication from the Acting Assistant Secretary, Land and Minerals Management, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Change to Delegated State Audit Functions'' (RIN010–AC51), received July 1, 1999; to the Committee on Energy and Natural Resources.

EC–4102. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of a certification of a proposed license for the export of defense articles or defense services in the amount of $50,000,000 for the United Kingdom; to the Committee on Foreign Relations.

EC–4103. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of a certification of a proposed license for the export of defense articles or defense services in the amount of $50,000,000 for the Netherlands, Germany, and Switzerland; to the Committee on Foreign Relations.

EC–4104. A communication from the Executive Director, Committee for Purchase From People Who Are Blind or Severely Disabled, transmitting, pursuant to law, the report of a rule entitled ''Procurement List; Additions,'' received July 1, 1999; to the Committee on Governmental Affairs.

EC–4105. A communication from the Secretary, Naval Sea Cadet Corps, transmitting, pursuant to law, the Corps' Annual Audit Report for the fiscal year ending December 31, 1998, received July 1, 1999; to the Committee on the Judiciary.

EC–4106. A communication from the Assistant Secretary, Employment and Training Administration, Department of Labor, transmitting, pursuant to law, the report of a rule entitled ''Labor Certification Process for the Temporary Employment of Nonimmigrant Aliens in Agriculture in the United States; Administrative Measures to Improve Program Performance'' (RIN1205–AB19), received July 6, 1999; to the Committee on Health, Education, Labor, and Pensions.

EC–4107. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled ''VISAS: Passports and Visas Not Required for Certain Nonimmigrants'' (RIN1400–A75), received July 6, 1999; to the Committee on the Judiciary.

EC–4108. A Communication from the Associate Administrator for Procurement, National Aeronautics and Space Administration, transmitting, pursuant to law, the report of a rule entitled ''NASA FAR Supplement; Protests to the Agency,'' received July 6, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4109. A communication from the Associate Administrator for Procurement, National Aeronautics and Space Administration, transmitting, pursuant to law, the report of a rule entitled ''Miscellaneous Administrative Revisions,'' received July 6, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4110. A communication from the Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Early Referral of Issues to Appeals'' (Revenue Procedure 99–28), received July 6, 1999; to the Committee on Finance.

EC–4111. A communication from the Deputy Secretary, Market Regulation, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled ''Form BD/Rule 15b1–1, Application for Registration as a Broker or Dealer'' (RIN3235–AH73), received July 6, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4112. A communication from the Assistant General Counsel for Regulations, Office of the Assistant Secretary for Housing-Federal Housing Commissioner, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a rule entitled ''Single Family Mortgage Insurance; Informed Consumer Choice Disclosure Notice; Technical Correction'' (FR–4411) (RIN2502–AH30), received July 2, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4113. A communication from the Assistant General Counsel for Regulations, Office of the Assistant Secretary for Housing-Federal Housing Commissioner, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a rule entitled ''Uniform Financial Reporting Standards for HUD Housing Programs; Technical Amendment'' (FR–4321) (RIN2501–AC49), received July 2, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4114. A communication from the Assistant General Counsel for Regulations, Office of the Assistant Secretary for Housing-Federal Housing Commissioner, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a rule entitled ''Disposition of HUD-Acquired Single Family Property; Office Next Door Sales Program'' (FR–4277–I–02) (RIN2502–AH37), received July 2, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4115. A communication from the Assistant General Counsel for Regulations, Office of the Assistant Secretary for Public and Indian Housing, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a rule entitled ''Comprehensive Improvement Assistance Program Formula Allocation Final Rule'' (FR–4462) (RIN2577–AB97), received July 2, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4116. A communication from the Assistant General Counsel for Regulations, Government National Mortgage Association, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a rule entitled ''Ginnie Mae MBS Program: Book-Entry Securities'' (FR–4331–F–02) (RIN2503–AA12), received July 2, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4117. A communication from the President of the United States, transmitting, pursuant to law, a report on the national emergency with respect to the actions and policies of the Afghan Taliban; to the Committee on Banking, Housing, and Urban Affairs.

EC–4118. A communication from the Secretary of Energy, transmitting, pursuant to law, the report of the Office of Inspector General for the period October 1, 1998, through March 31, 1999; to the Committee on Governmental Affairs.

EC–4119. A communication from the Assistant Secretary for Export Administration, Bureau of Export Administration, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Expansion of License Exception CIV Eligibility for 'Microprocessors' Controlled by ECCN 3A001'' (RIN 0694–AB90), received July 6, 1999; to the Committee on Banking, Housing, and Urban Affairs.

EC–4120. A communication from the Secretary of the Interior, transmitting, pursuant to law, the annual report for fiscal year 1998 of the Office of Surface Mining; to the Committee on Governmental Affairs.

EC–4121. A communication from the Secretary of Defense, transmitting, pursuant to law, the report of the Office of Inspector General relative to intelligence-related oversight activities for the period October 1, 1998, through March 31, 1999; to the Committee on Governmental Affairs.

EC–4122. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Bentazon, Extension of Tolerance for Emergency Exemptions'' (FRL #6087–5), received July 2, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4123. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Fosetyl-Al; Pesticide Tolerance'' (FRL #6090–3), received July 2, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4124. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Imazamox, Pesticide Tolerances for Emergency Exemptions'' (FRL6086–5), received July 2, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4125. A communication from the Manager, Federal Crop Insurance Corporation, Risk Management Agency, Farm and Foreign Agricultural Services, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Common Crop Insurance Regulations, Onion Crop Insurance Provision; Final Rule'', received July 6, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4126. A communication from the Administrator, Agricultural Marketing Service, Marketing and Regulatory Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Irish Potatoes Grown in Modoc and Siskiyou Counties, California, and in all Counties in Oregon, except Malheur County;

Temporary Suspension of Handling Regulations and Establishment of Reporting Requirements'' (FV99–947–1–IFR), received July 6, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4127. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Brucellosis in Cattle; State and Area Classifications; Kansas'' (APHIS Docket No. 99–051–1), received July 6, 1999; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4128. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of a proposed Technical Assistance Agreement with the United Kingdom; to the Committee on Foreign Relations.

EC–4129. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of a proposed license for the export of defense articles or defense services in the amount of $50,000,000 or more to Japan; to the Committee on Foreign Relations.

EC–4130. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of a proposed Manufacturing License Agreement with Norway; to the Committee on Foreign Relations.

EC–4131. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of a proposed Manufacturing License Agreement with Finland; to the Committee on Foreign Relations.

EC–4132. A communication from the Acting Deputy Director, Fish and Wildlife Service, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Final Rule; Safe Harbor Agreements and Candidate Conservation Agreements with Assurances'' (RIN1018–AO95), received July 2, 1999; to the Committee on Environment and Public Works.

EC–4133. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Consolidated Rules of Practice Governing the Administrative Assessment of Civil Penalties, Issuance of Compliance or Corrective Action Orders, and the Revocation, Termination or Suspension of Permits'' (FRL6087–5), received July 2, 1999; to the Committee on Environment and Public Works.

EC 4134. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Implementation Plan and Redesignation Request for the Williamson County, Tennessee Lead Nonattainment Area'' (FRL #6373–9), received July 2, 1999; to the Committee on Environment and Public Works.

EC 4135. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Project XL Rulemaking for New York State Public Utilities; Hazardous Waste Management System'' (FRL #6374–8), received July 2, 1999; to the Committee on Environment and Public Works.

EC 4136. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Maintenance Plan Revisions; Ohio'' (FRL #6375–4), received July 6, 1999; to the Committee on Environment and Public Works.

EC 4137. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Regulation of Fuels and Fuel Additives: Corrections to Standards and Requirements for Reformulated and Conventional Gasoline'' (FRL #6375–1), received July 6, 1999; to the Committee on Environment and Public Works.

EC 4138. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Consumer and Commercial Products: Wood Furniture, Aerospace, and Shipbuilding and Ship Repair Coatings: Control Techniques Guidelines in Lieu of Regulations'' (FRL #6375–2), received July 6, 1999; to the Committee on Environment and Public Works.

EC 4139. A communication from the Acting Director, Fish and Wildlife Service, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Endangered and Threatened Wildlife and Plants; Final Critical Habitat Designation for the Huachuca Water Umbel'' (RIN 1018–AF37), received July 6, 1999; to the Committee on Environment and Public Works.

EC 4140. A communication from the Acting Director, Fish and Wildlife Service, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Endangered and Threatened Wildlife and Plants; Final Critical Habitat Designation for the Cactus Ferruginous Pygmy-Owl'' (RIN 1018–AF36), received July 6, 1999; to the Committee on Environment and Public Works.

EC 4141. A communication from the Administrator, General Services Administration, transmitting, pursuant to law, the report of the fiscal year 2000 Capital Investment and Leasing Program; to the Committee on Environment and Public Works.

EC 4142. A communication from the Chairman, Nuclear Regulatory Commission, transmitting, pursuant to law, the annual report for fiscal year 1997; to the Committee on Environment and Public Works.

EC 4143. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of a proposed license for the export of defense articles or defense services in the amount of $50,000,000 or more to Japan; to the Committee on Foreign Relations.

PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated:

POM–238. A resolution adopted by the Military Order of the World Wars relative to increasing defense budgets and restoring the strength and credibility of our Armed Forces; to the Committee on Appropriations.

POM–239. A resolution by the Military Order of the World Wars relative to halting nuclear proliferation; to the Committee on Foreign Relations.

POM–240. A resolution adopted by the Military Order of the World Wars relative to Inter-Continental Ballistic Missile defense; to the Committee on Armed Services.

POM–241. A resolution adopted by the Military Order of the World Wars relative to funding and resources to combat nuclear, chemical, biological, computer cyberspace and other threats in the 21st Century; to the Committee on Appropriations.

POM–242. A resolution adopted by the Military Order of the World Wars relative to Panama and the Panama Canal; to the Committee on Armed Services.

POM–243. A joint resolution adopted by the Legislature of the State of Nevada relative to regulation of insurance providers; to the Committee on Banking, Housing, and Urban Affairs.

SENATE JOINT RESOLUTION NO. 22

Whereas, Congress is currently considering the enactment of H.R. 10 and S. 900 in an effort to reform certain outdated federal laws governing providers of financial services; and

Whereas, The reformation of those federal laws, many of which were enacted in response to the Great Depression, is necessary and appropriate to ensure that providers of financial services in this country can maintain their prominence in the modern domestic and global markets; and

Whereas, The provisions of H.R. 10 and S. 900, both of which provide for the facilitation of affiliation among banks, securities firms and insurance companies, could preempt the jurisdiction of this state:

1. To ensure the solvency and to regulate the trade practices of various providers of insurance in this state; and

2. To provide adequate protection to the residents of this state who purchase insurance from those providers, without establishing an effective mechanism for the federal exercise of that authority; and

Whereas, The purposes of H.R. 10 and S. 900 can be accomplished without preempting the authority of this state to regulate providers of insurance for the protection of its residents; and

Whereas, This state currently has an effective system of laws to monitor and ensure the financial stability of providers of insurance and to protect the residents of this state from unfair trade practices: Now, therefore, be it

Resolved by the Senate and Assembly of the State of Nevada, Jointly, That the Nevada Legislature hereby urges Congress to ensure that the provisions of H.R. 10 S. 900 and any similar federal legislation do not interfere with the jurisdiction of this state to regulate providers of insurance for the protection of its residents; and be it further

Resolved, That the Secretary of the Senate prepare and transmit a copy of this resolution to the Vice President of the United States as the presiding officer of the Senate, the Speaker of the house of Representatives and each member of the Nevada Congressional Delegation; and be it further

Resolved, That this resolution becomes effective upon passage and approval.

POM–244. A joint resolution adopted by the Legislature of the State of Illinois relative to reauthorization of the Older Americans Act; to the Committee on Health, Education, Labor, and Pensions.

SENATE JOINT RESOLUTION NO. 39

Whereas, The Older Americans Act promotes the dignity and value of every older person age 60 and over (numbering 2,000,000 in Illinois) through an Aging Network led by the Illinois Department on Aging, 13 area agencies on aging, 233 community-based senior service agencies, and 63 nutrition services agencies throughout Illinois; and

Whereas, The Older Americans Act is a successful federal program, with the U.S. Administration on Aging offering leadership in

Washington, D.C., the Illinois Department on Aging (the first state department on aging in the nation) at the State level, the area agencies on aging in 13 regions designated by the State covering all of Illinois, and community-based senior service agencies providing services in every community; and

Whereas, The Older Americans Act programs target resources and services to those in greatest economic and social need, promote the dignity and contributions of our senior citizens, support transportation services, provide home care, assist families and individuals with case management, guide those challenged by the legal system through legal assistance, provide for senior community service employment, offer information and assistance, establish multi-purpose senior centers as focal points on aging, serve congregate luncheon and home-delivered meals, provide health promotion and disease prevention activities, involve older persons in nutrition education, reach out to families with respite services for caregivers and small repair and home modifications, provide opportunities, education, and services, connect people in shared housing, and advocate to public and private policy makers on the issues of importance to older persons; and

Whereas, The success of this aging network over the past 31 years is marked by the delivery of significant service to older persons in their own homes and community with the following services examples of that success:

(1) 374,538 recipients of access services, including 235,148 Information and Assistance Services clients and 68,493 recipients of Case Management Services;

(2) 53,450 recipients of in-home services, including 6,460,533 home-delivered meals to 41,305 elders;

(3) 185,520 recipients of community services, including 3,636,855 meals to 79,012 congregate meal participants at 647 nutrition sites and services delivered from 170 Senior Centers;

(4) 760 recipients of employment services, including 760 senior community service employment program participants; and

(5) 98,600 recipients of nursing home ombudsman services; and

Whereas, The organizations serving older persons employ professionals dedicated to offering the highest level of service and caring workers who every day provide in-home care, rides, educational and social activities, shopping assistance, advice, and hope to those in greatest isolation and need; and

Whereas, The organizations serving older persons involve a multi-generational corps of volunteers who contribute to the governance, planning, and delivery of services to older persons in their own communities through participation on boards and advisory councils and in the provision of clerical support, programming, and direct delivery of service to seniors; and

Whereas, The Older Americans Act programs in Illinois leverage local funding for aging services and encourage contributions from older persons; and

Whereas, The Older Americans Act programs are the foundation for the Illinois Community Care Program which reaches out to those with the lowest incomes and greatest frailty to provide alternatives to long-term care, and the Illinois Elder Abuse and Neglect Interventions Program which assists families in the most difficult of domestic situations with investigation and practical interventions; and

Whereas, The Congress of the United States has not reauthorized the Older Americans Act since 1995 and only extends the program each year through level appropriations; and

Whereas, Expansion of the Older Americans Act is proposed in reauthorization legislation this year to offer family caregiver support, increased numbers of home-delivered meals, improved promotion of elder rights, consolidation of several programs and sub-titles of the law: Therefore, be it

Resolved, by the Senate of the Ninety-first General Assembly of the State of Illinois, the House of Representatives concurring herein, That we urge the Congress of the United States of America to reauthorize the Older Americans Act this year; and be it further

Resolved, That suitable copies of this resolution be delivered to the President pro tempore of the U.S. Senate, the Speaker of the U.S. House of Representatives, and each member of the Illinois congressional delegation.

Adopted by the Senate, May 26, 1999.

POM–245. A joint resolution adopted by the General Assembly of the State of Maryland relative to state regulation of self-funded employer-based health plans; to the Committee on Health, Education, Labor, and Pensions.

SENATE JOINT RESOLUTION 7

Whereas, The McCarran-Ferguson Act, passed by the U.S. Congress in 1945, established a statutory framework whereby responsibility for regulating insurance and the insurance industry was left largely to the states; and

Whereas, The Employee Retirement Income Security Act of 1974 (ERISA) significantly altered this concept by creating a federal framework for regulating employer-based pension and welfare benefit plans, including health plans; and

Whereas, ERISA effectively prohibits states from directly regulating many employer-based health plans because ERISA preempts state regulation of self-insured plans; and

Whereas, Available data suggests that self-funding of employer-based health plans is increasing at a significant rate among both small and large businesses; and

Whereas, Between 1989 and 1993, the United States General Accounting Office estimates that the number of self-funded plan enrollees increased by about 6,000,000 individuals; and

Whereas, Approximately 40% to 50% of employer-based health plans are presently self-funded by employers that retain most or all of the financial risk for their respective health plans; and

Whereas, With the growth in the self-funding of health plans, states have lost regulatory oversight over a growing portion of the health market; and

Whereas, Recent federal court decisions have struck down state laws regulating insured health plans by expanding ERISA's current preemption of state laws regulating self-insured plans to laws relating to ensured plans; and

Whereas, As these phenomena continue, state governments are losing their ability to mange their health care markets; and

Whereas, Many state legislatures, such as the Maryland General Assembly, have taken significant actions to increase access to care, to control costs, and to regulate against abuses by health plans; and

Whereas, ERISA preemption is a significant obstacle to the states adopting a wide range of health care reform and consumer protection strategies; and

Whereas, The states' inability to protect consumers enrolled in self-funded health plans that fail to provide the consumers' anticipated level of health care is gradually eroding the public's confidence in the American health care system because self-funded plans are afforded an unfair advantage over traditional health insurance plans due to a lack of adequate state or federal accountability, regulation, or remedy for the ERISA plan members who are denied coverage; and

Whereas, Over the past 24 years, state governments have gradually realized that ERISA is an impediment to ensuring adequate consumer protection for all individuals with employer-based health care coverage and to enacting administrative simplification and cost reduction reforms that could improve the efficiency and equity of their health care markets; and

Whereas, ERISA plan participants, their dependents, and their treating physicians believe that they have been denied coverage for medically necessary procedures because ERISA's remedy provisions have been narrowly interpreted and ERISA's preemption provisions have been broadly interpreted, thereby creating substantial economic incentives, with few disincentives for plan administrators to deny medically necessary benefits legitimately covered under ERISA plans; and

Whereas, The time has now come for the states to aggressively seek changes in ERISA to give them more flexibility in regulating health plans at the state level, to increase access to health care, and to lower health care costs: Now, therefore, be it

Resolved by the General Assembly of Maryland, That this General Assembly hereby requests the U.S. Congress to amend the Employment Retirement Income Security Act of 1974 (ERISA) to authorize each state to monitor and to regulate self-funded employer-based health plans in the interests of providing greater consumer protection and effecting significant health care reforms at the state level through the offices of the various insurance commissioners and states' attorneys general. Additionally, the United States Department of Labor should cooperatively refer complaints to the offices of the various insurance commissioners and states' attorneys general; and be it further

Resolved, That §502(a)(1)(B) of ERISA, which currently reads: ''(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;'', be amended to read: ''(B) to recover benefits due to him under the terms of his plan, to recover from the fiduciary compensatory damages caused by the fiduciary's failure to pay benefits due under the terms of the plan, to enforce his rights under the terms of the plan, or to timely authorize assurance of payment and clarify his rights to future benefits under the terms of the plans;''; and be it further

Resolved, This this General Assembly most fervently urges and encourages each state legislative body in the nation to enact this resolution, or one similar in context and form, as a show of solidarity in petitioning the federal government for greater state authority and responsibility in regulating self-funded employer-based health plans; and be it further

Resolved, That a copy of this Resolution be forwarded by the Department of Legislative Services to the Honorable Parris N. Glendening, Governor of Maryland; The Honorable Thomas V. Mike Miller, Jr., President of the Senate of Maryland; and the Honorable Casper R. Taylor, Jr., Speaker of the House of Delegates; and be it further

Resolved, That a copy of this Resolution be forwarded by the Department of Legislative Services to the National Conference of State Legislatures, 444 North Capitol Street, NW., Suite 515, Washington, DC 20001; and be it further

Resolved, That a copy of this Resolution be forwarded by the Department of Legislative Services to the President of the United States; the Secretary of the United States

Department of Labor; the Speaker and the Clerk of the United States House of Representatives; the President and the Secretary of the United States Senate; and to the presiding officer of each chamber of each state legislature in the nation; and be it further

Resolved, That a copy of this Resolution be forwarded by the Department of Legislative Services to the Maryland Congressional Delegation: Senators Paul S. Sarbanes and Barbara A. Mikulski, Senate Office Building, Washington, DC 20510; and Representatives Wayne T. Gilchrest, Robert L. Ehrlich, Jr., Benjamin L. Cardin, Albert R. Wynn, Steny Hamilton Hoyer, Roscoe G. Bartlett, Elijah E. Cummings, and Constance A. Morella, House Office Building, Washington, DC 20515.

POM–246. A joint resolution adopted by the General Assembly of the State of Maryland relative to state regulation of self-funded employer-based health plans; to the Committee on Health, Education, Labor, and Pensions.

HOUSE JOINT RESOLUTION 8

Whereas, The McCarran-Ferguson Act, passed by the U.S. Congress in 1945, established a statutory framework whereby responsibility for regulating insurance and the insurance industry was left largely to the states; and

Whereas, The Employee Retirement Income Security Act of 1974 (ERISA) significantly altered this concept by creating a federal framework for regulating employer-based pension and welfare benefit plans, including health plans; and

Whereas, ERISA effectively prohibits states from directly regulating many employer-based health plans because ERISA preempts state regulation of self-insured plans; and

Whereas, Available data suggests that self-funding or employer-based health plans in increasing at a significant rate among both small and large businesses; and

Whereas, Between 1989 and 1993, the United States General Accounting Office estimates that the number of self-funded plan enrollees increase by about 6,000,000 individuals; and

Whereas, Approximately 40% to 50% of employer-based health plans are presently self-funded by employers that retain most or all of the financial risk for their respective health plans; and

Whereas, With the growth in the self-funding of health plans, states have lost regulatory oversight over a growing portion of the health market; and

Whereas, Recent federal court decisions have struck down state laws regulating insured health plans by expanding ERISA's current preemption of state laws regulating self-insured plans to laws relating to insured plans; and

Whereas, As these phenomena, continue, state governments are losing their ability to manage their health care markets; and

Whereas, Many state legislatures, such as the Maryland General Assembly, have taken significant actions to increase access to care, to control costs, and to regulate against abuses by health plans; and

Whereas, ERISA preemption is a significant obstacle to the states adopting a wide range of health care reform and consumer protection strategies; and

Whereas, The states' inability to protect consumers enrolled in self-funded health plans that fail to provide the consumers' anticipated level of health care is gradually eroding the public's confidence in the American health care system because self-funded plans are afforded an unfair advantage over traditional health insurance plans due to a lack of adequate state or federal accountability, regulation, or remedy for the ERISA plan members who are denied coverage; and

Whereas, Over the past 24 years, state governments have gradually realized that ERISA is an impediment to ensuring adequate consumer protection for all individuals with employer-based health care coverage and to enacting administrative simplification and cost reduction reforms that could improve the efficiency and equity of their health care markets; and

Whereas, ERISA plan participants, their dependents, and their treating physicians believe that they have been denied coverage for medically necessary procedures because ERISA's remedy provisions have been narrowly interpreted and ERISA's preemption provisions have been broadly interpreted, thereby creating substantial economic incentives, with few disincentives for plan administrators to deny medically necessary benefits legitimately covered under ERISA plans; and

Whereas, The time has now come for the states to aggressively seek changes in ERISA to give them more flexibility in regulating health plans at the state level, to increase access to health care, and to lower health care costs: Now, therefore, be it

Resolved by the General Assembly of Maryland, That this General Assembly hereby requests the U.S. Congress to amend the Employment Retirement Income Security Act of 1974 (ERISA) to authorize each state to monitor and to regulate self-funded employer-based health plans in the interests of providing greater consumer protection and effecting significant health care reforms at the state level through the offices of the various insurance commissioners and states' attorneys general. Additionally, the United States Department of Labor should cooperatively refer complaints to the offices of the various insurance commissioners and states' attorneys general; and be it further

Resolved, That §502(a)(1)(B) of ERISA, which currently reads: ''(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;'', be amended to read: ''(B) to recover benefits due to him under the terms of his plan, to recover from the fiduciary compensatory damages caused by the fiduciary's failure to pay benefits due under the terms of the plan, to enforce his rights under the terms of the plan, or to timely authorize assurance of payment and clarify his rights to future benefits under the terms of the plans;''; and be it further

Resolved, That this General Assembly most fervently urges and encourages each state legislative body in the nation to enact this resolution, or one similar in context and form, as a show of solidarity in petitioning the federal government for greater state authority and responsibility in regulating self-funded employer-based health plans; and be it further

Resolved, That a copy of this Resolution be forwarded by the Department of Legislative Services to the Honorable Parris N. Glendening, Governor of Maryland; The Honorable Thomas V. Mike Miller, Jr., President of the Senate of Maryland; and the Honorable Casper R. Taylor, Jr., Speaker of the House of Delegates; and be it further

Resolved, That a copy of this Resolution be forwarded by the Department of Legislative Services to the National Conference of State Legislatures, 444 North Capitol Street, N.W., Suite 515, Washington, D.C. 20001; and be it further

Resolved, That a copy of this Resolution be forwarded by the Department of Legislative Services to the President of the United States; the Secretary of the United States Department of Labor; the Speaker and the Clerk of the United States House of Representatives; the President and the Secretary of the United States Senate; and to the presiding officer of each chamber of each state legislature in the nation; and be it further

Resolved, That a copy of this Resolution be forwarded by the Department of Legislative Services to the Maryland Congressional Delegation: Senators Paul S. Sarbanes and Barbara A. Mikulski, Senate Office Building, Washington, D.C. 20510; and Representatives Wayne T. Gilchrest, Robert L. Ehrlich, Jr., Benjamin L. Cardin, Albert R. Wynn, Steny Hamilton Hoyer, Roscoe G. Bartlett, Elijah E. Cummings, and Constance A. Morella, House Office Building, Washington, D.C. 20515.

POM–217. A joint resolution adopted by the Assembly of the State of Nevada relative to amending the Wild Free-Roaming Horses and Burros Act; to the Committee on Energy and Natural Resources.

ASSEMBLY JOINT RESOLUTION NO. 2

Whereas, On December 15, 1971, Congress enacted the provisions of the Wild Free-Roaming Horses and Burros Act, 16 U.S.C. §§1331 et seq.; and

Whereas, The purpose of the Act is to preserve the wild horses and burros living on the public lands managed by the Bureau of Land Management and the United States Forest Service and to protect those wild horses and burros from capture, branding, harassment and death; and

Whereas, Since 1971, the population of wild horses living on the public lands managed by the Bureau of Land Management and the United States Forest Service has increased dramatically, particularly in Nevada where the largest population of those wild horses exists; and

Whereas, the Act requires the Secretary of the Interior and the Secretary of Agriculture to manage the wild horses living on the public lands administered by the Bureau of Land Management and the United States Forest Service in a manner that will achieve and maintain a natural ecological balance on those public lands; and

Whereas, Pursuant to that Act, if the Secretary of the Interior or the Secretary of Agriculture determines that an overpopulation of wild horses exists in an area of the public lands managed by the Bureau of Land Management and the United States Forest Service, the secretary must remove the excess wild horses from those areas to achieve an appropriate level of management for the wild horses; and

Whereas, Although the provisions of the Act address the issue of overpopulation of wild horses, the Act does not require that the population of wild horses be maintained at a particular level, thereby allowing the population of wild horses to expand far beyond the level envisioned by Congress in 1971; and

Whereas, Allowing an excessive number of wild horses to live on the public lands managed by the Bureau of Land Management and the United States Forest Service causes those public lands to deteriorate from overuse and contravenes the purposes of the Taylor Grazing Act, 43 U.S.C. §§315 et seq., and the Federal Land Policy and Management Act of 1976, 43 U.S.C. §§1701 et seq., which are intended to protect those public lands from deterioration and overuse; and

Whereas, Requiring the Secretary of the Interior and the Secretary of Agriculture to maintain the population of wild horses living on the public lands managed by the Bureau of Land Management and the United States Forest Service at the level established for those wild horses in 1975 will:

1. Improve the condition of the ranges used by the wild horses;

2. Increase the population and improve the habitat of deer, antelope and other species of wildlife living on those public lands;

3. Allow an increased use of the public lands and the development of native flora and vegetation;

4. Improve conditions for hunting and other outdoor sports;

5. Reduce the amount of money required to shelter, feed and prepare wild horses for adoption; and

6. Reduce the risk of deaths of wild horses because of freezing, starvation and drought: Now, therefore, be it

Resolved by the Assembly and Senate of the State of Nevada, Jointly, That the Nevada Legislature urges Congress to amend the provisions of the Wild Free-Roaming Horses and Burros Act to require the Secretary of the Interior and the Secretary of Agriculture to establish the necessary regulations and procedures whereby horses and burros in excess of the appropriate management levels are gathered in a timely fashion, and unadoptable horses and burros are made available for sale at open market; and be it further

Resolved, That the Nevada Legislature urges Congress to include provisions in the Wild Free-Roaming Horses and Burros Act directing that the proceeds of sales of unadoptable horses and burros be granted to the state director of the federal land management agency responsible for the horses and burros which were gathered off public lands, prior to sale, and that these proceeds be used to augment wild horse and burro management programs in the state; and be it further

Resolved, That the establishment of the appropriate management levels should be based on sound scientific and locally-collected resource information that incorporates and fully acknowledges other existing multiple uses of the land, such as the needs of other wildlife and livestock living on the land; and be it further

Resolved, That the establishment of the appropriate management levels should be concluded by the end of the federal fiscal year 2002, and maintained thereafter, irrespective of the outlet capacity of the federal horse adoption programs; and be it further

Resolved, That the Chief Clerk of the Assembly prepare and transmit a copy of this resolution to the Vice President of the United States as the presiding officer of the Senate, the Speaker of the House of Representatives, each member of the Nevada Congressional Delegation and each legislature of the other 49 states; and be it further

Resolved, That this resolution becomes effective upon passage and approval.

REPORTS OF COMMITTEES SUBMITTED DURING ADJOURNMENT

Under the authority of the order of the Senate of July 1, 1999, the following reports of committees were submitted on July 8, 1999:

By Mr. THOMPSON, from the Committee on Governmental Affairs, without amendment:

S. 712: A bill to amend title 39, United States Code, to allow postal patrons to contribute to funding for highway-rail grade crossing safety through the voluntary purchase of certain specially issued United States postage stamps (Rept. No. 106–104).

By Mr. THOMPSON, from the Committee on Governmental Affairs, without amendment:

S. 1072: A bill to make certain technical and other corrections relating to the Centennial of Flight Commemoration Act (36 U.S.C. 143 note; 112 Stat. 3486 et seq.) (Rept. No. 106–105).

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. MCCAIN, from the Committee on Commerce, Science, and Transportation, with amendments:

S. 296: A bill to provide for continuation of the Federal research investment in a fiscally sustainable way, and for other purposes (Rept. No. 106–106).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. LAUTENBERG (for himself, Mrs. BOXER, Mr. DURBIN, Mr. MOYNIHAN, Mrs. FEINSTEIN, Mrs. MURRAY, Mr. KERRY, Mr. TORRICELLI, Mr. FEINGOLD, Mr. KOHL, Mr. KENNEDY, and Mr. SCHUMER):

S. 1345. A bill to amend title 18, United States Code, to prohibit certain interstate conduct relating to exotic animals; to the Committee on the Judiciary.

By Mr. BOND:

S. 1346. A bill to ensure the independence and nonpartisan operation of the Office of Advocacy of the Small Business Administration; to the Committee on Small Business.

By Mr. BROWNBACK:

S. 1347. A bill to amend the Internal Revenue Code of 1986 to exclude from gross income capital gain from the disposition of certain urban property, Indian reservation property, or farm property which has been held for more than 5 years; to the Committee on Finance.

By Mr. BROWNBACK (for himself, Mr. KYL, Mr. HAGEL, Mr. ALLARD, Mr. ENZI, Mr. SESSIONS, Mr. HELMS, and Mr. INHOFE):

S. 1348. A bill to require Congress and the President to fulfill their Constitutional duty to take personal responsibility for Federal laws; to the Committee on Governmental Affairs.

By Mr. THOMAS:

S. 1349. A bill to direct the Secretary of the Interior to conduct special resource studies to determine the national significance of specific sites as well as the suitability and feasibility of their inclusion as units of the National Park System; to the Committee on Energy and Natural Resources.

By Mr. GRASSLEY (for himself and Mr. TORRICELLI):

S. 1350. A bill to amend the Internal Revenue Code of 1986 to expand the availability of medical savings accounts; to the Committee on Finance.

By Mr. GRASSLEY (for himself, Mr. MURKOWSKI, and Mr. HARKIN):

S. 1351. A bill to amend the Internal Revenue Code of 1986 to extend and modify the credit for electricity produced from renewable resources; to the Committee on Finance.

By Mr. COVERDELL (for himself, Mr. THURMOND, Mr. CLELAND, and Mr. HOLLINGS):

S.J. Res. 29. A joint resolution to grant the consent of Congress to the boundary change between Georgia and South Carolina; to the Committee on the Judiciary.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. REID (for himself and Mr. DASCHLE):

S. Res. 137. A resolution to congratulate the United States Women's Soccer Team on winning the 1999 Women's World Cup Championship; to the Committee on the Judiciary.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. LAUTENBERG (for himself, Mrs. BOXER, Mr. DURBIN, Mr. MOYNIHAN, Mrs. FEINSTEIN, Mrs. MURRAY, Mr. KERRY, Mr. TORRICELLI, Mr. FEINGOLD, Mr. KOHL, Mr. KENNEDY, and Mr. SCHUMER):

S. 1345. A bill to amend title 18, United States Code, to prohibit certain interstate conduct relating to exotic animals; to the Committee on the Judiciary.

CAPTIVE EXOTIC ANIMAL PROTECTION ACT OF 1999

Mr. LAUTENBERG. Mr. President, I rise to introduce the Captive Exotic Animal Protection Act, which would prohibit the barbaric and unsporting practice of ''canned hunts,'' or caged kills. I am pleased to be joined by my cosponsors Senators BOXER, DURBIN, FEINGOLD, FEINSTEIN, KENNEDY, KERRY, KOHL, MOYNIHAN, MURRAY, SCHUMER, and TORRICELLI.

A typical canned hunt operation collects surplus animals from wild animal parks, circuses, and even petting zoos, and then sells the right to brutally kill these animals to so-called ''hunters.'' In reality, no hunting, tracking or shooting skills are required. For a price, any ''hunter'' is guaranteed a kill of the exotic animal of his choice—one located by a guide and blocked from escape. A wild boar ''kill'' may sell for $250, a pygmy goat for $400, while a rare Arabian Ibex may fetch up to $5000. The actual ''hunt'' of these tame animals occurs within a fenced enclosure, leaving the animal virtually no chance for escape. Fed and cared for by humans, these animals often have lost their instinctual impulse to flee from the so-called hunters who ''stalk'' them.

The actual killing methods employed by these hunters only compound the cruelty of slaughtering these often trusting animals. In order to preserve the animal as a ''trophy,'' hunters will fire multiple shots into non-vital organs, condemning the animal to a slow and painful death.

Canned hunts are condemned by pro-animal and pro-hunting groups alike for being cruel and unethical. Many real hunters believe that canned hunts are unethical and make a mockery of their sport. For example, the Boone and Crockett Club, a hunting organization founded by Teddy Roosevelt, has called canned hunts ''unfair'' and ''unsportsmanlike.'' Bill Burton, the

former outdoors writer for the Baltimore Sun and a hunter, testifying in support of this legislation, stated, ''[t]here is a common belief that the hunting of creatures which have no reasonable avenue to escape is not up to traditional standards. Shooting game in confinement is not within these standards.''

In addition to being unethical, these canned hunts present a serious health and safety problem for livestock and native wildlife. Accidental escapes of animals from exotic game ranches are not uncommon, posing a very real threat to nearby livestock and indigenous wildlife. John Talbott, acting director of the Wyoming Department of Fish and Game, has stated that, ''[t]uberculosis and other disease documented amount game ranch animals in surrounding states,'' pose ''an extremely serious threat to Wyoming's native big game.'' In recognition of this threat, Wyoming itself has banned canned hunting facilities, as have the States of California, Connecticut, Georgia, Maryland, Massachusetts, Nevada, New Jersey, North Carolina, Rhode Island, and Wisconsin. Unfortunately, the remaining States lack legislation to outlaw canned hunts, and because interstate commerce in exotic animals is common, federal legislation is essential to control these cruel practices.

My bill is similar to legislation I introduced in the 105th Congress, S. 995. The legislation I am introducing today will specifically target only canned hunt facilities, and will not affect any animal industries, such as cattle ranchers, rodeos, livestock shows, petting zoos, horse and dog racing, or wildlife hunting. Furthermore, this bill will not apply to large hunting ranches, such as those over 1,000 acres, which give the hunted animal a greater opportunity to escape. This bill merely seeks to ban the transport and trade of non-native, exotic animals for the purpose of staged trophy hunts.

The idea of a defenseless animal meeting a violent end as the target of a canned hunt is, at the very least, distasteful to many of us. In an era when many of us are seeking to curb violence in our culture, canned hunts are certainly one form of gratuitous brutality that does not belong in our society.

I urge my colleagues who want to understand the cruelty involved in a canned hunt to visit my office and view a videotape of an actual canned hunt. You will witness a defenseless Corsican ram, cornered near a fence, being shot over and over again with arrows, clearly experiencing an agonizing death, only to be dealt a final blow by a firearm after needless suffering.

Please join me in support of this legislation which will help to put an end to this needless suffering.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1345

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Captive Exotic Animal Protection Act of 1999''.

SEC. 2. TRANSPORT OR POSSESSION OF EXOTIC ANIMALS FOR PURPOSES OF KILLING OR INJURING THEM.

(a) IN GENERAL.—Chapter 3 of title 18, United States Code, is amended by adding at the end the following:

''§ 48. Exotic animals

''(a) PROHIBITION.—Whoever, in or affecting interstate or foreign commerce, knowingly transfers, transports, or possesses a confined exotic animal, for the purposes of allowing the killing or injuring of that animal for entertainment or for the collection of a trophy, shall be fined under this title, imprisoned not more than 1 year, or both.

''(b) DEFINITIONS.—In this section—

''(1) the term 'confined exotic animal' means a mammal of a species not historically indigenous to the United States, that has been held in captivity for the shorter of—

''(A) the greater part of the life of the animal; or

''(B) a period of 1 year;

whether or not the defendant knew the length of the captivity; and

''(2) the term 'captivity' does not include any period during which an animal—

''(A) lives as it would in the wild, surviving primarily by foraging for naturally occurring food, roaming at will over an open area of not less than 1,000 acres; and

''(B) has the opportunity to avoid hunters.''.

(b) CLERICAL AMENDMENT.—The analysis for chapter 3 of title 18, United States Code, is amended by adding at the end the following:

''48. Exotic animals.''.

By Mr. BOND:

S. 1346. A bill to ensure the independence and nonpartisan operation of the Office of Advocacy of the Small Business Administration; to the Committee on Small Business.

INDEPENDENT OFFICE OF ADVOCACY ACT

● Mr. BOND. Mr. President, today, I am introducing the Independent Office of Advocacy Act. This bill has been drafted to build on the success of the Office of Advocacy over the past 23 years. It is intended to strengthen the foundation to make the Office of Advocacy a stronger and more effective advocate for all small businesses throughout the United States.

The Office of Advocacy is a unique office within the Federal government. It is part of the Small Business Administration (SBA/Agency), and its director, the Chief Counsel for Advocacy, is nominated by the President and confirmed by the Senate. At the same time, the Office is also intended to be the independent voice for small business within the Federal government. It is supposed to develop proposals for changing government policies to help small businesses, and it is supposed to represent the views and interests of small businesses before other Federal agencies.

As the director of the Office of Advocacy, the Chief Counsel for Advocacy has a dual responsibility. On the one hand, he is the independent watchdog for small business. On the other hand, he is also a part of the President's Administration. As you can imagine, those are sometimes very difficult roles to play simultaneously.

The Independent Office of Advocacy Act is designed to make the Office of Advocacy and Chief Counsel for Advocacy a fully independent advocate within the Executive Branch acting on behalf of the small business community. The bill would establish a clear mandate that the Office of Advocacy will fight on behalf of small businesses regardless of the position taken on critical issues by the President and his Administration.

The Office of Advocacy as envisioned by the Independent Office of Advocacy Act will be unique within the executive branch. The Chief Counsel for Advocacy will be a wide-ranging advocate, who will be free to take positions contrary to the Administration's policies and to advocate change in government programs and attitudes as they impact small businesses.

In 1976, Congress established the Office of Advocacy in the SBA to be the eyes, ears and voice for small business within the Federal government. Over time, it has been assumed that the Office of Advocacy is the ''independent'' voice for small business. While I strongly believe that the Office of Advocacy and the Chief Counsel for Advocacy should be independent and free to advocate or support positions that might be contrary to the administration's policies, I have come to find that the Office is not as independent as necessary to do the job adequately for small business.

For example, funding for the Office of Advocacy comes from the Salaries and Expense Account of the SBA's budget. Staffing is allocated by the SBA Administrator to the Office of Advocacy from the overall staff allocation for the Agency. In 1990, there were 70 full-time employees working on behalf of small businesses in the Office of Advocacy. Today's allocation of staff is 49, and fewer are actually on-board as the result of the hiring freeze imposed by the SBA Administrator. The Independence of the Office is diminished when the Office of Advocacy staff is reduced to allow for increased staffing for new programs and additional initiatives in other areas of SBA, at the discretion of the Administrator.

In addition, the General Accounting Office (GAO) recently completed a report for me on personnel practices at the SBA (GAO/GGD–99–68). I was alarmed by the GAO's finding that Assistant and Regional Advocates hired by the Office of Advocacy share many of the attributes of Schedule C political appointees. In fact, Regional Advocates are frequently cleared by the White House personnel office—the same procedure followed for approving Schedule C political appointees.

The facts discussed in the GAO Report cast the Office of Advocacy in a

whole new light—one that had not been apparent until now. The report raises questions, concerns and suspicious regarding the independence of the Office of Advocacy. Has there been a time when the Office did not pursue a matter as vigorously as it might have were it not for direct or indirect political influence? Prior to receipt of the GAO Report, my response was a resounding ''No.'' But now, a question mark arises.

Let me take a moment and note that I will be unrelenting in my efforts to insure the complete independence of the Office of Advocacy in all matters, at all times, for the continued benefit of all small businesses. However, so long as the Administration controls the budget allocated to the Office of Advocacy and controls who is hired, the independence of the Office may be in jeopardy. We must correct this situation, and the sooner we do it, the better it will be for the small business community.

The Independent Office of Advocacy Act builds a firewall to prevent the political intrustion into the management of day-to-day operations of the Office of Advocacy. The bill requires that the SBA's budget include a separate account for the Office of Advocacy. No longer would its funds come from the general operating account of the Agency. The separate account would also provide for the number of full-time employees who would work within the Office of Advocacy. No longer would the Chief Counsel for Advocacy have to seek approval from the SBA Administrator to hire staff for the Office of advocacy.

The bill also continues the practice of allowing the Chief Counsel to hire individuals critical to the mission of the Office of Advocacy without going through the normal competitive procedures directed by federal law and the Office of Personnel Management (OPM). I beleive this special hiring authority, which is limited only to employees within the Office of Advocacy, is beneficial because it allows the Chief Counsel to hire quickly those persons who can best assist the Office in responding to changing issues and problems confronting small businesses.

Mr. Presdient, the Independent Office of Advocacy Act is a sound bill. The bill is the product of a great deal of thoughtful, objective review and consideration by me, the staff of the Committee on Small Business, representatives of the small business community, former Chief Councels for Advocacy and others. These individuals have also devoted much time and effort in actively participating in a Committee Roundtable discussion on the Office of Advocacy, which my Committee held on April 21, 1999. It is my hope the Committee on Small Business will be able to consider the Independent Office of Advocacy Act in the near future.●

By Mr. THOMAS:

S. 1349. A bill to direct the Secretary of the Interior to conduct special resource studies to determine the national significance of specific sites as well as the suitability and feasibility of their inclusion as units of the National Park System; to the Committee on Energy and Natural Resources.

NATIONAL PARK SYSTEM NEW AREA STUDY ACT OF 2000

Mr. THOMAS. Mr. President, I rise today to introduce the National Park System New Area Study Act of 2000.

Mr. President, last year when we passed the National Parks Vision 20–20 legislation, we made a number of revisions in the way we do business within the National Park System. One of those changes concerned the conduct of new park studies.

Prior to the National Park Service undertaking any new area studies, and from this point forward, Congress must act affirmatively on a list submitted by the Secretary of the Interior for studies on potential new units of the System.

Pursuant to Public Law 105–391, the Secretary has submitted a list and this legislation reflects the Secretary's request.

Mr. President, I ask unanimous request that the bill be printed in the RECORD.

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

S. 1349

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''National Park System New Area Study Act of 2000''.

SEC. 2. FINDINGS AND PURPOSES:

(a) FINDINGS.—Congress finds that pursuant to Public Law 105–391, the Administration has submitted a list of areas recommended for study for potential inclusion in the National Park System in fiscal year 2000.

(b) PURPOSE.—The purpose of this Act is to direct the Secretary of the Interior to direct special resource studies to determine the national significance of the sites, and/or areas, listed in Section 5 of this Act to determine the national significance of each site, and/or area, as well as the suitability and feasibility of their inclusion as units of the National Park System.

SEC. 3. DEFINITIONS.

In this Act:

(1) SECRETARY.—The term ''Secretary'' means the Secretary of the Interior acting through the Director of the National Park Service.

SEC. 4. STUDIES.

(a) IN GENERAL.—Not later than 2 years after the date on which funds are made available for the purpose of this Act, the Secretary, shall submit to the Committee on Energy and Natural Resources of the Senate and the Committee on Resources of the House of Representatives individual resource studies of the sites, and/or areas, listed in Section 5 of this Act.

(b) CONTENTS.—The study under subsection (a) shall—

(1) identify the location and the suitability and feasibility of designating the sites, and/or areas, as units of the National Park System; and

(2) include cost estimates for any necessary acquisition, development, operation and maintenance, and identification of alternatives for the management, administration, and protection of the area.

SEC. 5. SITES AND/OR AREAS.

(a) The areas recommended for study for potential inclusion in the National Park System include the following:

(1) Bioluminescent Bay, Mosquito Lagoon, Puerto Rico;

(2) Brandywine and Paoli Battlefields, Pennsylvania;

(3) Civil Rights Trail, Nationwide;

(4) Gaviota Coast Seashore, California;

(5) Kate Mullaney House, New York;

(6) Low Country Gullah Culture, South Carolina, Georgia and Florida;

(7) Nan Madol, Northern Marianas;

(8) Walden Pond and Woods, in Concord and Lincoln, Massachusetts; and

(9) World War II sites on Palau and Saipan.

SEC. 6. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as are necessary to carry out this Act.

By Mr. GRASSLEY (for himself and Mr. TORRICELLI):

S. 1350. A bill to amend the Internal Revenue Code of 1986 to expand the availability of medical savings accounts; to the Committee on Finance.

MEDICAL SAVINGS ACCOUNT IMPROVEMENT ACT OF 1999

Mr. GRASSLEY. Mr. President, today, on behalf of myself and my colleague, Senator TORRICELLI, I am introducing legislation, the Medical Savings Account Improvement Act of 1999, which would make it possible for any individual to purchase a medical savings account and which would liberalize existing law authorizing medical savings accounts in a number of other respects.

Medical savings accounts are a good idea, Mr. President. They are basically IRAs—an idea everybody understands—which must be used for payment of medical expenses.

The widespread use of medical savings accounts should have several beneficial consequences.

They should reduce health care costs. Administrative costs should be lower. Consumers with MSAs should use health care services in a more discriminating manner. Consumers with MSAs should be more selective in choosing providers. This should cause those providers to lower their prices to attract medical savings account holders as patients.

Medical savings accounts can also help to put the patient back into the health care equation. Patients should make more cost-conscious choices about routine health care. Patients with MSAs would have complete choice of provider.

Medical savings accounts should make health care coverage more dependable. MSAs are completely portable. MSAs are still the property of the individual even if they change jobs. Hence, for those with MSAs, job changes do not threaten them with the loss of health insurance.

Medical savings accounts should increase health care coverage. Perhaps as many as half of the more than 40 million Americans who are uninsured at

any point in time are without health insurance only for four months or less. A substantial number of these people are uninsured because they are between jobs. Use of medical savings accounts should reduce the number of the uninsured by equipping people to pay their own health expenses while unemployed.

Medical savings accounts should promote personal savings. Since pre-tax monies are deposited in them, there should be a strong tax incentive to use them.

Mr. President, our bill would do several things:

First, it would repeal the limitations on the number of MSAs that can be established.

Second, it stipulates that the availability of these accounts is not limited to employees of small employers and self-employed individuals.

Third, it increases the amount of the deduction allowed for contributions to medical savings accounts to 100 percent of the deduction.

Fourth, it permits both employees and employers to contribute to medical savings accounts.

Fifth, it reduces the permitted deductibles under high deductible plans from $1,500 in the case of individuals to $1,000 and from $3,000 in the case of couples to $2,000.

Finally, the bill would permit medical savings accounts to be offered under cafeteria plans.

Mr. President, I ask unanimous consent that the text of our bill be printed in the RECORD.

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

S. 1350

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medical Savings Account Improvement Act of 1999''.

SEC. 2. EXPANSION OF AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(B) Section 138 of such Code (relating to Medicare+Choice MSA) is amended by striking subsection (f).

(b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Section 220(c)(1)(A) of the Internal Revenue Code of 1986 (relating to eligible individual) is amended to read as follows:

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

''(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

''(I) which is not a high deductible health plan, and

''(II) which provides coverage for any benefit which is covered under the high deductible health plan.''

(2) CONFORMING AMENDMENTS.—

(A) Section 220(c)(1) of such Code is amended by striking subparagraph (C).

(B) Section 220(c) of such Code is amended by striking paragraph (4) (defining small employer) and by redesignating paragraph (5) as paragraph (4).

(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible (as of the first day of such month) of the individual's coverage under the high deductible health plan.''.

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking ''75 percent of''.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (4) of section 220(b) of such Code, as redesignated by subsection (b)(2)(C), is amended to read as follows:

''(4) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year.''.

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking ''$1,500'' and inserting ''$1,000'', and

(B) by striking ''$3,000'' in clause (ii) and inserting ''$2,000''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended—

(A) by striking ''1998'' and inserting ''1999''; and

(B) by striking ''1997'' and inserting ''1998''.

(f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking ''106(b),''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

Mr. TORRICELLI. Mr. President, I rise today, along with my distinguished colleague from Iowa, Senator GRASSLEY, to introduce legislation that will provide Americans more choices and control in their health care decisions.

Since becoming available in 1996, medical savings accounts (MSA's) have proven to be an effective solution for Americans who are self-employed, unsatisfied with their current health plan or working for a company unable to provide health insurance. By allowing consumers to save money tax-free to cover medical expenses, MSA's have ensured that people who previously were unable to acquire health coverage, such as single parents, the self-employed, small businesses and their employees, and working families, now have affordable medical coverage. In fact, since MSA's became available, the General Accounting Office reports that 37 percent of all MSA's have been purchased by people who were previously uninsured.

Due to current restrictions, however, the size of the market is limited. Congress must allow the benefits from MSA's to reach more Americans.

Our bill, the Medical Savings Account Effectiveness Act of 1999, will make MSA's a permanent health care option for all Americans by expanding enrollment beyond the current cap. This legislation will allow both employers and employees to contribute to an MSA and will allow policyholders to fully fund the deductible. In addition, it will lower the individual deductible to $1,000 and the family deductible to $2,000. Finally, it will allow MSA's to be offered through ''cafeteria plans.''

By expanding MSA's, this legislation will give policyholders direct control over medical expenditures, offer them a new freedom to select the physician or specialist of their choice, and make insurance affordable for millions of Americans.

By Mr. GRASSLEY (for himself, Mr. MURKOWSKI, and Mr. HARKIN):

S. 1351. A bill to amend the Internal Revenue Code of 1986 to extend and modify the credit for electricity produced from newable resources; to the Committee on Finance.

THE BIOMASS AND WIND ENERGY TAX CREDIT

Mr. GRASSLEY. Mr. President, I rise today to acknowledge the unfortunate expiration of the section 45 tax credit on June 30 for electricity produced from alternative energy sources. In response, I am introducing legislation to extend and expand the credit to help sustain the public benefits derived from these sources. As many of my colleagues know, I authored the section 45 credit in the Senate and it was included in the Energy Policy Act of 1992. I am being joined in this bipartisan effort today by Senator MURKOWSKI and Senator HARKIN.

Earlier this year, I introduced S. 414 to extend the wind energy portion of section 45, which has been extremely successful. The purpose of today's bill is to extend and expand the biomass portion of section 45 to include technologies such as biomass combustion and cofiring biomass with coal-fired facilities. Formerly, section 45 only allowed the use of closed-loop biomass, which has proven to be unworkable. Consequently, the biomass aspect of section 45 has never been utilized. The clean, controlled combustion of biomass, which in layman's terms consists of woodchips, agricultural byproducts, and untreated construction debris, is another proven, effective technology that currently generates numerous pollution avoidance and waste management public benefits across the nation.

Unfortunately, the 1992 bill restrictively defined qualifying biomass processes by requiring taxpayers to grow the biomass solely for the purposes of combustion. This then-untested theory has since proven to be singularly uneconomic, and taxpayers have never claimed one single cent of tax credits. My bill retains this dormant ''closed-loop'' biomass provision in the hopes that some day it may be found feasible.

In order to retain the environmental, waste management, and the rural employment benefits that we currently receive from the existing ''open-loop'' biomass facilities, by bill rewrites section 45 to allow tax credits for clean combustion of wood waste and similar residues in these unique facilities. These valuable, yet economically vulnerable, facilities that convert 20 million tons of waste into clean electricity annually, and which have never received section 45 tax credits, would be eligible for the same ten years of tax credits per facility, beginning at date of enactment.

Importantly, we have gone to great lengths to ensure that the definition of qualifying biomass materials is limited to organic, nonhazardous materials that are clearly proven to burn cleanly without any pollution risk. Also, to allay any concern that biomass plants might burn paper and thus possibly jeopardize the amount of paper that is available to be recycled, I have specifically excluded paper that is commonly recycled from the list of materials that would qualify for the credit.

One promising technology that does not yet operate here in the U.S., but has now been proven to be feasible and practical, involves the cofiring of biomass with coal. A partial tax credit for cofiring would stimulate economic growth in rural areas by creating new markets for forage crops. The environmental benefits from reduced coal plant emissions would also be substantial.

Finally, my bill acknowledges the potential that biomass combustion has to solve the nation's pressing poultry waste problem by making electricity produced from the combustion of poultry litter eligible for the sec. 45 tax credit. As Chairman ROTH has recently pointed out, the increased growth of our domestic chicken and turkey industry has created the need to find a new, creative means for disposing of the waste of some 600 million chickens in the Delaware, Maryland, and Virginia peninsula alone.

Today, much of the waste from these operations (deposited upon biomass materials) is spread on farmland, resulting in a nutrient runoff that has contaminated streams, rivers and bays, with devastating effect on the local environment. Fortunately, scientists in the United Kingdom have developed a combustion technology that cleanly disposes of the waste and produces clean electricity. While no such plants are currently operating in the U.S., state and local authorities in the affected jurisdictions assure us that, with the enactment of this critical tax credit legislation, action would be taken to build these plants immediately.

With regard to wind energy, and my involvement in supporting this technology which goes back to my authorship of the Wind Energy Incentives Act of 1992, I am proud to say that this credit is one of the success stories of section 45. The public policy benefits of wind energy are indisputable: it is clean, safe and abundant within the United States. I understand that every 10,000 megawatts of wind energy produced in the U.S. can reduce carbon monoxide emissions by 33 million metric tons by replacing the combustion of fossil fuels.

Mr. President, I believe this bill provides a common sense combination of current and new technologies to help maintain the economic, environmental and waste management benefits derived from wind and biomass power. This bill has strong support from both the biomass industry and environmental groups including the Union of Concerned Scientists and the Natural Resources Defense Council. I urge my colleagues to join in supporting this legislation.

Mr. President, I ask unanimous consent that a copy of the bill be printed in the RECORD.

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

S. 1351

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CREDIT FOR ELECTRICITY PRODUCED FROM RENEWABLE RESOURCES.

(a) EXTENSION AND MODIFICATION OF PLACED-IN-SERVICE RULES.—Paragraph (3) of section 45(c) of the Internal Revenue Code of 1986 is amended to read as follows:

''(3) QUALIFIED FACILITY.—

''(A) WIND FACILITIES.—In the case of a facility using wind to produce electricity, the term 'qualified facility' means any facility owned by the taxpayer which is originally placed in service after December 31, 1993, and before July 1, 2004.

''(B) BIOMASS FACILITIES.—In the case of a facility using biomass to produce electricity, the term 'qualified facility' means, with respect to any month, any facility owned, leased, or operated by the taxpayer which is originally placed in service before July 1, 2004, if, for such month—

''(i) biomass comprises not less than 75 percent (on a Btu basis) of the average monthly fuel input of the facility for the taxable year which includes such month, or

''(ii) in the case of a facility principally using coal to produce electricity, biomass comprises not more than 25 percent (on a Btu basis) of the average monthly fuel input of the facility for the taxable year which includes such month.

''(C) SPECIAL RULES.—

''(i) In the case of a qualified facility described in subparagraph (B)(i)—

''(I) the 10-year period referred to in subsection (a) shall be treated as beginning no earlier than the date of the enactment of this paragraph, and

''(II) subsection (b)(3) shall not apply to any such facility originally placed in service before January 1, 1997.

''(ii) In the case of a qualified facility described in subparagraph (B)(ii)—

''(I) the 10-year period referred to in subsection (a) shall be treated as beginning no earlier than the date of the enactment of this paragraph, and

''(II) the amount of the credit determined under subsection (a) with respect to any project for any taxable year shall be adjusted by multiplying such amount (determined without regard to this clause) by 0.59.''.

(b) CREDIT NOT TO APPLY TO ELECTRICITY SOLD TO UTILITIES UNDER CERTAIN CONTRACTS.—Section 45(b) of the Internal Revenue Code of 1986 (relating to limitations and adjustments) is amended by adding at the end the following:

''(4) CREDIT NOT TO APPLY TO ELECTRICITY SOLD TO UTILITIES UNDER CERTAIN CONTRACTS.—

''(A) IN GENERAL.—The credit determined under subsection (a) shall not apply to electricity—

''(i) produced at a qualified facility placed in service by the taxpayer after June 30, 1999, and

''(ii) sold to a utility pursuant to a contract originally entered into before January 1, 1987 (whether or not amended or restated after that date).

''(B) EXCEPTION.—Subparagraph (A) shall not apply if—

''(i) the prices for energy and capacity from such facility are established pursuant to an amendment to the contract referred to in subparagraph (A)(ii);

''(ii) such amendment provides that the prices set forth in the contract which exceed avoided cost prices determined at the time of delivery shall apply only to annual quantities of electricity (prorated for partial years) which do not exceed the greater of—

''(I) the average annual quantity of electricity sold to the utility under the contract during calendar years 1994, 1995, 1996, 1997, and 1998, or

''(II) the estimate of the annual electricity production set forth in the contract, or, if there is no such estimate, the greatest annual quantity of electricity sold to the utility under the contract in any of the calendar years 1996, 1997, or 1998; and

''(iii) such amendment provides that energy and capacity in excess of the limitation in clause (ii) may be—

''(I) sold to the utility only at prices that do not exceed avoided cost prices determined at the time of delivery, or

''(II) sold to a third party subject to a mutually agreed upon advance notice to the utility.

For purposes of this subparagraph, avoided cost prices shall be determined as provided for in 18 CFR 292.304(d)(1) or any successor regulation.''.

(c) QUALIFIED FACILITIES INCLUDE ALL BIOMASS FACILITIES.—

(1) IN GENERAL.—Subparagraph (B) of section 45(c)(1) of the Internal Revenue Code of 1986 (defining qualified energy resources) is amended to read as follows:

''(B) biomass.''.

(2) BIOMASS DEFINED.—Paragraph (2) of section 45(c) of such Code (relating to definitions) is amended to read as follows:

''(2) BIOMASS.—The term 'biomass' means—

''(A) any organic material from a plant which is planted exclusively for purposes of being used at a qualified facility to produce electricity, or

''(B) any solid, nonhazardous, cellulosic waste material which is segregated from other waste materials and which is derived from—

''(i) any of the following forest-related resources: mill residues, precommercial thinnings, slash, and brush, but not including old-growth timber,

''(ii) poultry waste,

''(iii) urban sources, including waste pallets, crates, and dunnage, manufacturing and construction wood wastes, and landscape or right-of-way tree trimmings, but not including unsegregated municipal solid waste (garbage) or paper that is commonly recycled, or

''(iv) agriculture sources, including orchard tree crops, vineyard, grain, legumes, sugar, and other crop by-products or residues.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to electricity produced after the date of the enactment of this Act.

By Mr. COVERDELL (for himself, Mr. THURMOND, Mr. CLELAND, and Mr. HOLLINGS):

S.J. Res. 29. A joint resolution to grant the consent of Congress to the boundary change between Georgia and South Carolina; to the Committee on the Judiciary.

GRANTING CONGRESSIONAL CONSENT FOR THE GEORGIA-SOUTH CAROLINA INTERSTATE COMPACT

Mr. COVERDELL. Mr. President, today I rise to offer a joint resolution to grant congressional consent to an Interstate Compact between my state of Georgia and the state of South Carolina which resolves a border dispute whose origin dates back to the Articles of Confederation between the two states. On June 25, 1990, the Supreme Court in Georgia vs. South Carolina (No. 74, Original) ruled that Georgia lost sovereignty over the Barnwell Islands in the Savannah River to South Carolina. These islands had shifted due to erosion and accretion since the time of the first scientifically accurate survey of the area in 1855. The Supreme Court further ordered the two states to determine a new boundary and submit it to the Court for final approval.

During the summer of 1993, the two states with the assistance of the National Oceanic and Atmospheric Administration (NOAA) reached an agreement on a common boundary. Subsequently, the agreement was adopted by the Georgia General Assembly on April 5, 1994, and by the South Carolina General Assembly on May 29, 1996.

On May 26, 1999, the agreed boundary was forwarded to Congress for its approval in accordance with the U.S. Constitution Article IV, Section 10. This Compact once adopted will amend the Beaufort Convention of 1787.

With passage of this resolution, granting Congress' consent to the Georgia-South Carolina Interstate Compact, Congress will have fulfilled its obligation, and the agreed upon boundary will be presented to the Supreme Court for its final approval and application. I am pleased to have my colleagues from South Carolina, Senators THURMOND and HOLLINGS, and my colleague from Georgia, Senator CLELAND, join me in sponsoring this historic piece of legislation. In this day, where members from both sides of the aisle are speaking of the need for more bipartisanship, I would like to commend these two great states for coming together and reaching an agreement on such a contentious issue and ask for the full Senate's support for this important and necessary legislation.

Mr. President, I ask for unanimous consent that the following chronology be included in the RECORD.

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

GEORGIA-SOUTH CAROLINA BORDER AGREEMENT FOR THE LOWER REACHES OF THE SAVANNAH RIVER TO THE SEA—CHRONOLOGY OF EVENTS

April 28, 1787—The Beaufort Convention: Under the Articles of Confederation of 1778, South Carolina and Georgia agreed that the boundary between the two states would be in the northern branch of the Savannah River, reserving all islands in the river to Georgia.

January 30, 1922—Georgia v. South Carolina (No. 16, Original): The U.S. Supreme Court held that where there were no islands in the boundary rivers, the boundary in on the water midway between the main banks when the water is at ordinary stage. When there are islands, the boundary is midway between the banks of the island and the South Carolina shore, with the water at ordinary stage.

June 25, 1990—Georgia v. South Carolina (No. 74, Original): The U.S. Supreme Court held that Georgia lost sovereignty over the Barnwell Islands to South Carolina by acquiescence, and that the Beaufort Convention did not control new islands that later emerged in the Savannah River. Accordingly, the Court generally adopted the findings (with some exceptions) of its Special Master, Senior Judge Walter E. Hoffman, with regard to several disputed islands and the headlands of the river. The Court directed the two states to determine the boundary in accordance with the principles in its rulings, and to submit the boundary to the Court for final approval.

June 24, 1991—Cooperative Agreement: Both states and the National Oceanic and Atmospheric Administration (NOAA) entered a cooperative agreement to survey the area and plot the boundary. In order to comply with the requirement that the river be charted as is existed prior to the dredgings and changes in the navigational courses which occurred in the 1880's, the parties adopted the Special Master's decision that the main thread of the Savannah River as it existed on the 1855 charts would be used. NOAA flew new aerial surveys of the river and plotted the 1855 thread of the river on the new surveys.

Summer, 1993—Joint Meetings and Negotiations: After NOAA completed its work, the states realized that the course of the river had changed so substantially since 1855 that using the 1855 thread of the river was unworkable. Because of recent navigational channel deepening efforts by the U.S. Corps of Engineers, Georgia and South Carolina agreed to use the northern edge of the shipping channel, including any turning basins, as the primary agreed upon boundary. More specifically, the ''new'' boundary would start from the middle of the river above Pennyworth Island, between Pennyworth Island and the South Carolina shore, and then to the tidegate and the northern edge of the Back River turning basin. After following the navigational channel to the buoy nearest the 3-mile territorial limit, the boundary would then depart eastward along the 104 degree bearing adopted by the Court.

April 5, 1994—Georgia General Assembly Adopts Agreed Boundary: Georgia adopted the agreed boundary line, using the Annual Survey—1992, Savannah Harbor, as amended by the Savannah Harbor Deepening Project. The line was plotted using the Georgia Plane Coordinate System.

May 29, 1996—South Carolina General Assembly Adopts Agreed Boundary: South Carolina adopted the agreed boundary line, but asked NOAA to covert the Georgia coordinates to points of latitude and longitude.

November, 1998—Charts assembled: Because only three original copies of the 1992 channel charts were available, a special printing of the color charts was run, with the Savannah Harbor Deepening Project charts bound together.

May 26, 1999—Agreed Boundary Forwarded for Congressional Approval: The States submitted the agreed boundary to the Congress for approval as an Interstate Compact pursuant to the United States Constitution, Article IV, Section 10, which amends the Beaufort Convention of 1787.

ADDITIONAL COSPONSORS

S. 17

At the request of Mr. DODD, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 17, a bill to increase the availability, affordability, and quality of child care.

S. 71

At the request of Ms. SNOWE, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 71, a bill to amend title 38, United States Code, to establish a presumption of service-connection for certain veterans with Hepatitis C, and for other purposes.

S. 115

At the request of Ms. SNOWE, the name of the Senator from Minnesota (Mr. WELLSTONE) was added as a cosponsor of S. 115, a bill to require that health plans provide coverage for a minimum hospital stay for mastectomies and lymph node dissection for the treatment of breast cancer and coverage for secondary consultations.

S. 210

At the request of Mr. MOYNIHAN, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 210, a bill to establish a medical education trust fund, and for other purposes.

S. 285

At the request of Mr. MCCAIN, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 285, a bill to amend title II of the Social Security Act to restore the link between the maximum amount of earnings by blind individuals permitted without demonstrating ability to engage in substantial gainful activity and the exempt amount permitted in determining excess earnings under the earnings test.

S. 424

At the request of Mr. COVERDELL, the name of the Senator from Wyoming (Mr. THOMAS) was added as a cosponsor of S. 424, a bill to preserve and protect the free choice of individuals and employees to form, join, or assist labor organizations, or to refrain from such activities.

S. 459

At the request of Mr. HATCH, the name of the Senator from Florida (Mr. MACK) was added as a cosponsor of S. 459, a bill to amend the Internal Revenue Code of 1986 to increase the State ceiling on private activity bonds.

At the request of Ms. MIKULSKI, her name was added as a cosponsor of S. 459, supra.

S. 472

At the request of Mr. GRASSLEY, the names of the Senator from Montana (Mr. BAUCUS) and the Senator from Arkansas (Mrs. LINCOLN) were added as cosponsors of S. 472, a bill to amend title XVIII of the Social Security Act to provide certain medicare beneficiaries with an exemption to the financial limitations imposed on physical, speech-language pathology, and occupational therapy services under part B of the medicare program, and for other purposes.

S. 484

At the request of Mr. CAMPBELL, the names of the Senator from Alabama (Mr. SHELBY) and the Senator from Arkansas (Mrs. LINCOLN) were added as cosponsors of S. 484, a bill to provide for the granting of refugee status in the United States to nationals of certain foreign countries in which American Vietnam War POW/MIAs or American Korean War POW/MIAs may be present, if those nationals assist in the return to the United States of those POW/MIAs alive.

S. 635

At the request of Mr. MACK, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. 635, a bill to amend the Internal Revenue Code of 1986 to more accurately codify the depreciable life of printed wiring board and printed wiring assembly equipment.

S. 660

At the request of Mr. BINGAMAN, the name of the Senator from Hawaii (Mr. INOUYE) was added as a cosponsor of S. 660, a bill to amend title XVIII of the Social Security Act to provide for coverage under part B of the medicare program of medical nutrition therapy services furnished by registered dietitians and nutrition professionals.

S. 662

At the request of Mr. CHAFEE, the name of the Senator from North Carolina (Mr. EDWARDS) was added as a cosponsor of S. 662, a bill to amend title XIX of the Social Security Act to provide medical assistance for certain women screened and found to have breast or cervical cancer under a federally funded screening program.

S. 685

At the request of Mr. CRAPO, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 685, a bill to preserve the authority of States over water within their boundaries, to delegate to States the authority of Congress to regulate water, and for other purposes.

S. 761

At the request of Mr. ABRAHAM, the name of the Senator from Nebraska (Mr. HAGEL) was added as a cosponsor of S. 761, a bill to regulate interstate commerce by electronic means by permitting and encouraging the continued expansion of electronic commerce through the operation of free market forces, and for other purposes.

S. 779

At the request of Mr. ABRAHAM, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 779, a bill to provide that no Federal income tax shall be imposed on amounts received by Holocaust victims or their heirs.

S. 789

At the request of Mr. MCCAIN, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 789, a bill to amend title 10, United States Code, to authorize payment of special compensation to certain severely disabled uniformed services retirees.

S. 800

At the request of Mr. MCCAIN, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 800, a bill to promote and enhance public safety through the use of 9–1–1 as the universal emergency assistance number, further deployment of wireless 9–1–1 service, support of States in upgrading 9–1–1 capabilities and related functions, encouragement of construction and operation of seamless, ubiquitous, and reliable networks for personal wireless services, and for other purposes.

S. 817

At the request of Mrs. BOXER, the names of the Senator from Georgia (Mr. CLELAND), the Senator from New Jersey (Mr. LAUTENBERG), the Senator from New Jersey (Mr. TORRICELLI), and the Senator from Washington (Mrs. MURRAY) were added as cosponsors of S. 817, a bill to improve academic and social outcomes for students and reduce both juvenile crime and the risk that youth will become victims of crime by providing productive activities during after school hours.

S. 821

At the request of Mr. LAUTENBERG, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of S. 821, a bill to provide for the collection of data on traffic stops.

S. 835

At the request of Mr. CHAFEE, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 835, a bill to encourage the restoration of estuary habitat through more efficient project financing and enhanced coordination of Federal and non-Federal restoration programs, and for other purposes.

S. 879

At the request of Mr. CONRAD, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 879, a bill to amend the Internal Revenue Code of 1986 to provide a shorter recovery period for the depreciation of certain leasehold improvements

S. 894

At the request of Mr. CLELAND, the names of the Senator from Massachusetts (Mr. KENNEDY) and the Senator from North Dakota (Mr. DORGAN) were added as cosponsors of S. 894, a bill to amend title 5, United States Code, to provide for the establishment of a program under which long-term care insurance is made available to Federal employees and annuitants, and for other purposes.

S. 897

At the request of Mr. ROBB, his name was added as a cosponsor of S. 897, a bill to provide matching grants for the construction, renovation and repair of school facilities in areas affected by Federal activities, and for other purposes.

S. 980

At the request of Mr. BAUCUS, the name of the Senator from Georgia (Mr. CLELAND) was added as a cosponsor of S. 980, a bill to promote access to health care services in rural areas.

S. 984

At the request of Ms. COLLINS, the name of the Senator from Washington (Mr. GORTON) was added as a cosponsor of S. 984, a bill to amend the Internal Revenue Code of 1986 to modify the tax credit for electricity produced from certain renewable resources.

S. 1003

At the request of Mr. ROCKEFELLER, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1003, a bill to amend the Internal Revenue Code of 1986 to provide increased tax incentives for the purchase of alternative fuel and electric vehicle, and for other purposes.

S. 1010

At the request of Mr. JEFFORDS, the name of the Senator from Michigan (Mr. ABRAHAM) was added as a cosponsor of S. 1010, a bill to amend the Internal Revenue Code of 1986 to provide for a medical innovation tax credit for clinical testing research expenses attributable to academic medical centers and other qualified hospital research organizations.

S. 1017

At the request of Mr. MACK, the names of the Senator from Ohio (Mr. DEWINE) and the Senator from Kentucky (Mr. BUNNING) were added as cosponsors of S. 1017, a bill to amend the Internal Revenue Code of 1986 to increase the State ceiling on the low-income housing credit.

At the request of Ms. MIKULSKI, her name was added as a cosponsor of S. 1017, supra.

S. 1023

At the request of Mr. MOYNIHAN, the names of the Senator from California (Mrs. FEINSTEIN) and the Senator from Minnesota (Mr. WELLSTONE) were added

as cosponsors of S. 1023, a bill to amend title XVIII of the Social Security Act to stabilize indirect graduate medical education payments.

S. 1024

At the request of Mr. MOYNIHAN, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1024, a bill to amend title XVIII of the Social Security Act to carve out from payments to Medicare+Choice organizations amounts attributable to disproportionate share hospital payments and pay such amounts directly to those disproportionate share hospitals in which their enrollees receive care.

S. 1070

At the request of Mr. BOND, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of S. 1070, a bill to require the Secretary of Labor to wait for completion of a National Academy of Sciences study before promulgating a standard, regulation or guideline on ergonomics.

S. 1144

At the request of Mr. VOINOVICH, the names of the Senator from Georgia (Mr. CLELAND) and the Senator from Virginia (Mr. ROBB) were added as cosponsors of S. 1144, a bill to provide increased flexibility in use of highway funding, and for other purposes.

S. 1159

At the request of Mr. STEVENS, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 1159, a bill to provide grants and contracts to local educational agencies to initiate, expand, and improve physical education programs for all kindergarten through 12th grade students.

S. 1165

At the request of Mr. MACK, the names of the Senator from Wyoming (Mr. THOMAS) and the Senator from Colorado (Mr. ALLARD) were added as cosponsors of S. 1165, a bill to amend the Internal Revenue Code of 1986 to repeal the limitation on the amount of receipts attributable to military property which may be treated as exempt foreign trade income.

S. 1166

At the request of Mr. NICKLES, the name of the Senator from Wyoming (Mr. THOMAS) was added as a cosponsor of S. 1166, a bill to amend the Internal Revenue Code of 1986 to clarify that natural gas gathering lines are 7-year property for purposes of depreciation.

S. 1185

At the request of Mr. ABRAHAM, the name of the Senator from Tennessee (Mr. FRIST) was added as a cosponsor of S. 1185, a bill to provide small business certain protections from litigation excesses and to limit the product liability of non-manufacturer product sellers.

S. 1187

At the request of Mr. DORGAN, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 1187, a bill to require the Secretary of the Treasury to mint coins in commemoration of the bicentennial of the Lewis and Clark Expedition, and for other purposes.

S. 1197

At the request of Mr. ROTH, the names of the Senator from Connecticut (Mr. DODD), the Senator from Mississippi (Mr. COCHRAN), the Senator from Massachusetts (Mr. KENNEDY), and the Senator from Wyoming (Mr. THOMAS) were added as cosponsors of S. 1197, a bill to prohibit the importation of products made with dog or cat fur, to prohibit the sale, manufacture, offer for sale, transportation, and distribution of products made with dog or cat fur in the United States, and for other purposes.

S. 1220

At the request of Mr. GRASSLEY, the names of the Senator from Ohio (Mr. DEWINE), the Senator from Arizona (Mr. KYL), the Senator from Wisconsin (Mr. KOHL), and the Senator from Nebraska (Mr. HAGEL) were added as cosponsors of S. 1220, a bill to provide additional funding to combat methamphetamine production and abuse, and for other purposes.

S. 1227

At the request of Mr. CHAFEE, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1227, a bill to amend title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to provide States with the option to allow legal immigrant pregnant women and children to be eligible for medical assistance under the medical program, and for other purposes.

S. 1277

At the request of Mr. BAUCUS, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 1277, a bill to amend title XIX of the Social Security Act to establish a new prospective payment system for Federally qualified health centers and rural health clinics.

S. 1313

At the request of Mr. CHAFEE, his name was added as a cosponsor of S. 1313, a bill to enable the State of Rhode Island to meet the criteria for recommendation as an Area of Application to the Boston-Worcester-Lawrence; Massachusetts, New Hampshire, Maine, and Connecticut Federal locality pay area.

S. 1318

At the request of Mr. JEFFORDS, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 1318, a bill to authorize the Secretary of Housing and Urban Development to award grants to States to supplement State and local assistance for the preservation and promotion of affordable housing opportunities for low-income families.

SENATE CONCURRENT RESOLUTION 9

At the request of Ms. SNOWE, the names of the Senator from Pennsylvania (Mr. SPECTER), the Senator from Massachusetts (Mr. KENNEDY), the Senator from California (Mrs. BOXER), and the Senator from Delaware (Mr. ROTH) were added as cosponsors of Senate Concurrent Resolution 9, a concurrent resolution calling for a United States effort to end restrictions on the freedoms and human rights of the enclaved people in the occupied area of Cyprus.

SENATE CONCURRENT RESOLUTION 12

At the request of Ms. COLLINS, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of Senate Concurrent Resolution 12, a concurrent resolution requesting that the United States Postal Service issue a commemorative postage stamp honoring the 100th anniversary of the founding of the Veterans of Foreign Wars of the United States.

SENATE CONCURRENT RESOLUTION 32

At the request of Mr. CONRAD, the name of the Senator from New Jersey (Mr. TORRICELLI) was added as a cosponsor of Senate Concurrent Resolution 32, a concurrent resolution expressing the sense of Congress regarding the guaranteed coverage of chiropractic services under the Medicare+Choice program.

SENATE CONCURRENT RESOLUTION 34

At the request of Mr. SPECTER, the names of the Senator from Massachusetts (Mr. KENNEDY) and the Senator from Michigan (Mr. LEVIN) were added as cosponsors of Senate Concurrent Resolution 34, a concurrent resolution relating to the observence of ''In Memory'' Day.

SENATE RESOLUTION 92

At the request of Mrs. BOXER, the name of the Senator from Delaware (Mr. BIDEN) was added as a cosponsor of Senate Resolution 92, a resolution expressing the sense of the Senate that funding for prostate cancer research should be increased substantially.

SENATE RESOLUTION 95

At the request of Mr. THURMOND, the names of the Senator from Iowa (Mr. GRASSLEY) and the Senator from New Hampshire (Mr. GREGG) were added as cosponsors of Senate Resolution 95, a resolution designating August 16, 1999, as ''National Airborne Day.''

SENATE RESOLUTION 99

At the request of Mr. REID, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of Senate Resolution 99, a resolution designating November 20, 1999, as ''National Survivors for Prevention of Suicide Day.''

SENATE RESOLUTION 101

At the request of Mr. FITZGERALD, the names of the Senator from Idaho (Mr. CRAPO), the Senator from Minnesota (Mr. GRAMS), the Senator from Wyoming (Mr. ENZI), the Senator from Kansas (Mr. BROWNBACK), the Senator from Montana (Mr. BURNS), and the Senator from Mississippi (Mr. COCHRAN) were added as cosponsors of Senate Resolution 101, a resolution expressing the sense of the Senate on agricultural trade negotiations.

SENATE RESOLUTION 137—TO CONGRATULATE THE U.S. WOMEN'S SOCCER TEAM ON WINNING THE 1999 WOMEN'S CUP CHAMPIONSHIP

Mr. REID (for himself and Mr. DASCHLE) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 137

Whereas the Americans blanked Germany in the second half of the quarter finals, before winning 3 to 2, shut out Brazil in the semifinals, 2 to 0, and then stymied China for 120 minutes Saturday, July 10, 1999;

Whereas the Americans outshot China 5–4 on penalty kicks after 120 minutes of regulation and overtime play ended in a 0–0 tie;

Whereas the United States team played the final match through heat, exhaustion and tension for 120 minutes, including two sudden-death 15-minute overtime periods;

Whereas the United States team played before a crowd of 90,185, the largest to witness a women's athletic event;

Whereas Title IX has created the opportunity for millions of American girls and women to compete in sports;

Whereas the United States becomes the first women's team to simultaneously reign as both Olympic and World Cup champions;

Whereas five Americans, forward Mia Hamm, midfielder Michelle Akers, goalkeeper Briana Scurry and defenders Brandi Chastain and Carla Overbeck, were chosen for the elite 1999 Women's World Cup All-Star team;

Whereas all the members of the 1999 U.S. women's World Cup team—defenders Brandi Chastain, Christie Pearce, Lorrie Fair, Joy Fawcett, Carla Overbeck, and Kate Sobrero; forwards Danielle Fotopoulos, Mia Hamm, Shannon MacMillan, Cindy Parlow, Kristine Lilly, and Tiffeny Milbrett; goalkeepers Tracy Ducar, Briana Scurry, and Saskia Webber; and midfielders Michelle Akers, Julie Foudy, Tiffany Roberts, Tisha Venturini, and Sara Whalen;—both on the playing field and on the practice field, demonstrated their devotion to the team and played an important part in the team's success;

Whereas the Americans will now set their sights on defending their Olympic title in Sydney 2000;

Resolved, That the Senate congratulates the United States Women's Soccer Team on winning the 1999 Women's World Cup Championship.

AMENDMENTS SUBMITTED

PATIENTS' BILL OF RIGHTS ACT

DASCHLE AMENDMENT NO. 1232

Mr. DASCHLE proposed an amendment to the bill (S. 1232) to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patients' Bill of Rights Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—PATIENTS' BILL OF RIGHTS

Subtitle A—Right to Advice and Care

SEC. 101. PATIENT RIGHT TO MEDICAL ADVICE AND CARE.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is amended—

(1) by redesignating subpart C as subpart D; and

(2) by inserting after subpart B the following:

''Subpart C—Patient Right to Medical Advice and Care

''SEC. 721. PATIENT ACCESS TO EMERGENCY MEDICAL CARE.

''(a) IN GENERAL.—To the extent that the group health plan (other than a fully insured group health plan) provides coverage for benefits consisting of emergency medical care (as defined in subsection (c)), except for items or services specifically excluded—

''(1) the plan shall provide coverage for benefits, without requiring preauthorization, for appropriate emergency medical screening examinations (within the capability of the emergency facility, including ancillary services routinely available to the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary to determine whether emergency medical care (as so defined) is necessary; and

''(2) the plan shall provide coverage for benefits, without requiring preauthorization, for additional emergency medical care to stabilize an emergency medical condition following an emergency medical screening examination (if determined necessary under paragraph (1)), pursuant to the definition of stabilize under section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

''(b) UNIFORM COST-SHARING REQUIRED AND OUT-OF-NETWORK CARE.—

''(1) UNIFORM COST-SHARING.—Nothing in this section shall be construed as preventing a group health plan (other than a fully insured group health plan) from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to coverage for benefits described in subsection (a), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in subsection (c)) provided to such similarly situated participants and beneficiaries under the plan.

''(2) OUT-OF-NETWORK CARE.—If a group health plan (other than a fully insured group health plan) provides any benefits with respect to emergency medical care (as defined in subsection (c)), the plan shall cover emergency medical care under the plan in a manner so that, if such care is provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider.

''(c) DEFINITION OF EMERGENCY MEDICAL CARE.—In this section:

''(1) IN GENERAL.—The term 'emergency medical care' means, with respect to a participant or beneficiary under a group health plan (other than a fully insured group health plan), covered inpatient and outpatient services that—

''(A) are furnished by any provider, including a nonparticipating provider, that is qualified to furnish such services; and

''(B) are needed to evaluate or stabilize (as such term is defined in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd)(e)(3)) an emergency medical condition (as defined in paragraph (2)).

''(2) 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) placing the health of the participant or beneficiary (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(B) serious impairment to bodily functions, or

''(C) serious dysfunction of any bodily organ or part.

''SEC. 722. OFFERING OF CHOICE OF COVERAGE OPTIONS.

''(a) REQUIREMENT.—

''(1) OFFERING OF POINT-OF-SERVICE COVERAGE OPTION.—Except as provided in paragraph (2), if a group health plan (other than a fully insured group health plan) provides coverage for benefits only through a defined set of participating health care professionals, the plan shall offer the participant the option to purchase point-of-service coverage (as defined in subsection (b)) for all such benefits for which coverage is otherwise so limited. Such option shall be made available to the participant at the time of enrollment under the plan and at such other times as the plan offers the participant a choice of coverage options.

''(2) EXCEPTION IN THE CASE OF MULTIPLE ISSUER OR COVERAGE OPTIONS.—Paragraph (1) shall not apply with respect to a participant in a group health plan (other than a fully insured group health plan) if the plan offers the participant 2 or more coverage options that differ significantly with respect to the use of participating health care professionals or the networks of such professionals that are used.

''(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term 'point-of-service coverage' means, with respect to benefits covered under a group health plan (other than a fully insured group health plan), coverage of such benefits when provided by a nonparticipating health care professional.

''(c) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan (other than a fully insured group health plan) of a small employer.

''(2) SMALL EMPLOYER.—For purposes of paragraph (1), the term 'small employer' means, in connection with a group health plan (other than a fully insured group health plan) with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of this paragraph, the provisions of subparagraph (C) of section 712(c)(1) shall apply in determining employer size.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring coverage for benefits for a particular type of health care professional;

''(2) as requiring an employer to pay any costs as a result of this section or to make equal contributions with respect to different health coverage options;

''(3) as preventing a group health plan (other than a fully insured group health plan) from imposing higher premiums or cost-sharing on a participant for the exercise of a point-of-service coverage option; or

''(4) to require that a group health plan (other than a fully insured group health plan) include coverage of health care professionals that the plan excludes because of fraud, quality of care, or other similar reasons with respect to such professionals.

''SEC. 723. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(a) GENERAL RIGHTS.—

''(1) WAIVER OF PLAN REFERRAL REQUIREMENT.—If a group health plan described in subsection (b) requires a referral to obtain coverage for speciality care, the plan shall waive the referral requirement in the case of a female participant or beneficiary who seeks coverage for routine obstetrical care or routine gynecological care.

''(2) RELATED ROUTINE CARE.—With respect to a participant or beneficiary described in paragraph (1), a group health plan described in subsection (b) shall treat the ordering of other routine care that is related to routine obstetric or gynecologic care, by a physician who specializes in obstetrics and gynecology as the authorization of the primary care provider for such other routine care.

''(b) APPLICATION OF SECTION.—A group health plan described in this subsection is a group health plan (other than a fully insured group health plan), that—

''(1) provides coverage for routine obstetric care (such as pregnancy-related services) or routine gynecologic care (such as preventive women's health examinations); and

''(2) requires the designation by a participant or beneficiary of a participating primary care provider who is not a physician who specializes in obstetrics or gynecology.

''(c) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of obstetric or gynecologic care described in subsection (a);

''(2) to preclude the plan from requiring that the physician who specializes in obstetrics or gynecology notify the designated primary care provider or the plan of treatment decisions; or

''(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine obstetric or routine gynecologic care.

''SEC. 724. PATIENT ACCESS TO PEDIATRIC CARE.

''(a) IN GENERAL.—In the case of a group health plan (other than a fully insured group health plan) that provides coverage for routine pediatric care and that requires the designation by a participant or beneficiary of a participating primary care provider, if the designated primary care provider is not a physician who specializes in pediatrics—

''(1) the plan may not require authorization or referral by the primary care provider in order for a participant or beneficiary to obtain coverage for routine pediatric care; and

''(2) the plan shall treat the ordering of other routine care related to routine pediatric care by such a specialist as having been authorized by the designated primary care provider.

''(b) RULES OF CONSTRUCTION.—Nothing in subsection (a) shall be construed—

''(1) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of any pediatric care provided to, or ordered for, a participant or beneficiary;

''(2) to preclude a group health plan from requiring that a specialist described in subsection (a) notify the designated primary care provider or the plan of treatment decisions; or

''(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine pediatric care.

''SEC. 725. ACCESS TO SPECIALISTS.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall ensure that participants and beneficiaries have access to specialty care when such care is covered under the plan. Such access may be provided through contractual arrangements with specialized providers outside of the network of the plan.

''(b) TREATMENT PLANS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to prohibit a group health plan (other than a fully insured group health plan) from requiring that speciality care be provided pursuant to a treatment plan so long as the treatment plan is—

''(A) developed by the specialist, in consultation with the primary care provider, and the participant or beneficiary;

''(B) approved by the plan; and

''(C) in accordance with the applicable quality assurance and utilization review standards of the plan.

''(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan from requiring the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all other necessary medical information.

''(c) REFERRALS.—Nothing in this section shall be construed to prohibit a plan from requiring an authorization by the primary care provider of the participant or beneficiary in order to obtain coverage for speciality services so long as such authorization is for an adequate number of referrals under an approved treatment plan if such a treatment plan is required by the plan.

''(d) SPECIALITY CARE DEFINED.—For purposes of this subsection, the term ''speciality care'' means, with respect to a condition, care and treatment provided by a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise (including age-appropriate expertise) through appropriate training and experience.

''SEC. 726. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan (other than a fully insured group health plan) and a health care provider is terminated (as defined in paragraph (2)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such group health plan, and an individual who is a participant or beneficiary in the plan is undergoing a course of treatment from the provider at the time of such termination, the plan shall—

''(A) notify the individual on a timely basis of such termination;

''(B) provide the individual with an opportunity to notify the plan of a need for transitional care; and

''(C) in the case of termination described in paragraph (2), (3), or (4) of subsection (b), and subject to subsection (c), permit the individual to continue or be covered with respect to the course of treatment with the provider's consent during a transitional period (as provided under subsection (b)).

''(2) TERMINATED.—In this section, the term 'terminated' includes, with respect to a

contract, the expiration or nonrenewal of the contract by the group health plan, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

''(3) CONTRACTS.—For purposes of this section, the term 'contract between a group health plan (other than a fully insured group health plan) and a health care provider' shall include a contract between such a plan and an organized network of providers.

''(b) TRANSITIONAL PERIOD.—

''(1) GENERAL RULE.—Except as provided in paragraph (3), the transitional period under this subsection shall permit the participant or beneficiary to extend the coverage involved for up to 90 days from the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) INSTITUTIONAL CARE.—Subject to paragraph (1), the transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status if the care was scheduled before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such care.

''(3) PREGNANCY.—Notwithstanding paragraph (1), if—

''(A) a participant or beneficiary has entered the second trimester of pregnancy at the time of a provider's termination of participation; and

''(B) the provider was treating the pregnancy before the date of the termination;

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—Subject to paragraph (1), if—

''(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) prior to a provider's termination of participation; and

''(B) the provider was treating the terminal illness before the date of termination;

the transitional period under this subsection shall be for care directly related to the treatment of the terminal illness.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan (other than a fully insured group health plan) may condition coverage of continued treatment by a provider under subsection (a)(1)(C) upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or at the rates applicable under the replacement plan after the date of the termination of the contract with the group health plan) and not to impose cost-sharing with respect to the individual 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 provider agrees to adhere to the quality assurance standards of the plan responsible for payment under paragraph (1) and to provide to such plan necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan'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.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

''(e) DEFINITION.—In this section, the term 'health care provider' or 'provider' means—

''(1) 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

''(2) 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.

''SEC. 727. PROTECTION OF PATIENT-PROVIDER COMMUNICATIONS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (other than a fully insured group health plan and in relation to a participant or beneficiary) shall not prohibit or otherwise restrict a health care professional from advising such a participant or beneficiary who is a patient of the professional about the health status of the participant or beneficiary or medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether coverage for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan (other than a fully insured group health plan) to provide specific benefits under the terms of such plan.

''SEC. 728. PATIENT'S RIGHT TO PRESCRIPTION DRUGS.

''To the extent that a group health plan (other than a fully insured group health plan) provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan shall—

''(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary; and

''(2) in accordance with the applicable quality assurance and utilization review standards of the plan, provide for exceptions from the formulary limitation when a nonformulary alternative is medically necessary and appropriate.

''SEC. 729. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE SERVICES.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) may not—

''(1) prohibit or otherwise discourage a participant or beneficiary from self-paying for behavioral health care services once the plan has denied coverage for such services; or

''(2) terminate a health care provider because such provider permits participants or beneficiaries to self-pay for behavioral health care services—

''(A) that are not otherwise covered under the plan; or

''(B) for which the group health plan provides limited coverage, to the extent that the group health plan denies coverage of the services.

''(b) RULE OF CONSTRUCTION.—Nothing in subsection (a)(2)(B) shall be construed as prohibiting a group health plan from terminating a contract with a health care provider for failure to meet applicable quality standards or for fraud.

''SEC. 730. GENERALLY APPLICABLE PROVISION.

''In the case of a group health plan that provides benefits under 2 or more coverage options, the requirements of this subpart, other than section 722, shall apply separately with respect to each coverage option.''.

(b) DEFINITION.—Section 733(a) of the Employee Retirement Income Security Act of 1974 (42 U.S.C. 1191(a)) is amended by adding at the end the following:

''(3) FULLY INSURED GROUP HEALTH PLAN.—The term 'fully insured group health plan' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.''.

(c) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended—

(1) in the item relating to subpart C, by striking ''Subpart C'' and inserting ''Subpart D''; and

(2) by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new items:

''SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

''Sec. 721. Patient access to emergency medical care.
''Sec. 722. Offering of choice of coverage options.
''Sec. 723. Patient access to obstetric and gynecological care.
''Sec. 724. Patient access to pediatric care.
''Sec. 725. Access to specialists.
''Sec. 726. Continuity of care.
''Sec. 727. Protection of patient-provider communications.
''Sec. 728. Patient's right to prescription drugs.
''Sec. 729. Self-payment for behavioral health care services.
''Sec. 730. Generally applicable provisions.''.

SEC. 102. COMPREHENSIVE INDEPENDENT STUDY OF PATIENT ACCESS TO CLINICAL TRIALS AND COVERAGE OF ASSOCIATED ROUTINE COSTS.

(a) STUDY BY THE INSTITUTE OF MEDICINE.—Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall enter into a contract with the Institute of Medicine to conduct a comprehensive study of patient access to clinical trials and the coverage of routine patient care costs by private health plans and insurers.

(b) MATTERS TO BE ASSESSED.—The study shall assess the following:

(1) The factors that hinder patient participation in clinical trials, including health plan and insurance policies and practices.

(2) The ability of health plans and investigators to distinguish between routine patient care costs and costs associated with clinical trials.

(3) The potential impact of health plan coverage of routine costs associated with clinical trials on health care premiums.

(c) REPORT.—

(1) IN GENERAL.—Not later than 12 months after the date of the execution of the contract referred to in subsection (a), the Institute of Medicine shall submit a report on the study conducted pursuant to that contract to the Committee on Health, Education, Labor and Pensions of the Senate.

(2) MATTERS INCLUDED.—The report submitted under paragraph (1) shall set forth the findings, conclusions, and recommendations of the Institute of Medicine for—

(A) increasing patient participation in clinical trials;

(B) encouraging collaboration between the public and private sectors; and

(C) improving analysis of determining routine costs associated with the conduct of clinical trials.

(3) COPY TO SECRETARY.—Concurrent with the submission of the report under paragraph (1), the Institute of Medicine shall transmit a copy of the report to the Secretary.

(d) FUNDING.—Out of funds appropriated to the Department of Health and Human Services for fiscal year 2000, the Secretary shall provide for such funding as the Secretary determines is necessary in order to carry out the study and report by the Institute of Medicine under this section.

SEC. 103. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle B—Right to Information About Plans and Providers

SEC. 111. INFORMATION ABOUT PLANS.

(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105–277), is amended by adding at the end the following:

"SEC. 714. HEALTH PLAN COMPARATIVE INFORMATION.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides coverage in connection with group health insurance coverage, shall, not later than 12 months after the date of enactment of this section, and at least annually thereafter, provide for the disclosure, in a clear and accurate form to each participant and each beneficiary who does not reside at the same address as the participant, or upon request to an individual eligible for coverage under the plan, of the information described in subsection (b).

''(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a plan or issuer from entering into any agreement under which the issuer agrees to assume responsibility for compliance with the requirements of this section and the plan is released from liability for such compliance.

''(3) PROVISION OF INFORMATION.—Information shall be provided to participants and beneficiaries under this section at the address maintained by the plan or issuer with respect to such participants or beneficiaries.

''(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each package option available under a group health plan the following:

''(1) A description of the covered items and services under each such plan and any in- and out-of-network features of each such plan, including a summary description of the specific exclusions from coverage under the plan.

''(2) A description of any cost-sharing, including premiums, deductibles, coinsurance, and copayment amounts, for which the participant or beneficiary will be responsible, including any annual or lifetime limits on benefits, for each such plan.

''(3) A description of any optional supplemental benefits offered by each such plan and the terms and conditions (including premiums or cost-sharing) for such supplemental coverage.

''(4) A description of any restrictions on payments for services furnished to a participant or beneficiary by a health care professional that is not a participating professional and the liability of the participant or beneficiary for additional payments for these services.

''(5) A description of the service area of each such plan, including the provision of any out-of-area coverage.

''(6) A description of the extent to which participants and beneficiaries may select the primary care provider of their choice, including providers both within the network and outside the network of each such plan (if the plan permits out-of-network services).

''(7) A description of the procedures for advance directives and organ donation decisions if the plan maintains such procedures.

''(8) A description of the requirements and procedures to be used to obtain preauthorization for health services (including telephone numbers and mailing addresses), including referrals for specialty care.

''(9) A description of the definition of medical necessity used in making coverage determinations by each such plan.

''(10) A summary of the rules and methods for appealing coverage decisions and filing grievances (including telephone numbers and mailing addresses), as well as other available remedies.

''(11) A summary description of any provisions for obtaining off-formulary medications if the plan utilizes a defined formulary for providing specific prescription medications.

''(12) A summary of the rules for access to emergency room care. Also, any available educational material regarding proper use of emergency services.

''(13) A description of whether or not coverage is provided for experimental treatments, investigational treatments, or clinical trials and the circumstances under which access to such treatments or trials is made available.

''(14) A description of the specific preventative services covered under the plan if such services are covered.

''(15) A statement regarding—

''(A) the manner in which a participant or beneficiary may access an obstetrician, gynecologist, or pediatrician in accordance with section 723 or 724; and

''(B) the manner in which a participant or beneficiary obtains continuity of care as provided for in section 726.

''(16) A statement that the following information, and instructions on obtaining such information (including telephone numbers and, if available, Internet websites), shall be made available upon request:

''(A) The names, addresses, telephone numbers, and State licensure status of the plan's participating health care professionals and participating health care facilities, and, if available, the education, training, speciality qualifications or certifications of such professionals.

''(B) A summary description of the methods used for compensating participating health care professionals, such as capitation, fee-for-service, salary, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(C) A summary description of the methods used for compensating health care facilities, including per diem, fee-for-service, capitation, bundled payments, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(D) A summary description of the procedures used for utilization review.

''(E) The list of the specific prescription medications included in the formulary of the plan, if the plan uses a defined formulary.

''(F) A description of the specific exclusions from coverage under the plan.

''(G) Any available information related to the availability of translation or interpretation services for non-English speakers and people with communication disabilities, including the availability of audio tapes or information in Braille.

''(H) Any information that is made public by accrediting organizations in the process of accreditation if the plan is accredited, or any additional quality indicators that the plan makes available.

''(c) MANNER OF DISTRIBUTION.—The information described in this section shall be distributed in an accessible format that is understandable to an average plan participant or beneficiary.

''(d) RULE OF CONSTRUCTION.—Nothing in this section may be construed to prohibit a group health plan, or health insurance issuer in connection with group health insurance coverage, from distributing any other additional information determined by the plan or issuer to be important or necessary in assisting participants and beneficiaries or upon request potential participants and beneficiaries in the selection of a health plan or from providing information under subsection (b)(15) as part of the required information.

''(e) 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 part 1, to reduce duplication with respect to any information that is required to be provided under any such requirements.

''(f) HEALTH CARE PROFESSIONAL.—In this section, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the health plan involved for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711, and inserting ''sections 711 and 714''.

(B) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) is amended by inserting after the item relating to section 713, the following:

''Sec. 714. Health plan comparative information.''.

(b) INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Health plan comparative information.''; and

(2) by inserting after section 9812 the following:

"SEC. 9813. HEALTH PLAN COMPARATIVE INFORMATION.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—A group health plan shall, not later than 12 months after the date of enactment of this section, and at least annually thereafter, provide for the disclosure, in a clear and accurate form to each participant and each beneficiary who does not reside at the same address as the participant, or upon request to an individual eligible for coverage under the plan, of the information described in subsection (b).

''(2) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a plan from entering into any agreement under which a health insurance issuer agrees to assume responsibility for compliance with the requirements of this section and the plan is released from liability for such compliance.

''(3) PROVISION OF INFORMATION.—Information shall be provided to participants and beneficiaries under this section at the address maintained by the plan with respect to such participants or beneficiaries.

''(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each package option available under a group health plan the following:

''(1) A description of the covered items and services under each such plan and any in- and out-of-network features of each such plan, including a summary description of the specific exclusions from coverage under the plan.

''(2) A description of any cost-sharing, including premiums, deductibles, coinsurance, and copayment amounts, for which the participant or beneficiary will be responsible, including any annual or lifetime limits on benefits, for each such plan.

''(3) A description of any optional supplemental benefits offered by each such plan and the terms and conditions (including premiums or cost-sharing) for such supplemental coverage.

''(4) A description of any restrictions on payments for services furnished to a participant or beneficiary by a health care professional that is not a participating professional and the liability of the participant or beneficiary for additional payments for these services.

''(5) A description of the service area of each such plan, including the provision of any out-of-area coverage.

''(6) A description of the extent to which participants and beneficiaries may select the primary care provider of their choice, including providers both within the network and outside the network of each such plan (if the plan permits out-of-network services).

''(7) A description of the procedures for advance directives and organ donation decisions if the plan maintains such procedures.

''(8) A description of the requirements and procedures to be used to obtain preauthorization for health services (including telephone numbers and mailing addresses), including referrals for specialty care.

''(9) A description of the definition of medical necessity used in making coverage determinations by each such plan.

''(10) A summary of the rules and methods for appealing coverage decisions and filing grievances (including telephone numbers and mailing addresses), as well as other available remedies.

''(11) A summary description of any provisions for obtaining off-formulary medications if the plan utilizes a defined formulary for providing specific prescription medications.

''(12) A summary of the rules for access to emergency room care. Also, any available educational material regarding proper use of emergency services.

''(13) A description of whether or not coverage is provided for experimental treatments, investigational treatments, or clinical trials and the circumstances under which access to such treatments or trials is made available.

''(14) A description of the specific preventative services covered under the plan if such services are covered.

''(15) A statement regarding—

''(A) the manner in which a participant or beneficiary may access an obstetrician, gynecologist, or pediatrician in accordance with section 723 or 724; and

''(B) the manner in which a participant or beneficiary obtains continuity of care as provided for in section 726.

''(16) A statement that the following information, and instructions on obtaining such information (including telephone numbers and, if available, Internet websites), shall be made available upon request:

''(A) The names, addresses, telephone numbers, and State licensure status of the plan's participating health care professionals and participating health care facilities, and, if available, the education, training, speciality qualifications or certifications of such professionals.

''(B) A summary description of the methods used for compensating participating health care professionals, such as capitation, fee-for-service, salary, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(C) A summary description of the methods used for compensating health care facilities, including per diem, fee-for-service, capitation, bundled payments, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(D) A summary description of the procedures used for utilization review.

''(E) The list of the specific prescription medications included in the formulary of the plan, if the plan uses a defined formulary.

''(F) A description of the specific exclusions from coverage under the plan.

''(G) Any available information related to the availability of translation or interpretation services for non-English speakers and people with communication disabilities, including the availability of audio tapes or information in Braille.

''(H) Any information that is made public by accrediting organizations in the process of accreditation if the plan is accredited, or any additional quality indicators that the plan makes available.

''(c) MANNER OF DISTRIBUTION.—The information described in this section shall be distributed in an accessible format that is understandable to an average plan participant or beneficiary.

''(d) RULE OF CONSTRUCTION.—Nothing in this section may be construed to prohibit a group health plan from distributing any other additional information determined by the plan to be important or necessary in assisting participants and beneficiaries or upon request potential participants and beneficiaries in the selection of a health plan or from providing information under subsection (b)(15) as part of the required information.

''(e) HEALTH CARE PROFESSIONAL.—In this section, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the health plan involved for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.''.

SEC. 112. INFORMATION ABOUT PROVIDERS.

(a) STUDY.—The Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine for the conduct of a study, and the submission to the Secretary of a report, that includes—

(1) an analysis of information concerning health care professionals that is currently available to patients, consumers, States, and professional societies, nationally and on a State-by-State basis, including patient preferences with respect to information about such professionals and their competencies;

(2) an evaluation of the legal and other barriers to the sharing of information concerning health care professionals; and

(3) recommendations for the disclosure of information on health care professionals, including the competencies and professional qualifications of such practitioners, to better facilitate patient choice, quality improvement, and market competition.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall forward to the appropriate committees of Congress a copy of the report and study conducted under subsection (a).

Subtitle C—Right to Hold Health Plans Accountable

SEC. 121. AMENDMENT TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended to read as follows:

"SEC. 503. CLAIMS PROCEDURE, COVERAGE DETERMINATION, GRIEVANCES AND APPEALS.

''(a) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every employee benefit plan shall—

''(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant; and

''(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

''(b) COVERAGE DETERMINATIONS UNDER GROUP HEALTH PLANS.—

''(1) PROCEDURES.—

''(A) IN GENERAL.—A group health plan or health insurance issuer conducting utilization review shall ensure that procedures are in place for—

''(i) making determinations regarding whether a participant or beneficiary is eligible to receive a payment or coverage for health services under the plan or coverage involved and any cost-sharing amount that the participant or beneficiary is required to pay with respect to such service;

''(ii) notifying a covered participant or beneficiary (or the authorized representative of such participant or beneficiary) and the treating health care professionals involved regarding determinations made under the plan or issuer and any additional payments that the participant or beneficiary may be required to make with respect to such service; and

''(iii) responding to requests, either written or oral, for coverage determinations or

for internal appeals from a participant or beneficiary (or the authorized representative of such participant or beneficiary) or the treating health care professional with the consent of the participant or beneficiary.

''(B) ORAL REQUESTS.—With respect to an oral request described in subparagraph (A)(iii), a group health plan or health insurance issuer may require that the requesting individual provide written evidence of such request.

''(2) TIMELINE FOR MAKING DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—A group health plan or a health insurance issuer shall maintain procedures to ensure that prior authorization determinations concerning the provision of non-emergency items or services are made within 30 days from the date on which the request for a determination is submitted, except that such period may be extended where certain circumstances exist that are determined by the Secretary to be beyond control of the plan or issuer.

''(B) EXPEDITED DETERMINATION.—

''(i) IN GENERAL.—A prior authorization determination under this subsection shall be made within 72 hours, in accordance with the medical exigencies of the case, after a request is received by the plan or issuer under clause (ii) or (iii).

''(ii) REQUEST BY PARTICIPANT OR BENEFICIARY.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of a participant or beneficiary if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the participant or beneficiary.

''(iii) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if the request involved indicates that the treating health care professional has reasonably documented, based on the medical exigencies, that a determination under the procedures described in subparagraph (A) could seriously jeopardize the life or health of the participant or beneficiary.

''(C) CONCURRENT DETERMINATIONS.—A plan or issuer shall maintain procedures to certify or deny coverage of an extended stay or additional services.

''(D) RETROSPECTIVE DETERMINATION.—A plan or issuer shall maintain procedures to ensure that, with respect to the retrospective review of a determination made under paragraph (1), the determination shall be made within 30 working days of the date on which the plan or issuer receives necessary information.

''(3) NOTICE OF DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(A), the plan or issuer shall issue notice of such determination to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and, consistent with the medical exigencies of the case, to the treating health care professional involved not later than 2 working days after the date on which the determination is made.

''(B) EXPEDITED DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(B), the plan or issuer shall issue notice of such determination to the participant or beneficiary (or the authorized representative of the participant or beneficiary), and consistent with the medical exigencies of the case, to the treating health care professional involved within the 72 hour period described in paragraph (2)(B).

''(C) CONCURRENT REVIEWS.—With respect to the determination under a plan or issuer under paragraph (2)(C) to certify or deny coverage of an extended stay or additional services, the plan or issuer shall issue notice of such determination to the treating health care professional and to the participant or beneficiary involved (or the authorized representative of the participant or beneficiary) within 1 working day of the determination.

''(D) RETROSPECTIVE REVIEWS.—With respect to the retrospective review under a plan or issuer of a determination made under paragraph (2)(D), the plan or issuer shall issue written notice of an approval or disapproval of a determination under this subparagraph to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and health care provider involved within 5 working days of the date on which such determination is made.

''(E) REQUIREMENTS OF NOTICE OF ADVERSE COVERAGE DETERMINATIONS.—A written notice of an adverse coverage determination under this subsection, or of an expedited adverse coverage determination under paragraph (2)(B), shall be provided to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and treating health care professional (if any) involved and shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average participant or beneficiary;

''(ii) the procedures for obtaining additional information concerning the determination; and

''(iii) notification of the right to appeal the determination and instructions on how to initiate an appeal in accordance with subsection (d).

''(c) GRIEVANCES.—A group health plan or a health insurance issuer shall have written procedures for addressing grievances between the plan or issuer offering health insurance coverage in connection with a group health plan and a participant or beneficiary. Determinations under such procedures shall be non-appealable.

''(d) INTERNAL APPEAL OF COVERAGE DETERMINATIONS.—

''(1) RIGHT TO APPEAL.—

''(A) IN GENERAL.—A participant or beneficiary (or the authorized representative of the participant or beneficiary) or the treating health care professional with the consent of the participant or beneficiary (or the authorized representative of the participant or beneficiary), may appeal any adverse coverage determination under subsection (b) under the procedures described in this subsection.

''(B) TIME FOR APPEAL.—A plan or issuer shall ensure that a participant or beneficiary has a period of not less than 180 days beginning on the date of an adverse coverage determination under subsection (b) in which to appeal such determination under this subsection.

''(C) FAILURE TO ACT.—The failure of a plan or issuer to issue a determination under subsection (b) within the applicable timeline established for such a determination under such subsection shall be treated as an adverse coverage determination for purposes of proceeding to internal review under this subsection.

''(2) RECORDS.—A group health plan and a health insurance issuer shall maintain written records, for at least 6 years, with respect to any appeal under this subsection for purposes of internal quality assurance and improvement. Nothing in the preceding sentence shall be construed as preventing a plan and issuer from entering into an agreement under which the issuer agrees to assume responsibility for compliance with the requirements of this section and the plan is released from liability for such compliance.

''(3) ROUTINE DETERMINATIONS.—A group health plan or a health insurance issuer shall complete the consideration of an appeal of an adverse routine determination under this subsection not later than 30 working days after the date on which a request for such appeal is received.

''(4) EXPEDITED DETERMINATION.—

''(A) IN GENERAL.—An expedited determination with respect to an appeal under this subsection shall be made in accordance with the medical exigencies of the case, but in no case more than 72 hours after the request for such appeal is received by the plan or issuer under subparagraph (B) or (C).

''(B) REQUEST BY PARTICIPANT OR BENEFICIARY.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of a participant or beneficiary if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the participant or beneficiary.

''(C) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if the request involved indicates that the treating health care professional has reasonably documented, based on the medical exigencies of the case that a determination under the procedures described in paragraph (2) could seriously jeopardize the life or health of the participant or beneficiary.

''(5) CONDUCT OF REVIEW.—A review of an adverse coverage determination under this subsection shall be conducted by an individual with appropriate expertise who was not directly involved in the initial determination.

''(6) LACK OF MEDICAL NECESSITY.—A review of an appeal under this subsection relating to a determination to deny coverage based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, shall be made only by a physician with appropriate expertise, including age-appropriate expertise, who was not involved in the initial determination.

''(7) NOTICE.—

''(A) IN GENERAL.—Written notice of a determination made under an internal review process shall be issued to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and the treating health care professional not later than 2 working days after the completion of the review (or within the 72-hour period referred to in paragraph (4) if applicable).

''(B) ADVERSE COVERAGE DETERMINATIONS.—With respect to an adverse coverage determination made under this subsection, the notice described in subparagraph (A) shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average participant or beneficiary;

''(ii) the procedures for obtaining additional information concerning the determination; and

''(iii) notification of the right to an independent external review under subsection (e) and instructions on how to initiate such a review.

''(e) INDEPENDENT EXTERNAL REVIEW.—

''(1) ACCESS TO REVIEW.—

''(A) IN GENERAL.—A group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan shall have written procedures to

permit a participant or beneficiary (or the authorized representative of the participant or beneficiary) access to an independent external review with respect to an adverse coverage determination concerning a particular item or service (including a circumstance treated as an adverse coverage determination under subparagraph (B)) where—

''(i) the particular item or service involved—

''(I)(aa) would be a covered benefit, when medically necessary and appropriate under the terms and conditions of the plan, and the item or service has been determined not to be medically necessary and appropriate under the internal appeals process required under subsection (d) or there has been a failure to issue a coverage determination as described in subparagraph (B); and

''(bb)(AA) the amount of such item or service involved exceeds a significant financial threshold; or

''(BB) there is a significant risk of placing the life or health of the participant or beneficiary in jeopardy; or

''(II) would be a covered benefit, when not considered experimental or investigational under the terms and conditions of the plan, and the item or service has been determined to be experimental or investigational under the internal appeals process required under subsection (d) or there has been a failure to issue a coverage determination as described in subparagraph (B); and

''(ii) the participant or beneficiary has completed the internal appeals process under subsection (d) with respect to such determination.

''(B) FAILURE TO ACT.—The failure of a plan or issuer to issue a coverage determination under subsection (d)(6) within the applicable timeline established for such a determination under such subsection shall be treated as an adverse coverage determination for purposes of proceeding to independent external review under this subsection.

''(2) INITIATION OF THE INDEPENDENT EXTERNAL REVIEW PROCESS.—

''(A) FILING OF REQUEST.—A participant or beneficiary (or the authorized representative of the participant or beneficiary) who desires to have an independent external review conducted under this subsection shall file a written request for such a review with the plan or issuer involved not later than 30 working days after the receipt of a final denial of a claim under subsection (d). Any such request shall include the consent of the participant or beneficiary (or the authorized representative of the participant or beneficiary) for the release of medical information and records to independent external reviewers regarding the participant or beneficiary.

''(B) INFORMATION AND NOTICE.—Not later than 5 working days after the receipt of a request under subparagraph (A), or earlier in accordance with the medical exigencies of the case, the plan or issuer involved shall select an external appeals entity under paragraph (3)(A) that shall be responsible for designating an independent external reviewer under paragraph (3)(B).

''(C) PROVISION OF INFORMATION.—The plan or issuer involved shall forward necessary information (including medical records, any relevant review criteria, the clinical rationale consistent with the terms and conditions of the contract between the plan or issuer and the participant or beneficiary for the coverage denial, and evidence of the coverage of the participant or beneficiary) to the independent external reviewer selected under paragraph (3)(B).

''(D) NOTIFICATION.—The plan or issuer involved shall send a written notification to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and the plan administrator, indicating that an independent external review has been initiated.

''(3) CONDUCT OF INDEPENDENT EXTERNAL REVIEW.—

''(A) DESIGNATION OF EXTERNAL APPEALS ENTITY BY PLAN OR ISSUER.—

''(i) IN GENERAL.—A plan or issuer that receives a request for an independent external review under paragraph (2)(A) shall designate a qualified entity described in clause (ii), in a manner designed to ensure that the entity so designated will make a decision in an unbiased manner, to serve as the external appeals entity.

''(ii) QUALIFIED ENTITIES.—A qualified entity shall be—

''(I) an independent external review entity licensed or credentialed by a State;

''(II) a State agency established for the purpose of conducting independent external reviews;

''(III) any entity under contract with the Federal Government to provide independent external review services;

''(IV) any entity accredited as an independent external review entity by an accrediting body recognized by the Secretary for such purpose; or

''(V) any other entity meeting criteria established by the Secretary for purposes of this subparagraph.

''(B) DESIGNATION OF INDEPENDENT EXTERNAL REVIEWER BY EXTERNAL APPEALS ENTITY.—The external appeals entity designated under subparagraph (A) shall, not later than 30 days after the date on which such entity is designated under subparagraph (A), or earlier in accordance with the medical exigencies of the case, designate one or more individuals to serve as independent external reviewers with respect to a request received under paragraph (2)(A). Such reviewers shall be independent medical experts who shall—

''(i) be appropriately credentialed or licensed in any State to deliver health care services;

''(ii) not have any material, professional, familial, or financial affiliation with the case under review, the participant or beneficiary involved, the treating health care professional, the institution where the treatment would take place, or the manufacturer of any drug, device, procedure, or other therapy proposed for the participant or beneficiary whose treatment is under review;

''(iii) have expertise (including age-appropriate expertise) in the diagnosis or treatment under review and, when reasonably available, be of the same specialty as the physician treating the participant or beneficiary or recommending or prescribing the treatment in question;

''(iv) receive only reasonable and customary compensation from the group health plan or health insurance issuer in connection with the independent external review that is not contingent on the decision rendered by the reviewer; and

''(v) not be held liable for decisions regarding medical determinations (but may be held liable for actions that are arbitrary and capricious).

''(4) STANDARD OF REVIEW.—

''(A) IN GENERAL.—An independent external reviewer shall—

''(i) make an independent determination based on the valid, relevant, scientific and clinical evidence to determine the medical necessity, appropriateness, experimental or investigational nature of the proposed treatment; and

''(ii) take into consideration appropriate and available information, including any evidence-based decision making or clinical practice guidelines used by the group health plan or health insurance issuer; timely evidence or information submitted by the plan, issuer, patient or patient's physician; the patient's medical record; expert consensus; and medical literature as defined in section 556(5) of the Federal Food, Drug, and Cosmetic Act.

''(B) NOTICE.—The plan or issuer involved shall ensure that the participant or beneficiary receives notice, within 30 days after the determination of the independent medical expert, regarding the actions of the plan or issuer with respect to the determination of such expert under the independent external review.

''(5) TIMEFRAME FOR REVIEW.—

''(A) IN GENERAL.—The independent external reviewer shall complete a review of an adverse coverage determination in accordance with the medical exigencies of the case.

''(B) LIMITATION.—Notwithstanding subparagraph (A), a review described in such subparagraph shall be completed not later than 30 working days after the later of—

''(i) the date on which such reviewer is designated; or

''(ii) the date on which all information necessary to completing such review is received.

''(6) BINDING DETERMINATION.—The determination of an independent external reviewer under this subsection shall be binding upon the plan or issuer if the provisions of this subsection or the procedures implemented under such provisions were complied with by the independent external reviewer.

''(7) STUDY.—Not later than 2 years after the date of enactment of this section, the General Accounting Office shall conduct a study of a statistically appropriate sample of completed independent external reviews. Such study shall include an assessment of the process involved during an independent external review and the basis of decision-making by the independent external reviewer. The results of such study shall be submitted to the appropriate committees of Congress.

''(8) EFFECT ON CERTAIN PROVISIONS.—Nothing in this section shall be construed as affecting or modifying section 514 of this Act with respect to a group health plan.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a plan administrator or plan fiduciary or health plan medical director from requesting an independent external review by an independent external reviewer without first completing the internal review process.

''(g) DEFINITIONS.—In this section:

''(1) ADVERSE COVERAGE DETERMINATION.—The term 'adverse coverage determination' means a coverage determination under the plan which results in a denial of coverage or reimbursement.

''(2) COVERAGE DETERMINATION.—The term 'coverage determination' means with respect to items and services for which coverage may be provided under a health plan, a determination of whether or not such items and services are covered or reimbursable under the coverage and terms of the contract.

''(3) GRIEVANCE.—The term 'grievance' means any complaint made by a participant or beneficiary that does not involve a coverage determination.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' shall have the meaning given such term in section 733(a). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 733(b)(1). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 733(b)(2).

''(7) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means a coverage determination prior to the provision of the items and services as a condition of coverage of the items and services under the coverage.

''(8) TREATING HEALTH CARE PROFESSIONAL.—The term 'treating health care professional' with respect to a group health plan, health insurance issuer or provider sponsored organization means a physician (medical doctor or doctor of osteopathy) or other health care practitioner who is acting within the scope of his or her State licensure or certification for the delivery of health care services and who is primarily responsible for delivering those services to the participant or beneficiary.

''(9) UTILIZATION REVIEW.—The term 'utilization review' with respect to a group health plan or health insurance coverage means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.''

(b) ENFORCEMENT.—Section 502(c)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)(1)) is amended by inserting after ''or section 101(e)(1)'' the following: '', or fails to comply with a coverage determination as required under section 503(e)(6),''.

(c) CONFORMING AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the item relating to section 503 and inserting the following new item:

''Sec. 503. Claims procedures, coverage determination, grievances and appeals.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after 1 year after the date of enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

TITLE II—GENETIC INFORMATION AND SERVICES

SEC. 201. SHORT TITLE.

This title may be cited as the ''Genetic Information Nondiscrimination in Health Insurance Act of 1999''.

SEC. 202. AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 702(a)(1)(F) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(a)(1)(F)) is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 111(a), is further amended by adding at the end the following:

''SEC. 715. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''A group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).''.

(3) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 702(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)) is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 715.''.

(B) TABLE OF CONTENTS.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974, as amended by section 111(a), is further amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Prohibiting premium discrimination against groups on the basis of predictive genetic information.''.

(b) LIMITATION ON COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Section 702 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182) is amended by adding at the end the following:

''(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 in connection with a group health plan, shall not request or require predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).

''(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 in connection with a group health plan, 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 in connection with a group health plan, 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) PREPARATION OF WRITTEN NOTICE.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, 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—

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

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

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, 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.''.

(c) DEFINITIONS.—Section 733(d) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(d)) is amended by adding at the end the following:

''(5) 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).

''(6) 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 (including information about a request for or receipt of genetic services).

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

''(8) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(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) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

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

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(9) 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 physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(d) EFFECTIVE DATE.—Except as provided in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning 1 year after the date of the enactment of this Act.

SEC. 203. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

(a) AMENDMENTS RELATING TO THE GROUP MARKET.—

(1) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION IN THE GROUP MARKET.—

(A) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 2702(a)(1)(F) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(1)(F)) is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(B) NO DISCRIMINATION IN PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105–277), is amended by adding at the end the following new section:

''SEC. 2707. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION IN THE GROUP MARKET.

''A group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).''.

(C) CONFORMING AMENDMENT.—Section 2702(b) of the Public Health Service Act (42 U.S.C. 300gg–1(b)) is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 2707.''.

(D) LIMITATION ON COLLECTION AND DISCLOSURE OF PREDICTIVE GENETIC INFORMATION.—Section 2702 of the Public Health Service Act (42 U.S.C. 300gg–1) is amended by adding at the end the following:

''(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 in connection with a group health plan, shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(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 in connection with a group health plan, 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 in connection with a group health plan, 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) PREPARATION OF WRITTEN NOTICE.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, 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—

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

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

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, 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.''.

(2) DEFINITIONS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg–91(d)) is amended by adding at the end the following:

''(15) 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).

''(16) 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 (including information about a request for or receipt of genetic services).

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

''(18) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(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) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

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

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(19) 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 physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(b) AMENDMENT RELATING TO THE INDIVIDUAL MARKET.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–51 et seq.) (relating to other requirements), as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105-277) is amended—

(1) by redesignating such subpart as subpart 2; and

(2) by adding at the end the following:

''SEC. 2753. PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''(a) PROHIBITION ON PREDICTIVE GENETIC INFORMATION AS A CONDITION OF ELIGIBILITY.—A health insurance issuer offering health insurance coverage in the individual market may not use predictive genetic information as a condition of eligibility of an individual to enroll in individual health insurance coverage (including information about a request for or receipt of genetic services).

''(b) PROHIBITION ON PREDICTIVE GENETIC INFORMATION IN SETTING PREMIUM RATES.—A health insurance issuer offering health insurance coverage in the individual market shall not adjust premium rates for individuals on the basis of predictive genetic information concerning such an individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a health insurance issuer offering health insurance coverage in the individual market shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

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

''(A) IN GENERAL.—Notwithstanding paragraph (1), a health insurance issuer offering health insurance coverage in the individual market 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 health insurance issuer offering health insurance coverage in the individual market 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) PREPARATION OF WRITTEN NOTICE.—A health insurance issuer offering health insurance coverage in the individual market shall post or provide, in writing and in a clear and conspicuous manner, notice of the issuer's confidentiality practices, that shall include—

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

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

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A health insurance issuer offering health insurance coverage in the individual market 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 issuer.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to—

(1) group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after 1 year after the date of enactment of this Act; and

(2) health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after 1 year after the date of enactment of this Act.

SEC. 204. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

(a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 9802(a)(1)(F) of the Internal Revenue Code of 1986 is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 111(b), is further amended by adding at the end the following:

''SEC. 9814. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''A group health plan shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).''.

(B) CONFORMING AMENDMENT.—Section 9802(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or the receipt of genetic services), see section 9814.''.

(C) AMENDMENT TO TABLE OF SECTIONS.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 111(b), is further amended by adding at the end the following:

''Sec. 9814. Prohibiting premium discrimination against groups on the basis of predictive genetic information.''.

(b) LIMITATION ON COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Section 9802 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(d) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

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

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan 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; DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (e), of such predictive genetic information.

''(e) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan's confidentiality practices, that shall include—

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

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

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan 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.''.

(c) DEFINITIONS.—Section 9832(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(6) 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).

''(7) 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 (including information about a request for or receipt of genetic services).

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

''(9) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(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) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

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

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(10) 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 physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(d) EFFECTIVE DATE.—Except as provided in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning after 1 year after the date of the enactment of this Act.

TITLE III—HEALTHCARE RESEARCH AND QUALITY

SEC. 301. SHORT TITLE.

This title may be cited as the ''Healthcare Research and Quality Act of 1999''.

SEC. 302. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended to read as follows:

''TITLE IX—AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

''PART A—ESTABLISHMENT AND GENERAL DUTIES

''SEC. 901. MISSION AND DUTIES.

''(a) IN GENERAL.—There is established within the Public Health Service an agency to be known as the Agency for Healthcare Research and Quality. In carrying out this subsection, the Secretary shall redesignate

the Agency for Health Care Policy and Research as the Agency for Healthcare Research and Quality.

''(b) MISSION.—The purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of healthcare services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions. The Agency shall promote healthcare quality improvement by—

''(1) conducting and supporting research that develops and presents scientific evidence regarding all aspects of healthcare, including—

''(A) the development and assessment of methods for enhancing patient participation in their own care and for facilitating shared patient-physician decision-making;

''(B) the outcomes, effectiveness, and cost-effectiveness of healthcare practices, including preventive measures and long-term care;

''(C) existing and innovative technologies;

''(D) the costs and utilization of, and access to healthcare;

''(E) the ways in which healthcare services are organized, delivered, and financed and the interaction and impact of these factors on the quality of patient care;

''(F) methods for measuring quality and strategies for improving quality; and

''(G) ways in which patients, consumers, purchasers, and practitioners acquire new information about best practices and health benefits, the determinants and impact of their use of this information;

''(2) synthesizing and disseminating available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and

''(3) advancing private and public efforts to improve healthcare quality.

''(c) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND PRIORITY POPULATIONS.—In carrying out subsection (b), the Director shall undertake and support research, demonstration projects, and evaluations with respect to the delivery of health services—

''(1) in rural areas (including frontier areas);

''(2) for low-income groups, and minority groups;

''(3) for children;

''(4) for elderly; and

''(5) for people with special healthcare needs, including disabilities, chronic care and end-of-life healthcare.

''(d) APPOINTMENT OF DIRECTOR.—There shall be at the head of the Agency an official to be known as the Director for Healthcare Research and Quality. The Director shall be appointed by the Secretary. The Secretary, acting through the Director, shall carry out the authorities and duties established in this title.

''SEC. 902. GENERAL AUTHORITIES.

''(a) IN GENERAL.—In carrying out section 901(b), the Director shall support demonstration projects, conduct and support research, evaluations, training, research networks, multi-disciplinary centers, technical assistance, and the dissemination of information, on healthcare, and on systems for the delivery of such care, including activities with respect to—

''(1) the quality, effectiveness, efficiency, appropriateness and value of healthcare services;

''(2) quality measurement and improvement;

''(3) the outcomes, cost, cost-effectiveness, and use of healthcare services and access to such services;

''(4) clinical practice, including primary care and practice-oriented research;

''(5) healthcare technologies, facilities, and equipment;

''(6) healthcare costs, productivity, organization, and market forces;

''(7) health promotion and disease prevention, including clinical preventive services;

''(8) health statistics, surveys, database development, and epidemiology; and

''(9) medical liability.

''(b) HEALTH SERVICES TRAINING GRANTS.—

''(1) IN GENERAL.—The Director may provide training grants in the field of health services research related to activities authorized under subsection (a), to include pre- and post-doctoral fellowships and training programs, young investigator awards, and other programs and activities as appropriate. In carrying out this subsection, the Director shall make use of funds made available under section 487 as well as other appropriated funds.

''(2) REQUIREMENTS.—In developing priorities for the allocation of training funds under this subsection, the Director shall take into consideration shortages in the number of trained researchers addressing the priority populations.

''(c) MULTIDISCIPLINARY CENTERS.—The Director may provide financial assistance to assist in meeting the costs of planning and establishing new centers, and operating existing and new centers, for multidisciplinary health services research, demonstration projects, evaluations, training, and policy analysis with respect to the matters referred to in subsection (a).

''(d) RELATION TO CERTAIN AUTHORITIES REGARDING SOCIAL SECURITY.—Activities authorized in this section shall be appropriately coordinated with experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Amendments of 1967. Activities under subsection (a)(2) of this section that affect the programs under titles XVIII, XIX and XXI of the Social Security Act shall be carried out consistent with section 1142 of such Act.

''(e) DISCLAIMER.—The Agency shall not mandate national standards of clinical practice or quality healthcare standards. Recommendations resulting from projects funded and published by the Agency shall include a corresponding disclaimer.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to imply that the Agency's role is to mandate a national standard or specific approach to quality measurement and reporting. In research and quality improvement activities, the Agency shall consider a wide range of choices, providers, healthcare delivery systems, and individual preferences.

''PART B—HEALTHCARE IMPROVEMENT RESEARCH

''SEC. 911. HEALTHCARE OUTCOME IMPROVEMENT RESEARCH.

''(a) EVIDENCE RATING SYSTEMS.—In collaboration with experts from the public and private sector, the Agency shall identify and disseminate methods or systems that it uses to assess healthcare research results, particularly methods or systems that it uses to rate the strength of the scientific evidence behind healthcare practice, recommendations in the research literature, and technology assessments. The Agency shall make methods and systems for evidence rating widely available. Agency publications containing healthcare recommendations shall indicate the level of substantiating evidence using such methods or systems.

''(b) HEALTHCARE IMPROVEMENT RESEARCH CENTERS AND PROVIDER-BASED RESEARCH NETWORKS.—In order to address the full continuum of care and outcomes research, to link research to practice improvement, and to speed the dissemination of research findings to community practice settings, the Agency shall employ research strategies and mechanisms that will link research directly with clinical practice in geographically diverse locations throughout the United States, including—

''(1) Healthcare Improvement Research Centers that combine demonstrated multidisciplinary expertise in outcomes or quality improvement research with linkages to relevant sites of care;

''(2) Provider-based Research Networks, including plan, facility, or delivery system sites of care (especially primary care), that can evaluate and promote quality improvement; and

''(3) other innovative mechanisms or strategies to link research with clinical practice.

''SEC. 912. PRIVATE-PUBLIC PARTNERSHIPS TO IMPROVE ORGANIZATION AND DELIVERY.

''(a) SUPPORT FOR EFFORTS TO DEVELOP INFORMATION ON QUALITY.—

''(1) SCIENTIFIC AND TECHNICAL SUPPORT.—In its role as the principal agency for healthcare research and quality, the Agency may provide scientific and technical support for private and public efforts to improve healthcare quality, including the activities of accrediting organizations.

''(2) ROLE OF THE AGENCY.—With respect to paragraph (1), the role of the Agency shall include—

''(A) the identification and assessment of methods for the evaluation of the health of—

''(i) enrollees in health plans by type of plan, provider, and provider arrangements; and

''(ii) other populations, including those receiving long-term care services;

''(B) the ongoing development, testing, and dissemination of quality measures, including measures of health and functional outcomes;

''(C) the compilation and dissemination of healthcare quality measures developed in the private and public sector;

''(D) assistance in the development of improved healthcare information systems;

''(E) the development of survey tools for the purpose of measuring participant and beneficiary assessments of their healthcare; and

''(F) identifying and disseminating information on mechanisms for the integration of information on quality into purchaser and consumer decision-making processes.

''(b) CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS.—

''(1) IN GENERAL.—The Secretary, acting through the Director and in consultation with the Commissioner of Food and Drugs, shall establish a program for the purpose of making one or more grants for the establishment and operation of one or more centers to carry out the activities specified in paragraph (2).

''(2) REQUIRED ACTIVITIES.—The activities referred to in this paragraph are the following:

''(A) The conduct of state-of-the-art clinical, laboratory, or health services research for the following purposes:

''(i) To increase awareness of—

''(I) new uses of drugs, biological products, and devices;

''(II) ways to improve the effective use of drugs, biological products, and devices; and

''(III) risks of new uses and risks of combinations of drugs and biological products.

''(ii) To provide objective clinical information to the following individuals and entities:

''(I) Healthcare practitioners and other providers of healthcare goods or services.

''(II) Pharmacists, pharmacy benefit managers and purchasers.

''(III) Health maintenance organizations and other managed healthcare organizations.

''(IV) Healthcare insurers and governmental agencies.

''(V) Patients and consumers.

''(iii) To improve the quality of healthcare while reducing the cost of Healthcare through—

''(I) an increase in the appropriate use of drugs, biological products, or devices; and

''(II) the prevention of adverse effects of drugs, biological products, and devices and the consequences of such effects, such as unnecessary hospitalizations.

''(B) The conduct of research on the comparative effectiveness, cost-effectiveness, and safety of drugs, biological products, and devices.

''(C) Such other activities as the Secretary determines to be appropriate, except that grant funds may not be used by the Secretary in conducting regulatory review of new drugs.

''(c) REDUCING ERRORS IN MEDICINE.—The Director shall conduct and support research and build private-public partnerships to—

''(1) identify the causes of preventable healthcare errors and patient injury in healthcare delivery;

''(2) develop, demonstrate, and evaluate strategies for reducing errors and improving patient safety; and

''(3) promote the implementation of effective strategies throughout the healthcare industry.

''SEC. 913. INFORMATION ON QUALITY AND COST OF CARE.

''(a) IN GENERAL.—In carrying out 902(a), the Director shall—

''(1) conduct a survey to collect data on a nationally representative sample of the population on the cost, use and, for fiscal year 2001 and subsequent fiscal years, quality of healthcare, including the types of healthcare services Americans use, their access to healthcare services, frequency of use, how much is paid for the services used, the source of those payments, the types and costs of private health insurance, access, satisfaction, and quality of care for the general population including rural residents and for the populations identified in section 901(c); and

''(2) develop databases and tools that provide information to States on the quality, access, and use of healthcare services provided to their residents.

''(b) QUALITY AND OUTCOMES INFORMATION.—

''(1) IN GENERAL.—Beginning in fiscal year 2001, the Director shall ensure that the survey conducted under subsection (a)(1) will—

''(A) identify determinants of health outcomes and functional status, and their relationships to healthcare access and use, determine the ways and extent to which the priority populations enumerated in section 901(c) differ from the general population with respect to such variables, measure changes over time with respect to such variable, and monitor the overall national impact of changes in Federal and State policy on healthcare;

''(B) provide information on the quality of care and patient outcomes for frequently occurring clinical conditions for a nationally representative sample of the population including rural residents; and

''(C) provide reliable national estimates for children and persons with special healthcare needs through the use of supplements or periodic expansions of the survey.

In expanding the Medical Expenditure Panel Survey, as in existence on the date of enactment of this title, in fiscal year 2001 to collect information on the quality of care, the Director shall take into account any outcomes measurements generally collected by private sector accreditation organizations.

''(2) ANNUAL REPORT.—Beginning in fiscal year 2003, the Secretary, acting through the Director, shall submit to Congress an annual report on national trends in the quality of healthcare provided to the American people.

''SEC. 914. INFORMATION SYSTEMS FOR HEALTHCARE IMPROVEMENT.

''(a) IN GENERAL.—In order to foster a range of innovative approaches to the management and communication of health information, the Agency shall support research, evaluations and initiatives to advance—

''(1) the use of information systems for the study of healthcare quality, including the generation of both individual provider and plan-level comparative performance data;

''(2) training for healthcare practitioners and researchers in the use of information systems;

''(3) the creation of effective linkages between various sources of health information, including the development of information networks;

''(4) the delivery and coordination of evidence-based healthcare services, including the use of real-time healthcare decision-support programs;

''(5) the utility and comparability of health information data and medical vocabularies by addressing issues related to the content, structure, definitions and coding of such information and data in consultation with appropriate Federal, State and private entities;

''(6) the use of computer-based health records in all settings for the development of personal health records for individual health assessment and maintenance, and for monitoring public health and outcomes of care within populations; and

''(7) the protection of individually identifiable information in health services research and healthcare quality improvement.

''(b) DEMONSTRATION.—The Agency shall support demonstrations into the use of new information tools aimed at improving shared decision-making between patients and their care-givers.

''SEC. 915. RESEARCH SUPPORTING PRIMARY CARE AND ACCESS IN UNDERSERVED AREAS.

''(a) PREVENTIVE SERVICES TASK FORCE.—

''(1) ESTABLISHMENT AND PURPOSE.—The Director may periodically convene a Preventive Services Task Force to be composed of individuals with appropriate expertise. Such a task force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the healthcare community, and updating previous clinical preventive recommendations.

''(2) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operations of the Preventive Services Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

''(3) OPERATION.—In carrying out its responsibilities under paragraph (1), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

''(b) PRIMARY CARE RESEARCH.—

''(1) IN GENERAL.—There is established within the Agency a Center for Primary Care Research (referred to in this subsection as the 'Center') that shall serve as the principal source of funding for primary care practice research in the Department of Health and Human Services. For purposes of this paragraph, primary care research focuses on the first contact when illness or health concerns arise, the diagnosis, treatment or referral to specialty care, preventive care, and the relationship between the clinician and the patient in the context of the family and community.

''(2) RESEARCH.—In carrying out this section, the Center shall conduct and support research concerning—

''(A) the nature and characteristics of primary care practice;

''(B) the management of commonly occurring clinical problems;

''(C) the management of undifferentiated clinical problems; and

''(D) the continuity and coordination of health services.

''SEC. 916. CLINICAL PRACTICE AND TECHNOLOGY INNOVATION.

''(a) IN GENERAL.—The Director shall promote innovation in evidence-based clinical practice and healthcare technologies by—

''(1) conducting and supporting research on the development, diffusion, and use of healthcare technology;

''(2) developing, evaluating, and disseminating methodologies for assessments of healthcare practices and healthcare technologies;

''(3) conducting intramural and supporting extramural assessments of existing and new healthcare practices and technologies;

''(4) promoting education, training, and providing technical assistance in the use of healthcare practice and healthcare technology assessment methodologies and results; and

''(5) working with the National Library of Medicine and the public and private sector to develop an electronic clearinghouse of currently available assessments and those in progress.

''(b) SPECIFICATION OF PROCESS.—

''(1) IN GENERAL.—Not later than December 31, 2000, the Director shall develop and publish a description of the methodology used by the Agency and its contractors in conducting practice and technology assessment.

''(2) CONSULTATIONS.—In carrying out this subsection, the Director shall cooperate and consult with the Assistant Secretary for Health, the Administrator of the Health Care Financing Administration, the Director of the National Institutes of Health, the Commissioner of Food and Drugs, and the heads of any other interested Federal department or agency, and shall seek input, where appropriate, from professional societies and other private and public entities.

''(3) METHODOLOGY.—The Director, in developing assessment methodology, shall consider—

''(A) safety, efficacy, and effectiveness;

''(B) legal, social, and ethical implications;

''(C) costs, benefits, and cost-effectiveness;

''(D) comparisons to alternate technologies and practices; and

''(E) requirements of Food and Drug Administration approval to avoid duplication.

''(c) SPECIFIC ASSESSMENTS.—

''(1) IN GENERAL.—The Director shall conduct or support specific assessments of healthcare technologies and practices.

''(2) REQUESTS FOR ASSESSMENTS.—The Director is authorized to conduct or support assessments, on a reimbursable basis, for the Health Care Financing Administration, the Department of Defense, the Department of Veterans Affairs, the Office of Personnel Management, and other public or private entities.

''(3) GRANTS AND CONTRACTS.—In addition to conducting assessments, the Director may make grants to, or enter into cooperative agreements or contracts with, entities described in paragraph (4) for the purpose of conducting assessments of experimental, emerging, existing, or potentially outmoded healthcare technologies, and for related activities.

''(4) ELIGIBLE ENTITIES.—An entity described in this paragraph is an entity that is

determined to be appropriate by the Director, including academic medical centers, research institutions and organizations, professional organizations, third party payers, governmental agencies, and consortia of appropriate research entities established for the purpose of conducting technology assessments.

"SEC. 917. COORDINATION OF FEDERAL GOVERNMENT QUALITY IMPROVEMENT EFFORTS.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—To avoid duplication and ensure that Federal resources are used efficiently and effectively, the Secretary, acting through the Director, shall coordinate all research, evaluations, and demonstrations related to health services research, quality measurement and quality improvement activities undertaken and supported by the Federal Government.

''(2) SPECIFIC ACTIVITIES.—The Director, in collaboration with the appropriate Federal officials representing all concerned executive agencies and departments, shall develop and manage a process to—

''(A) improve interagency coordination, priority setting, and the use and sharing of research findings and data pertaining to Federal quality improvement programs, technology assessment, and health services research;

''(B) strengthen the research information infrastructure, including databases, pertaining to Federal health services research and healthcare quality improvement initiatives;

''(C) set specific goals for participating agencies and departments to further health services research and healthcare quality improvement; and

''(D) strengthen the management of Federal healthcare quality improvement programs.

''(b) STUDY BY THE INSTITUTE OF MEDICINE.—

''(1) IN GENERAL.—To provide Congress, the Department of Health and Human Services, and other relevant departments with an independent, external review of their quality oversight, quality improvement and quality research programs, the Secretary shall enter into a contract with the Institute of Medicine—

''(A) to describe and evaluate current quality improvement, quality research and quality monitoring processes through—

''(i) an overview of pertinent health services research activities and quality improvement efforts conducted by all Federal programs, with particular attention paid to those under titles XVIII, XIX, and XXI of the Social Security Act; and

''(ii) a summary of the partnerships that the Department of Health and Human Services has pursued with private accreditation, quality measurement and improvement organizations; and

''(B) to identify options and make recommendations to improve the efficiency and effectiveness of quality improvement programs through—

''(i) the improved coordination of activities across the medicare, medicaid and child health insurance programs under titles XVIII, XIX and XXI of the Social Security Act and health services research programs;

''(ii) the strengthening of patient choice and participation by incorporating state-of-the-art quality monitoring tools and making information on quality available; and

''(iii) the enhancement of the most effective programs, consolidation as appropriate, and elimination of duplicative activities within various federal agencies.

''(2) REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall enter into a contract with the Institute of Medicine for the preparation—

''(i) not later than 12 months after the date of enactment of this title, of a report providing an overview of the quality improvement programs of the Department of Health and Human Services for the medicare, medicaid, and CHIP programs under titles XVIII, XIX, and XXI of the Social Security Act; and

''(ii) not later than 24 months after the date of enactment of this title, of a final report containing recommendations.

''(B) REPORTS.—The Secretary shall submit the reports described in subparagraph (A) to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Commerce of the House of Representatives.

"PART C—GENERAL PROVISIONS

"SEC. 921. ADVISORY COUNCIL FOR HEALTHCARE RESEARCH AND QUALITY.

''(a) ESTABLISHMENT.—There is established an advisory council to be known as the Advisory Council for Healthcare Research and Quality.

''(b) DUTIES.—

''(1) IN GENERAL.—The Advisory Council shall advise the Secretary and the Director with respect to activities proposed or undertaken to carry out the purpose of the Agency under section 901(b).

''(2) CERTAIN RECOMMENDATIONS.—Activities of the Advisory Council under paragraph (1) shall include making recommendations to the Director regarding—

''(A) priorities regarding healthcare research, especially studies related to quality, outcomes, cost and the utilization of, and access to, healthcare services;

''(B) the field of healthcare research and related disciplines, especially issues related to training needs, and dissemination of information pertaining to healthcare quality; and

''(C) the appropriate role of the Agency in each of these areas in light of private sector activity and identification of opportunities for public-private sector partnerships.

''(c) MEMBERSHIP.—

''(1) IN GENERAL.—The Advisory Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Advisory Council shall be voting members other than the individuals designated under paragraph (3)(B) as ex officio members.

''(2) APPOINTED MEMBERS.—The Secretary shall appoint to the Advisory Council 21 appropriately qualified individuals. At least 17 members of the Advisory Council shall be representatives of the public who are not officers or employees of the United States. The Secretary shall ensure that the appointed members of the Council, as a group, are representative of professions and entities concerned with, or affected by, activities under this title and under section 1142 of the Social Security Act. Of such members—

''(A) 4 shall be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to healthcare;

''(B) 4 shall be individuals distinguished in the practice of medicine of which at least 1 shall be a primary care practitioner;

''(C) 3 shall be individuals distinguished in the other health professions;

''(D) 4 shall be individuals either representing the private healthcare sector, including health plans, providers, and purchasers or individuals distinguished as administrators of healthcare delivery systems;

''(E) 4 shall be individuals distinguished in the fields of healthcare quality improvement, economics, information systems, law, ethics, business, or public policy, including at least 1 individual specializing in rural aspects in 1 or more of these fields; and

''(F) 2 shall be individuals representing the interests of patients and consumers of healthcare.

''(3) EX OFFICIO MEMBERS.—The Secretary shall designate as ex officio members of the Advisory Council—

''(A) the Assistant Secretary for Health, the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Care Financing Administration, the Assistant Secretary of Defense (Health Affairs), and the Under Secretary for Health of the Department of Veterans Affairs; and

''(B) such other Federal officials as the Secretary may consider appropriate.

''(d) TERMS.—Members of the Advisory Council appointed under subsection (c)(2) shall serve for a term of 3 years. A member of the Council appointed under such subsection may continue to serve after the expiration of the term of the members until a successor is appointed.

''(e) VACANCIES.—If a member of the Advisory Council appointed under subsection (c)(2) does not serve the full term applicable under subsection (d), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

''(f) CHAIR.—The Director shall, from among the members of the Advisory Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Advisory Council.

''(g) MEETINGS.—The Advisory Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the Director or the chair.

''(h) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—

''(1) APPOINTED MEMBERS.—Members of the Advisory Council appointed under subsection (c)(2) shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Advisory Council unless declined by the member. Such compensation may not be in an amount in excess of the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day during which such member is engaged in the performance of the duties of the Advisory Council.

''(2) EX OFFICIO MEMBERS.—Officials designated under subsection (c)(3) as ex officio members of the Advisory Council may not receive compensation for service on the Advisory Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

''(i) STAFF.—The Director shall provide to the Advisory Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

"SEC. 922. PEER REVIEW WITH RESPECT TO GRANTS AND CONTRACTS.

''(a) REQUIREMENT OF REVIEW.—

''(1) IN GENERAL.—Appropriate technical and scientific peer review shall be conducted with respect to each application for a grant, cooperative agreement, or contract under this title.

''(2) REPORTS TO DIRECTOR.—Each peer review group to which an application is submitted pursuant to paragraph (1) shall report its finding and recommendations respecting the application to the Director in such form and in such manner as the Director shall require.

''(b) APPROVAL AS PRECONDITION OF AWARDS.—The Director may not approve an

application described in subsection (a)(1) unless the application is recommended for approval by a peer review group established under subsection (c).

''(c) ESTABLISHMENT OF PEER REVIEW GROUPS.—

''(1) IN GENERAL.—The Director shall establish such technical and scientific peer review groups as may be necessary to carry out this section. Such groups shall be established without regard to the provisions of title 5, United States Code, that govern appointments in the competitive service, and without regard to the provisions of chapter 51, and subchapter III of chapter 53, of such title that relate to classification and pay rates under the General Schedule.

''(2) MEMBERSHIP.—The members of any peer review group established under this section shall be appointed from among individuals who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group. Officers and employees of the United States may not constitute more than 25 percent of the membership of any such group. Such officers and employees may not receive compensation for service on such groups in addition to the compensation otherwise received for these duties carried out as such officers and employees.

''(3) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, peer review groups established under this section may continue in existence until otherwise provided by law.

''(4) QUALIFICATIONS.—Members of any peer-review group shall, at a minimum, meet the following requirements:

''(A) Such members shall agree in writing to treat information received, pursuant to their work for the group, as confidential information, except that this subparagraph shall not apply to public records and public information.

''(B) Such members shall agree in writing to recuse themselves from participation in the peer-review of specific applications which present a potential personal conflict of interest or appearance of such conflict, including employment in a directly affected organization, stock ownership, or any financial or other arrangement that might introduce bias in the process of peer-review.

''(d) AUTHORITY FOR PROCEDURAL ADJUSTMENTS IN CERTAIN CASES.—In the case of applications for financial assistance whose direct costs will not exceed $100,000, the Director may make appropriate adjustments in the procedures otherwise established by the Director for the conduct of peer review under this section. Such adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented or provider-based research, and for such other purposes as the Director may determine to be appropriate.

''(e) REGULATIONS.—The Director shall issue regulations for the conduct of peer review under this section.

''SEC. 923. CERTAIN PROVISIONS WITH RESPECT TO DEVELOPMENT, COLLECTION, AND DISSEMINATION OF DATA.

''(a) STANDARDS WITH RESPECT TO UTILITY OF DATA.—

''(1) IN GENERAL.—To ensure the utility, accuracy, and sufficiency of data collected by or for the Agency for the purpose described in section 901(b), the Director shall establish standard methods for developing and collecting such data, taking into consideration—

''(A) other Federal health data collection standards; and

''(B) the differences between types of healthcare plans, delivery systems, healthcare providers, and provider arrangements.

''(2) RELATIONSHIP WITH OTHER DEPARTMENT PROGRAMS.—In any case where standards under paragraph (1) may affect the administration of other programs carried out by the Department of Health and Human Services, including the programs under title XVIII, XIX or XXI of the Social Security Act, or may affect health information that is subject to a standard developed under part C of title XI of the Social Security Act, they shall be in the form of recommendations to the Secretary for such program.

''(b) STATISTICS AND ANALYSES.—The Director shall—

''(1) take appropriate action to ensure that statistics and analyses developed under this title are of high quality, timely, and duly comprehensive, and that the statistics are specific, standardized, and adequately analyzed and indexed; and

''(2) publish, make available, and disseminate such statistics and analyses on as wide a basis as is practicable.

''(c) AUTHORITY REGARDING CERTAIN REQUESTS.—Upon request of a public or private entity, the Director may conduct or support research or analyses otherwise authorized by this title pursuant to arrangements under which such entity will pay the cost of the services provided. Amounts received by the Director under such arrangements shall be available to the Director for obligation until expended.

''SEC. 924. DISSEMINATION OF INFORMATION.

''(a) IN GENERAL.—The Director shall—

''(1) without regard to section 501 of title 44, United States Code, promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title;

''(2) ensure that information disseminated by the Agency is science-based and objective and undertakes consultation as necessary to assess the appropriateness and usefulness of the presentation of information that is targeted to specific audiences;

''(3) promptly make available to the public data developed in such research, demonstration projects, and evaluations;

''(4) provide, in collaboration with the National Library of Medicine where appropriate, indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to healthcare to public and private entities and individuals engaged in the improvement of healthcare delivery and the general public, and undertake programs to develop new or improved methods for making such information available; and

''(5) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

''(b) PROHIBITION AGAINST RESTRICTIONS.—Except as provided in subsection (c), the Director may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

''(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Director) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Director) to its publication or release in other form.

''(d) PENALTY.—Any person who violates subsection (c) shall be subject to a civil monetary penalty of not more than $10,000 for each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act are imposed and collected.

''SEC. 925. ADDITIONAL PROVISIONS WITH RESPECT TO GRANTS AND CONTRACTS.

''(a) FINANCIAL CONFLICTS OF INTEREST.—With respect to projects for which awards of grants, cooperative agreements, or contracts are authorized to be made under this title, the Director shall by regulation define—

''(1) the specific circumstances that constitute financial interests in such projects that will, or may be reasonably expected to, create a bias in favor of obtaining results in the projects that are consistent with such interests; and

''(2) the actions that will be taken by the Director in response to any such interests identified by the Director.

''(b) REQUIREMENT OF APPLICATION.—The Director may not, with respect to any program under this title authorizing the provision of grants, cooperative agreements, or contracts, provide any such financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Director determines to be necessary to carry out the program in involved.

''(c) PROVISION OF SUPPLIES AND SERVICES IN LIEU OF FUNDS.—

''(1) IN GENERAL.—Upon the request of an entity receiving a grant, cooperative agreement, or contract under this title, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of the Department of Health and Human Services.

''(2) CORRESPONDING REDUCTION IN FUNDS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of the financial assistance involved by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Director. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

''(d) APPLICABILITY OF CERTAIN PROVISIONS WITH RESPECT TO CONTRACTS.—Contracts may be entered into under this part without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

''SEC. 926. CERTAIN ADMINISTRATIVE AUTHORITIES.

''(a) DEPUTY DIRECTOR AND OTHER OFFICERS AND EMPLOYEES.—

''(1) DEPUTY DIRECTOR.—The Director may appoint a deputy director for the Agency.

''(2) OTHER OFFICERS AND EMPLOYEES.—The Director may appoint and fix the compensation of such officers and employees as may be necessary to carry out this title. Except as otherwise provided by law, such officers and employees shall be appointed in accordance with the civil service laws and their compensation fixed in accordance with title 5, United States Code.

''(b) FACILITIES.—The Secretary, in carrying out this title—

''(1) may acquire, without regard to the Act of March 3, 1877 (40 U.S.C. 34), by lease or

otherwise through the Director of General Services, buildings or portions of buildings in the District of Columbia or communities located adjacent to the District of Columbia for use for a period not to exceed 10 years; and

''(2) may acquire, construct, improve, repair, operate, and maintain laboratory, research, and other necessary facilities and equipment, and such other real or personal property (including patents) as the Secretary deems necessary.

''(c) PROVISION OF FINANCIAL ASSISTANCE.—The Director, in carrying out this title, may make grants to public and nonprofit entities and individuals, and may enter into cooperative agreements or contracts with public and private entities and individuals.

''(d) UTILIZATION OF CERTAIN PERSONNEL AND RESOURCES.—

''(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Director, in carrying out this title, may utilize personnel and equipment, facilities, and other physical resources of the Department of Health and Human Services, permit appropriate (as determined by the Secretary) entities and individuals to utilize the physical resources of such Department, and provide technical assistance and advice.

''(2) OTHER AGENCIES.—The Director, in carrying out this title, may use, with their consent, the services, equipment, personnel, information, and facilities of other Federal, State, or local public agencies, or of any foreign government, with or without reimbursement of such agencies.

''(e) CONSULTANTS.—The Secretary, in carrying out this title, may secure, from time to time and for such periods as the Director deems advisable but in accordance with section 3109 of title 5, United States Code, the assistance and advice of consultants from the United States or abroad.

''(f) EXPERTS.—

''(1) IN GENERAL.—The Secretary may, in carrying out this title, obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Such experts or consultants shall be obtained in accordance with section 3109 of title 5, United States Code, except that the limitation in such section on the duration of service shall not apply.

''(2) TRAVEL EXPENSES.—

''(A) IN GENERAL.—Experts and consultants whose services are obtained under paragraph (1) shall be paid or reimbursed for their expenses associated with traveling to and from their assignment location in accordance with sections 5724, 5724a(a), 5724a(c), and 5726(C) of title 5, United States Code.

''(B) LIMITATION.—Expenses specified in subparagraph (A) may not be allowed in connection with the assignment of an expert or consultant whose services are obtained under paragraph (1) unless and until the expert agrees in writing to complete the entire period of assignment, or 1 year, whichever is shorter, unless separated or reassigned for reasons that are beyond the control of the expert or consultant and that are acceptable to the Secretary. If the expert or consultant violates the agreement, the money spent by the United States for the expenses specified in subparagraph (A) is recoverable from the expert or consultant as a statutory obligation owed to the United States. The Secretary may waive in whole or in part a right of recovery under this subparagraph.

''(g) VOLUNTARY AND UNCOMPENSATED SERVICES.—The Director, in carrying out this title, may accept voluntary and uncompensated services.

''SEC. 927. FUNDING.

''(a) INTENT.—To ensure that the United States's investment in biomedical research is rapidly translated into improvements in the quality of patient care, there must be a corresponding investment in research on the most effective clinical and organizational strategies for use of these findings in daily practice. The authorization levels in subsection (b) provide for a proportionate increase in healthcare research as the United States investment in biomedical research increases.

''(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this title, there are authorized to be appropriated $250,000,000 for fiscal year 2000, and such sums as may be necessary for each of the fiscal years 2001 through 2006.

''(c) EVALUATIONS.—In addition to amounts available pursuant to subsection (b) for carrying out this title, there shall be made available for such purpose, from the amounts made available pursuant to section 241 (relating to evaluations), an amount equal to 40 percent of the maximum amount authorized in such section 241 to be made available for a fiscal year.

''SEC. 928. DEFINITIONS.

''In this title:

''(1) ADVISORY COUNCIL.—The term 'Advisory Council' means the Advisory Council on Healthcare Research and Quality established under section 921.

''(2) AGENCY.—The term 'Agency' means the Agency for Healthcare Research and Quality.

''(3) DIRECTOR.—The term 'Director' means the Director for the Agency for Healthcare Research and Quality.''.

SEC. 303. REFERENCES.

Effective upon the date of enactment of this Act, any reference in law to the ''Agency for Health Care Policy and Research'' shall be deemed to be a reference to the ''Agency for Healthcare Research and Quality''.

TITLE IV—MISCELLANEOUS PROVISIONS

SEC. 401. SENSE OF THE COMMITTEE.

It is the sense of the Committee on Health, Education, Labor, and Pensions of the Senate that the Congress should take measures to further the purposes of this Act, including any necessary changes to the Internal Revenue Code of 1986 or to other Acts to—

(1) promote equity and prohibit discrimination based on genetic information with respect to the availability of health benefits;

(2) provide for the full deduction of health insurance costs for self-employed individuals;

(3) provide for the full availability of medical savings accounts;

(4) provide for the carryover of unused benefits from cafeteria plans, flexible spending arrangements, and health flexible spending accounts; and

(5) permit contributions towards medical savings account through the Federal employees health benefits program.

KENNEDY (AND OTHERS) AMENDMENT NO. 1233

Mr. DASCHLE (for Mr. KENNEDY) (for himself, Mr. REID, Mr. DURBIN, Mr. WELLSTONE, Mr. WYDEN, Mr. REED, Mrs. MURRAY, Mr. DASCHLE, and Mr. CHAFEE) proposed an amendment to amendment No. 1232 proposed by Mr. DASCHLE to the bill, S. 1344, supra; as follows:

At the appropriate place insert the following:

SEC. ___. APPLICATION TO ALL HEALTH PLANS.

(a) ERISA.—Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as added by section 101(a)(2) of this Act, is amended by adding at the end the following:

''SEC. 730A. APPLICATION OF PROVISIONS.

''(a) APPLICATION TO GROUP HEALTH PLANS.—The provisions of this subpart, and sections 714 and 503, shall apply to group health plans and health insurance issuers offering health insurance coverage in connection with a group health plan.

''(b) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a group health plan that provides benefits under 2 or more coverage options, the requirements of this subpart, other than section 722, shall apply separately with respect to each coverage option.

''(c) 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 this 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 721 (relating to access to emergency care).

''(B) Section 722 (relating to choice of coverage options), but only insofar as the plan is meeting such requirement through an agreement with the issuer to offer the option to purchase point-of-service coverage under such section.

''(C) Section 723, 724 and 725 (relating to access to specialty care).

''(D) Section 726) (relating to continuity in case of termination of provider (or, issuer in connection with health insurance coverage) contract) but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(E) Section 727 (relating to patient-provider communications).

''(F) Section 728 (relating to prescription drugs).

''(G) Section 729 (relating to self-payment for certain services).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 714, 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) GRIEVANCE AND INTERNAL APPEALS.—With respect to the grievance system and internal appeals process required to be established under section 503, 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 system and process (and is not liable for the issuer's failure to provide for such system and process), if the issuer is obligated to provide for (and provides for) such system and process.

''(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 503, 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 section 727, the group health plan shall not be liable for such violation unless the plan caused such violation.

''(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.

''(d) CONFORMING REGULATIONS.—The Secretary may issue regulations to coordinate the requirements on group health plans under this section with the requirements imposed under the other provisions of this title.''.

(b) APPLICATION TO GROUP MARKET UNDER PUBLIC HEALTH SERVICE ACT.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.), as amended by section 203(a)(1)(B), is further amended by adding at the end the following new section:

''SEC. 2708. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with the following patient protection requirements, and each health insurance issuer shall comply with such patient protection requirements with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection:

''(1) The requirements of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) The requirements of section 714 of the Employee Retirement Income Security Act of 1974.

''(3) The requirements of subsections (b) through (g) of section 503 of the Employee Retirement Income Security Act of 1974.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 104(b)(1) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(c) APPLICATION TO INDIVIDUAL MARKET UNDER PUBLIC HEALTH SERVICE ACT.—Subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-51 et seq.), as amended by section 203(b)(2), is further amended by adding at the end the following new section:

''SEC. 2754. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with the following patient protection requirements with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection:

''(1) The requirements of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) The requirements of section 714 of the Employee Retirement Income Security Act of 1974.

''(3) The requirements of section 503 of the Employee Retirement Income Security Act of 1974.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 104(b)(1) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such subtitle as if such section applied to such issuer and such issuer were a group health plan.

''(c) NONAPPLICATION OF CERTAIN PROVISION.—Section 2763(a) shall not apply to the provisions of this section.''.

(d) APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Standard relating to patients' bill of rights.''; and

(2) by inserting after section 9812 the following:

''SEC. 9813. STANDARD RELATING TO PATIENTS' BILL OF RIGHTS.

''A group health plan shall comply with the following requirements (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section:

''(1) The requirements of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) The requirements of section 714 of the Employee Retirement Income Security Act of 1974.

''(3) The requirements of section 503 of the Employee Retirement Income Security Act of 1974.''.

(e) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2708)'' after ''requirements of such subparts''.

(f) NO IMPACT ON SOCIAL SECURITY TRUST FUND.—

(1) IN GENERAL.—Nothing in the amendments made by this section shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(2) TRANSFERS.—

(A) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this section has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(B) TRANSFER OF FUNDS.—If, under subparagraph (A), the Secretary of the Treasury estimates that the enactment of this section 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 section.

(g) INFORMATION REQUIREMENTS.—

(1) INFORMATION FROM GROUP HEALTH PLANS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following:

''(7) INFORMATION FROM GROUP HEALTH PLANS.—

''(A) PROVISION OF INFORMATION BY GROUP HEALTH PLANS.—The administrator of a group health plan subject to the requirements of paragraph (1) shall provide to the Secretary such of the information elements described in subparagraph (C) as the Secretary specifies, and in such manner and at such times as the Secretary may specify (but not more frequently than 4 times per year), with respect to each individual covered under the plan who is entitled to any benefits under this title.

''(B) PROVISION OF INFORMATION BY EMPLOYERS AND EMPLOYEE ORGANIZATIONS.—An employer (or employee organization) that maintains or participates in a group health plan subject to the requirements of paragraph (1) shall provide to the administrator of the plan such of the information elements required to be provided under subparagraph (A), and in such manner and at such times as the Secretary may specify, at a frequency consistent with that required under subparagraph (A) with respect to each individual described in subparagraph (A) who is covered under the plan by reason of employment with that employer or membership in the organization.

''(C) INFORMATION ELEMENTS.—The information elements described in this subparagraph are the following:

''(i) ELEMENTS CONCERNING THE INDIVIDUAL.—

''(I) The individual's name.

''(II) The individual's date of birth.

''(III) The individual's sex.

''(IV) The individual's social security insurance number.

''(V) The number assigned by the Secretary to the individual for claims under this title.

''(VI) The family relationship of the individual to the person who has or had current or employment status with the employer.

''(ii) ELEMENTS CONCERNING THE FAMILY MEMBER WITH CURRENT OR FORMER EMPLOYMENT STATUS.—

''(I) The name of the person in the individual's family who has current or former employment status with the employer.

''(II) That person's social security insurance number.

''(III) The number or other identifier assigned by the plan to that person.

''(IV) The periods of coverage for that person under the plan.

''(V) The employment status of that person (current or former) during those periods of coverage.

''(VI) The classes (of that person's family members) covered under the plan.

''(iii) PLAN ELEMENTS.—

''(I) The items and services covered under the plan.

''(II) The name and address to which claims under the plan are to be sent.

''(iv) ELEMENTS CONCERNING THE EMPLOYER.—

''(I) The employer's name.

''(II) The employer's address.

''(III) The employer identification number of the employer.

''(D) USE OF IDENTIFIERS.—The administrator of a group health plan shall utilize a unique identifier for the plan in providing information under subparagraph (A) and in other transactions, as may be specified by the Secretary, related to the provisions of this subsection. The Secretary may provide to the administrator the unique identifier described in the preceding sentence.

''(E) PENALTY FOR NONCOMPLIANCE.—Any entity that knowingly and willfully fails to comply with a requirement imposed by the previous subparagraphs shall be subject to a civil money penalty not to exceed $1,000 for each incident of such failure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as those provisions apply to a penalty or proceeding under section 1128A(a).''

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect 180 days after the date of the enactment of this Act.

(h) MODIFICATION TO FOREIGN TAX CREDIT CARRYBACK AND CARRYOVER PERIODS.—

(1) IN GENERAL.—Section 904(c) of the Internal Revenue Code of 1986 (relating to limitation on credit) is amended—

(A) by striking ''in the second preceding taxable year,'', and

(B) by striking ''or fifth'' and inserting ''fifth, sixth, or seventh''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to credits arising in taxable years beginning after December 31, 2001.

(i) LIMITATIONS ON WELFARE BENEFIT FUNDS OF 10 OR MORE EMPLOYER PLANS.—

(1) BENEFITS TO WHICH EXCEPTION APPLIES.—Section 419A(f)(6)(A) of the Internal Revenue Code of 1986 (relating to exception for 10 or more employer plans) is amended to read as follows:

''(A) IN GENERAL.—This subpart shall not apply to a welfare benefit fund which is part of a 10 or more employer plan if the only benefits provided through the fund are 1 or more of the following:

''(i) Medical benefits.

''(ii) Disability benefits.

''(iii) Group term life insurance benefits which do not provide for any cash surrender value or other money that can be paid, assigned, borrowed, or pledged for collateral for a loan.

The preceding sentence shall not apply to any plan which maintains experience-rating arrangements with respect to individual employers.''

(2) LIMITATION ON USE OF AMOUNTS FOR OTHER PURPOSES.—Section 4976(b) of such Act (defining disqualified benefit) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR 10 OR MORE EMPLOYER PLANS EXEMPTED FROM PREFUNDING LIMITS.—For purposes of paragraph (1)(C), if—

''(A) subpart D of part I of subchapter D of chapter 1 does not apply by reason of section 419A(f)(6) to contributions to provide 1 or more welfare benefits through a welfare benefit fund under a 10 or more employer plan, and

''(B) any portion of the welfare benefit fund attributable to such contributions is used for a purpose other than that for which the contributions were made,

then such portion shall be treated as reverting to the benefit of the employers maintaining the fund.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

(j) MODIFICATION OF INSTALLMENT METHOD AND REPEAL OF INSTALLMENT METHOD FOR ACCRUAL METHOD TAXPAYERS.—

(1) REPEAL OF INSTALLMENT METHOD FOR ACCRUAL BASIS TAXPAYERS.—

(A) IN GENERAL.—Subsection (a) of section 453 of the Internal Revenue Code of 1986 (relating to installment method) is amended to read as follows:

''(a) USE OF INSTALLMENT METHOD.—

''(1) IN GENERAL.—Except as otherwise provided in this section, income from an installment sale shall be taken into account for purposes of this title under the installment method.

''(2) ACCRUAL METHOD TAXPAYER.—The installment method shall not apply to income from an installment sale if such income would be reported under an accrual method of accounting without regard to this section. The preceding sentence shall not apply to a disposition described in subparagraph (A) or (B) of subsection (l)(2).''

(B) CONFORMING AMENDMENTS.—Sections 453(d)(1), 453(i)(1), and 453(k) of such Act are each amended by striking ''(a)'' each place it appears and inserting ''(a)(1)''.

(2) MODIFICATION OF PLEDGE RULES.—Paragraph (4) of section 453A(d) of such Act (relating to pledges, etc., of installment obligations) is amended by adding at the end the following: ''A payment shall be treated as directly secured by an interest in an installment obligation to the extent an arrangement allows the taxpayer to satisfy all or a portion of the indebtedness with the installment obligation.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to sales or other dispositions occurring on or after the date of the enactment of this Act.

SANTORUM (AND OTHERS) AMENDMENT NO. 1234

Mr. NICKLES (for Mr. SANTORUM) (for himself, Mr. BOND, Mr. NICKLES, Mr. HUTCHINSON, Mr. CRAIG, and Ms. COLLINS) proposed an amendment to amendment No. 1233 proposed by Mr. DASCHLE to the bill, S. 1344, supra; as folows:

Strike all after the first word in line three and insert the following:

SENSE OF THE SENATE CONCERNING THE SCOPE OF A PATIENTS' BILL OF RIGHTS.

(a) FINDINGS.—The Senate makes the following findings:

(1) Congress agreed that States should have primary responsibility for the regulation of health insurance when it passed the McCarran-Ferguson Act in 1945.

(2) The States have done a good job in responding to the consumer concerns associated with a rapidly evolving health care delivery system and have already adopted statutory and regulatory protections for consumers in fully-insured health plans and have tailored these protections to fit the needs of their States' consumers and health care marketplaces.

(3) 117,000,000 Americans who are enrolled in fully insured plans, governmental plans and individual policies are protected by State patient protections.

(4) Forty-two States have already enacted a Patient's Bill of Rights.

(5) Forty-seven States already enforce consumer protections regarding gag clauses on doctor-patient communications.

(6) Forty States already enforce consumer protections for access to emergency care services.

(7) Thirty-one States already enforce consumer protections requiring a prudent layperson standard for emergency care.

(8) The Employee Retirement Income Security Act of 1974 (referred to in this section as ''ERISA'') expressly prohibits States from regulating the self-funded employer sponsored plans that currently cover 48,000,000 Americans.

(9) The National Association of Insurance Commissioners has recommended that Congress should focus its legislative activities on consumers in self-funded ERISA plans, which are under the Federal Government's exclusive jurisdiction, and preserve the State protections that already exist for consumers in fully insured ERISA plans.

(10) The National Association of Insurance Commissioners has expressly stated that they do not endorse the concept of a Federal floor with regard to patient protections.

(11) Senate bill 6 (106th Congress) would greatly expand the Federal regulatory role over private health insurance.

(12) It would be inappropriate to set Federal health insurance standards that not only duplicate the responsibility of the 50 State insurance departments but that also would have to be enforced by the Health Care Financing Administration if a State fails to enact the standard.

(13) One size does not fit all, and what may be appropriate for one State may not be necessary in another.

(14) It is irresponsible to propose vastly expanding the Federal Government's role in regulating private health insurance at a time when the Health Care Financing Administration is having such a difficult time fulfilling its current and primary responsibilities for Medicare.

(15) In August, 1998, the United States Court of Appeals affirmed a district court ruling that the Health Care Financing Administration failed to enforce due process requirements and monitor health maintenance organization denials of medical service to medicare beneficiaries.

(16) On April 13, 1999, the General Accounting Office testified that the Health Care Financing Administration failed to use its authority to ensure that medicare beneficiaries were informed of their appeals rights under managed care plans.

(17) The General Accounting Office testified at a July, 1998 hearing in the Ways and Means Committee of the House of Representatives that the Health Care Financing Administration missed 25 percent of the implementation deadlines for the consumer and quality improvements to the Medicare program under the Balanced Budget Act of 1997.

(18) The Health Care Financing Administration should not be given new, broad regulatory authority as they have not adequately met their current responsibilities.

(19) The Health Care Financing Administration took 10 years to implement a 1987 law establishing new nursing home standards.

(20) The Health Care Financing Administration has yet to update its 1985 fire safety standards for hospitals.

(21) The Health Care Financing Administration is utilizing 1976 health and safety standards for the treatment of end-stage kidney disease.

(22) ERISA preempts State requirements relating to coverage determinations, grievances and appeals, and requirements relating to independent external review.

(23) In a recent judicial decision in Texas (*Corporate Health Insurance, Inc. V. The Texas Department of Insurance*), the lower court held that ERISA does preempt the State's external review law as it relates to group health plans.

(b) DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS INCREASED.—IN GENERAL.—Section 162(l)(1) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended to read as follows:

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

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

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

GRAHAM (AND OTHERS) AMENDMENT NO. 1235

Mr. GRAHAM (for himself, Mr. REID, Mr. CHAFEE, Mrs. MURRAY, Mr. DURBIN, Ms. MIKULSKI, Mr. SCHUMER, Mr. KENNEDY, Mr. DASCHLE, Mr. BAUCUS, Mr. FEINGOLD, and Mr. DORGAN) proposed an amendment to amendment No. 1233 proposed by Mr. DASCHLE to the bill, S. 1344, supra; as follows:

At the appropriate place insert the following:

SEC. ___. ACCESS TO EMERGENCY CARE.

(a) ERISA.—Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as added by section 101(a)(2) of this Act, is amended by adding at the end the following:

"SEC. 730A. ACCESS TO EMERGENCY CARE.

''(a) COVERAGE OF EMERGENCY SERVICES.—

''(1) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with group health insurance coverage, provides any benefits with respect to emergency services (as defined in paragraph (2)(B)), the plan or issuer shall cover emergency services furnished under the plan or coverage—

''(A) without the need for any prior authorization determination;

''(B) whether or not 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 by a nonparticipating health care provider or without prior authorization by the plan or issuer, 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 by the plan or issuer; 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 701 (or section 2701 of the Public Health Service Act or section 9801 of the Internal Revenue Code of 1986 as applicable) and other than applicable cost-sharing).

''(2) DEFINITIONS.—In this section:

''(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—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—

''(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 an emergency medical condition (as defined in subparagraph (A)), 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.

''(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—In the case of services (other than emergency services) for which benefits are available under a group health plan, or a health insurance issuer in connection with group health insurance coverage, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with the guidelines established under section 1852(d)(2) of the Social Security Act (relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of a participant, beneficiary or enrollee after a participant, beneficiary or enrollee has been determined to be stable), or, in the absence of guidelines under such section, such guidelines as the Secretary shall establish to carry out this subsection), if the services are maintenance care or post-stabilization care covered under such guidelines.

''(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

''(1) IN GENERAL.—If a group health plan, or health insurance coverage offered 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.

''(d) APPLICATION OF SECTION.—This section shall supersede the provisions of section 721 and section 721 shall have no effect.

''(e) REVIEW.—Failure to meet the requirements of this section shall constitute an appealable decision under this Act.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—Pursuant to rules of the Secretary, if a health insurance issuer offers group health insurance coverage in connection with a group health plan and takes an action in violation of any provision of this subchapter, the group health plan shall not be liable for such violation unless the plan caused such violation.

''(g) APPLICABILITY.—The provisions of this section shall apply to group health plans and health insurance issuers as if included in—

''(1) subpart 2 of part A of title XXVII of the Public Health Service Act;

''(2) the first subpart 3 of part B of title XXVII of the Public Health Service Act (relating to other requirements); and

''(3) subchapter B of chapter 100 of the Internal Revenue Code of 1986.

''(h) NONAPPLICATION OF CERTAIN PROVISION.—Only for purposes of applying the requirements of this section under section 714 of the Employee Retirement Income Security Act of 1974 (as added by section 301 of this Act), sections 2707 and 2753 of the Public Health Service Act (as added by sections 201 and 202 of this Act), and section 9813 of the Internal Revenue Code of 1986 (as added by section 401 of this Act)—

''(1) section 2721(b)(2) of the Public Health Service Act and section 9831(a)(1) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section; and

''(2) with respect to limited scope dental benefits, subparagraph (A) of section 733(c)(2) of the Employee Retirement Income Security Act of 1974, subparagraph (A) of section 2791(c)(2) of the Public Health Service Act, and subparagraph (A) of section 9832(c)(2) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section.

''(i) NO IMPACT ON SOCIAL SECURITY TRUST FUND.—

''(1) IN GENERAL.—Nothing in this section shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

''(2) TRANSFERS.—

''(A) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this section has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

''(B) TRANSFER OF FUNDS.—If, under subparagraph (A), the Secretary of the Treasury estimates that the enactment of this section 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 section.

''(j) LIMITATION ON ACTIONS.—

''(1) IN GENERAL.—Except as provided for in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 by a participant or beneficiary seeking relief based on the application of any provision in this section.

''(2) PERMISSIBLE ACTIONS.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 by a participant or beneficiary seeking relief based on the application of this section 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 for) 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) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.

''(k) EFFECTIVE DATE.—The provisions of this section shall apply to group health plans for plan years beginning after, and to health insurance issuers for coverage offered or sold after, October 1, 2000.''.

(b) INFORMATION REQUIREMENTS.—

(1) INFORMATION FROM GROUP HEALTH PLANS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following:

''(7) INFORMATION FROM GROUP HEALTH PLANS.—

''(A) PROVISION OF INFORMATION BY GROUP HEALTH PLANS.—The administrator of a group health plan subject to the requirements of paragraph (1) shall provide to the Secretary such of the information elements described in subparagraph (C) as the Secretary specifies, and in such manner and at such times as the Secretary may specify (but not more frequently than 4 times per year), with respect to each individual covered under the plan who is entitled to any benefits under this title.

''(B) PROVISION OF INFORMATION BY EMPLOYERS AND EMPLOYEE ORGANIZATIONS.—An employer (or employee organization) that maintains or participates in a group health plan subject to the requirements of paragraph (1) shall provide to the administrator of the plan such of the information elements required to be provided under subparagraph (A), and in such manner and at such times as the Secretary may specify, at a frequency consistent with that required under subparagraph (A) with respect to each individual described in subparagraph (A) who is covered under the plan by reason of employment

with that employer or membership in the organization.

''(C) INFORMATION ELEMENTS.—The information elements described in this subparagraph are the following:

''(i) ELEMENTS CONCERNING THE INDIVIDUAL.—

''(I) The individual's name.

''(II) The individual's date of birth.

''(III) The individual's sex.

''(IV) The individual's social security insurance number.

''(V) The number assigned by the Secretary to the individual for claims under this title.

''(VI) The family relationship of the individual to the person who has or had current or employment status with the employer.

''(ii) ELEMENTS CONCERNING THE FAMILY MEMBER WITH CURRENT OR FORMER EMPLOYMENT STATUS.—

''(I) The name of the person in the individual's family who has current or former employment status with the employer.

''(II) That person's social security insurance number.

''(III) The number or other identifier assigned by the plan to that person.

''(IV) The periods of coverage for that person under the plan.

''(V) The employment status of that person (current or former) during those periods of coverage.

''(VI) The classes (of that person's family members) covered under the plan.

''(iii) PLAN ELEMENTS.—

''(I) The items and services covered under the plan.

''(II) The name and address to which claims under the plan are to be sent.

''(iv) ELEMENTS CONCERNING THE EMPLOYER.—

''(I) The employer's name.

''(II) The employer's address.

''(III) The employer identification number of the employer.

''(D) USE OF IDENTIFIERS.—The administrator of a group health plan shall utilize a unique identifier for the plan in providing information under subparagraph (A) and in other transactions, as may be specified by the Secretary, related to the provisions of this subsection. The Secretary may provide to the administrator the unique identifier described in the preceding sentence.

''(E) PENALTY FOR NONCOMPLIANCE.—Any entity that knowingly and willfully fails to comply with a requirement imposed by the previous subparagraphs shall be subject to a civil money penalty not to exceed $1,000 for each incident of such failure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as those provisions apply to a penalty or proceeding under section 1128A(a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect 180 days after the date of the enactment of this Act.

(c) MODIFICATION OF INSTALLMENT METHOD AND REPEAL OF INSTALLMENT METHOD FOR ACCRUAL METHOD TAXPAYERS.—

(1) REPEAL OF INSTALLMENT METHOD FOR ACCRUAL BASIS TAXPAYERS.—

(A) IN GENERAL.—Subsection (a) of section 453 of the Internal Revenue Code of 1986 (relating to installment method) is amended to read as follows:

''(a) USE OF INSTALLMENT METHOD.—

''(1) IN GENERAL.—Except as otherwise provided in this section, income from an installment sale shall be taken into account for purposes of this title under the installment method.

''(2) ACCRUAL METHOD TAXPAYER.—The installment method shall not apply to income from an installment sale if such income would be reported under an accrual method of accounting without regard to this section. The preceding sentence shall not apply to a disposition described in subparagraph (A) or (B) of subsection (l)(2).''

(B) CONFORMING AMENDMENTS.—Sections 453(d)(1), 453(i)(1), and 453(k) of such Act are each amended by striking ''(a)'' each place it appears and inserting ''(a)(1)''.

(2) MODIFICATION OF PLEDGE RULES.—Paragraph (4) of section 453A(d) of such Act (relating to pledges, etc., of installment obligations) is amended by adding at the end the following: ''A payment shall be treated as directly secured by an interest in an installment obligation to the extent an arrangement allows the taxpayer to satisfy all or a portion of the indebtedness with the installment obligation.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to sales or other dispositions occurring on or after the date of the enactment of this Act.

NOTICES OF HEARINGS

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. CRAIG. Mr. President, I would like to announce for the public that a hearing has been scheduled before the Subcommittee on Forests and Public Land Management of the Senate Committee on Energy and Natural Resources.

The hearing will take place Wednesday, July 21, 1999, at 2 p.m., in room SD–366 of the Dirksen Senate Office Building in Washington, DC.

The purpose of this hearing is to receive testimony on S. 1184, a bill to authorize the Secretary of Agriculture to dispose of land for recreation or other public purposes. S. 1129, a bill to facilitate the acquisition of inholdings in Federal land management units and the disposal of surplus public land, and for other purposes, and H.R. 150, a bill to amend the act popularly known as the Recreation and Public Purposes Act to authorize disposal of certain public lands or national forest lands to local education agencies for use for elementary or secondary schools, including public charter schools, and for other purposes.

Those who wish to submit written statements should write to the Committee on Energy and Natural Resources, U.S. Senate, Washington, DC 20510. For further information, please call Mark Rey at (202) 224–6170.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. CRAIG. Mr. President, I would like to announce for the public that a hearing has been scheduled before the Subcommittee on Forests and Public Land Management of the Senate Committee on Energy and Natural Resources.

The hearing will take place Wednesday, July 22, 1999, at 2 p.m., in room SD–366 of the Dirksen Senate Office Building in Washington, DC.

The purpose of this hearing is to receive testimony from the U.S. General Accounting Office on a recent GAO report, 99–166, regarding Forest Service land management priorities. Within this context, GAO will also provide an evaluation of title I and title II of S. 1320, a bill to provide to the Federal land management agencies the authority and capability to manage effectively the Federal lands, and for other purposes.

Those who wish to submit written statements should write to the Committee on Energy and Natural Resources, U.S. Senate, Washington, DC 20510. For further information, please call Mark Rey at (202) 224–6170.

COMMITTEE ON INDIAN AFFAIRS
COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. CAMPBELL. Mr. President, I announce that the Senate Committee on Indian Affairs and the Senate Committee on Energy and Natural Resources will meet during the session of the Senate on Wednesday, July 14, 1999, at 9:30 a.m., to conduct a joint oversight hearing on the Report of the General Accounting Office (GAO) on the Interior Department's Planned Trust Fund Reform. The hearing will be held in room 216 of the Hart Senate Office Building.

Those wishing additional information should contact the Committee on Indian Affairs at (202) 224–2251.

ADDITIONAL STATEMENTS

OLIVER NORTH ARTICLE ON GENERAL CHUCK KRULAK, USMC

● Mr. BURNS. Mr. President, a couple of weeks ago, I stood on the floor in recognition of General Chuck Krulak's retirement as Commandant of the United States Marine Corps. Since then, I've attended the change of command ceremony at the Marine Barracks, and I must say, I was impressed with how General Krulak reminded us once again what makes Marines and the U.S. Marine Corps important.

I am equally impressed with the conduct of General James Jones, the new Commandant, and his recognition of the challenge he faces in following General Krulak's command. I wish him well and encourage him to continue the traditions maintained by his predecessor in dealing with Congress.

I come to the floor again today for one final addition to General Krulak's record before Congress. Oliver North wrote an excellent editorial recently in the Washington Times that captures the exceptional performance of the Commandant. I ask consent to have it printed in the RECORD.

The material follows:

SEMPER FIDELIS

(By Lt. Col. Oliver L. North (Ret.))

WASHINGTON, DC.—One recent morning, an invitation arrived in the mail. It was to a retirement ceremony at the Marine Barracks here in our nation's capital. I've probably been to more than a hundred of these rites of passage since I joined the Corps more than three decades ago. I won't be able to attend and had to send my sincere regrets for the invitation was to the retirement ceremony for a friend—General Charles C. Krulak, the 31st Commandant of the Marine Corps.

Now, Marine Lieutenant Colonels, even those of us no longer on active service, aren't in the habit of referring to Generals as friends—particularly when the General in question is the top Marine. And we sure don't offer a public critique of his performance as Commandant of all Marines. It just isn't done.

But in this case, somebody needs to do it. Because when Chuck Krulak takes off his Dress Blues with those four stars on the shoulders for the last time as he will at the end of this month, the conscience of the Joint Chiefs of Staff will have retired. And in this town, that kind of moral authority is going to be missed more than most people realize.

For four years, Chuck Krulak has been ''the General who tells it like it is''—in public and in private. Whether in testimony on Capitol Hill, in the Pentagon's ''tank'' where the Joint Chiefs of Staff meet, or at the White House, Chuck Krulak could be counted upon to tell the truth—whether they wanted to hear it or not. His reputation for integrity in a city that too little values this virtue is unparalleled—and a credit to the Corps of Marines he has led through some of the most tumultuous events in our history. His steadfast devotion to his 174,000 Marines is evident in all that he has said and done as Commandant. And very little of it endeared him to an administration hell bent on downsizing, feminizing, and de-''moralizing'' America's Armed Forces.

When General Krulak was appointed Commandant in 1995, the Clinton White House was busy taking an axe to America's defense establishment. By the time these draconian cuts were done, the Army would lose eight active combat divisions. The Air Force and Navy would lose 20 air wings—and 2,000 combat aircraft. Another 232 strategic bombers, 13 ballistic missile submarines, four aircraft carriers, all of our battleships, and more than 100 other combat vessels would be sent to the boneyard. Only the Marine Corps was able to withstand Commander-in-Chief Clinton's quest for a mothballed military.

And it didn't stop there. The Marines were badgered to make their boot camps co-ed. General Krulak said no. The Corps was told that it should put women in ground combat assignments in their expeditionary forces. Again, the top Marine said no. When the Pentagon started talking about relaxing the standard on sexual misconduct, Chuck Krulak just said, no. And when a Clinton political appointee responsible for ''feminizing'' the military decried the Marines as ''extremists,'' the Commandant fired back a blistering response that yes, they were, ''extremely fit, extremely faithful and extremely patriotic.'' In every case he was right.

And he didn't give an inch when the vaunted Clinton ''National Security Team'' acted as though the Marines had done so much for so long with so little that they could continue to do everything with nothing forever. Faced with unprecedented global commitments and the prospect of declining readiness, Krulak pulled no punches. He told the House and Senate Armed Services Committees that the Marines were ready to perform Mission Impossible—but that they needed to be better armed and equipped. He got what he wanted.

While the other branches of our Armed Forces struggle to meet recruiting and retention goals, lower their entrance standards, ease training requirements and try to make military service less ''military''—the Corps has done exactly the opposite. Krulak extended boot camp—adding his ''Crucible Training'' to the already rigorous initiation into the Corps. His Marines loved him for it, and the Corps has thrived.

The power brokers in Washington, who favor ''yes men'' over honest men, probably won't miss Chuck Krulak very much. But his Marines will. And I will—mostly because I remember him as a young Captain of Infantry, thirty years ago, when we served together in a corner of hell called Vietnam. He was then, as he is today, a warrior and a man of principle, integrity and character. He embodied then, as he does today, the guiding ethos of the Marines—Semper Fidelis—Always Faithful.

Mr. BURNS. Mr. President, I believe you can see how fitting it is that this article be included in the RECORD.●

MEREDITH GARDNER

● Mr. MOYNIHAN. Mr. President. I rise today to pay tribute to Meredith Gardner, long unsung contributor to the identification of spies. Described by the FBI's Robert Joseph Lamphere as ''the greatest counter-intelligence tool this country has ever known,'' Gardner was the National Security Agency's leading enabler of the reading of thousands of enciphered cables intercepted from Soviet foreign intelligence in the 1940's. The NSA, under its various names, spent four decades deciphering what Moscow intended to be an unbreakable Soviet cipher. Gardner and his team painstakingly worked on these messages in a project which came to be known eventually as ''VENONA.'' The resulting VENONA decrypts, which were finally revealed publicly in 1995, detail the Soviet's espionage efforts in the United States during and after World War II.

Gardner has a genius for learning languages, and is fluent in German, Spanish, French and Russian and has had courses in Old High and Middle High German, Old Norse, Gothic, Lithuanian, and Sanskrit. He taught languages at the Universities of Texas and Wisconsin before being recruited by the U.S. Army's Signals Intelligence Service (the precursor to the National Security Agency) shortly after the Japanese bombed Pearl Harbor. The Army wanted people fluent in many languages to work on breaking German and Japanese codes. Until 1955 Gardner worked at Arlington Hall, a former girl's school located 10 miles outside Washington, which served as the Army's headquarters for code-breaking operations. Gardner soon added Japanese to his repertoire of languages. By chance, he became the first American to read in an intercepted message the Japanese word for atom bomb, ''genshibakudan.''

When the war with Japan ended, the NSA phased out its Japanese section. Gardner learned that there was a section working on Soviet Union messages (its existence was kept secret) and he transferred into it. Gardner insists that the most arduous efforts to make the messages readable had already been done before he came along. First, the messages had to be sorted into at least four varieties, each used by representatives of separate Soviet government departments. It had also been discovered that some messages could be paired as having been ''randomized'' by the same pad and page carrying random additive digits (and hence were solvable).

Such mixed pairs were worked on by a small group of women led by Katurah ''Katie'' McDonald. This group had already produced a remarkable amount of code text, and the code-groups that had appeared so far had even been indexed in context by a card machine. The material was just awaiting the appointment of a linguist, and Gardner ''appointed himself'' to be it. It was the easy stage, but without it all the preparatory work would have been for nothing.

Gardner's reconstruction of the foreign intelligence (VENONA) code book was slow at first, but gained momentum. Because some recruits were named in the messages and given cover names, it became obvious that the FBI ought to receive translations of the cables. Special agent Robert Joseph Lamphere was assigned to be the (very efficient) link between the NSA and FBI. The next is history.

Gardner spent 27 years working on the ''Russian problem'' before retiring in 1972. He and his wife of 56 years, Blanche, who also worked for the Army Security Agency, now spend part of their time teaching Latin to a small group of students. I commend Mr. Gardner for the invaluable assistance he has given to our country, which we are only now beginning to realize and understand. I salute Mr. Gardner for his dedicated and important service.●

TRIBUTE TO MR. LARRY STOLTE, ON HIS RETIREMENT

● Mr. SMITH of New Hampshire. Mr. President, I rise today to acknowledge and commend Mr. Larry Stolte as he retires from the United States Fish and Wildlife Service.

Larry's career in New England began as a fisheries biologist in 1969 with the New Hampshire Fish and Game Department, working on the introduction of Coho salmon in the Great Bay area. In 1975, he joined the United States Fish and Wildlife Service and became the Atlantic Salmon Planner for New England. Larry took the lead in developing an Atlantic salmon strategic plan for southern New England, and chaired the state committee that developed the Atlantic salmon plan for Maine's rivers.

While working to restore Atlantic salmon to New England's waterways, Larry began researching the ''king of gamefish'' in the Merrimack River. He documented his research in a book titled ''The Forgotten Salmon of the Merrimack,'' which was published in 1981 and is recognized by many as the most accurate record of the history of the Atlantic salmon in the Merrimack River.

For the past 15 years, Larry has been the Fish and Wildlife Service's coordinator for anadromous fish restoration in the Merrimack River. He has also

chaired the U.S. Atlantic Salmon Assessment Committee and has been a working member of the International Commission on the Exploration of the Seas' North Atlantic Salmon Working Group.

Larry has devoted his entire career to restoring anadromous fish to New England rivers. His dedication and perseverance has been an inspiration to those who have worked toward this effort. Upon his retirement from the United States Fish and Wildlife Service, Larry and his wife Tracy will reside in Montana. I would like to thank Larry for his hard work and dedication to the restoration efforts of New England Rivers. It is an honor to represent Larry in the United States Senate.●

OUR OUTSTANDING AMBASSADOR IN BEIJING—JIM SASSER

●Mr. KENNEDY. Mr. President. I join many other Senators in welcoming our former colleague, Ambassador James Sasser, back to the United States after his outstanding service as our Ambassador to the People's Republic of China.

America has vital foreign policy interests in China, and Ambassador Sasser has represented those interests skillfully and effectively for more than three years.

During his service as Ambassador, he has worked diligently to restore high level summitry between China and the United States. His able leadership has made the American Embassy in Beijing more responsive to the concerns and interests of American business. He has also worked tirelessly to promote dialogue with the Dalai Lama.

In the aftermath of the tragic, mistaken bombing of China's embassy in Belgrade in May, America's embassy in Beijing was under siege, and Ambassador Sasser was virtually held hostage in the embassy. During this extraordinarily difficult time, he ensured that American personnel were safe and accounted for. He displayed remarkable courage during this ordeal, and made America proud of him.

All of us who worked with Ambassador Sasser in the Senate knew he would excel when President Clinton nominated him for this position. I congratulate him on a job well done. We are proud of his remarkable accomplishments and the efforts he has made to strengthen the U.S.-China relationship.●

HONORING KBHP RADIO FOR THE CRYSTAL RADIO AWARD

● Mr. GRAMS. Mr. President, I rise today to pay tribute to a Minnesota radio station from Bemidji, KBHP–FM, for geing honored with the 1999 Crystal Radio Award given by the National Association of Broadcasters. The Crystal Radio Award recognizes stations for their year-round commitment to community service. KBHP–FM was one of ten stations chosen to receive Crystals, making this their third award since 1987. Since the Award's inception in 1987, eight other stations in Minnesota have joined the ranks receiving the Crystal. These stations are WJON–AM in St Cloud, KSJN–FM in St. Paul, WWTC–AM, WCCO–AM, KQRS–FM/AM in Minneapolis (twice), KCUE–AM in Red Wing, KWOA–AM in Worthington, and WLTE–FM in Minneapolis.

I congratulate KBHP–FM for this great achievement and enter into the RECORD a brief description of the Station's work from the Cyrystal Radio Award program.●

ROBERT B. CONROY

● Mr. LIBERMAN. Mr. Presdient, I rise today to pay tribute to Robert B. Conroy of Westport Connecticut. Captain Conroy is a dedicated Veteran of World War II, a proud family man, and a fine example of the powerful American Spirit that weaves it way through the nation's history.

A member of the 359th Fighter Squardon and the 356th Fighter Group, Captain Conroy's plane was shot down by German forces over France in Janaury of 1944. Despite his injuries, Captain Conroy survived as a prisoner of war in Stalag Luft I for sixteen months until the camp was liberated by Russian troops.

Captain Conroy's list of medals, including the Purple Heart and the Distinguished Flying Cross, only begin to tell the story about what makes him a true American hero. After his military career, Captain Conroy raised and supported a family while building a successful career in advertising. The principles of honor, integrity, and devotion to duty that he displayed during World War II have remained a critical part of his life and are the same principles he has instilled in his children. I hope my colleagues will join me in thanking Captain Robert Conroy for his service, both military and civilian, to this great nation.●

TRIBUTE TO SY MAHFUZ

● Mr. SMITH of New Hampshire. Mr. President, I rise today to honor Sy Mahfuz, of Nashua, New Hampshire, for being selected a 1999 Business Leader of the Year by *Business NH Magazine.*

Sy, the owner of Persian Rug Galleries, has lived in Nashua for 46 years. His business is a fixture on Main Street and draws customers from all over the Northeast and New York. Persian Rug Galleries is known for both the quality of its products and the expertise of its employees.

Sy dedicates his time both to his business and to the community. In 1994, he fought to pass a bill which protests consumers from ''going out of business'' sales. He also is a major organizer of many downtown events. His leadership role in planning Twist the Night Away brought an estimated 100,000 people to Nashua's Main Street in 1998.

Sy's sense of responsibility for both his colleagues and neighbors has brought him success in the past. With his determination to succeed rooted in this responsibility he will surely continue to be a positive role model for his community.

Mr. President, I would like to wish Sy my sincere congratulations and best wishes. While running a successful family business, Sy had dedicated much of his time to having a positive impact on his community. His accomplishments are truly remarkable. It is an honor to represent him in the United States Senate.●

50TH ANNIVERSARY OF THE AIR FORCE MEDICAL SERVICE

● Mr. INOUYE. Mr. President, this month marks the 50th anniversary of the Air Force Medical Service. On July 1, 1949, the Air Force Medical Service was created, beginning a strong and rich tradition of providing health care to military personnel and their families.

Since the Korean War, the Air Force Medical Service has provided aerospace medicine support to our aviators. From ensuring pilots are physically fit to stand the rigors of flight to bringing physiological expertise to the design of fighter jet aircraft, aerospace medical personnel have maximized the performance and safety of our pilots.

Aeromedical evacuation of casualties proved valuable during World War II, and became the preferred mode of casualty evacuation during the Korean War. The Air Force Medical Service is responsible for fixed wing aircraft evacuation and manages a world-wide system for peacetime and wartime aeromedical evacuation.

Today, the Air Force Medical Service operates 37 medical center and hospitals and 41 clinics around the world, providing health care to a wide range of beneficiaries. When the Air Force Medical Services was created, only 4 percent of military troops had dependents. However, seventy percent of military personnel serving today have families. These dynamic changes have broadened the needs and expectations for medical services. In recent years, constrained resources and the initiation of TRICARE have added to the challenges. The Air Force Medical Service has always found innovative ways to ensure the mission was accomplished.

I congratulate the 52,000 men and women of the Air Force Medical Service on this milestone. I am confident that the proud traditions of the Air Force Medical Service will continue as its men and women provide the best combat medical support, aeromedical evaluation of the sick and injured, and health care to Air Force communities.●

RECOGNITION OF GENE CLAWSON, JR.

● Mr. BURNS. Mr. President, I rise today to recognize a great Montanan

who is a man of extraordinary talents and accomplishments, one of the most notable being President of the Amateur Trapshooting Association. This Association is the largest clay target shooting organization in the world with more than 100,000 members. This year as President, he will preside over the Grand American 100th Anniversary trapshoot in Vandalia, Ohio from August 12–21, 1999.

This past week in Missoula, Montana, July 8 was designated Gene Clawson, Jr. Day by the Montana State Trapshooting Association to recognize his dedication and service to this sport. Gene's dedication started over 40 years ago when he began shooting with his father and brother. When Gene started, he dominated state junior competitions and earned All-American status. His dedication and love for the sport propelled him to win 10 state championships, a national doubles Class AA championship. He was selected to the Montana All-State Team thirty-one times and in 1995 he was inducted into the Montana State Trapshooting Association Hall of Fame. One of his more phenomenal accomplishments was shooting the amazing ''perfect'' doubles score of 100 for a total of sixteen times.

Gene's service to trapshooting also has been an unusual example of unfaltering support and leadership. Gene started out helping his father with the duties of secretary-treasurer of the Missoula Trap and Skeet Club. From there his involvement grew to include being on the club's board of directors, Montana's delegate to the Amateur Trapshooting Association, and the Western Zone Vice-President for the Association in which he presided over 13 western States and Canadian provinces. Now as the President of the Amateur Trapshooting Association, he deals with virtually all of the Association's business. In all his endeavors, he has gained the respect and admiration of many people as well as to inspiring others to participate in the this exciting sport.

In addition to being a master of his sport, he is also a successful businessman. He has been President of the family-owned business, Clawson Manufacturing, for over 30 years. When his father started the business in 1948, they concentrated on unfinished furniture and cut stock. Since then, Gene has moved the company into designing, producing, and selling windows and roof trusses worldwide.

Gene is also a dedicated family man. Ranging in ages from 12 to 79, the Clawsons are an amazing example of family tradition, devotion, support, and success. For several years, three generations of Clawsons have hunted elk, waterfowl, and upland birds together. Three of Gene's sons (Nick, Bill, and Brad) have followed in their father's footsteps in excelling at trapshooting competitions. Now his grandson has joined the firing line. In these days when guns are associated with destroying families, it is refreshing to see an example of how the shooting sports can bring a family closer together.

Mr. President, I recognize Mr. Gene Clawson, Jr. and congratulate him for his accomplishments as an amateur trapshooter, father, and businessman. I was him and his family the best and much success in their future endeavors. Please join with me in recognizing this great Montanan and outstanding American.●

DEINSTITUTIONALIZATION OF THE MENTALLY ILL

Mr. MOYNIHAN. Mr. President, this past Friday (July 9, 1999), the Washington Post carried an excellent op-ed piece, ''Deinstitutionalization Hasn't Worked,'' by E. Fuller Torrey and Mary T. Zdanowicz. The authors are the president and executive director, respectively, of the Treatment Advocacy Center. They write about the continued stigma attached to mental illness. They write about barriers to treatment. Most important, they write about the aftermaths of deinstitutionalization, and the seemingly horrific effects this policy has had.

In this morning's New York Times (July 12, 1999), Fox Butterfield writes about a Department of Justice report released yesterday which states that some 283,800 inmates in the nation's jails and prisons suffer from mental illness. (This is a conservative estimate.) As Butterfield puts it, ''. . . jails and prisons have become the nation's new mental hospitals.''

Over the past 45 years, we have emptied state mental hospitals, but we have not provided commensurate outpatient treatment. Increasingly, individuals with mental illnesses are left to fend for themselves on the streets, where they victimize others or, more frequently, are victimized themselves. Eventually, many wind up in prison, where the likelihood of treatment is nearly as remote.

This is a cautionary tale, instructive of what is possible and also what we ought to be aware of. I was in the Harriman administration in New York in the 1950s. Early in 1955, Harriman met with his new Commissioner of Mental Hygiene, Paul Hoch, who described the development of a tranquilizer derived from rauwolfia by Dr. Nathan S. Kline at what was then known as Rockland State Hospital (it is now the Rockland Psychiatric Center) in Orangeburg. The medication had been clinically tested and appeared to be an effective treatment of many patients. Dr. Hoch recommended that it be used system wide; Harriman found the money.

That same year Congress created a Joint Commission on Mental Health and Illness with a view to formulating ''comprehensive and realistic recommendations'' in this area which was then a matter of considerable public concern. Year after year the population of mental institutions grew; year after year new facilities had to be built. Ballot measures to approve the issuance of general obligation bonds for building the facilities appeared just about every election. Or so it seemed.

The discovery of tranquilizers was adventitious. Physicians were seeking cures for disorders they were just beginning to understand. Even a limited success made it possible to believe that the incidence of this particular range of disorders, which had seemingly required persons to be confined against their will or even awareness, could be greatly reduced. The Congressional Commission submitted its report in 1961; it was seen to propose a nationwide program of deinstitutionalization.

Late in 1961 President Kennedy appointed an interagency committee to prepare legislative recommendations based on the report. I represented Secretary of Labor Arthur J. Goldberg on this committee and drafted its final submission. This included the recommendation of the National Institute of Mental Health that 2,000 ''community mental health centers'' (one for every 100,000 people) be built by 1980. A buoyant Presidential Message to Congress followed early in 1963. ''If we apply our medical knowledge and social insights fully,'' President Kennedy stated, ''all but a small portion of the mentally ill can eventually achieve a wholesome and a constructive social adjustment.'' A ''concerted national attack on mental disorders [was] now possible and practical.'' The President signed the Community Mental Health Centers Construction Act on October 31, 1963—his last public bill signing ceremony. He gave me a pen.

The mental hospitals emptied out. The number of patients in state and county mental hospitals peaked in 1955 at 558,922 and has declined every year since then, to 61,722 in 1996. But we never came near to building the 2,000 community mental health centers. Only some 482 received Federal construction funds from 1963 to 1980. The next year, 1981, the program was folded into the Alcohol, Drug Abuse, and Mental Health block grant program, where it disappeared from view.

Even when centers were built, the results were hardly as hoped for. David Musto has noted that the planners had bet on improving national mental health ''by improving the quality of general community life through expert knowledge [my emphasis], not merely by more effective treatment of the already ill.'' The problem was: there is no such knowledge. Nor is there. But the belief there was such knowledge took hold within sectors of the profession, which saw institutions as an unacceptable mode of social control. These activists subscribed to a redefining mode of their own, which they considered altruistic: mental patients were said to have been ''labeled,'' and were not to be drugged. So as the Federal government turned to other matters, the mental institutions continued to release patients, essentially to fend for themselves. There was no connection made: we're quite capable of that

in the public sphere. Professor Frederick F. Siegel of Cooper Union observed: ''in the great wave of moral deregulation that began in the mid-1960s, the poor and the insane were freed from the fetters of middle-class mores.'' Soon, the homeless appeared. Only to be defined as victims of an insufficient supply of affordable housing. No argument, no amount of evidence has yet affected that fixed ideological view.

I commend these two articles to my colleagues and ask that they be printed in the RECORD.

The articles follow:

[From the Washington Post, July 9, 1999]

DEINSTITUTIONALIZATION HASN'T WORKED

''WE HAVE LOST EFFECTIVELY 93 PERCENT OF OUR STATE PSYCHIATRIC HOSPITAL BEDS SINCE 1955''

(By E. Fuller Torrey and Mary T. Zdanowicz)

The White House Conference on Mental Health identified stigma and discrimination as the most important barriers to treatment for the mentally ill. For the most severely ill, there are more significant barriers to treatment, such as laws that prevent treating individuals until they become dangerous. These laws and our failure to treat individuals with schizophrenia and manic-depressive illness are, ironically, the leading causes of stigma and discrimination against those with mental illnesses.

Stigma is created by the sort of headlines that result when a person is not being treated for mental illness and shoots two Capitol police officers to death, or pushes an innocent victim in front of a speeding subway train. Some 20 years of research has proven this point.

A 1996 study published in the Journal of Community Psychology demonstrated that negative attitudes toward people with mental illnesses increased greatly after people read newspaper articles reporting violent crimes by the mentally ill. Henry J. Steadman, an influential public opinion researcher, wrote as far back as 1981: ''Recent research data on contemporary populations of ex-mental patients supports these public fears [of dangerousness] to an extent rarely acknowledged by mental health professionals. . . . It is [therefore] futile and inappropriate to badger the news and entertainment media with appeals to help destigmatize the mentally ill.''

Tipper Gore and the White House must tackle 30 years of failed deinstitutionalization policy if they hope to win the battle of mental illness stigma and solve the nation's mental illness crisis. Hundreds of thousands of vulnerable Americans are eking out a pitiful existence on city streets, underground in subway tunnels or in jails and prisons because of the misguided efforts of civil rights advocates to keep the severely ill out of hospitals and out of treatment.

The images of these gravely ill citizens on our city landscapes are bleak reminders of the failure of deinstitutionalization. They are seen huddling over steam grates in the cold, animatedly carrying on conversations with invisible companions, wearing filthy, tattered clothing, urinating and defecating on sidewalks or threatening passersby. Worse still, they frequently are seen being carried away on stretchers as victims of suicide or violent crime, or in handcuffs as perpetrators of violence against others.

All of this occurs under the watchful eyes of fellow citizens and government officials who do nothing but shake their heads in blind tolerance. The consequences of failing to treat these illnesses are devastating. While Americans with untreated severe mental illnesses represent less than one percent of our population, they commit almost 1,000 homicides in the United States each year. At least one-third of the estimated 600,000 homeless suffer from schizophrenia or manic-depressive illness, and 28 percent of them forage for some of their food in garbage cans. About 170,000 individuals, or 10 percent, of our jail and prison populations suffer from these illnesses, costing American taxpayers a staggering $8.5 billion per year.

Moreover, studies suggest that delaying treatment results in permanent harm, including increased treatment resistance, worsening severity of symptoms, increased hospitalizations and delayed remission of symptoms. In addition, persons suffering from severe psychiatric illnesses are frequently victimized. Studies have shown that 22 percent of women with untreated schizophrenia have been raped. Suicide rates for these individuals are 10 to 15 times higher than the general population.

Weak state treatment laws coupled with inadequate psychiatric hospital beds have only served to compound the devastation for this population. Nearly half of those suffering from these insidious illnesses do not realize they are sick and in need of treatment, because their brain disease has affected their self-awareness. Because they do not believe they are sick, they refuse medication. Most state laws today prohibit treating individuals over their objection unless they pose an immediate danger to themselves. In other words, an individual must have a finger on the trigger of a gun before any medical care will be prescribed.

Studies have proved that outpatient commitment is effective in ensuring treatment compliance. While many states have some form of assisted treatment on the books, the challenge remains in getting them to utilize what is at their disposal rather than tolerating the revolving-door syndrome of hospital admissions, readmissions, abandonment to the streets and incarceration that engulfs those not receiving treatment.

Adequate care in psychiatric facilities also must be available. Between 5 and 10 percent of the 3.5 million people suffering from schizophrenia and manic-depressive illness require long-term hospitalization—which means hospitalization in state psychiatric hospitals. This critical need is not being met, since we have lost effectively 93 percent of our state psychiatric hospital beds since 1955.

It is time to recognize that feel-good mental health policies have caused grave suffering for those most ill and that real solutions must be developed. The lives of millions of Americans depend on it.

[From the New York Times July 12, 1999]

NATIONAL REPORT—PRISONS BRIM WITH MENTALLY ILL, STUDY FINDS

(By Fox Butterfield)

The first comprehensive study of the rapidly growing number of emotionally disturbed people in the nation's jails and prison has found that there are 283,800 inmates with mental illness, about 16 percent of the jail population. The report confirms the belief of many state, local and Federal experts that jails and prisons have become the nation's new mental hospitals.

The study, released by the Justice Department yesterday, paints a grim statistical portrait, detailing how mentally ill inmates tend to follow a revolving door from homelessness to incarceration and then back to the streets with little treatment, many of them arrested for crimes that grow out of their illnesses.

The report found that mentally ill inmates in state prisons were more than twice as likely to have been homeless before their arrests than other inmates, twice as likely to have been physically or sexually abused in childhood and far more likely to have been using drugs or alcohol.

In another reflection of their chaotic lives, the study found that emotionally disturbed inmates had many more incarcerations than other inmates. More than three-quarters of them had been sentenced to jail or prison before, and have had served three or more prior sentences.

One of the most striking findings in the study, and the one most likely to be disputed, is that mentally ill inmates in state prisons were more likely than other prisoners to have been convicted of a violent crime. Too, many emotionally disturbed inmates were arrested for little more than bizarre behavior or petty crimes, like loitering or public intoxication, but the report, by the Justice Department's Bureau of Justice Statistics, did not offer any breakdown on this category of convictions.

Moreover, once incarcerated, emotionally disturbed inmates in state prisons spend an average of 15 months longer behind bars than others, often because their delusions, hallucinations or paranoia make hem more likely to get into fights or receive disciplinary reports.

''This study provides data to show that the incarceration of the mentally ill is a disastrous, horrible social issue,'' said Kay Redfield Jamison, a professor of psychiatry at the Johns Hopkins School of Medicine. ''There is something fundamentally broken in the system that covers both hospitals and jails,'' said Professor Jamison, the author of ''Night Falls Fast: Understanding Suicide,'' to be published later this year by Knopf.

With the wholesale closings of public mental hospitals in the 1960's, and the prison boom of the last two decades, jails are often the only institutions open 24 hours a day and required to take the emotionally disturbed.

The hospitals were closed at a time when new antipsychotic drugs made medicating patients in the community seem a humane alternative to long-term hospitalization. From a high of 559,000 in 1955, the number of patients in state hospitals dropped to 69,000 in 1995.

But drugs work only when taken and many states failed to build a promised network of clinics to monitor patients. To compound the problem, for-profit hospitals began turning away the psychotic, who tend to be more expensive and stay longer than other patients, and are often without health insurance.

At the same time, the number of jail and prison beds has quadrupled in the last 25 years, with 1.8 million Americans now behind bars.

''Jails have become the poor person's mental hospitals,'' said Linda A. Teplin, a professor of psychiatry and director of the psycho-legal studies program at Northwestern University.

After years of inattention by the Government, the problem has generated a flurry of interest in the Clinton Administration, led by Tipper Gore and Attorney General Janet Reno, whose department is sponsoring a major conference on it next week.

All previous estimates of the number of emotionally disturbed inmates have been based on research by Professor Teplin in the Cook County Jail in Chicago. She found that 9.5 percent of male inmates there had experienced a severe mental disorder like schizophrenia, manic depression or major depression, four times the rate in the general population.

Professor Teplin said that while she welcomed the Justice Department count, it was

open to question because the study relied on reports by the inmates themselves, who were asked whether they had a mental condition or had ever received treatment for a mental problem. People with emotional disorders often are not aware of them or do not want to report them, she said, so the Justice Department estimate of more than a quarter-million inmates with mental illness may actually be too low, Professor Teplin said.

In addition, she said, the study was not conducted by mental health professionals using diagnostic tests, so it was impossible to tell what mental disorders the inmates suffered from, and whether they were severe illnesses, like schizophrenia, or generally less severe problems, like anxiety disorders.

The study found that 53 percent of emotionally disturbed inmates in state prisons were sentenced for a violent crime, compared with 46 percent of other prisoners. Specifically, 13.2 percent of mentally ill inmates in prisons had been convicted of murder, compared with 11.4 percent of other prisoners, and 12.4 percent of mentally ill inmates had been convicted of sexual assault, compared with 7.9 percent of other prisoners.

Advocates for the mentally ill have worked hard to show that emotionally disturbed people are no more violent than others, to try to lessen the stigma surrounding mental illness. But recent research, while confirming that mentally ill people may not be more violent than others, suggests that they can become violent in a number of conditions, including when they are off their medications or are taking drugs or alcohol.

In another important finding, also subject to differing interpretations, the study found that reported rates of mental illness varied by race and gender, with white and female inmates reporting higher rates than black and male inmates. The highest rates of mental illness were among white female state prisoners, with an estimated 29 percent of them reporting emotional disorders, compared with 20 percent of black female prisoners. Overall, 22.6 percent of white state prisoners were identified as mentally ill, compared with 13.5 percent of black prisoners.

Dr. Dorothy Otnow-Lewis, a psychiatrist, said the differences were a result of white psychiatrists ''being very bad at recognizing mental illness in minority individuals.'' Psychiatrists are more likely to dismiss aggressive behavior in men, particularly black men, as a result of their being bad, rather than being mad, said Dr. Lewis, who is a senior criminal justice fellow at the Center on Crime, Communities and Culture of the Soros Foundation.

Michael Faenza, the president of the National Mental Health Association, said the study ''shows that the criminal justice system is just a revolving door for a person with mental illness, from the street to jail and back without treatment.''

Professor Jamison noted that jails and prisons are not conducive to treatment, even when it is available. ''Inmates get deprived of sleep,'' she said, ''and isolation can exacerbate their hallucinations or delusions.''●

TRIBUTE TO CLD CONSULTING ENGINEERS

● Mr. SMITH of New Hampshire. Mr. President, I rise today to pay tribute to CLD Consulting Engineering, a recipient of the ''Business of the Year Award'' from Business NH Magazine. They have shown incredible success, ingenuity, and community service, virtues that are indeed worthy of recognition.

CLD, a civil engineering firm, has specialized in public projects which benefit many New Hampshire residents. These projects include the transformation of Manchester's Elm Street into a more pedestrian-friendly environment, improving the traffic pattern at the Mall of New Hampshire, and a new project to design Manchester's new two-mile long Riverwalk.

In addition to engineering designs, CLD has had an extremely positive impact in the community. The firm has sponsored a Boy Scout Explorer Post, engineering competitions, high school internships, and mentoring programs at local schools. I applaud not only their business success, but also their dedication to serving their community.

As a former small business owner myself, I understand the hard work and dedication required for success in business. Once again, I wish to congratulate CLD Consulting Engineers for being selected as a 1999 Business of the Year by the Business NH Magazine. It is an honor to represent them in the United States Senate.●

OPEN-MARKET REORGANIZATION FOR THE BETTERMENT OF INTERNATIONAL TELECOMMUNICATIONS ACT

The text of S. 376, passed by the Senate on July 1, 1999, follows:

S. 376

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Open-market Reorganization for the Betterment of International Telecommunications Act''.

SEC. 2. PURPOSE.

It is the purpose of this Act to promote a fully competitive domestic and international market for satellite communications services for the benefit of consumers and providers of satellite services by fully encouraging the privatization of the intergovernmental satellite organizations, INTELSAT and Inmarsat, and reforming the regulatory framework of the COMSAT Corporation.

SEC. 3. FINDINGS.

The Congress finds that:

(1) International satellite communications services constitute a critical component of global voice, video and data services, play a vital role in the integration of all nations into the global economy and contribute toward the ability of developing countries to achieve sustainable development.

(2) The United States played a pivotal role in stimulating the development of international satellite communications services by enactment of the Communications Satellite Act of 1962 (47 U.S.C. 701–744), and by its critical contributions, through its signatory, the COMSAT Corporation, in the establishment of INTELSAT, which has successfully established global satellite networks to provide member countries with worldwide access to telecommunications services, including critical lifeline services to the developing world.

(3) The United States played a pivotal role in stimulating the development of international satellite communications services by enactment of the International Maritime Satellite Telecommunications Act (47 U.S.C. 751–757), and by its critical contributions, through its signatory, COMSAT, in the establishment of Inmarsat, which enabled member countries to provide mobile satellite services such as international maritime and global maritime distress and safety services to include other satellite services, such as land mobile and aeronautical communications services.

(4) By statute, COMSAT, a publicly traded corporation, is the sole United States signatory to INTELSAT and, as such, is responsible for carrying out United States commitments under the INTELSAT Agreement and the INTELSAT Operating Agreement. Pursuant to a binding Headquarters Agreement, the United States, as a party to INTELSAT, has satisfied many of its obligations under the INTELSAT Agreement.

(5) In the 37 years since enactment of the Communications Satellite Act of 1962, satellite technology has advanced dramatically, large-scale financing options have improved immensely and international telecommunications policies have shifted from those of natural monopolies to those based on market forces, resulting in multiple private commercial companies around the world providing, or preparing to provide, the domestic, regional, and global satellite telecommunications services that only INTELSAT and Inmarsat had previously had the capabilities to offer.

(6) Private commercial satellite communications systems now offer the latest telecommunications services to more and more countries of the world with declining costs, making satellite communications an attractive complement as well as an alternative to terrestrial communications systems, particularly in lesser developed countries.

(7) To enable consumers to realize optimum benefits from international satellite communications services, and to enable these systems to be competitive with other international telecommunication systems, such as fiber optic cable, the global trade and regulatory environment must support vigorous and robust competition.

(8) In particular, all satellite systems should have unimpeded access to the markets that they are capable of serving, and the ability to compete in a fair and meaningful way within those markets.

(9) Transforming INTELSAT and Inmarsat from intergovernmental organizations into conventional satellite services companies is a key element in bringing about the emergence of a fully competitive global environment for satellite services.

(10) The issue of privatization of any State-owned firm is extremely complex and multi-faceted. For that reason, the sale of a firm at arm's length does not automatically, and in all cases, extinguish any prior subsidies or government conferred advantages.

(11) It is in the interest of the United States to negotiate the removal of its reservation in the Fourth Protocol to the General Agreement on Trade in Services regarding INTELSAT's and Inmarsat's access to the United States market through COMSAT as soon as possible, but such reservation cannot be removed without adequate assurance that the United States market for satellite services will not be disrupted by such INTELSAT or Inmarsat access.

(12) The Communications Satellite Act of 1962, and other applicable United States laws, need to be updated to encourage and complete the pro-competitive privatization of INTELSAT and Inmarsat, to update the domestic United States regulatory regime governing COMSAT, and to ensure a competitively neutral United States framework for the provision of domestic and international telecommunications services via satellite systems.

SEC. 4. ESTABLISHMENT OF SATELLITE SERVICES COMPETITION; PRIVATIZATION.

The Communications Satellite Act of 1962 (47 U.S.C. 701) is amended by adding at the end the following:

"TITLE VI—SATELLITE SERVICES COMPETITION AND PRIVATIZATION

''SUBTITLE A—TRANSITION TO A PRIVATIZED INTELSAT

"SEC. 601. POLICY OF THE UNITED STATES.

''It is the policy of the United States to—

''(1) encourage INTELSAT to privatize in a pro-competitive manner as soon as possible, but not later than January 1, 2002, recognizing the need for a reasonable transition and process to achieve a full, pro-competitive restructuring; and

''(2) work constructively with its international partners in INTELSAT, and with INTELSAT itself, to bring about a prompt restructuring that will ensure fair competition, both in the United States as well as in the global markets served by the INTELSAT system; and

''(3) encourage Inmarsat's full implementation of the terms and conditions of its privatization agreement.

"SEC. 602. ROLE OF COMSAT.

''(a) ADVOCACY.—As the United States signatory to INTELSAT, COMSAT shall act as an aggressive advocate of pro-competitive privatization of INTELSAT. With respect to the consideration within INTELSAT of any matter related to its privatization, COMSAT shall fully consult with the United States Government prior to exercising its voting rights and shall exercise its voting rights in a manner fully consistent with any instructions issued. In the event that the United States signatory to INTELSAT is acquired after enactment of this section, the President and the Commission shall assure that the instructional process safeguards against conflicts of interest.

''(b) ANNUAL REPORTS.—The President and the Commission shall report annually to the Committee on Commerce of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate, respectively, on the progress being made by INTELSAT and Inmarsat to privatize and complete privatization in a pro-competitive manner.

"SEC. 603. RESTRICTIONS PENDING PRIVATIZATION.

''(a) INTELSAT shall be prohibited from entering the United States market directly to provide any satellite communications services or space segment capacity to carriers (other than the United States signatory) or end users in the United States until July 1, 2001 or until INTELSAT achieves a pro-competitive privatization pursuant to section 613 (a) if privatization occurs earlier.

''(b) Notwithstanding subsection (a), INTELSAT shall be prohibited from entering the United States market directly to provide any satellite communications services or space segment capacity to any foreign signatory, or affiliate thereof, and no carrier, other than the United States signatory, nor any end user, shall be permitted to invest directly in INTELSAT.

''(c) Pending INTELSAT's privatization, the Commission shall ensure that the United States signatory is compensated by direct access users for the costs it incurs in fulfilling its obligations under this Act.

''(d) The provisions of subsections (b) and (c) shall remain in effect only until INTELSAT achieves a pro-competitive privatization pursuant to section 613 (a).

''SUBTITLE B—ACTIONS TO ENSURE PRO-COMPETITIVE SATELLITE SERVICES

"SEC. 611. PRIVATIZATION.

''(a) IN GENERAL.—The President shall seek a pro-competitive privatization of INTELSAT as soon as practicable, but no later than January 1, 2002. Such privatization shall be confirmed by a final decision of the INTELSAT Assembly of Parties and shall be followed by a timely initial public offering taking into account relative market conditions.

''(b) ENSURE CONTINUATION OF PRIVATIZATION.—The President and the Commission shall seek to ensure that the privatization of Inmarsat continues in a pro-competitive manner.

"SEC. 612. PROVISION OF SERVICES IN THE UNITED STATES BY PRIVATIZED AFFILIATES OF INTERGOVERNMENTAL SATELLITE ORGANIZATIONS.

''(a) IN GENERAL.—With respect to any application for a satellite earth station or space station under title III of the Communications Act of 1934 (47 U.S.C 301 et seq.) or any application under section 214 of that Act (47 U.S.C. 214), or any letter of intent to provide service in the United States via non-United States licensed space segment, submitted by a privatized IGO affiliate or successor, the Commission—

''(1) shall apply a presumption in favor of entry to an IGO affiliate or successor licensed by a WTO Member for services covered by United States commitments under the WTO Basic Telecom Agreement;

''(2) may attach conditions to any grant of authority to an IGO affiliate or successor that raises the potential for competitive harm; or

''(3) shall in the exceptional case in which an application by an IGO affiliate or successor would pose a very high risk to competition in the United States satellite market, deny the application.

''(b) DETERMINATION FACTORS.—In determining whether an application to serve the United States market by an IGO affiliate raises the potential for competitive harm or risk under subsection (a)(2), the Commission shall determine whether any potential anti-competitive or market distorting consequences of continued relationships or connections exist between an IGO and its affiliates including—

''(1) whether the IGO affiliate is structured to prevent anti-competitive practices such as collusive behavior or cross-subsidization;

''(2) the degree of affiliation between the IGO and its affiliate;

''(3) whether the IGO affiliate can directly or indirectly benefit from IGO privileges and immunities;

''(4) the ownership structure of the affiliate and the effect of IGO and other Signatory ownership and whether the affiliate is independent of IGO signatories or former signatories who control telecommunications market access in their home territories;

''(5) the existence of clearly defined arm's-length conditions governing the affiliate-IGO relationship including separate officers, directors, employees, and accounting systems;

''(6) the existence of fair market valuing for permissible business transactions between an IGO and its affiliate that is verifiable by an independent audit and consistent with normal commercial practice and generally accepted accounting principles;

''(7) the existence of common marketing;

''(8) the availability of recourse to IGO assets for credit or capital;

''(9) whether an IGO registers or coordinates spectrum or orbital locations on behalf of its affiliate; and

''(10) whether the IGO affiliate has corporate charter provisions prohibiting re-affiliation with the IGO after privatization.

''(c) SUNSET.—The provisions of subsection (b) shall cease to have effect upon approval of the application pursuant to section 613.

''(d) PUBLIC INTEREST DETERMINATION.—Nothing in this Act affects the Commission's ability to make a public interest determination concerning any application pertaining to entry into the United States market.

"SEC. 613. PRESIDENTIAL NEGOTIATING OBJECTIVES AND FCC CRITERIA FOR PRIVATIZED IGOs.

''(a) IN GENERAL.—Upon a final decision of the INTELSAT Assembly of Parties creating the legal structure and characteristics of the privatized INTELSAT and recognizing that Inmarsat transitioned into a private company on April 15, 1999, the President shall within 30 days report to the Congress on the extent to which such privatization framework meets each of the criteria in subsection (c), and whether taking into consideration all other relevant competitive factors, entry of a privatized INTELSAT or Inmarsat into the United States market will not be likely to distort competition.

''(b) PURPOSE OF PRIVATIZATION CRITERIA.—The criteria provided in subsection (c) shall be used as—

''(1) the negotiation objectives for achieving the privatization of INTELSAT no later than January 1, 2002, and also for Inmarsat;

''(2) the standard for measuring, pursuant to subsection (a), whether negotiations have resulted in an acceptable framework for achieving the pro-competitive privatization of INTELSAT and Inmarsat; and

''(3) licensing criteria by the Commission in making its independent determination of whether the certified framework for achieving the pro-competitive privatization of INTELSAT and Inmarsat has been properly implemented by the privatized INTELSAT and Inmarsat.

''(c) PRIVATIZATION CRITERIA.—A pro-competitively privatized INTELSAT or Inmarsat—

''(1) has no privileges or immunities limiting legal accountability, commercial transparency, or taxation and does not unfairly benefit from ownership by former signatories who control telecommunications market access to their home territories;

''(2) has submitted to the jurisdiction of competition and independent regulatory authorities of a nation that is a signatory to the World Trade Organization Agreement on Basic Telecommunications and that has implemented or accepted the agreement's reference paper on regulatory principles;

''(3) can offer assurance of an arm's-length relationship in all respects between itself and any IGO affiliate;

''(4) has given due consideration to the international connectivity requirements of thin route countries;

''(5) can demonstrate that the valuation of assets to be transferred post-privatization is in accordance with generally accepted accounting principles;

''(6) has access to orbital locations and associated spectrum post-privatization in accordance with the same regulatory processes and fees applicable to other commercial satellite systems;

''(7) conducts technical coordinations post-privatization under normal, established ITU procedures;

''(8) has an ownership structure in the form of a stock corporation or other similar and accepted commercial mechanism, and a commitment to a timely initial public offering has been established for the sale or purchase of company shares;

''(9) shall not acquire, or enjoy any agreements or arrangements which secure, exclusive access to any national telecommunications market; and

''(10) will have accomplished a privatization consistent with the criteria listed in this subsection at the earliest possible date, but not later than January 1, 2002, for INTELSAT and Inmarsat.

''(d) FCC INDEPENDENT DETERMINATION ON IMPLEMENTATION.—After the President has

made a report to Congress pursuant to subsection (a), with respect to any application for a satellite earth station or space station under title III of the Communications Act of 1934 (47 U.S.C. 301) or any application under section 214 of the Communications Act of 1934 (47 U.S.C. 214), or any letter of intent to provide service in the United States via a non-United States licensed space segment, submitted by a privatized affiliate prior to the privatized IGO, or by a privatized IGO, the Commission shall determine whether the enumerated objectives for a pro-competitive privatization of INTELSAT and Inmarsat under this section have been implemented with respect to the privatized IGO, but in making that consideration, may neither contract or expand the privatization criteria in subsection (c).

''(e) AUTHORITY TO DENY AN APPLICATION.—Nothing in this section affects the Commission's authority to condition or deny an application on the basis of the public interest.

''SEC. 614. FAILURE TO PRIVATIZE IN A TIMELY MANNER.

''(a) REPORT.—In the event that INTELSAT fails to fully privatize as provided in section 611 by January 1, 2002, the President shall—

''(1) instruct all instrumentalities of the United States Government to grant a preference for procurement of satellite services from commercial private sector providers of satellite space segment rather than IGO providers;

''(2) immediately commence deliberations to determine what additional measures should be implemented to ensure the rapid privatization of INTELSAT;

''(3) no later than March 31, 2002, issue a report delineating such other measures to the Committee on Commerce of the House of Representatives, and Committee on Commerce, Science, and Transportation of the Senate; and

''(4) withdraw as a party from INTELSAT.

''(b) RESERVATION CLAUSE.—The President may determine, after consulting with Congress, that in consideration of privatization being imminent, it is in the national interest of the United States to provide a reasonable extension of time for completion of privatization.

''SUBTITLE C—COMSAT GOVERNANCE AND OPERATION

''SEC. 621. ELIMINATION OF PRIVILEGES AND IMMUNITIES.

''(a) COMSAT.—COMSAT shall not have any privilege or immunity on the basis of its status as a signatory or a representative of the United States to INTELSAT and Inmarsat, except that COMSAT retains its privileges and immunities—

''(1) for those actions taken in its role as the United States signatory to INTELSAT or Inmarsat upon instruction of the United States Government; and

''(2) for actions taken when acting as the United States signatory in fulfilling signatory obligations under the INTELSAT Operating Agreement.

''(b) NO JOINT OR SEVERAL LIABILITY.—If COMSAT is found liable for any action taken in its status as a signatory or a representative of the party to INTELSAT, any such liability shall be limited to the portion of the judgment that corresponds to COMSAT's percentage of the responsibility, as determined by the trier of fact.

''(c) PROSPECTIVE EFFECT OF ELIMINATION.—The elimination of privileges and immunities contained in this section shall apply only to actions or decisions taken by COMSAT after the date of enactment of the Open-market Reorganization for the Betterment of International Telecommunications Act.

''SEC. 622. ABROGATION OF CONTRACTS PROHIBITED.

''Nothing in this Act or the Communications Act of 1934 (47 U.S.C. 151 et seq.) shall be construed to modify or invalidate any contract or agreement involving COMSAT, INTELSAT, or any terms or conditions of such agreement in force on the date of enactment of the Open-market Reorganization for the Betterment of International Telecommunications Act, or to give the Commission authority, by rule-making or any other means, to invalidate any such contract or agreement, or any terms and conditions of such contract or agreement.

''SEC. 623. PERMITTED COMSAT INVESTMENT.

''Nothing in this Act shall be construed as precluding COMSAT from investing in or owning satellites or other facilities independent from INTELSAT, or from providing services through reselling capacity over the facilities of satellite systems independent from INTELSAT. This section shall not be construed as restricting the types of contracts which can be executed or services which may be provided by COMSAT over the independent satellites or facilities described in this subsection.

''SUBTITLE D—GENERAL PROVISIONS

''SEC. 631. PROMOTION OF EFFICIENT USE OF ORBITAL SLOTS AND SPECTRUM.

''All satellite system operators authorized to access the United States market should make efficient and timely use of orbital and spectrum resources in order to ensure that these resources are not warehoused to the detriment of other new or existing satellite system operators. Where these assurances cannot be provided, satellite system operators shall arbitrate their rights to these resources according to ITU procedures.

''SEC. 632. PROHIBITION ON PROCUREMENT PREFERENCES.

''Except pursuant to section 615 of this Act, nothing in this title or the Communications Act of 1934 (47 U.S.C. 151 et seq.) shall be construed to authorize or require any preference in Federal Government procurement of telecommunications services, for the satellite space segment provided by INTELSAT or Inmarsat, nor shall anything in this title or that Act be construed to result in a bias against the use of INTELSAT or Inmarsat through existing or future contract awards.

''SEC. 633. SATELLITE AUCTIONS.

''Notwithstanding any other provision of law, the Commission shall not assign by competitive bidding orbital locations or spectrum used for the provision of international or global satellite communications services. The President shall oppose in the International Telecommunications Union and in other bilateral and multilateral negotiations any assignment by competitive bidding of orbital locations, licenses, or spectrum used for the provision of such services.

''SEC. 634. RELATIONSHIP TO OTHER LAWS.

''Whenever the application of the provisions of this Act is inconsistent with the provisions of the Communications Act of 1934, the provisions of this Act shall govern.

''SEC. 635. EXCLUSIVITY ARRANGEMENTS.

''(a) IN GENERAL.—No satellite operator shall acquire or enjoy the exclusive right of handling traffic to or from the United States, its territories or possessions, and any other country or territory by reason of any concession, contract, understanding, or working arrangement to which the satellite operator or any persons or companies controlling or controlled by the operator are parties.

''(b) EXCEPTION.—In enforcing the provisions of this subsection, the Commission—

''(1) shall not require the termination of existing satellite telecommunications services under contract with, or tariff commitment to, such satellite operator; but

''(2) may require the termination of new services only to the country that has provided the exclusive right to handle traffic, if the Commission determines the public interest, convenience, and necessity so requires.

''SUBTITLE E—DEFINITIONS

''SEC. 641. DEFINITIONS.

''(a) IN GENERAL.—In this title:

''(1) INTELSAT.—The term 'INTELSAT' means the International Telecommunications Satellite Organization established pursuant to the Agreement Relating to the International Telecommunications Satellite Organization.

''(2) INMARSAT.—The term 'Inmarsat' means the International Mobile Satellite Organization established pursuant to the Convention on the International Maritime Satellite Organization and may also refer to INMARSAT Limited when appropriate.

''(3) COMSAT.—The term 'COMSAT' means the corporation established pursuant to title III of this Act and its successors and assigns.

''(4) SIGNATORY.—The term 'signatory' means the telecommunications entity designated by a party that has signed the Operating Agreement and for which such Agreement has entered into force.

''(5) PARTY.—The term 'party' means, in the case of INTELSAT, a nation for which the INTELSAT agreement has entered into force or been provisionally applied, and in the case of INMARSAT, a nation for which the Inmarsat convention entered into force.

''(6) COMMISSION.—The term 'Commission' means the Federal Communications Commission.

''(7) INTERNATIONAL TELECOMMUNICATION UNION; ITU.—The terms 'International Telecommunication Union' and 'ITU' mean the intergovernmental organization that is a specialized agency of the United Nations in which member countries cooperate for the development of telecommunications, including adoption of international regulations governing terrestrial and space uses of the frequency spectrum as well as use of the geostationary orbital arc.

''(8) PRIVATIZED INTELSAT.—The term 'privatized INTELSAT' means any entity created from the privatization of INTELSAT from the assets of INTELSAT.

''(9) PRIVATIZED INMARSAT.—The term 'privatized Inmarsat' means any entity created from the privatization of Inmarsat from the assets of Inmarsat, namely INMARSAT, Ltd.

''(10) ORBITAL LOCATION.—The term 'orbital location' means the location for placement of a satellite in geostationary orbits as defined in the International Telecommunication Union Radio Regulations.

''(11) SPECTRUM.—The term 'spectrum' means the range of frequencies used to provide radio communication services.

''(12) SPACE SEGMENT.—The term 'space segment' means the satellites, and the tracking, telemetry, command, control, monitoring and related facilities and equipment used to support the operation of satellites owned or leased by INTELSAT and Inmarsat or an IGO successor or affiliate.

''(13) INTELSAT AGREEMENT.—The term 'INTELSAT agreement' means the agreement relating to the International Telecommunications Satellite Organization, including all of its annexes (TIAS 7532, 23 UST 3813).

''(14) OPERATING AGREEMENT.—The term 'operating agreement' means—

''(A) in the case of INTELSAT, the agreement, including its annex but excluding all titles of articles, opened for signature at

Washington on August 20, 1971, by governments or telecommunications entities designated by governments in accordance with the provisions of The Agreement; and

''(B) in the case of Inmarsat, the Operating Agreement on the International Maritime Satellite Organization, including its annexes.

''(15) HEADQUARTERS AGREEMENT.—The term 'headquarters agreement' means the binding international agreement, dated November 24, 1976, between the United States and INTELSAT covering privileges, exemptions, and immunities with respect to the location of INTELSAT's headquarters in Washington, D.C.

''(16) DIRECT-TO-HOME SATELLITE SERVICES.—The term 'direct-to-home satellite services' means the distribution or broadcasting of programming or services by satellite directly to the subscriber's premises without the use of ground receiving or distribution equipment, except at the subscriber's premises or in the uplink process to the satellite.

''(17) IGO.—The term 'IGO' means the Intergovernmental Satellite organizations, INTELSAT and Inmarsat.

''(18) IGO AFFILIATE.—The term 'IGO affiliate' means any entity in which an IGO owns or has owned an equity interest of 10 percent or more.

''(19) IGO SUCCESSOR.—The term 'IGO Successor' means an entity which holds substantially all the assets of a pre-existing IGO.

''(20) GLOBAL MARITIME DISTRESS AND SAFETY SERVICES.—The term 'global maritime distress and safety services' means the automated ship-to-shore distress alerting system which uses satellite and advanced terrestrial systems for international distress communications and promoting maritime safety in general, permitting the worldwide alerting of vessels, coordinated search and rescue operations, and dissemination of maritime safety information.

''(b) COMMON TERMS.—Except as otherwise provided in subsection (a), terms used in this title that are defined in section 3 of the Communications Act of 1934 (47 U.S.C. 153) have the meaning provided in that section.''.

SEC. 5. CONFORMING CHANGES.

(a) REPEAL OF FEDERAL COORDINATION AND PLANNING PROVISIONS.—Section 201 of the Communications Satellite Act of 1962 (47 U.S.C. 721) is amended to read as follows:

''SEC. 201. IMPLEMENTATION OF POLICY.

''The Federal Communications Commission, in its administration of the Communications Act of 1934, shall make rules and regulations to carry out the provisions of this Act.''.

(b) REPEAL OF GOVERNMENT-ESTABLISHED CORPORATION PROVISIONS.—

(1) IN GENERAL.—Section 301 of the Communications Satellite Act of 1962 (47 U.S.C. 731) is amended to read as follows:

''SEC. 301. CORPORATION.

''The corporation organized under the provisions of this title, as this title existed before the enactment of the Open-market Reorganization for the Betterment of International Telecommunications Act, known as COMSAT, and its successors and assigns, are subject to the provisions of this Act. The right to repeal, alter, or amend this Act at any time is expressly reserved.''.

(2) CONFORMING CHANGES.—Title III of the Communications Satellite Act of 1962 (47 U.S.C. 731 et seq.) is amended—

(A) by striking ''**CREATION OF A COMMUNICATIONS SATELLITE**'' in the caption of title III;

(B) by striking sections 302, 303, and 304;

(C) by redesignating section 305 as section 302; and

(D) by striking subsection (c) of section 302, as redesignated.

(c) REPEAL OF CERTAIN MISCELLANEOUS PROVISIONS.—Title IV of the Communications Satellite Act of 1962 (47 U.S.C. 741 et seq.) is amended—

(1) by striking section 402;

(2) by striking subsection (a) of section 403 and redesignating subsections (b) and (c) as subsections (a) and (b), respectively; and

(3) by striking section 404.

SEC. 6. INTERNATIONAL MARITIME SATELLITE TELECOMMUNICATIONS ACT AMENDMENTS.

(a) REPEAL OF SUPERSEDED AUTHORITY.—Title V of the Communications Satellite Act of 1962 (47 U.S.C. 751 et seq.) is amended—

(1) by striking sections 502, 503, 504, and 505; and

(2) by inserting after section 501 the following:

''SEC. 502. GLOBAL SATELLITE SAFETY SERVICES AFTER PRIVATIZATION OF BUSINESS OPERATIONS OF INMARSAT.

''In order to ensure the continued provision of global maritime distress and safety satellite telecommunications services after privatization of the business operations of Inmarsat, the President may maintain membership in the International Mobile Satellite Organization on behalf of the United States.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on the date on which the International Mobile Satellite Organization ceases to operate directly a global mobile satellite system.

DISTRICT OF COLUMBIA APPROPRIATIONS ACT, 2000

the text of S. 1283, passed by the Senate on July 1, 1999, follows:

S. 1283

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That, the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the District of Columbia for the fiscal year ending September 30, 2000, and for other purposes, namely:

FEDERAL FUNDS

FEDERAL PAYMENT TO THE DISTRICT OF COLUMBIA CORRECTIONS TRUSTEE OPERATIONS

For payment to the District of Columbia Corrections Trustee, $176,000,000 for the administration and operation of correctional facilities and for the administrative operating costs of the Office of the Corrections Trustee, as authorized by section 11202 of the National Capital Revitalization and Self-Government Improvement Act of 1997, as amended: *Provided,* That said sums shall be paid quarterly by the Treasury of the United States based on quarterly apportionments approved by the Office of Management and Budget.

FEDERAL PAYMENT TO THE DISTRICT OF COLUMBIA COURTS

Notwithstanding any other provision of law, $136,440,000 for payment to the Joint Committee on Judicial Administration in the District of Columbia; of which not to exceed $128,440,000 shall be for District of Columbia Courts operation, to be allocated as follows: for the District of Columbia Court of Appeals, $7,403,000; for the District of Columbia Superior Court, $78,561,000; for the District of Columbia Court System, $42,476,000; and of which not to exceed $8,000,000 shall remain available until September 30, 2001 for capital improvements for District of Columbia courthouse facilities: *Provided,* That of amounts available for District of Columbia Courts operation, $6,900,000 shall be for the Counsel for Child Abuse and Neglect program pursuant to section 1101 of title 11, D.C. Code, and section 2304 of title 16, D.C. Code, and of which $26,036,000 shall be to carry out sections 2602 and 2604 of title 11, D.C. Code, relating to representation of indigents in criminal cases under the Criminal Justice Act, in total, $32,936,000: *Provided further,* That, subject to normal reprogramming requirements contained in section 116 of this Act, this $32,936,000 may be used for other purposes under this heading: *Provided further,* That funds under this heading to carry out the District of Columbia Criminal Justice Act (D.C. Code, sec. 11–2601 et seq.), shall be available for obligations incurred under the Act in each fiscal year since fiscal year 1975: *Provided further,* That funds under this heading to carry out the District of Columbia Neglect Representation Equity Act of 1984 (D.C. Code, sec. 16–2304), shall be available for obligations incurred under the Act in each fiscal year since fiscal year 1985: *Provided further,* That funds under this heading to carry out the District of Columbia Guardianship, Protective Proceedings, and Durable Power of Attorney Act of 1986 (D.C. Code, sec. 21–2060), shall be available for obligations incurred under the Act in each fiscal year since fiscal year 1989: *Provided further,* That all amounts under this heading shall be paid quarterly by the Treasury of the United States based on quarterly apportionments approved by the Office of Management and Budget, with payroll and financial services to be provided on a contractual basis with the General Services Administration [GSA], said services to include the preparation of monthly financial reports, copies of which shall be submitted directly by GSA to the President and to the Committees on Appropriations of the Senate and House of Representatives, the Committee on Governmental Affairs of the Senate, and the Committee on Government Reform of the House of Representatives.

FEDERAL PAYMENT TO THE COURT SERVICES AND OFFENDER SUPERVISION AGENCY FOR THE DISTRICT OF COLUMBIA

For payment to the Court Services and Offender Supervision Agency for the District of Columbia, $80,300,000, as authorized by the National Capital Revitalization and Self-Government Improvement Act of 1997, as amended; of which $47,100,000 shall be for necessary expenses of Parole Revocation, Adult Probation and Offender Supervision, to include expenses relating to supervision of adults subject to protection orders or provision of services for or related to such persons; $17,400,000 shall be available to the Public Defender Service; and $15,800,000 shall be available to the Pretrial Services Agency: *Provided,* That, notwithstanding any other provision of law, said sums shall be paid quarterly by the Treasury based on quarterly apportionments approved by the Office of Management and Budget. Upon the Agency's certification as a Federal entity, as authorized by such Act, and notwithstanding any other provision of law, the Public Defender Service shall be subject to quarterly apportionment by the Office of Management and Budget: *Provided further,* That, of the amounts made available under this heading, $5,873,000 shall be available only for individuals on probation or supervised release for drug screening and testing.

FEDERAL PAYMENT FOR DISTRICT OF COLUMBIA RESIDENT TUITION SUPPORT

For payment to the District of Columbia, $17,000,000, for a program, to be administered by the Mayor, for District of Columbia resident tuition support, subject to the enactment of authorizing legislation specifically referencing this program: *Provided,* That said funds will be used to pay the difference between in-State and out-of-State tuition at

public institutions of higher education on behalf of eligible District of Columbia residents: *Provided further,* That awarding of said funds shall be prioritized on the basis of a resident's academic merit and other factors as authorized.

FEDERAL PAYMENT FOR METROPOLITAN POLICE DEPARTMENT

For payment to the Metropolitan Police Department, $1,000,000, for a program to eliminate open air drug trafficking in the District of Columbia.

DISTRICT OF COLUMBIA FUNDS

OPERATING EXPENSES

DIVISION OF EXPENSES

The following amounts are appropriated for the District of Columbia for the current fiscal year out of the general fund of the District of Columbia, except as otherwise specifically provided.

GOVERNMENTAL DIRECTION AND SUPPORT

Governmental direction and support, $162,356,000 (including $137,134,000 from local funds, $11,670,000 from Federal funds, and $13,552,000 from other funds): *Provided,* That not to exceed $2,500 for the Mayor, $2,500 for the Chairman of the Council of the District of Columbia, and $2,500 for the City Administrator shall be available from this appropriation for official purposes: *Provided further,* That any program fees collected from the issuance of debt shall be available for the payment of expenses of the debt management program of the District of Columbia: *Provided further,* That no revenues from Federal sources shall be used to support the operations or activities of the Statehood Commission and Statehood Compact Commission: *Provided further,* That the District of Columbia shall identify the sources of funding for Admission to Statehood from its own locally-generated revenues: *Provided further,* That all employees permanently assigned to work in the Office of the Mayor shall be paid from funds allocated to the Office of the Mayor: *Provided further,* That, notwithstanding any other provision of law now or hereafter enacted, no Member of the District of Columbia Council eligible to earn a part-time salary of $92,520, exclusive of the Council Chairman, shall be paid a salary of more than $84,635 during fiscal year 2000.

ECONOMIC DEVELOPMENT AND REGULATION

Economic development and regulation, $190,335,000 (including $52,911,000 from local funds; $84,751,000 from Federal funds, and $52,673,000 from other funds), of which $15,000,000 collected by the District of Columbia in the form of BID tax revenue shall be paid to the respective BIDs pursuant to the Business Improvement Districts Act of 1996 (D.C. Law 11–134; D.C. Code, sec. 1–2271 et seq.), and the Business Improvement Districts Temporary Amendment Act of 1997 (D.C. Law 12–23): *Provided,* That such funds are available for acquiring services provided by the General Services Administration: *Provided further,* That Business Improvement Districts shall be exempt from taxes levied by the District of Columbia.

PUBLIC SAFETY AND JUSTICE

Public safety and justice, including purchase or lease of 135 passenger-carrying vehicles for replacement only, including 130 for police-type use and five for fire-type use, without regard to the general purchase price limitation for the current fiscal year, $778,470,000 (including $565,211,000 from local funds, $29,012,000 from Federal funds, and $184,247,000 from other funds): *Provided,* That the Metropolitan Police Department is authorized to replace not to exceed 25 passenger-carrying vehicles and the Department of Fire and Emergency Medical Services of the District of Columbia is authorized to replace not to exceed five passenger-carrying vehicles annually whenever the cost of repair to any damaged vehicle exceeds three-fourths of the cost of the replacement: *Provided further,* That not to exceed $500,000 shall be available from this appropriation for the Chief of Police for the prevention and detection of crime: *Provided further,* That the Metropolitan Police Department shall provide quarterly reports to the Committees on Appropriations of the House and Senate on efforts to increase efficiency and improve the professionalism in the department: *Provided further,* That notwithstanding any other provision of law, or Mayor's Order 86–45, issued March 18, 1986, the Metropolitan Police Department's delegated small purchase authority shall be $500,000: *Provided further,* That the District of Columbia government may not require the Metropolitan Police Department to submit to any other procurement review process, or to obtain the approval of or be restricted in any manner by any official or employee of the District of Columbia government, for purchases that do not exceed $500,000: *Provided further,* That the Mayor shall reimburse the District of Columbia National Guard for expenses incurred in connection with services that are performed in emergencies by the National Guard in a militia status and are requested by the Mayor, in amounts that shall be jointly determined and certified as due and payable for these services by the Mayor and the Commanding General of the District of Columbia National Guard: *Provided further,* That such sums as may be necessary for reimbursement to the District of Columbia National Guard under the preceding proviso shall be available from this appropriation, and the availability of the sums shall be deemed as constituting payment in advance for emergency services involved: *Provided further,* That the Metropolitan Police Department is authorized to maintain 3,800 sworn officers, with leave for a 50 officer attrition: *Provided further,* That $100,000 shall be available for inmates released on medical and geriatric parole: *Provided further,* That, commencing on December 31, 1999, the Metropolitan Police Department shall provide to the Committees on Appropriations of the Senate and House of Representatives, the Committee on Governmental Affairs of the Senate, and the Committee on Government Reform of the House of Representatives, quarterly reports on the status of crime reduction in each of the 83 police service areas established throughout the District of Columbia: *Provided further,* That $900,000 in local funds shall be available for the operations of the Office of Citizen Complaint Review.

PUBLIC EDUCATION SYSTEM

Public education system, including the development of national defense education programs, $867,411,000 (including $721,847,000 from local funds, $120,951,000 from Federal funds, and $24,613,000 from other funds), to be allocated as follows: $713,197,000 (including $600,936,000 from local funds, $106,213,000 from Federal funds, and $6,048,000 from other funds), for the public schools of the District of Columbia; $10,700,000 from local funds for the District of Columbia Teachers' Retirement Fund; $17,000,000 from local funds for a program for District of Columbia resident tuition support; $27,885,000 from local funds (not including funds already made available for District of Columbia public schools) for public charter schools: *Provided,* That if the entirety of this allocation has not been provided as payments to any public charter schools currently in operation through the per pupil funding formula, the funds shall be available for new public charter schools on a per pupil basis: *Provided further,* That $480,000 of this amount shall be available to the District of Columbia Public Charter School Board for administrative costs: $72,347,000 (including $40,491,000 from local funds, $13,536,000 from Federal funds, and $18,320,000 from other funds) for the University of the District of Columbia; $24,171,000 (including $23,128,000 from local funds, $798,000 from Federal funds, and $245,000 from other funds) for the Public Library; $2,111,000 (including $1,707,000 from local funds and $404,000 from Federal funds) for the Commission on the Arts and Humanities: *Provided further,* That the public schools of the District of Columbia are authorized to accept not to exceed 31 motor vehicles for exclusive use in the driver education program: *Provided further,* That not to exceed $2,500 for the Superintendent of Schools, $2,500 for the President of the University of the District of Columbia, and $2,000 for the Public Librarian shall be available from this appropriation for official purposes: *Provided further,* That none of the funds contained in this Act may be made available to pay the salaries of any District of Columbia Public School teacher, principal, administrator, official, or employee who knowingly provides false enrollment or attendance information under article II, section 5 of the Act entitled ''An Act to provide for compulsory school attendance, for the taking of a school census in the District of Columbia, and for other purposes'', approved February 4, 1925 (D.C. Code, sec. 31–401 et seq.): *Provided further,* That this appropriation shall not be available to subsidize the education of any nonresident of the District of Columbia at any District of Columbia public elementary and secondary school during fiscal year 2000 unless the nonresident pays tuition to the District of Columbia at a rate that covers 100 percent of the costs incurred by the District of Columbia which are attributable to the education of the nonresident (as established by the Superintendent of the District of Columbia Public Schools): *Provided further,* That this appropriation shall not be available to subsidize the education of nonresidents of the District of Columbia at the University of the District of Columbia, unless the Board of Trustees of the University of the District of Columbia adopts, for the fiscal year ending September 30, 2000, a tuition rate schedule that will establish the tuition rate for nonresident students at a level no lower than the nonresident tuition rate charged at comparable public institutions of higher education in the metropolitan area: *Provided further,* That the District of Columbia Public Schools shall not spend less than $365,500,000 on local schools through the Weighted Student Formula in fiscal year 2000: *Provided further,* That notwithstanding any other provision of law, the Chief Financial Officer of the District of Columbia shall apportion from the budget of the Public Education System a sum totaling five percent (5 percent) of the total budget to be set aside until the current student count for Public and Charter schools has been completed, and that this amount shall be apportioned between the Public and Charter schools based on their respective student population count: *Provided further,* That the District of Columbia Public Schools may spend $500,000 to engage in a Schools Without Violence program based on a model developed by the University of North Carolina, located in Greensboro, North Carolina.

HUMAN SUPPORT SERVICES

Human support services, $1,526,111,000 (including $635,123,000 from local funds, $875,814,000 from Federal funds, and $15,174,000 from other funds): *Provided,* That $25,150,000 of this appropriation, to remain available until expended, shall be available solely for District of Columbia employees' disability compensation: *Provided further,*

That a peer review committee shall be established to review medical payments and the type of service received by a disability compensation claimant: *Provided further,* That the District of Columbia shall not provide free government services such as water, sewer, solid waste disposal or collection, utilities, maintenance, repairs, or similar services to any legally constituted private nonprofit organization, as defined in section 411(5) of the Stewart B. McKinney Homeless Assistance Act (101 Stat. 485; Public Law 100–77; 42 U.S.C. 11371), providing emergency shelter services in the District, if the District would not be qualified to receive reimbursement pursuant to such Act (101 Stat. 485; Public Law 100–77; 42 U.S.C. 11301 et seq.).

PUBLIC WORKS

Public works, including rental of one passenger-carrying vehicle for use by the Mayor and three passenger-carrying vehicles for use by the Council of the District of Columbia and leasing of passenger-carrying vehicles, $271,395,000 (including $258,341,000 from local funds, $3,099,000 from Federal funds, and $9,955,000 from other funds): *Provided,* That this appropriation shall not be available for collecting ashes or miscellaneous refuse from hotels and places of business.

RECEIVERSHIP PROGRAMS

For all agencies of the District of Columbia government under court ordered receivership, $337,077,000 (including $212,606,000 from local funds, $106,111,000 from Federal funds, and $18,360,000 from other funds).

WORKFORCE INVESTMENTS

For workforce investments, $8,500,000 from local funds, to be transferred by the Mayor of the District of Columbia within the various appropriation headings in this Act for which employees are properly payable.

RESERVE

For a reserve to be established by the Chief Financial Officer of the District of Columbia and the District of Columbia Financial Responsibility and Management Assistance Authority, $150,000,000.

DISTRICT OF COLUMBIA FINANCIAL RESPONSIBILITY AND MANAGEMENT ASSISTANCE AUTHORITY

For the District of Columbia Financial Responsibility and Management Assistance Authority, established by section 101(a) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995, approved April 17, 1995 (109 Stat. 97; Public Law 104–8), $3,140,000.

REPAYMENT OF LOANS AND INTEREST

For payment of principal, interest and certain fees directly resulting from borrowing by the District of Columbia to fund District of Columbia capital projects as authorized by sections 462, 475, and 490 of the District of Columbia Home Rule Act, approved December 24, 1973, as amended, and that funds shall be allocated for expenses associated with the Wilson Building, $328,417,000 from local funds: *Provided,* That for equipment leases, the Mayor may finance $27,527,000 of equipment cost, plus cost of issuance not to exceed two percent of the par amount being financed on a lease purchase basis with a maturity not to exceed five years: *Provided further,* That $5,300,000 is allocated to the Metropolitan Police Department, $3,200,000 for the Fire and Emergency Medical Services Department, $350,000 for the Department of Corrections, $15,949,000 for the Department of Public Works and $2,728,000 for the Public Benefit Corporation.

REPAYMENT OF GENERAL FUND RECOVERY DEBT

For the purpose of eliminating the $331,589,000 general fund accumulated deficit as of September 30, 1990, $38,286,000 from local funds, as authorized by section 461(a) of the District of Columbia Home Rule Act, approved December 24, 1973, as amended (105 Stat. 540; Public Law 102–106; D.C. Code, sec. 47–321(a)(1)).

PAYMENT OF INTEREST ON SHORT-TERM BORROWING

For payment of interest on short-term borrowing, $9,000,000 from local funds.

CERTIFICATES OF PARTICIPATION

For lease payments in accordance with the Certificates of Participation involving the land site underlying the building located at One Judiciary Square, $7,950,000 from local funds.

OPTICAL AND DENTAL INSURANCE PAYMENTS

For optical and dental insurance payments, $1,295,000 from local funds.

PRODUCTIVITY BANK

The Chief Financial Officer of the District of Columbia shall, under the direction of the Mayor and the District of Columbia Financial Responsibility and Management Assistance Authority, finance projects totaling $20,000,000 in local funds that result in cost savings or additional revenues, by an amount equal to such financing.

PRODUCTIVITY SAVINGS

The Chief Financial Officer of the District of Columbia shall, under the direction of the Mayor and the District of Columbia Financial Responsibility and Management Assistance Authority, make reductions totaling $20,000,000 in local funds to be allocated to projects funded through the Productivity Bank that produce cost savings or additional revenues in an amount equal to the Productivity Bank financing.

PROCUREMENT AND MANAGEMENT SAVINGS

The Chief Financial Officer of the District of Columbia shall, under the direction of the Mayor and the District of Columbia Financial Responsibility and Management Assistance Authority, make reductions of $14,457,000 for general supply schedule savings and $7,000,000 for management reform savings, in local funds to one or more of the appropriation headings in this Act: *Provided,* That the Mayor submits a resolution to the Council authorizing the management reform savings and the Council approves the resolution.

ENTERPRISE AND OTHER FUNDS

WATER AND SEWER AUTHORITY AND THE WASHINGTON AQUEDUCT

For the Water and Sewer Authority and the Washington Aqueduct, $279,608,000 from other funds (including $236,075,000 for the Water and Sewer Authority and $43,533,000 for the Washington Aqueduct) of which $35,222,000 shall be apportioned and payable to the District's debt service fund for repayment of loans and interest incurred for capital improvement projects.

For construction projects, $197,169,000, as authorized by An Act authorizing the laying of watermains and service sewers in the District of Columbia, the levying of assessments therefore, and for other purposes, approved April 22, 1904 (33 Stat. 244; Public Law 58–140; D.C. Code, sec. 43–1512 et seq.): *Provided,* That the requirements and restrictions that are applicable to general fund capital improvements projects and set forth in this Act under the Capital Outlay appropriation title shall apply to projects approved under this appropriation title.

LOTTERY AND CHARITABLE GAMES ENTERPRISE FUND

For the Lottery and Charitable Games Enterprise Fund, established by the District of Columbia Appropriation Act for the fiscal year ending September 30, 1982, approved December 4, 1981 (95 Stat. 1174, 1175; Public Law 97–91), as amended, for the purpose of implementing the Law to Legalize Lotteries, Daily Numbers Games, and Bingo and Raffles for Charitable Purposes in the District of Columbia, effective March 10, 1981 (D.C. Law 3–172; D.C. Code, secs. 2–2501 et seq. and 22–1516 et seq.), $234,400,000: *Provided,* That the District of Columbia shall identify the source of funding for this appropriation title from the District's own locally-generated revenues: *Provided further,* That no revenues from Federal sources shall be used to support the operations or activities of the Lottery and Charitable Games Control Board.

SPORTS AND ENTERTAINMENT COMMISSION

For the Sports and Entertainment Commission, $10,846,000 from other funds for expenses incurred by the Armory Board in the exercise of its powers granted by the Act entitled ''An Act To Establish A District of Columbia Armory Board, and for other purposes'', approved June 4, 1948 (62 Stat. 339; D.C. Code, sec. 2–301 et seq.) and the District of Columbia Stadium Act of 1957, approved September 7, 1957 (71 Stat. 619; Public Law 85–300; D.C. Code, sec. 2–321 et seq.): *Provided,* That the Mayor shall submit a budget for the Armory Board for the forthcoming fiscal year as required by section 442(b) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 824; Public Law 93–198; D.C. Code, sec. 47–301(b)).

D.C. HEALTH AND HOSPITALS PUBLIC BENEFIT CORPORATION

For the District of Columbia Health and Hospitals Public Benefit Corporation, established by D.C. Law 11–212, D.C. Code, sec. 32–262.2, effective April 9, 1997, $133,443,000 of which $44,435,000 shall be derived by transfer from the general fund and $89,008,000 from other funds.

D.C. RETIREMENT BOARD

For the D.C. Retirement Board, established by section 121 of the District of Columbia Retirement Reform Act of 1979, approved November 17, 1979 (93 Stat. 866; D.C. Code, sec. 1–711), $9,892,000 from the earnings of the applicable retirement funds to pay legal, management, investment, and other fees and administrative expenses of the District of Columbia Retirement Board: *Provided,* That the District of Columbia Retirement Board shall provide to the Congress and to the Council of the District of Columbia a quarterly report of the allocations of charges by fund and of expenditures of all funds: *Provided further,* That the District of Columbia Retirement Board shall provide the Mayor, for transmittal to the Council of the District of Columbia, an itemized accounting of the planned use of appropriated funds in time for each annual budget submission and the actual use of such funds in time for each annual audited financial report.

CORRECTIONAL INDUSTRIES FUND

For the Correctional Industries Fund, established by the District of Columbia Correctional Industries Establishment Act, approved October 3, 1964 (78 Stat. 1000; Public Law 88–622), $1,810,000 from other funds.

WASHINGTON CONVENTION CENTER ENTERPRISE FUND

For the Washington Convention Center Enterprise Fund, $50,226,000 from other funds.

CAPITAL OUTLAY

(INCLUDING RESCISSIONS)

For construction projects, a net increase of $1,218,637,500 (including an increase of $1,260,524,000 and a rescission of $41,886,500 from local funds appropriated under this heading in prior fiscal years, and an additional $1,260,524,000 of which $929,450,000 is

from local funds, $54,050,000 is from the highway trust fund, and $277,024,000 is from Federal funds), to remain available until expended: *Provided,* That funds for use of each capital project implementing agency shall be managed and controlled in accordance with all procedures and limitations established under the Financial Management System: *Provided further,* That all funds provided by this appropriation title shall be available only for the specific projects and purposes intended: *Provided further,* That notwithstanding the foregoing, all authorizations for capital outlay projects, except those projects covered by the first sentence of section 23(a) of the Federal-Aid Highway Act of 1968, approved August 23, 1968 (82 Stat. 827; Public Law 90–495; D.C. Code, sec. 7–134, note), for which funds are provided by this appropriation title, shall expire on September 30, 2001, except authorizations for projects as to which funds have been obligated in whole or in part prior to September 30, 2001: *Provided further,* That, upon expiration of any such project authorization, the funds provided herein for the project shall lapse.

GENERAL PROVISIONS

SECTION 101. The expenditure of any appropriation under this Act for any consulting service through procurement contract, pursuant to 5 U.S.C. 3109, shall be limited to those contracts where such expenditures are a matter of public record and available for public inspection, except where otherwise provided under existing law, or under existing Executive Order issued pursuant to existing law.

SEC. 102. Except as otherwise provided in this Act, all vouchers covering expenditures of appropriations contained in this Act shall be audited before payment by the designated certifying official, and the vouchers as approved shall be paid by checks issued by the designated disbursing official.

SEC. 103. Whenever in this Act an amount is specified within an appropriation for particular purposes or objects of expenditure, such amount, unless otherwise specified, shall be considered as the maximum amount that may be expended for said purpose or object rather than an amount set apart exclusively therefor.

SEC. 104. Appropriations in this Act shall be available, when authorized by the Mayor, for allowances for privately owned automobiles and motorcycles used for the performance of official duties at rates established by the Mayor: *Provided,* That such rates shall not exceed the maximum prevailing rates for such vehicles as prescribed in the Federal Property Management Regulations 101–7 (Federal Travel Regulations).

SEC. 105. Appropriations in this Act shall be available for expenses of travel and for the payment of dues of organizations concerned with the work of the District of Columbia government, when authorized by the Mayor: *Provided,* That, in the case of the Council of the District of Columbia, funds may be expended with the authorization of the chair of the Council.

SEC. 106. There are appropriated from the applicable funds of the District of Columbia such sums as may be necessary for making refunds and for the payment of judgments that have been entered against the District of Columbia government: *Provided,* That nothing contained in this section shall be construed as modifying or affecting the provisions of section 11(c)(3) of title XII of the District of Columbia Income and Franchise Tax Act of 1947, approved March 31, 1956 (70 Stat. 78; Public Law 84–460; D.C. Code, sec. 47–1812.11(c)(3)).

SEC. 107. Appropriations in this Act shall be available for the payment of public assistance without reference to the requirement of section 544 of the District of Columbia Public Assistance Act of 1982, effective April 6, 1982 (D.C. Law 4–101; D.C. Code, sec. 3–205.44), and for payment of the non-Federal share of funds necessary to qualify for grants under subtitle A of title II of the Violent Crime Control and Law Enforcement Act of 1994.

SEC. 108. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein.

SEC. 109. No funds appropriated in this Act for the District of Columbia government for the operation of educational institutions, the compensation of personnel, or for other educational purposes may be used to permit, encourage, facilitate, or further partisan political activities. Nothing herein is intended to prohibit the availability of school buildings for the use of any community or partisan political group during non-school hours.

SEC. 110. None of the funds appropriated in this Act shall be made available to pay the salary of any employee of the District of Columbia government whose name, title, grade, salary, past work experience, and salary history are not available for inspection by the House and Senate Committees on Appropriations, the Subcommittee on the District of Columbia of the House Committee on Government Reform, the Subcommittee on Oversight of Government Management, Restructuring and the District of Columbia of the Senate Committee on Governmental Affairs, and the Council of the District of Columbia, or their duly authorized representative.

SEC. 111. There are appropriated from the applicable funds of the District of Columbia such sums as may be necessary for making payments authorized by the District of Columbia Revenue Recovery Act of 1977, effective September 23, 1977 (D.C. Law 2–20; D.C. Code, sec. 47–421 et seq.).

SEC. 112. No part of this appropriation shall be used for publicity or propaganda purposes or implementation of any policy including boycott designed to support or defeat legislation pending before Congress or any State legislature.

SEC. 113. At the start of the fiscal year, the Mayor shall develop an annual plan, by quarter and by project, for capital outlay borrowings: *Provided,* That within a reasonable time after the close of each quarter, the Mayor shall report to the Council of the District of Columbia and the Congress the actual borrowings and spending progress compared with projections.

SEC. 114. The Mayor shall not borrow any funds for capital projects unless the Mayor has obtained prior approval from the Council of the District of Columbia, by resolution, identifying the projects and amounts to be financed with such borrowings.

SEC. 115. The Mayor shall not expend any moneys borrowed for capital projects for the operating expenses of the District of Columbia government.

SEC. 116. None of the funds provided under this Act to the agencies funded by this Act, both Federal and District government agencies, that remain available for obligation or expenditure in fiscal year 2000, or provided from any accounts in the Treasury of the United States derived by the collection of fees available to the agencies funded by this Act, shall be available for obligation or expenditure for an agency through a reprogramming of funds which: (1) creates new programs; (2) eliminates a program, project, or responsibility center; (3) establishes or changes allocations specifically denied, limited or increased by Congress in the Act; (4) increases funds or personnel by any means for any program, project, or responsibility center for which funds have been denied or restricted; (5) reestablishes through reprogramming any program or project previously deferred through reprogramming; (6) augments existing programs, projects, or responsibility centers through a reprogramming of funds in excess of $1,000,000 or 10 percent, whichever is less; or (7) increases by 20 percent or more personnel assigned to a specific program, project, or responsibility center; unless the Appropriations Committees of both the Senate and House of Representatives are notified in writing 30 days in advance of any reprogramming as set forth in this section.

SEC. 117. None of the Federal funds provided in this Act shall be obligated or expended to procure passenger automobiles as defined in the Automobile Fuel Efficiency Act of 1980, approved October 10, 1980 (94 Stat. 1824; Public Law 96–425; 15 U.S.C. 2001(2)), with an Environmental Protection Agency estimated miles per gallon average of less than 22 miles per gallon: *Provided,* That this section shall not apply to security, emergency rescue, or armored vehicles.

SEC. 118. (a) Strike the last sentence of section 422(7) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 790; Public Law 93–198; D.C. Code, sec. 1–242(7)).

(b) Notwithstanding section 4(a) of the District of Columbia Redevelopment Act of 1945, approved August 2, 1946 (60 Stat. 793; Public Law 79–592; D.C. Code, sec. 5–803(a)), the Board of Directors of the District of Columbia Redevelopment Land Agency shall be paid, during any fiscal year, per diem compensation at a rate established by the Mayor.

SEC. 119. Notwithstanding any other provisions of law, the provisions of the District of Columbia Government Comprehensive Merit Personnel Act of 1978, effective March 3, 1979 (D.C. Law 2–139; D.C. Code, sec. 1–601.1 et seq.), enacted pursuant to section 422(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 790; Public Law 93–198; D.C. Code, sec. 1–242(3)), shall apply with respect to the compensation of District of Columbia employees: *Provided,* That for pay purposes, employees of the District of Columbia government shall not be subject to the provisions of title 5, United States Code.

SEC. 120. No later than 30 days after the end of the first quarter of the fiscal year ending September 30, 2000, the Mayor of the District of Columbia shall submit to the Council of the District of Columbia the new fiscal year 2000 revenue estimates as of the end of the first quarter of fiscal year 2000. These estimates shall be used in the budget request for the fiscal year ending September 30, 2001. The officially revised estimates at midyear shall be used for the midyear report.

SEC. 121. No sole source contract with the District of Columbia government or any agency thereof may be renewed or extended without opening that contract to the competitive bidding process as set forth in section 303 of the District of Columbia Procurement Practices Act of 1985, effective February 21, 1986 (D.C. Law 6–85; D.C. Code, sec. 1–1183.3), except that the District of Columbia government or any agency thereof may renew or extend sole source contracts for which competition is not feasible or practical: *Provided,* That the determination as to whether to invoke the competitive bidding process has been made in accordance with duly promulgated rules and procedures and said determination has been reviewed and approved by the District of Columbia Financial Responsibility and Management Assistance Authority.

SEC. 122. For purposes of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, the term ''program, project, and activity'' shall be synonymous

with and refer specifically to each account appropriating Federal funds in this Act, and any sequestration order shall be applied to each of the accounts rather than to the aggregate total of those accounts: *Provided,* That sequestration orders shall not be applied to any account that is specifically exempted from sequestration by the Balanced Budget and Emergency Deficit Control Act of 1985.

SEC. 123. In the event a sequestration order is issued pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, after the amounts appropriated to the District of Columbia for the fiscal year involved have been paid to the District of Columbia, the Mayor of the District of Columbia shall pay to the Secretary of the Treasury, within 15 days after receipt of a request therefor from the Secretary of the Treasury, such amounts as are sequestered by the order: *Provided,* That the sequestration percentage specified in the order shall be applied proportionately to each of the Federal appropriation accounts in this Act that are not specifically exempted from sequestration by such Act.

SEC. 124. (a) An entity of the District of Columbia government may accept and use a gift or donation during fiscal year 2000 if—

(1) the Mayor approves the acceptance and use of the gift or donation: *Provided,* That the Council of the District of Columbia may accept and use gifts without prior approval by the Mayor; and

(2) the entity uses the gift or donation to carry out its authorized functions or duties.

(b) Each entity of the District of Columbia government shall keep accurate and detailed records of the acceptance and use of any gift or donation under subsection (a) of this section, and shall make such records available for audit and public inspection.

(c) For the purposes of this section, the term ''entity of the District of Columbia government'' includes an independent agency of the District of Columbia.

(d) This section shall not apply to the District of Columbia Board of Education, which may, pursuant to the laws and regulations of the District of Columbia, accept and use gifts to the public schools without prior approval by the Mayor.

SEC. 125. None of the Federal funds provided in this Act may be used by the District of Columbia to provide for salaries, expenses, or other costs associated with the offices of United States Senator or United States Representative under section 4(d) of the District of Columbia Statehood Constitutional Convention Initiatives of 1979, effective March 10, 1981 (D.C. Law 3–171; D.C. Code, sec. 1–113(d)).

SEC. 126. (a) The University of the District of Columbia shall submit to the Mayor, the District of Columbia Financial Responsibility and Management Assistance Authority, and the Council of the District of Columbia no later than 15 calendar days after the end of each quarter a report that sets forth—

(1) current quarter expenditures and obligations, year-to-date expenditures and obligations, and total fiscal year expenditure projections versus budget, broken out on the basis of control center, responsibility center, and object class, and for all funds, non-appropriated funds, and capital financing;

(2) a list of each account for which spending is frozen and the amount of funds frozen, broken out by control center, responsibility center, detailed object, and for all funding sources;

(3) a list of all active contracts in excess of $10,000 annually, which contains the name of each contractor; the budget to which the contract is charged, broken out on the basis of control center and responsibility center, and contract identifying codes used by the University of the District of Columbia; payments made in the last quarter and year-to-date, the total amount of the contract and total payments made for the contract and any modifications, extensions, renewals; and specific modifications made to each contract in the last month;

(4) all reprogramming requests and reports that have been made by the University of the District of Columbia within the last quarter in compliance with applicable law; and

(5) changes made in the last quarter to the organizational structure of the University of the District of Columbia, displaying previous and current control centers and responsibility centers, the names of the organizational entities that have been changed, the name of the staff member supervising each entity affected, and the reasons for the structural change.

(b) The Mayor, the Authority, and the Council shall provide the Congress by February 1, 2000, a summary, analysis, and recommendations on the information provided in the quarterly reports.

SEC. 127. Funds authorized or previously appropriated to the government of the District of Columbia by this or any other Act to procure the necessary hardware and installation of new software, conversion, testing, and training to improve or replace its financial management system are also available for the acquisition of accounting and financial management services and the leasing of necessary hardware, software or any other related goods or services, as determined by the District of Columbia Financial Responsibility and Management Assistance Authority.

SEC. 128. None of the funds contained in this Act may be made available to pay the fees of an attorney who represents a party who prevails in an action, including an administrative proceeding, brought against the District of Columbia Public Schools under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.) if—

(1) the hourly rate of compensation of the attorney exceeds the hourly rate of compensation under section 11–2604(a), District of Columbia Code; or

(2) the maximum amount of compensation of the attorney exceeds the maximum amount of compensation under section 11–2604(b)(1), District of Columbia Code, except that compensation and reimbursement in excess of such maximum may be approved for extended or complex representation in accordance with section 11–2604(c), District of Columbia Code.

SEC. 129. None of the funds appropriated under this Act shall be expended for any abortion except where the life of the mother would be endangered if the fetus were carried to term or where the pregnancy is the result of an act of rape or incest.

SEC. 130. None of the funds made available in this Act may be used to implement or enforce the Health Care Benefits Expansion Act of 1992 (D.C. Law 9–114; D.C. Code, sec. 36–1401 et seq.) or to otherwise implement or enforce any system of registration of unmarried, cohabiting couples (whether homosexual, heterosexual, or lesbian), including but not limited to registration for the purpose of extending employment, health, or governmental benefits to such couples on the same basis that such benefits are extended to legally married couples.

SEC. 131. The Superintendent of the District of Columbia Public Schools shall submit to the Congress, the Mayor, the District of Columbia Financial Responsibility and Management Assistance Authority, and the Council of the District of Columbia no later than 15 calendar days after the end of each quarter a report that sets forth—

(1) current quarter expenditures and obligations, year-to-date expenditures and obligations, and total fiscal year expenditure projections versus budget, broken out on the basis of control center, responsibility center, agency reporting code, and object class, and for all funds, including capital financing;

(2) a list of each account for which spending is frozen and the amount of funds frozen, broken out by control center, responsibility center, detailed object, and agency reporting code, and for all funding sources;

(3) a list of all active contracts in excess of $10,000 annually, which contains the name of each contractor; the budget to which the contract is charged, broken out on the basis of control center, responsibility center, and agency reporting code; and contract identifying codes used by the District of Columbia Public Schools; payments made in the last quarter and year-to-date, the total amount of the contract and total payments made for the contract and any modifications, extensions, renewals; and specific modifications made to each contract in the last month;

(4) all reprogramming requests and reports that are required to be, and have been, submitted to the Board of Education; and

(5) changes made in the last quarter to the organizational structure of the D.C. Public Schools, displaying previous and current control centers and responsibility centers, the names of the organizational entities that have been changed, the name of the staff member supervising each entity affected, and the reasons for the structural change.

SEC. 132. (a) IN GENERAL.—The Superintendent of the District of Columbia Public Schools and the University of the District of Columbia shall annually compile an accurate and verifiable report on the positions and employees in the public school system and the university, respectively. The annual report shall set forth—

(1) the number of validated schedule A positions in the District of Columbia public schools and the University of the District of Columbia for fiscal year 1999, fiscal year 2000, and thereafter on full-time equivalent basis, including a compilation of all positions by control center, responsibility center, funding source, position type, position title, pay plan, grade, and annual salary; and

(2) a compilation of all employees in the District of Columbia public schools and the University of the District of Columbia as of the preceding December 31, verified as to its accuracy in accordance with the functions that each employee actually performs, by control center, responsibility center, agency reporting code, program (including funding source), activity, location for accounting purposes, job title, grade and classification, annual salary, and position control number.

(b) SUBMISSION.—The annual report required by subsection (a) of this section shall be submitted to the Congress, the Mayor, the District of Columbia Council, the Consensus Commission, and the Authority, not later than February 15 of each year.

SEC. 133. (a) No later than October 1, 1999, or within 30 calendar days after the date of the enactment of this Act, whichever occurs later, and each succeeding year, the Superintendent of the District of Columbia Public Schools and the University of the District of Columbia shall submit to the appropriate congressional committees, the Mayor, the District of Columbia Council, the Consensus Commission, and the District of Columbia Financial Responsibility and Management Assistance Authority, a revised appropriated funds operating budget for the public school system and the University of the District of Columbia for such fiscal year that is in the total amount of the approved appropriation and that realigns budgeted data for personal services and other-than-personal services, respectively, with anticipated actual expenditures.

(b) The revised budget required by subsection (a) of this section shall be submitted in the format of the budget that the Superintendent of the District of Columbia Public Schools and the University of the District of Columbia submit to the Mayor of the District of Columbia for inclusion in the Mayor's budget submission to the Council of the District of Columbia pursuant to section 442 of the District of Columbia Home Rule Act, Public Law 93–198, as amended (D.C. Code, sec. 47–301).

SEC. 134. The District of Columbia Financial Responsibility and Management Assistance Authority, acting on behalf of the District of Columbia Public Schools [DCPS] in formulating the DCPS budget, the Board of Trustees of the University of the District of Columbia, the Board of Library Trustees, and the Board of Governors of the University of the District of Columbia School of Law shall vote on and approve the respective annual or revised budgets for such entities before submission to the Mayor of the District of Columbia for inclusion in the Mayor's budget submission to the Council of the District of Columbia in accordance with section 442 of the District of Columbia Home Rule Act, Public Law 93–198, as amended (D.C. Code, sec. 47–301), or before submitting their respective budgets directly to the Council.

SEC. 135. (a) CEILING ON TOTAL OPERATING EXPENSES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the total amount appropriated in this Act for operating expenses for the District of Columbia for fiscal year 2000 under the caption ''Division of Expenses'' shall not exceed the lesser of—

(A) the sum of the total revenues of the District of Columbia for such fiscal year; or

(B) $5,486,829,000 (of which $152,753,000 shall be from intra-District funds and $3,108,304,000 shall be from local funds), which amount may be increased by the following:

(i) proceeds of one-time transactions, which are expended for emergency or unanticipated operating or capital needs approved by the District of Columbia Financial Responsibility and Management Assistance Authority; or

(ii) after notification to the Council, additional expenditures which the Chief Financial Officer of the District of Columbia certifies will produce additional revenues during such fiscal year at least equal to 200 percent of such additional expenditures, and that are approved by the Authority.

(2) ENFORCEMENT.—The Chief Financial Officer of the District of Columbia and the Authority shall take such steps as are necessary to assure that the District of Columbia meets the requirements of this section, including the apportioning by the Chief Financial Officer of the appropriations and funds made available to the District during fiscal year 2000, except that the Chief Financial Officer may not reprogram for operating expenses any funds derived from bonds, notes, or other obligations issued for capital projects.

(b) ACCEPTANCE AND USE OF GRANTS NOT INCLUDED IN CEILING.—

(1) IN GENERAL.—Notwithstanding subsection (a), the Mayor, in consultation with the Chief Financial Officer, during a control year, as defined in section 305(4) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995, approved April 17, 1995 (Public Law 104–8; 109 Stat. 152), may accept, obligate, and expend Federal, private, and other grants received by the District government that are not reflected in the amounts appropriated in this Act.

(2) REQUIREMENT OF CHIEF FINANCIAL OFFICER REPORT AND AUTHORITY APPROVAL.—No such Federal, private, or other grant may be accepted, obligated, or expended pursuant to paragraph (1) until—

(A) the Chief Financial Officer of the District of Columbia submits to the Authority a report setting forth detailed information regarding such grant; and

(B) the Authority has reviewed and approved the acceptance, obligation, and expenditure of such grant in accordance with review and approval procedures consistent with the provisions of the District of Columbia Financial Responsibility and Management Assistance Act of 1995.

(3) PROHIBITION ON SPENDING IN ANTICIPATION OF APPROVAL OR RECEIPT.—No amount may be obligated or expended from the general fund or other funds of the District government in anticipation of the approval or receipt of a grant under paragraph (2)(B) of this subsection or in anticipation of the approval or receipt of a Federal, private, or other grant not subject to such paragraph.

(4) QUARTERLY REPORTS.—The Chief Financial Officer of the District of Columbia shall prepare a quarterly report setting forth detailed information regarding all Federal, private, and other grants subject to this subsection. Each such report shall be submitted to the Council of the District of Columbia, and to the Committees on Appropriations of the House of Representatives and the Senate, not later than 15 days after the end of the quarter covered by the report.

(c) REPORT ON EXPENDITURES BY FINANCIAL RESPONSIBILITY AND MANAGEMENT ASSISTANCE AUTHORITY.—Not later than 20 calendar days after the end of each fiscal quarter starting October 1, 1999, the Authority shall submit a report to the Committees on Appropriations of the House of Representatives and the Senate, the Committee on Government Reform of the House, and the Committee on Governmental Affairs of the Senate providing an itemized accounting of all non-appropriated funds obligated or expended by the Authority for the quarter. The report shall include information on the date, amount, purpose, and vendor name, and a description of the services or goods provided with respect to the expenditures of such funds.

SEC. 136. If a department or agency of the government of the District of Columbia is under the administration of a court-appointed receiver or other court-appointed official during fiscal year 2000 or any succeeding fiscal year, the receiver or official shall prepare and submit to the Mayor, for inclusion in the annual budget of the District of Columbia for the year, annual estimates of the expenditures and appropriations necessary for the maintenance and operation of the department or agency. All such estimates shall be forwarded by the Mayor to the Council, for its action pursuant to sections 446 and 603(c) of the District of Columbia Home Rule Act, without revision but subject to the Mayor's recommendations. Notwithstanding any provision of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 790; Public Law 93–198; D.C. Code, sec. 1–101 et seq.), the Council may comment or make recommendations concerning such annual estimates but shall have no authority under such Act to revise such estimates.

SEC. 137. (a) Notwithstanding any other provision of law, rule, or regulation, an employee of the District of Columbia public schools shall be—

(1) classified as an Educational Service employee;

(2) placed under the personnel authority of the Board of Education; and

(3) subject to all Board of Education rules.

(b) School-based personnel shall constitute a separate competitive area from nonschool-based personnel who shall not compete with school-based personnel for retention purposes.

SEC. 138. (a) Except as otherwise provided in this section, none of the funds made available by this Act or by any other Act may be used to provide any officer or employee of the District of Columbia with an official vehicle unless the officer or employee uses the vehicle only in the performance of the officer's or employee's official duties. For purposes of this paragraph, the term ''official duties'' does not include travel between the officer's or employee's residence and workplace (except: (1) in the case of an officer or employee of the Metropolitan Police Department who resides in the District of Columbia or is otherwise designated by the Chief of the Department; (2) at the discretion of the Fire Chief, an officer or employee of the D.C. Fire and Emergency Ambulance Department who resides in the District of Columbia and is on call 24 hours a day; (3) the Mayor of the District of Columbia; and (4) the Chairman of the Council of the District of Columbia).

(b) The Mayor of the District of Columbia shall submit, by November 15, 1999, an inventory, as of September 30, 1999, of all vehicles owned, leased or operated by the District of Columbia government. The inventory shall include, but not be limited to, the department to which the vehicle is assigned; the year and make of the vehicle; the acquisition date and cost; the general condition of the vehicle; annual operating and maintenance costs; current mileage; and whether the vehicle is allowed to be taken home by a District officer or employee and if so, the officer or employee's title and resident location.

SEC. 139. (a) For purposes of determining the amount of funds expended by any entity within the District of Columbia government during fiscal year 2000 and each succeeding fiscal year, any expenditures of the District government attributable to any officer or employee of the District government who provides services which are within the authority and jurisdiction of the entity (including any portion of the compensation paid to the officer or employee attributable to the time spent in providing such services) shall be treated as expenditures made from the entity's budget, without regard to whether the officer or employee is assigned to the entity or otherwise treated as an officer or employee of the entity.

(b) The District of Columbia Government Comprehensive Merit Personnel Act of 1978 (D.C. Code, sec. 1–601.1 et seq.), as amended, is further amended in section 2408(a) by deleting ''1999'' and inserting, ''2000''; in subsection (b), by deleting ''1999'' and inserting ''2000''; in subsection (i), by deleting ''1999'' and inserting, ''2000''; and in subsection (k), by deleting ''1999'' and inserting, ''2000''.

SEC. 140. Notwithstanding any other provision of law, not later than 120 days after the date that a District of Columbia Public Schools [DCPS] student is referred for evaluation or assessment—

(1) the District of Columbia Board of Education, or its successor, and DCPS shall assess or evaluate a student who may have a disability and who may require special education services; and

(2) if a student is classified as having a disability, as defined in section 101(a)(1) of the Individuals with Disabilities Education Act (84 Stat. 175; 20 U.S.C. 1401(a)(1)) or in section 7(8) of the Rehabilitation Act of 1973 (87 Stat. 359; 29 U.S.C. 706(8)), the Board and DCPS shall place that student in an appropriate program of special education services.

SEC. 141. Notwithstanding any provision of any Federally-granted charter or any other provision of law, beginning with fiscal year 1999 and for each fiscal year thereafter, the real property of the National Education Association located in the District of Columbia

shall be subject to taxation by the District of Columbia in the same manner as any similar organization.

SEC. 142. None of the funds contained in this Act may be used for purposes of the annual independent audit of the District of Columbia government (including the District of Columbia Financial Responsibility and Management Assistance Authority) for fiscal year 2000 unless—

(1) the audit is conducted by the Inspector General of the District of Columbia pursuant to section 208(a)(4) of the District of Columbia Procurement Practices Act of 1985 (D.C. Code, sec. 1–1182.8(a)(4)); and

(2) the audit includes a comparison of audited actual year-end results with the revenues submitted in the budget document for such year and the appropriations enacted into law for such year.

SEC. 143. Nothing in this Act shall be construed to authorize any office, agency or entity to expend funds for programs or functions for which a reorganization plan is required but has not been approved by the District of Columbia Financial Responsibility and Management Assistance Authority. Appropriations made by this Act for such programs or functions are conditioned only on the approval by the Authority of the required reorganization plans.

SEC. 144. Notwithstanding any other provision of law, rule, or regulation, the evaluation process and instruments for evaluating District of Columbia Public Schools employees shall be a non-negotiable item for collective bargaining purposes.

SEC. 145. None of the funds contained in this Act may be used by the District of Columbia Corporation Counsel or any other officer or entity of the District government to provide assistance for any petition drive or civil action which seeks to require Congress to provide for voting representation in Congress for the District of Columbia.

SEC. 146. None of the funds contained in this Act may be used after April 1, 2000, to transfer or confine inmates classified above the medium security level, as defined by the Federal Bureau of Prisons classification instrument, to the Northeast Ohio Correctional Center located in Youngstown, Ohio.

SEC. 147. (a) No later than November 1, 1999, or within 30 calendar days after the date of the enactment of this Act, whichever occurs later, the Chief Financial Officer shall submit to the appropriate committees of Congress, the Mayor, and the District of Columbia Financial Responsibility and Management Assistance Authority a revised appropriated funds operating budget for all agencies of the District of Columbia government for such fiscal year that is in the total amount of the approved appropriation and that realigns budgeted data for personal services and other-than-personal-services, respectively, with anticipated actual expenditures.

(b) The revised budget required by subsection (a) of this section shall be submitted in the format of the budget that the District of Columbia government submitted pursuant to section 442 of the District of Columbia Home Rule Act, Public Law 93–198, as amended (D.C. Code, sec. 47–301).

SEC. 148. (a) Section 202(i) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995 (Public Law 104–8) is amended to read as follows:

''(i) RESERVE.—

''(1) IN GENERAL.—Beginning with fiscal year 2000, the plan or budget submitted pursuant to this Act shall contain $150,000,000 for a reserve to be established by the Mayor, Council of the District of Columbia, Chief Financial Officer for the District of Columbia, and the District of Columbia Financial Responsibility and Management Assistance Authority.

''(2) CONDITIONS ON USE.—The reserve funds—

''(A) shall only be expended according to criteria established by the Chief Financial Officer and approved by the Mayor, Council of the District of Columbia, and District of Columbia Financial Responsibility and Management Assistance Authority, but, in no case may any of the reserve funds be expended until any other surplus funds have been used;

''(B) shall not be used to fund the agencies of the District of Columbia government under court ordered receivership; and

''(C) shall not be used to fund shortfalls in the projected reductions budgeted in the budget proposed by the District of Columbia government for general supply schedule savings and management reform savings.

''(3) REPORT REQUIREMENT.—The Authority shall notify the Appropriations Committees of both the Senate and House of Representatives in writing 30 days in advance of any expenditure of the reserve funds.''.

(b) Section 202 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995 (Public Law 104–8) is amended by adding at the end the following:

''(j) POSITIVE FUND BALANCE.—

''(1) IN GENERAL.—The District of Columbia shall maintain at the end of a fiscal year an annual positive fund balance in the general fund of not less than 4 percent of the projected general fund expenditures for the following fiscal year.

''(2) EXCESS FUNDS.—Of funds remaining in excess of the amounts required by paragraph (1)—

''(A) not more than 50 percent may be used for authorized non-recurring expenses; and

''(B) not less than 50 percent shall be used to reduce the debt of the District of Columbia.''.

SEC. 149. Notwithstanding any other provision of law, funds provided by section 131 of Division A of Public Law 105–277 (112 Stat. 2681–552) may also be used by the Mayor, in consultation with the Council of the District of Columbia and the National Capital Revitalization Corporation, for the purposes of providing offsets against local taxes for commercial revitalization in empowerment zones and low and moderate income areas.

SEC. 150. WIRELESS COMMUNICATIONS. (a) IN GENERAL.—Notwithstanding any other provision of law, not later than 7 days after the date of enactment of this Act, the Secretary of the Interior, acting through the Director of the National Park Service, shall—

(1) implement the notice of decision approved by the National Capital Regional Director, dated April 7, 1999, including the provisions of the notice of decision concerning the issuance of right-of-way permits at market rates; and

(2) expend such sums as are necessary to carry out paragraph (1).

(b) ANTENNA APPLICATIONS.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, a Federal agency that receives an application to locate a wireless communications antenna on Federal property in the District of Columbia or surrounding area over which the Federal agency exercises control shall take final action on the application, including action on the issuance of right-of-way permits at market rates.

(2) GUIDANCE.—In making a decision concerning wireless service in the District of Columbia or surrounding area, a Federal agency described in paragraph (1) may consider, but shall not be bound by, any decision or recommendation of—

(A) the National Capital Planning Commission; or

(B) any other area commission or authority.

SEC. 151. (a) FINDINGS.—The Senate finds the following:

(1) The District of Columbia has recently witnessed a spate of senseless killings of innocent citizens caught in the crossfire of shootings. A Justice Department crime victimization survey found that while the city saw a decline in the homicide rate between 1996 and 1997, the rate was the highest among a dozen cities and more than double the second highest city.

(2) The District of Columbia has not made adequate funding available to fight drug abuse in recent years, and the city has not deployed its resources as effectively as possible. In fiscal year 1998, $20,900,000 was spent on publicly funded drug treatment in the District compared to $29,000,000 in fiscal year 1993. The District's Addiction and Prevention and Recovery Agency currently has only 2,200 treatment slots, a 50 percent drop from 1994, with more than 1,100 people on waiting lists.

(3) The District of Columbia has seen a rash of inmate escapes from halfway houses. According to Department of Corrections records, between October 21, 1998 and January 19, 1999, 376 of the 1,125 inmates assigned to halfway houses walked away. Nearly 280 of the 376 escapees were awaiting trial including 2 charged with murder.

(4) The District of Columbia public schools system faces serious challenges in correcting chronic problems, particularly long-standing deficiencies in providing special education services to the 1 in 10 District students needing program benefits, including backlogged assessments, and repeated failure to meet a compliance agreement on special education reached with the Department of Education.

(5) Deficiencies in the delivery of basic public services from cleaning streets to waiting time at Department of Motor Vehicles to a rat population estimated earlier this year to exceed the human population have generated considerable public frustration.

(6) Last year, the District of Columbia forfeited millions of dollars in Federal grants after Federal auditors determined that several agencies exceeded grant restrictions and in other instances, failed to spend funds before the grants expired.

(7) Findings of a 1999 report by the Annie E. Casey Foundation that measured the well-being of children reflected that, with 1 exception, the District ranked worst in the United States in every category from infant mortality to the rate of teenage births to statistics chronicling child poverty.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that in considering the District of Columbia's fiscal year 2001 budget, the Senate will take into consideration progress or lack of progress in addressing the following issues:

(1) Crime, including the homicide rate, implementation of community policing, the number of police officers on local beats, and the closing down of open-air drug markets.

(2) Access to drug abuse treatment, including the number of treatment slots, the number of people served, the number of people on waiting lists, and the effectiveness of treatment programs.

(3) Management of parolees and pretrial violent offenders, including the number of halfway house escapes and steps taken to improve monitoring and supervision of halfway house residents to reduce the number of escapes.

(4) Education, including access to special education services and student achievement.

(5) Improvement in basic city services, including rat control and abatement.

(6) Application for and management of Federal grants.

(7) Indicators of child well-being.

SEC. 152. The Mayor, prior to using Federal Medicaid payments to Disproportionate Share Hospitals to serve a small number of childless adults, should consider the recommendations of the Health Care Development Commission that has been appointed by the Council of the District of Columbia to review this program, and consult and report to Congress on the use of these funds.

SEC. 153. GAO STUDY OF DISTRICT OF COLUMBIA CRIMINAL JUSTICE SYSTEM. Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall—

(1) conduct a study of the law enforcement, court, prison, probation, parole, and other components of the criminal justice system of the District of Columbia, in order to identify the components most in need of additional resources, including financial, personnel, and management resources; and

(2) submit to Congress a report on the results of the study under paragraph (1).

SEC. 154. TERMINATION OF PAROLE FOR ILLEGAL DRUG USE. (a) ARREST FOR VIOLATION OF PAROLE.—Section 205 of title 24 of the District of Columbia Code is amended—

(1) in the first sentence, by striking ''If the'' and inserting the following:

''(a) If the''; and

(2) by adding at the end the following:

''(b) Notwithstanding subsection (a), with respect to a prisoner who is convicted of a crime of violence (as defined in §23–1331) and who is released on parole at any time during the term or terms of the prisoner's sentence for that offense, the Board of Parole shall issue a warrant for the retaking of the prisoner in accordance with this section, if the Board, or any member thereof, has reliable information (including positive drug test results) that the prisoner has illegally used a controlled substance (as defined in §33–501) at any time during the term or terms of the prisoner's sentence.''.

(b) HEARING AFTER ARREST; TERMINATION OF PAROLE.—Section 206 of title 24 of the District of Columbia Code is amended by adding at the end the following:

''(c) Notwithstanding any other provision of this section, with respect to a prisoner with respect to whom a warrant is issued under section 205(b), if, after a hearing under this section, the Board of Parole determines that the prisoner has illegally used a controlled substance (as defined in §33–501) at any time during the term or terms of the prisoner's sentence, the Board shall terminate the parole of that prisoner.''.

This Act may be cited as the ''District of Columbia Appropriations Act, 2000''.

ORDERS FOR TUESDAY, JULY 13, 1999

Mr. NICKLES. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in recess until the hour of 9:30 a.m. on Tuesday, July 13. I further ask unanimous consent that on Tuesday, immediately following the prayer, the Journal of proceedings be approved to date, the morning hour be deemed to have expired, the time for the two leaders be reserved for their use later in the day, and the Senate then begin a period of morning business until 10 a.m. with Senators speaking for up to 5 minutes each with the following exceptions:

Senator ASHCROFT, or his designee, 20 minutes;

Senator DASCHLE, or his designee, 10 minutes.

Mr. President, I further ask unanimous consent that the Senate stand in recess from the hours of 12:30 to 2:15 p.m. for the weekly policy conferences to meet. I finally ask unanimous consent that when the Senate reconvenes at 2:15 p.m. Senator SMITH of New Hampshire be recognized for a point of personal privilege for not to exceed 45 minutes.

Mr. REID. Reserving the right to object, Mr. President, I say to my friend, the majority whip, that I hope during the evening or in the morning the majority would agree that we can tomorrow, until this bill is concluded, alternate the offering of amendments. That way we don't have Senators trying to, in effect, jump ahead of someone else. I think it would add to much better movement of this bill. I hope my friend could move that along.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I appreciate Senator REID's suggestion. I think it is a good suggestion. It is certainly my intention to alternate. I think the unanimous consent request agreement that we have calls for alternating first-degree amendments and says that each side shall have a second-degree amendment. It didn't say we would be alternating from first-degree to second-degree amendments. I think the suggestion of my colleague from Nevada is a good one, and I will work with him to see that is the normal order of business. We may at some point have a unanimous consent agreement to do that but not at this time. I appreciate his suggestion, and as always, it is a pleasure for me to work with him to see if we can keep the Senate working together in a collegial and fair manner.

Mr. REID. Mr. President, further reserving the right to object, I also say to my friend that I hope tomorrow the two leaders can work out a time that we can vote. I assume it would be after the conferences—the problem being now, with Senator SMITH being recognized for a point of personal privilege, it would be sometime after that. But I hope the leaders can work that out as quickly as possible.

Mr. NICKLES. Mr. President, again I appreciate the clarification of my colleague from Nevada. I think it would be our intention to vote on the amendments. We now have a substitute offered. We have three amendments that are pending in line. I expect there will be additional amendments offered tomorrow and throughout the course of business.

For the information of all of our colleagues, we expect to have several votes in the next few days. With Senator SMITH's speech tomorrow afternoon, my guess is that we will be voting on the amendments as previously ordered sometime shortly after Senator SMITH's statement.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

PROGRAM

Mr. NICKLES. Mr. President, for the information of all Senators, the Senate will be in a period of morning business tomorrow until 10 a.m. Following morning business, the Senate will resume consideration of the Patients' Bill of Rights. Further amendments to the bill are expected to be offered and debated throughout Tuesday's session of the Senate. For the information of all Senators, votes can be expected on or in relation to the pending amendments throughout Tuesday's session.

Mr. REID. Mr. President, if the Senator will yield, I also alert Members that tomorrow at 10 o'clock when we come in we are going to complete debate on the emergency care amendment that was offered this evening. The majority has about 35 minutes and the minority about 10 minutes, so that Members have some idea of what we are going to be doing at 10 o'clock tomorrow morning. Those wishing to speak on that issue should be ready to do so.

Mr. NICKLES. Mr. President, I appreciate my colleague's thoughts on that. For the information of all Senators, we will be debating the emergency room amendment at 10 o'clock followed by subsequent amendments.

EFFORTS TO SECURE THE RELEASE OF HUMANITARIAN WORKERS IN THE FEDERAL REPUBLIC OF YUGOSLAVIA

Mr. NICKLES. Mr. President, I ask unanimous consent that the Senate now proceed to the immediate consideration of H. Con. Res. 144.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

A resolution (H. Con. Res. 144) urging the United States Government and the United Nations to undertake urgent and strenuous efforts to secure the release of Branko Jelen, Steve Pratt, and Peter Wallace, 3 humanitarian workers employed in the Federal Republic of Yugoslavia by CARE International, who are being unjustly held as prisoners by the Government of the Federal Republic of Yugoslavia.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. NICKLES. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table, and that any statements relating to the resolution be printed in the RECORD.

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

The concurrent resolution (H. Con. Res. 144) was agreed to.

The preamble was agreed to.

RECESS UNTIL 9:30 A.M. TOMORROW

Mr. NICKLES. Mr. President, if there is no further business to come before the Senate, I now ask unanimous consent that the Senate stand in recess under the previous order.

There being no objection, the Senate, at 7:37 p.m., recessed until Tuesday, July 13, 1999, at 9:30 a.m.