hundreds of thousands of Americans. Some retirees and veterans could not promptly receive their social services, such as Medicare benefits. Families could not obtain passports, or visit national parks and museums. Millions of dollars were lost to small business owners and local communities. Federal employees were furloughed with a fear of not getting paid, although they were—at again, a loss to the taxpayer. Even our troops stationed overseas were affected by the shutdown. The interruption caused immeasurable financial damage to the American people and to this country, bottom line.

The most serious damage done by the 27-day shutdown was that it shook the American people's confidence in their government and in their elected officials. Even today, we have not yet undone this damage. We need to restore the public's faith in its leaders by showing that we have learned from our mistakes. Passage of this good-government contingency plan will send a clear message to the American people that we will no longer allow them to be held hostage in budget disputes between Congress and the White House or among ourselves.

We all have different philosophies and policies on budget priorities, and of course we will not always agree. But there are essential functions and services of the federal government we must continue regardless of our differences in budget priorities.

More often, without a good-government contingency plan, the continuing resolution has become impossible as we argue over funding levels and whether pork project ''A'' or pork project ''B'' deserves our support. Debate on program funding is not based on merits but on political leverage. As a result, billions of the taxpayers' hard-earned dollars are wasted in this process.

The virtue of this amendment is that it would allow us to debate issues about our spending policy and the merits of budget priorities while we continue to keep essential government functions operating. The American people will no longer be held hostage to a government shutdown. So, as I said earlier, there are still plenty of uncertainties involved in our budget and appropriations process, particularly this year. If we continue on our current course and the government again shuts down as it did three years ago, it will be another devastating blow to the American people, from senior citizens to disaster victims.

We must ensure that a good-government contingency plan is in place to keep the government up and running in the event that a budget agreement is not reached.

Mr. President, this good-government contingency plan is sound policy, I believe it is wise policy, and it is responsible policy. With a dwindling number of legislative days left in this Congress, I strongly believe that it is vitally important to immediately consider and pass this overdue measure to end the annual shutdown battle we face every year. This should be non-controversial legislation we can all support. I therefore strongly urge the Senate leadership to bring this legislation up for a full debate and vote as earlier agreed.

Is there any time remaining?

The PRESIDING OFFICER. The Senator has 7 minutes and 19 seconds remaining.

Mr. GRAMS. Mr. President, I yield back my remaining time, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

The distinguished Senator from Tennessee is recognized.

PATIENTS' BILL OF RIGHTS

Mr. FRIST. Mr. President, I rise today to speak on the Patients' Bill of Rights, a bill that was introduced last week by my colleague from Oklahoma, Senator DON NICKLES, and members of the Senate Republican Task Force on Health Care Quality, our distinguished majority leader, TRENT LOTT, with a total of 47 cosponsors.

I am really quite pleased with this particular bill. I have had the opportunity to work on the task force because it is a product of months and months of very thoughtful discussion, vigorous debate among ourselves. I think, as most people know, on the task force were some of our most conservative members and some of our most moderate members within our caucus. It really is a consensus proposal to improve health care quality. As a practicing physician, I am absolutely convinced that health care is delivered best when that relationship between the doctor and the patient is given the very highest priority. My goal in this debate, the debate that we will have over the coming weeks, is to do everything possible to empower patients and doctors to be that focal point, to be that place where ultimately the quality of care is decided.

Much of the debate will center around who is practicing medicine today. Is it bureaucrats in Washington? Is it bureaucrats in health maintenance organizations? Is it bureaucrats in the U.S. Congress? Ultimately, I think that we can address this issue, if in coming together in a bipartisan way with a reasonable, timely voice, with a reasonable thought, come back to that central premise that the doctor and the patient or the nurse and the patient, at the level where that really very intimate interaction is carried out, where one's problems are professed and treatment plans and diagnoses are generated, if we keep coming back to that as being the central focus of the Patients' Bill of Rights in everything that we do over the next several weeks, we will be doing a great service to the public, to all Americans.

Now, our proposal that has been put forth is grounded on a Patients' Bill of Rights. It offers a number of protections for individuals, for patients, for potential patients, and that is No. 1, by guaranteeing full access to information as to what is in one's health plan.

If you ask your typical Tennessean or American, you say, what really does your plan cover and what does it not cover, most of us, including me, throw up our hands and say, ''I don't know.'' If you, going back to my own field, develop a cardiomyopathy and a sick heart, it deteriorates over time and you need a heart transplant, does your plan, I could ask any of my colleagues, cover heart transplants? And they will probably say, ''I don't know. I understand it is very expensive. I also understand it could save my life. But I don't know the answer to that question.''

We need to guarantee full access to everybody. Whether it is a health maintenance organization, a managed care plan, any type of plan, we need to guarantee that patient full access to that information. We do that in our bill.

Secondly, we do need to make sure that patients receive the necessary emergency care, and it really does boil down to the fact that if a so-called prudent lay person, meaning somebody with average intelligence, common sense, develops chest pain, they don't know whether it is indigestion or a massive heart attack. They go to the emergency room. They should be able to walk into that emergency room and be taken care of without fear that coverage will be denied for that particular service. We address that right up front. We allow patients to keep their doctor during a pregnancy or extended illness even if their doctor for some reason leaves a plan or is terminated from a plan, so-called continuity of care. We allow individual patients direct access to that pediatrician without having to go through a gatekeeper or to that obstetrician or gynecologist without having to go through a gatekeeper first.

The great fear I think that all of us in America have today, and I think it is the fear that, again, drives much of the debate, is that our health plan will not be there for us if we get sick. If my young 11-year-old son develops a heart murmur, a virus, will there be somebody there to help him? Will that health plan respond to those needs? Or will my HMO deny me seeing the doctor who I feel is the very best person to take care of my son, who I know and people have told me is a better doctor. Will I be denied the opportunity to see that doctor by my health plan?

Many people fear that they will be denied the benefits they have even paid for and that they have been promised. Others are absolutely convinced today that their health plan cares much more about cost, cares much more about profits, cares much more about the

bottom line than about quality. And that is because of the focus on cost and saving money.

We in this body talk about how we have to slow the cost of health care, we have to reduce health expenditures because of all of those pressures. HMOs have been allowed to go too far. They have not been held accountable. Our bill takes that focus and puts it right on quality, on quality. I say that because you can list 10 rights, and you can list 400 mandates, and you can say we have licked the problem. Unless you come back to focusing on quality, you have made yourself feel good. We have responded to the public sentiment of let's bash the HMOs, but you have done nothing for that next generation, nothing for the overall health care system unless you come back to those two principles: The doctor-patient, the primacy of that doctor-patient interaction, No. 1, and, No. 2, focus on quality.

Therefore, you will see in the bills that are before us—and there are basically two bills, one from each side of the aisle, although I hope that both sides will end up to some degree through debate coming to a bipartisan agreement, but the bills are very different, and I think that is where the debate is going to have to play out because every day you are exposed on this floor and through press conferences to ''Let's kill the HMOs, capture that sentiment, put these mandates on the people and we fix the system.''

What we have to do as a body is figure out really how to fix the system with the help of the American people, recognize that our health care system is changing and changing dynamically, and what we define as quality is changing dynamically. And thus whatever we do we cannot establish a system through well-intended mandates which rigidify this system and destroy the dynamism that is inherent in the public marketplace, in the private marketplace, in private industry, in Government-run programs today which recognize that quality is a new science, it is an evolving science, it is dynamic, it is energetic, everyday breakthroughs are made on how we determine quality. So let's be very careful and make sure that we, through well-intended mandates, don't come and box in this dynamism which is so important to the future of health care delivery.

Our bill focuses on quality. Now, any physician today—and I am a physician. I have worked with managed care before coming to the Senate—any physician will tell you that managed care—and we use the word ''HMOs'' and everybody needs to recognize that managed care is a broad spectrum of entities. But a physician will tell you, anybody who has worked with an HMO, HMOs have gone too far. Not all of them. HMOs too often control the whole issue of what service is covered and what is not, regardless of what that physician may feel is in the best interest of the patient. And that same physician will very quickly tell you that what coverage you are allowed to give that patient ultimately defines the care and the outcome of that patient.

Therefore, I don't blame my fellow physicians coming forward and saying, listen, I am being held accountable for decisions that I am not even allowed to make, whether it is coverage or admission to a hospital or the number of days in a hospital. I am not making that decision, yet I am held accountable.

Well, our bill hits this inequity head on. Basically, it says it is not fair. That is inequitable. You, physician, you should not be held accountable. The HMO should be held accountable.

We need to fix the system. The critical measure of this bill that we have put forward is to hold the health plans accountable for the coverage decisions they make and to take the whole essence and the power of denial of care out of the hands of the HMOs and place it in the hands of the way we fix the system—a strong appeals process internally and a strong external appeals process where decisions can be made by medical experts—yes, physicians—medical experts independent of the plan.

Our bill requires that health plans make coverage determinations rapidly, quickly, not weeks later or months later or years later. We put some time specifically, actually in the bill; we say it must be made sometime but definitely not later than 72 hours after the request. We want to protect patients, before harm occurs, by setting up a process that is not present in many—I don't know whether to say most or not—but it is simply not present in many of the HMOs today. But it is a process for patients and their families to get an immediate answer over what is covered and what is not covered and, if there is a disagreement, resolution right then and there, not a year later or 5 years later or 2 years later, after whatever potential for harm may occur.

Furthermore, we require health plans to provide quick internal grievance, as well as these independent, external, appeals processes in areas where there might be some question, like: Is a particular procedure or use of a device investigational or experimental? The whole point is, we need to hold the plans accountable. And we do it by fixing the system.

Our bill provides protections for patients who rely on health plans that States do not. This will be another issue, but our bill basically says that there are a group of people who are unprotected today. Yes, the purpose of our bill, and where we see the Federal responsibility as being, is to protect the unprotected, the people who, by law, are not being protected by an entity. That is the group that we focus on. We fix the system where it is broken, without this whole issue—which has really captured the attention of the press and really taken focus away from the quality issue, which is the really important issue—this issue about lining the pockets of trial lawyers in the process of the bills that are discussed today.

We do demand that all 125 million Americans have this strong internal appeals process, grievance process, as well as external appeals process. We want the questions answered up front, when it really matters, and not years later by a trial lawyer.

Our bill guarantees patients the right to access their own medical information. It gives them the right to make modifications and to amend their medical information if they find something that is incorrect. In addition, we require health plans to inform you of the plan's practices with regard to confidentiality of medical information, with regard to privacy of your medical record. We require health plans to establish safeguards to protect that confidentiality, to protect that privacy, to protect that security of your health information.

As you can tell, I just believe the heart of the problem that we have today with HMOs is that they focus too much on cost, on the bottom line, without anybody coming in and demanding that they look at quality—quality. Our bill, more than any other bill, focuses on this issue of quality.

Some believe that quality can be legislated today. It is a subtle issue, but it is a point that I have a real obligation to make because I have been so intimately involved. That is, the science of quality and understanding what quality is today in health care is a relatively young science. It is a science that is maybe 10 years old. I think you can crystallize that by asking yourself, What is quality today? How did I choose my doctor? Did I choose my doctor because I knew that he was a better doctor than the doctor across town? If you feel your doctor is pretty good, step back and ask yourself, Do I really know he is a good doctor? Or is he just a nice guy? Does he just answer the telephone when I call? What are the standards that we, as a society, have to compare one doctor to another doctor? We are entrusting our lives to them for a heart transplant or heart surgery. How do we judge them? The information is not there. The answer is: We don't have the answer.

Therefore, we as a body have to be very careful before we come in and mandate what quality is, because we don't know what quality is. We are learning about it, but it is an evolving science. It is something we are learning about on an ongoing basis. It is important because one approach mandates quality, the other says let's support and figure out what quality is. That is the Federal responsibility: Let's pull together the private entities, the public entities; let's take advantage of state-of-the-art information systems; let's coordinate this information and determine what quality is and then disseminate that information out so we

can educate people broadly so they can answer that very basic question, ''Do I have a good doctor or do I not have a good doctor?'' Or, ''Is that plan a good plan for me and that one a bad plan for me?''

Mandating data collection: Right now, there are plans being proposed on both sides in the House and Senate that just say let's collect more data, let's have all information from a health plan—demographics and age and gender and outcome and results and patient satisfaction surveys—let's just collect all that data and send it to the Secretary of Health and Human Services. It sounds pretty good, if we knew what it meant, if it didn't mean that a doctor is going to have to sit down and talk to a patient and then go take a piece of paper and fill out a 20-point questionnaire and then give it to a bureaucrat, whom he has had to go out and hire to sit in his office to compile it for a health care plan that has another whole system, to send it to the Secretary of Health and Human Services, who gets this data from millions and millions of doctor-patient interactions. And what are we going to do with it? Let's invest in the science of figuring out what we do with it before we mandate the collection.

Our legislation promotes quality improvement by supporting research, to give patients and physicians better and more useful information to judge quality. Our Patients' Bill of Rights establishes an agency. We call it the Agency for Health Care Quality Research, AHQR. I hate to use those initials, but by the time this debate is finished, I hope everybody in America knows what AHQR is. Its purpose is to foster overall improvement in health care quality through supporting pertinent health sciences research, then disseminating that information through public and private partnerships—pretty simple, pretty straightforward. I believe it is the fundamental problem we have today with managed care, with HMOs, with focusing on dollars, with focusing on the bottom line, because nobody is focusing on quality.

Some of my colleagues will come forward and say, ''You mean as a Republican you want to create a whole new Federal bureaucracy and agency?'' The answer is no. We don't do it very well, I think, in Washington. But when we go in one direction, I think it is important to build on the past, and we have done just that. The agency that we propose is built on the platform of a current agency which I feel is doing a very good job. But we take that agency, called the Agency for Health Care Policy and Research, we refocus the agency on quality, because quality is the issue today. It may have been ''cost'' 5 years ago, but it is ''quality'' today. Then we enhance that agency to become the hub and the driving force of all of the many quality efforts that are going on in Federal programs today.

There are many different agencies all across this country, Federal agencies, that do focus on health care. They all have—not all of them, but many of them have programs and a little subdivision devoted to quality. Our Agency for Health Care Quality Research will help coordinate all of those many very positive efforts. We will focus on not just HMO quality, where so much of the debate and anger is, but we will focus on quality on the managed care setting, the urban setting, the rural setting, the setting of the solo private practitioner. This agency will have, as its mission, improving quality, and the disseminating of that information to everybody in health care today.

Thus, if we agree that this fundamental issue on our debate is that HMOs have, to some extent—I don't want to sort of categorize them because I don't think that is fair—but if the debate is that HMOs have ignored quality because of an almost obsession with cost, then let's hit the problem; let's go after how we, as a nation, can improve quality and what is our Federal responsibility. If we are talking about a Patients' Bill of Rights, the ones that we have in our bill are very, very important. But I think the most basic right for a patient is that right to quality health care. That is what our bill, like no other bill, addresses.

This particular agency has a role that is not to mandate. It is not to mandate a national definition of ''quality,'' but, rather, it is to support the science that is necessary to provide information to patients so they will know whether or not they are receiving good quality of care, to provide information to physicians so they can compare what they are doing to the next physician and modify their behavior, so they will know what good quality is and modify their behavior so they can deliver better care to all of their patients, information to enable employers and individuals to become wise purchasers or wise shoppers of health care based not on cost, or not on cost alone, but on cost and quality.

The agency will stimulate public-private partnerships to advance and share what we learn about quality. Quality just means different things to different people. It is constantly being refined. As I said, it is just a few years old as a science; therefore, in collaboration with the private sector, the agency will conduct and will coordinate health science research that really will accelerate our understanding of what quality means to clinicians and to patients, how to measure that quality and how to use this information to improve your own health and your own quality of life.

This agency will have as a major purpose and objective the sharing of this information. We have medical advances that are made daily. We see them in the newspaper; we see them on the news each night when we go home. In truth, many of these discoveries do not make it out into the general practice of medicine for too long. We need to do a better job in narrowing the gap between what we know and what we do, and this agency will accomplish that.

We need to get the science that we know is good science quicker to the American people by sharing this information among public entities and private entities, and this effective dissemination will be a major purpose of the agency.

In addition, the agency will develop evidence rating systems to know what a good doctor is, what a good plan is, whether or not the treatment that has been recommended for your diabetes is an effective treatment.

This agency will play a vital role in facilitating innovative inpatient care in this whole area of new technologies and assessment of new technologies. As chairman of the Science, Technology, and Space Subcommittee of the Commerce Committee and the Public Health and Safety Subcommittee of the Labor Committee, we held hearings and people came before us again and again about new technologies and the confusing methodologies that our Federal Government has set up, that each agency has set up, hoops through which they need to travel before that new technology is disseminated or shared with the American people.

The agency that we are setting up will establish a consistent methodology with coordination across Federal agencies so that people will know what guidelines they must follow in a consistent way to have technologies evaluated and then appropriately disseminated.

In its mission to promote and facilitate quality and quality development, this particular agency will have a focus on improved information-based computer systems which are so necessary for quality scoring and which will facilitate informed decisionmaking by providers, by physicians, by nurses, and by patients. The agency will aggressively support the development of these state-of-the-art information systems for health care quality which then can be shared both by the public and the private sector. The setting is important. Again, as I mentioned previously, so much of the discussion today, as we talk about bills of rights, is focused just on health maintenance organizations.

I think it is important for our colleagues to realize that our bill goes beyond just health maintenance organizations and looks at quality in all different settings. Quality improvement applies to the care that is given in that solo private practitioner's office in the managed care setting or at the health maintenance organization. This agency will understand that part of its mission will be to specifically address quality in rural areas in underserved areas, using such technologies as telemedicine and other long-distance-type technologies.

Our bill addresses the fact that patients do want to know if they are receiving good care, but compared to what? Statistically accurate, sample-

based national surveys will efficiently provide reliable and affordable data without the other approach, which is excessively mandated, overly intrusive, potentially destructive mandatory reporting requirements, which as I have described previously, in the long run take away time from that doctor-patient interaction.

You simply do not need to have a doctor, after every patient interaction, fill out a questionnaire at every visit and then send that information to Washington. It can be a waste of physician time, taking time away from the patient, and will ultimately drive up what patients have to pay for the care they receive. Our approach is very different.

As I mentioned, they are sample-based national surveys. We expand the current Medical Expenditure Panel Survey to require that outcomes be measured and reported to Congress so that as a nation—as a nation—we can better determine the state of quality and the cost of quality in our Nation's health care.

The role of the Agency for Health Care Policy and Research is not to mandate national standards of clinical practice. Definitions and measures of quality, as I said, are an evolving science, a science that is critically important to our ability to make educated, informed decisions.

Another aspect of our bill that is important for our colleagues to understand is a part of the bill—because it is a very important part of the bill—is the strong focus on women's health issues. As a nation, it is time that we focus on diseases and health issues that are faced by women. In our bill we specifically emphasize women's health research and prevention activities at the National Institutes of Health and at the Centers for Disease Control and Prevention. The goal is to support the critical role that our public health agencies—the NIH and the CDC—play in providing a broad spectrum of activities to improve women's health. That includes research, screening, prevention, treatment, and education.

Among others, these provisions in women's health promote basic and clinical research for the aging process in women, for osteoporosis, for breast cancer, Paget's disease, for ovarian cancer. We expand our research efforts in the important area of cardiovascular disease. Many people—in fact, I am sure many of our colleagues—do not realize that the No. 1 killer, cause of death for U.S. women is cardiovascular disease. We need to expand our research efforts there. We do that in our bill.

Our bill reauthorizes the National Breast and Cervical Cancer Screening Program which provides crucial screening services for breast and cervical cancers to underserved women. Our bill supports data collection through the National Center for Health Statistics and National Program of Cancer Registries, which are the leading sources of national data on the health status of women. Support of these valuable programs will help ensure scientific progress in our fight against these diseases and will lessen the burden of these diseases on millions of women and their families.

Another component of our bill which is not in any bill currently before the U.S. Senate except for ours—which is not a part of the Patients' Bill of Rights in the House of Representatives—it is a part of the bill, again, which I feel demonstrates that this piece of legislation is forward thinking; it fulfills our responsibility, I believe, of looking ahead and seeing what obvious challenges there are, challenges that could potentially disrupt the delivery of health care in this country—that is our responsibility—and to respond, and to respond now, before they become potentially debilitating, have a debilitating effect on health care in this country.

This provision is one—and it is a right—it is one of the Bill of Rights, and it is a right that every woman and every man and every child should be free from the fear that an insurance plan or an HMO will discriminate against them because of a positive genetic test.

The human genome project, a 15-year, very successful project, initiated by our Federal Government, being carried out in a wonderfully unique public-private partnership, by the year 2005, we will have defined over 3 billion bits of genetic information called DNA which comprise the human genome which explains in large part our genetic makeup—3 billion bits of information defined over this very successful program.

We have learned tremendous scientific progress, but it has introduced the fact that once we link these genes to diseases and conditions—and we see it happening almost every day; there was an article in the Washington Post just yesterday about linking several genes with Alzheimer's disease and the onset or when Alzheimer's disease comes being linked to these genes.

Again, tremendous science, yet it strikes right at the heart of this fear that the information in some way will not be used to help you but will be used to hurt you, that access to that information and the result of whether or not you have that gene will be used by an HMO or an insurance company to deny you coverage, to increase your premium, to use against you that fear in not getting a test, a potentially beneficial test. If you had a test which, with 80 percent predictability, said you were going to have breast cancer, wouldn't you want to know the result of that test? I would, because it means I might get a mammogram once a year instead of once every 2 years, or I might do a breast exam once a week instead of once a month, because we know the earlier diagnosis of best cancer, earlier detection, means earlier treatment, and earlier treatment means cure instead of delay, which means, many times, it cannot be cured.

The promise of that test will be defeated unless we act, and we act today, to eliminate the fear of genetic discrimination based on genetic tests which are coming online at a rapid pace. Our ability to predict what diseases individuals may be at risk for in the future has caused grave concern that this powerful information—information that affects every one of us in the room; we all have this genetic information; we all carry it in our genes—the fear that that information might be used against you.

I am really troubled when the Tennessee Breast Cancer Coalition tells me that genetic counselors right now are facing women every day who are afraid to even have these genetic tests performed. Women are avoiding genetic testing due to concerns that they will lose their insurance coverage even though that genetic test might be saving them. We must prohibit discrimination in health insurance against healthy individuals and their families based on genetic information.

Think about it—3 billion of these little bits of information on a single human genome; we all carry genetic mutations that may place us at risk in the future for some disease, even if we are healthy today. Therefore, each of us is at potential risk for discrimination.

If I receive a genetic test that shows I am at risk for cancer, diabetes, or heart disease, should this predictive information be used against me or my family? The answer is no. That is a right. We address that right in our bill. I think it an important point because it shows our bill is forward looking, looking to the future, not a set of rigid mandates based on what we think we know about quality today, but we look to the future.

I want to commend the Senator from Maine, Senator SNOWE, whose original bill provided the framework and really the sound principles upon which this legislation is based. She has supported our task force effort and worked with us in a step-by-step way to craft this legislation. I also would like to mention Senator JEFFORDS, who had the foresight to include these provisions, since we are talking about basic rights.

Our bill very specifically prohibits health insurers from requiring collection of the results of these predictive genetic tests. It prohibits them from using that information, if they do have it, to deny coverage. And it prohibits insurers from using that information, if they do have it, to adjust rates or to increase rates.

Preventing genetic discrimination does have enormous implications that I will continue to come back to, and that is improving quality. It improves the quality of care to an individual patient. But also, if one is afraid to have the results of a genetic test released to somebody outside or participate in a large protocol, investigational protocol, that means that research overall

into what these tests mean and how they might be beneficial will be slowed down, thus affecting the quality of health care for all Americans.

Lastly, our bill enhances access and choice of health insurance coverage in a number of ways which we will debate on the floor, areas that increase access to and affordability of health care of several areas, that include provisions which I am very excited about, and that is to allow the self-employed individuals, for the first time, to fully conduct their health care expenses. It only makes sense. We have really been punishing self-employed individuals, not giving them the same tax treatment that somebody has if they are working for a large company. It doesn't make sense. What we want to do is level that playing field and allow these self-employed individuals to fully deduct their health care expenses, just like people who work for large companies. It addresses access, because it means that these self-employed individuals are more likely to go out and enter the insurance market.

Our bill provides greater flexibility to employees who use the so-called flexible spending accounts to pay for health care. Our bill gives individuals the opportunity to have control over the health care decisions and costs through medical savings accounts. Medical savings accounts allow a patient to access the physician of their choice and to choose the medical treatment that they want if they choose that option.

As you can tell, our bill contains a lot. The reason that I wanted this afternoon to outline our bill is to make sure that our colleagues spend the next several days looking very carefully at the differences between the two bills that are before us, because the approach is very, very different. Both bills are well intended. I will say that I am very hopeful that we can pass a bill, a strong Bill of Rights. But that Bill of Rights needs to include a right to quality health care for all Americans. Our approach is very, very different. The intentions, I believe, of both bills are the same.

I am hopeful that we can engage in this debate without too much in the way of rhetoric. There is a lot of rhetoric that has been thrown on the floor here and in press conferences, but I hope we can come back and say this is an important issue. It is not one, really, to play politics with. It is not one to defer to another Congress or to filibuster or to make a part of the next elections. It is the sort of issues that we, as trustees to the American people, have an obligation to address and to address in this Congress.

Our Patients' Bill of Rights offers all Americans quality improvement based on the foundation of strong science. Our Patients' Bill of Rights offers all Americans patient protection, to access the care they need from the doctor they choose. Our Patient Bill of Rights offers all Americans trust in that doctor-patient relationship, that central point through which I believe quality needs to be defined and health care delivered. We reinstate that trust. Our Patient's Bill of Rights offers all Americans access to more affordable health insurance coverage. Our bill does represent a forward-looking approach to provide for continuous improvement in health care quality, and it meets our goal of assuring that the doctor and the patient define quality—not HMOs, not bureaucrats, not trial attorneys, and not the U.S. Congress.

Mr. GORTON addressed the Chair.

The PRESIDING OFFICER. The Senator from Washington is recognized.

VETO OF COVERDELL LEGISLATION AND RELEASE OF HOUSE EDUCATION AND THE WORKFORCE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS REPORT

Mr. GORTON. Mr. President, our self-proclaimed ''Education President'' has just seen fit to veto the most significant bipartisan education legislation passed by the 105th Congress—the Education Savings and School Excellence Act. As many Americans know, this legsilation's main feature is to allow families to establish education savings accounts in which parents can invest $2,000 a year and allow that money to grow tax free. Parents can use the money to pay for school expenses including tutoring, computers, school fees and private school tuition.

Why has the President seen fit to veto this legislation? Well, he has received a great deal of pressure from those who believe that we should not increase the control parents have over the education of their children.

In addition to providing tax-free education savings accounts for families, this legislation includes provisions that would: authorize a literacy program to improve the reading skills of America's youth; allow Federal funding for education reform projects that provide same gender schools and classrooms; allow States to make awards to public schools that demonstrate a high level of academic achievement; and allow states to test teachers and provide merit pay programs.

With the recent news that 60 percent of prospective teachers in Massachuesetts taking a basic certification test were unable to pass, it is unfortunate that the President's veto will not allow States like Massachusetts to help current and prospective teachers reach their full potential, as well as reward those who perform in a superior manner. I signed a letter to the President along with 42 other senators asking that he sign the education savings account legislation and pointing out this very feature. Unfortunately, our plea fell on deaf ears.

Mr. President, I have worked diligently to fashion, over the past year a return to our parents, teachers, principals, superintendents and school board members control over the education of their children. The Federal Government has too much influence and misuses too many resources that would be better spent in classrooms across America.

As a member of the Senate Budget Committee Education Task Force, I found that no one in the Federal Government even knows exactly how many education programs are overseen by the Federal Government. Although the Department of Education annually publishes a ''Digest of Education Statistics,'' the most recent version of which is over 500 pages in length, there is no mention of how many education programs are administered by Federal agencies.

I have, however, heard testimony from the General Accounting Office about the duplication of Federal education programs. In January of this year Dr. Carlotta Joyner of the GAO appeared before the Senate Budget Committee Education Task Force and presented us with a graphic that highlights the web of Federal education programs in only three areas of education: at-risk and delinquent youth, early childhood programs, and teacher training programs. Dr. Joyner explained to us that 15 Federal departments and agencies administer 127 at-risk and delinquent youth programs, 11 Federal departments and agencies administer more than 90 early childhood programs, and 9 Federal departments and agencies administer 86 teacher training programs.

It is no wonder that more and more, States and local school districts are suffocated by a tidal wave of papers, forms and programs, each of which no doubt began with good intentions. The net result of this tidal wave, however, is precisely what makes it difficult to set priorities in each of the states and school districts across the country to determine that which will best serve their students.

As I have stated previously, the only reason I can discern that the President would veto this legislation is that he believes that schools will be improved through more control from Washington, D.C. Unlike the President, however, I believe our best hope for improving the education of our children is to put the American people in charge of their local schools.

I also believe it is appropriate at this time to give my colleagues in the Senate some good news on the education front. Last Friday, the House Education and Workforce Subcommittee on Oversight and Investigations adopted a report entitled ''Education at a Crossroads: What Works and What's Wasted in Education Today'' by a vote of 5–2. This report is a result of two-and-a-half years of work by that subcommittee and the dedication of it's chairman, Congressman HOEKSTRA. The report is more than 70 pages long and I will not touch on all the issues it discusses, but I do want to point out some of the conclusions the subcommittee reached.