S. 1062. A bill to amend the Fair Labor Standards Act of 1938 to provide for an increase in the Federal minimum wage; read the first time.

By Mr. NELSON of Florida (for himself, Mr. BURNS, and Mrs. CLINTON):

S. 1063. A bill to promote and enhance public safety and to encourage the rapid deployment of IP-enabled voice services; to the Committee on Commerce, Science, and Transportation.

By Mr. COCHRAN (for himself, Mr. KENNEDY, Mr. WARNER, Ms. CANTWELL, Ms. COLLINS, and Mr. DAYTON):

S. 1064. A bill to amend the Public Health Service Act to improve stroke prevention, diagnosis, treatment, and rehabilitation; to the Committee on Health, Education, Labor, and Pensions.

By Mr. THUNE (for himself and Mrs. CLINTON):

S. 1065. A bill to amend title 10, United States Code, to extend child care eligibility for children of members of the Armed Forces who die in the line of duty; to the Committee on Armed Services.

By Mr. VOINOVICH (for himself, Ms. STABENOW, Mr. BUNNING, Mr. LEVIN, Mr. ALEXANDER, Mr. DEWINE, Mr. MCCONNELL, and Mr. FRIST):

S. 1066. A bill to authorize the States (and subdivisions thereof), the District of Columbia, territories, and possessions of the United States to provide certain tax incentives to any person for economic development purposes; to the Committee on Finance.

By Mrs. LINCOLN (for herself, Mr. BROWNBACK, Mr. JEFFORDS, and Mr. DORGAN):

S. 1067. A bill to require the Secretary of Health and Human Services to undertake activities to ensure the provision of services under the PACE program to frail elders living in rural areas, and for other purposes; to the Committee on Finance.

By Mrs. DOLE (for herself and Mr. BAUCUS):

S. 1068. A bill to provide for higher education affordability, access, and opportunity; to the Committee on Health, Education, Labor, and Pensions.

By Mrs. FEINSTEIN:

S. 1069. A bill to suspend temporarily the duty on certain cases or containers for toys; to the Committee on Finance.

By Mrs. FEINSTEIN:

S. 1070. A bill to suspend temporarily the duty on certain cases for toys; to the Committee on Finance.

By Mrs. FEINSTEIN:

S. 1071. A bill to extend the temporary suspension of duty on certain bags for toys; to the Committee on Finance.

By Mrs. FEINSTEIN:

S. 1072. A bill to extend the temporary suspension of duty on cases for certain children's products; to the Committee on Finance.

By Mrs. FEINSTEIN:

S. 1073. A bill to extend the temporary suspension of duty on certain children's products; to the Committee on Finance.

By Mr. HARKIN:

S. 1074. A bill to improve the health of Americans and reduce health care costs by reorienting the Nation's health care system toward prevention, wellness, and self care; to the Committee on Finance.

By Mr. THUNE (for himself, Ms. SNOWE, Mr. BINGAMAN, Ms. COLLINS, Mr. DOMENICI, Mr. GREGG, Mr. JOHNSON, Mr. LOTT, Ms. MURKOWSKI, Mr. STEVENS, and Mr. SUNUNU):

S. 1075. A bill to postpone the 2005 round of defense base closure and realignment; to the Committee on Armed Services.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. DEWINE (for himself and Mrs. FEINSTEIN):

S. Res. 145. A resolution designating June 2005 as ''National Safety Month''; to the Committee on the Judiciary.

By Ms. CANTWELL (for herself, Mrs. MURRAY, Mr. STEVENS, and Mr. PRYOR):

S. Res. 146. A resolution recognizing the 25th anniversary of the eruption of Mount St. Helens; considered and agreed to.

By Ms. MURKOWSKI (for herself, Mr. CRAPO, Mr. DEWINE, Mr. CRAIG, Ms. LANDRIEU, Mrs. LINCOLN, Mr. VITTER, Mr. ALLEN, and Mrs. FEINSTEIN):

S. Res. 147. A resolution designating June 2005 as ''National Internet Safety Month''; considered and agreed to.

By Mr. LOTT (for himself and Mr. DODD):

S. Res. 148. A resolution to authorize the display of the Senate Leadership Portrait Collection in the Senate Lobby; considered and agreed to.

ADDITIONAL COSPONSORS

S. 471

At the request of Mr. SPECTER, the names of the Senator from Minnesota (Mr. DAYTON), the Senator from North Dakota (Mr. DORGAN), the Senator from Wisconsin (Mr. FEINGOLD) and the Senator from Hawaii (Mr. AKAKA) were added as cosponsors of S. 471, a bill to amend the Public Health Service Act to provide for human embryonic stem cell research.

S. 484

At the request of Mr. WARNER, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 484, a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

S. 499

At the request of Mr. DODD, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 499, a bill to amend the Consumer Credit Protection Act to ban abusive credit practices, enhance consumer disclosures, protect underage consumers, and for other purposes.

S. 537

At the request of Mr. BINGAMAN, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 537, a bill to increase the number of well-trained mental health service professionals (including those based in schools) providing clinical mental health care to children and adolescents, and for other purposes.

S. 603

At the request of Ms. LANDRIEU, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 603, a bill to amend the Consumer Credit Protection Act to assure meaningful disclosures of the terms of rental-purchase agreements, including disclosures of all costs to consumers under such agreements, to provide certain substantive rights to consumers under such agreements, and for other purposes.

S. 635

At the request of Mr. SANTORUM, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 635, a bill to amend title XVIII of the Social Security Act to improve the benefits under the medicare program for beneficiaries with kidney disease, and for other purposes.

S. 662

At the request of Ms. COLLINS, the name of the Senator from New Mexico (Mr. BINGAMAN) was added as a cosponsor of S. 662, a bill to reform the postal laws of the United States.

S. 792

At the request of Mr. DORGAN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 792, a bill to establish a National sex offender registration database, and for other purposes.

S. 881

At the request of Ms. CANTWELL, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 881, a bill to provide for equitable compensation to the Spokane Tribe of Indians of the Spokane Reservation for the use of tribal land for the production of hydropower by the Grand Coulee Dam, and for other purposes.

S.J. RES. 18

At the request of Mr. MCCONNELL, the name of the Senator from Florida (Mr. MARTINEZ) was added as a cosponsor of S.J. Res. 18, a joint resolution approving the renewal of import restrictions contained in the Burmese Freedom and Democracy Act of 2003.

At the request of Mrs. FEINSTEIN, the names of the Senator from New Jersey (Mr. CORZINE), the Senator from Maryland (Ms. MIKULSKI), the Senator from Wisconsin (Mr. KOHL) and the Senator from Wisconsin (Mr. FEINGOLD) were added as cosponsors of S.J. Res. 18, supra.

S. RES. 104

At the request of Mr. FEINGOLD, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. Res. 104, a resolution expressing the sense of the Senate encouraging the active engagement of Americans in world affairs and urging the Secretary of State to take the lead and coordinate with other governmental agencies and non-governmental organizations in creating an online database of international exchange programs and related opportunities.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. COLEMAN (for himself, Mr. SMITH, Ms. SNOWE, Mr. DAYTON, and Mr. HARKIN):

S. 1060. A bill to amend the Internal Revenue Code of 1986 to allow a credit against income tax for the purchase of hearing aids; to the Committee on Finance.

Mr. COLEMAN. Mr. President, today I am introducing legislation to help millions of Americans enjoy the gift of sound. I am pleased to be joined by Senators GORDON SMITH, OLYMPIA J. SNOWE, MARK DAYTON, and TOM HARKIN, who I know care as deeply about these issues as I do.

Hearing loss is one of the most common and widespread health problems affecting Americans today. In fact, thirty-three babies are born each day with hearing loss, making deafuess the most common birth defect in America. According to the National Council on Aging, as many as 70 percent of our elderly experience hearing loss. All told, 31.5 million Americans currently suffer from some form of hearing loss.

The good news is that 95 percent of individuals with hearing loss can be successfully treated with hearing aids. Unfortunately, however, only 22 percent of Americans suffering from hearing loss can afford to use this technology. In other words, over 24 million Americans will live without sound because they cannot afford treatment.

That is why we are introducing the Hearing Aid Assistance Tax Credit Act.

This legislation provides help to those who need it most, our children and seniors, by providing a tax credit of up to $500, once every 5 years, toward the purchase of any ''qualified hearing aid'' as defined by the Federal Food, Drug, and Cosmetic Act.

Hearing aids are not just portals to sound, but portals to success in school, business, and life. That is why a number of diverse organizations, including the Hearing Industries Association, Self Help for Hard of Hearing People, the International Hearing Society, the Deaf and Hard of Hearing Alliance, American Speech-Language-Hearing Association, and the American Academy of Audiology support the Hearing Aid Assistance Tax Credit Act.

I ask unanimous consent that their letters of support be printed in the RECORD.

Hearing loss may be one of the most common health problems in the United States, but it doesn't have to be. We can tackle the problem head on with the Hearing Aid Assistance Tax Credit Act.

I look forward to working with my colleagues this Congress to approve this commonsense solution to a serious problem.

There being no objection, the materials were ordered to be printed in the RECORD, as follows:

DEAF AND HARD OF HEARING ALLIANCE: A COALITION OF CONSUMER AND PROFESSIONAL ORGANIZATIONS,

May 18, 2005.

Hon. NORM COLEMAN,
U.S. Senate,
Washington, DC.

DEAR SENATOR COLEMAN: We, the undersigned, representing both consumer and health professional organizations of the Deaf and Hard of Hearing Alliance (DHHA), write to express our strong support for the ''Hearing Aid Assistance Tax Credit Act'' you are introducing in the Senate today. While we support and encourage more comprehensive solutions, we believe your legislation can aid some who presently have no options but to pay out of pocket for these essential devices.

Enactment of your legislation will provide a tax credit of up to $500 per hearing aid, available once every five years, towards the purchase of a hearing aid(s) for individuals age 55 and over, or those purchasing a hearing aid for a dependent.

As you have pointed out with the introduction of this bill, special tax treatment would improve access to hearing aids since only 22 percent of Americans who could benefit from hearing aids currently use them. Approximately 1 million children under the age of 18 and nearly 10 million Americans over the age of 54 have a diagnosed hearing loss but are not currently using a hearing aid.

The expense of the hearing aid is an important factor why Americans with hearing loss go without these devices. Some 40 percent of individuals with hearing loss have incomes of less than $30,000 per year. Nearly 30 percent of those with hearing loss cite financial constraints as a core reason they do not use hearing aids. In 2002, the average cost for a hearing aid was over $1,400, and almost two-thirds of individuals with hearing loss require two devices, thereby increasing the average out of pocket expense to over $2,800. The new tax credit you propose will assist many who might otherwise do without and have limited options.

Hearing aids are presently not covered under Medicare, or under the vast majority of state mandated benefits. In fact, 71.4% of hearing aid purchases do not involve third party payments, placing the entire burden of the hearing aid purchase on the consumer.

The need is real. Hearing loss affects 2–3 infants per 1,000 births. For adults, hearing loss usually occurs more gradually, but increases dramatically with age. Ten million older Americans experience age-related hearing loss. For workers, noise induced hearing loss is the second most self-reported occupational injury. Ten million young adults and working aged Americans have noise-induced hearing loss.

Enactment of your bill will make a difference in the lives of some people with hearing loss. Currently 1.28 million Americans of all ages purchase hearing aids each year, with many individuals requiring two devices, bringing the total number of hearing aids purchased across all age groups to approximately 2 million. This number has remained constant over recent years. While the legislation is not intended to cover the full cost of hearing aids, it will provide some measure of financial assistance to the groups who are in need of these devices but are unable to afford them.

Thank you for your leadership on this important issue. We look forward to working with you to seek enactment of your legislation during the 109th Congress.

Sincerely,

Alexander Graham Bell Association for the Deaf & Hard of Hearing (AGBell), American Academy of Audiology (AAA), American Speech-Language-Hearing Association (ASHA), Conference of Educational Administrators of Schools and Programs for the Deaf (CEASD), Cued Language Network of America (CLNA), Media Access Group at WGBH.

National Association of the Deaf (NAD), National Court Reporters Association (NCRA), National Cued Speech Association (NCSA), Self Help for Hard of Hearing People (SHHH), Telecommunications for the Deaf, Inc. (TDI), TECHUnit.

MAY 17, 2005.

Hon. NORM COLEMAN,
U.S. Senate,
Washington, DC.

DEAR SENATOR COLEMAN: The American Speech-Language-Hearing Association (ASHA) commends you for your continued leadership on behalf of the estimated 28 million American children and adults with hearing loss by introducing legislation to provide assistance to those purchasing hearing aids. The Hearing Aid Assistance Tax Credit Act will provide financial assistance to those who need hearing aids, but are unable to afford them. This bill will provide much needed assistance to those adults over 55 years of age and families with children who experience hearing loss.

Studies indicate that when children with hearing loss receive early intervention and treatment with devices such as hearing aids, their speech and language development improves dramatically, making the need for special education services less likely and costly. Research has also shown that the quality of life greatly improves for elderly individuals who use hearing aids.

On behalf of the 118,000 audiologists, speech-language pathologists, and hearing, speech, and language scientists qualified to meet the needs of the estimated 49 million (or 1 in 6) children and adults in the United States with communication disorders, we thank you for introducing this important piece of legislation and look forward to working with you and your staff.

Sincerely,

DOLORES E. BATTLE,
President, American Speech-Language-Hearing Association.

INTERNATIONAL HEARING SOCIETY,
Livonia, MI, May 16, 2005.

Hon. NORM COLEMAN,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR COLEMAN: On behalf of the International Hearing Society (IHS), I write to enthusiastically endorse the Hearing Aid Assistance Tax Credit Act. IHS represents the vast majority of traditional hearing aid dispensers (hearing aid specialists) in the United States. Hearing aid specialists are licensed in 49 states (and registered in Colorado) specifically to provide hearing health services. Our members test hearing; select, fit and dispense hearing aids; and provide hearing rehabilitation and counseling services. Hearing aid specialists dispense approximately one-half of all hearing aids in this country.

IHS is deeply appreciative of your interest in improving access to hearing health care. Only approximately 20% of those who could benefit from amplification actually utilize hearing aids. Allowing a credit against tax for the purchase of hearing aids would likely promote access to this effective but dramatically underutilized device.

We look forward to working together to promote the nation's hearing health, a vital component of overall health and well-being. Please contact me or our Washington Counsel Karen S. Sealander of McDermott Will & Emery with questions or for further information.

Sincerely,

HARLAN S. CATO,
President.

MAY 18, 2005.

Hon. NORM COLEMAN,
U.S. Senate,
Washington, DC.,

DEAR SENATOR COLEMAN: On behalf of the Hearing Industries Association (HTA) and the individuals with hearing loss served by our members, I want to thank you for introducing the Hearing Aid Assistance Tax Credit Act, and offer HIA's strong endorsement and support for this worthwhile legislation.

The Hearing Industries Association (HIA) is dedicated to providing information about, promoting the use of, and enhancing access to amplification devices in the United States. These devices include externally worn hearing aids, implantable hearing aids (cochlear, middle ear and brain stem) and an array of assistive listening devices (both personal and public area communication systems used in auditoriums, theaters, classrooms and public buildings). Our members work with the medical community and hearing aid professionals to treat hearing loss in children and adults, and we have seen firsthand the dramatic benefit that hearing aids can provide in terms of greater safety, increased ability to communicate, and an overall significantly enhanced quality of life.

For the 31.5 million Americans who have some degree of hearing loss, the vast majority (95%) can be treated with hearing aids. Yet only 20% of those with hearing loss use hearing aids, while a full 30% cite financial constraints as the reason they do not use hearing aids. This modest bill would help countless older adults and children who need hearing aids, but simply cannot afford them. The benefits, in terms of reduced special education costs for children, as well as reduced injuries and psychological and mental disorders associated with hearing loss in older adults, are immense.

Again, on behalf of HIA and the individuals with hearing loss whom we serve, we applaud your leadership in introducing the Hearing Aid Assistance Tax Credit Act, and look forward to working with you to pass the bill in the 109th Congress.

Sincerely,

CAROLE ROGIN,
Hearing Industries Association.

DEAR SENATOR COLEMAN: On behalf of Self Help for Hard of Hearing People, the Nation's largest consumer group for people with hearing loss, we would like to express our support of the Hearing Aid Assistance Tax Credit Act.

More than 28 million Americans at all stages of life have some form of hearing loss. If left untreated, hearing loss can severely reduce the quality of one's personal and professional life. A landmark study conducted by the National Council on Aging (NCOA) concluded that hearing loss was associated with, among other things: depression, impaired memory, social isolation and reduced general health. For infants and children left untreated, the cost to schools for special education and other programs can exceed $420,000, with additional lifetime costs of $1 million in lost wages and other health complications, according to a respected 1995 study published in the International Journal of Pediatric Otorhinolaryngology.

While fully 95 percent of individuals with hearing loss could be successfully treated with hearing aids, only 22 percent currently use them, according to the largest national consumer survey on hearing loss in America. Almost ⅓ of the individuals surveyed cite financial constraints as a core reason they do not use hearing aids, which is not surprising since hearing aids are not covered under Medicare, or under the vast majority of state mandated benefits. In fact, over 71 percent of all hearing aid purchases involve no third party payments, thereby placing the entire burden of the purchase on the consumer.

The Hearing Aid Assistance Tax Credit Act offers a practical, low cost, and common sense solution to help older individuals who may not otherwise be able to afford to purchase a hearing aid, or those purchasing a hearing aid for their child. The bill is not intended to cover the full cost of hearing aids, but would simply provide some measure of financial assistance to the populations who are most in need of these devices but may not be able to afford them: those approaching or in retirement, and families with children.

This bipartisan initiative is endorsed by virtually the entire spectrum of organizations and consumer groups within the hearing health community. We view this legislation as an effective and responsible means to encourage individuals to treat their hearing loss in order to maintain or improve quality of life.

We are pleased to offer you our support.

Respectfully,

TERRY PORTIS,
Executive Director,
Self Help for Hard of Hearing People.

AMERICAN ACADEMY OF AUDIOLOGY,
Reston, VA, May 17, 2005.

Hon. NORM COLEMAN,
U.S. Senate, Hart Senate Office Building,
Washington, DC.

DEAR SENATOR COLEMAN: The American Academy of Audiology, the largest organization of audiologists representing over 9,700 audiologists, commends you on your leadership on hearing health care issues and championing policies that benefit individuals with hearing loss.

The Academy supports the Hearing Aid Assistance Tax Credit Act which would provide a tax credit of up to $500 per hearing aid, available once every five years, towards the purchase of a hearing aid(s) for individuals age 55 and over, or those purchasing a hearing aid for a dependent. As you have pointed out with the introduction of this bill, special tax treatment would improve access to hearing aids since only 22 percent of Americans who could benefit from hearing aids currently use them. Approximately, 1 million children under the age of 18 and nearly 10 million Americans over the age of 54 have a diagnosed hearing loss but are not currently using a hearing aid.

Hearing aids are presently not covered under Medicare, or under the vast majority of state mandated benefits. In fact, 71.4 percent of hearing aid purchases do not involve third party payments, placing the entire burden of the hearing aid purchase on the patient/consumer. This legislation is a beginning step to helping some individuals with this expense and raises the awareness of the impact that hearing loss has on today's society.

In addition, the Academy endorses the Hearing Health Accessibility Act (S. 277) to provide Medicare beneficiaries with the option of going to an audiologist or a physician for hearing and balance diagnostic tests. Direct access would improve Medicare beneficiaries' access to hearing care without diminishing the important role of medical doctors, or expanding the scope of practice for audiology. The Academy urges you to support this legislation as well.

The Academy appreciates the opportunity to work with you to promote these important initiatives in the 109th Congress. Again, we thank you for your leadership in introducing the Hearing Aid Assistance Tax Credit Act and for your dedication to the needs of individuals with hearing loss and the health care professionals providing the services they need to fully function in society.

Sincerely,

RICHARD E. GANS,
President.

S. 1060

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 ''Hearing Aid Assistance Tax Credit Act''.

SEC. 2. CREDIT FOR HEARING AIDS FOR SENIORS AND DEPENDENTS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is amended by inserting after section 25B the following new section:

''SEC. 25C. CREDIT FOR HEARING AIDS.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter an amount equal to the amount paid during the taxable year, not compensated by insurance or otherwise, by the taxpayer for the purchase of any qualified hearing aid.

''(b) MAXIMUM AMOUNT.—The amount allowed as a credit under subsection (a) shall not exceed $500 per qualified hearing aid.

''(c) QUALIFIED HEARING AID.—For purposes of this section, the term 'qualified hearing aid' means a hearing aid—

''(1) which is described in section 874.3300 of title 21, Code of Federal Regulations, and is authorized under the Federal Food, Drug, and Cosmetic Act for commercial distribution, and

''(2) which is intended for use—

''(A) by the taxpayer, but only if the taxpayer (or the spouse intending to use the hearing aid, in the case of a joint return) is age 55 or older, or

''(B) by an individual with respect to whom the taxpayer, for the taxable year, is allowed a deduction under section 151(c) (relating to deduction for personal exemptions for dependents).

''(d) ELECTION ONCE EVERY 5 YEARS.—This section shall apply to any individual for any taxable year only if such individual elects (at such time and in such manner as the Secretary may by regulations prescribe) to have this section apply for such taxable year. An election to have this section apply may not be made for any taxable year if such election is in effect with respect to such individual for any of the 4 taxable years preceding such taxable year.

''(e) DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under subsection (a) for any expense for which a deduction or credit is allowed under any other provision of this chapter.''.

(b) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25B the following new item:

''Sec. 25C . Credit for hearing aids.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2004.

By Mr. NELSON of Florida (for himself, Mr. BURNS, and Mrs. CLINTON):

S. 1063. A bill to promote and enhance public safety and to encourage the rapid deployment of IP-enabled voice services; to the Committee on Commerce, Science, and Transportation.

Mr. NELSON of Florida. Mr. President, I rise today with my colleagues,

Senators BURNS and CLINTON, to introduce the ''IP-Enabled Voice Communications and Public Safety Act of 2005'' and 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. 1063

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 ''IP–Enabled Voice Communications and Public Safety Act of 2005''.

SEC. 2. EMERGENCY SERVICE.

(a) 911 AND E–911 SERVICES.—Notwithstanding section 2(b) or any other provision of the Communications Act of 1934, the Commission shall prescribe regulations to establish a set of requirements or obligations on providers of IP-enabled voice service to ensure that 911 and E–911 services are available to customers to IP-enabled voice service. Such regulations shall include an appropriate transition period by which to comply with such requirements or obligations and take into consideration available industry technological and operational standards, including network security.

(b) NON-DISCRIMINATORY ACCESS TO CAPABILITIES.—Each entity with ownership or control of the necessary emergency services infrastructure shall provide any requesting IP-enabled voice service provider with nondiscriminatory access to their equipment, network, databases, interfaces and any other related capabilities necessary for the delivery and completion of 911 and E911 calls and information related to such 911 or E911 calls. Such access shall be consistent with industry standards established by the National Emergency Number Association or other applicable industry standards organizations. Such entity shall provide access to the infrastructure at just and reasonable, nondiscriminatory rates, terms and conditions. The telecommunications carrier or other entity shall provide such access to the infrastructure on a stand-alone basis.

(c) STATE AUTHORITY.—Nothing in this Act, the Communications Act of 1934, or any Commission regulation or order shall prevent the imposition on or collection from a provider of voice services, including IP-enabled voice services, of any fee or charge specifically designated or presented as dedicated by a State, political subdivision thereof, or Indian tribe on an equitable, and nondiscriminatory basis for the support of 911 and E–911 services if no portion of the revenue derived from such fee or charge is obligated or expended for any purpose other than support of 911 and E–911 services or enhancements of such services.

(d) STANDARD.—The Commission may establish regulations imposing requirements or obligations on providers of voice services, entities with ownership or control of emergency services infrastructure under subsections (a) and (b) only to the extent that the Commission determines such regulations are technologically and operationally feasible.

(e) CUSTOMER NOTICE.—Prior to the compliance with the rules as required by subsection (a), a provider of an IP-enabled voice service that is not capable of providing 911 and E–911 services shall provide a clear and conspicuous notice of the unavailability of such services to each customer at the time of entering into a contract for such service with that customer.

(f) VOICE SERVICE PROVIDER RESPONSIBILITY.—An IP-enabled voice service provider shall have the sole responsibility for the proper design, operation, and function of the 911 and E911 access capabilities offered to the provider's customers.

(g) PARITY OF PROTECTION FOR PROVISION OR USE OF IP-ENABLED VOICE SERVICE.—

(1) PROVIDER PARITY.—If a provider of an IP-enabled voice service offers 911 or E–911 services in compliance with the rules required by subsection (a), that provider, its officers, directors, employees, vendors, and agents, shall have immunity or other protection from liability of a scope and extent that is not less than the scope and extent of immunity or other protection from liability that any local exchange company, and its officers directors, employees, vendors, or agents, have under the applicable Federal and State law (whether through statute, judicial decision, tariffs filed by such local exchange company, or otherwise), including in connection with an act or omission involving the release of subscriber information related to the emergency calls or emergency services to a public safety answering point, emergency medical service provider, or emergency dispatch provider, public safety, fire service, or law enforcement official, or hospital emergency or trauma care facility.

(2) USER PARITY.—A person using an IP-enabled voice service that offers 911 or E–911 services pursuant to this subsection shall have immunity or other protection from liability of a scope and extent that is not less than the scope and extent of immunity or other protection from liability under applicable law in similar circumstances of a person using 911 or E–911 service that is not provided through an IP-enabled voice service.

(3) PSAP PARITY.—In matters related to IP-enabled 911 and E–911 communications, a PSAP, and its employees, vendors, agents, and authorizing government entity (if any) shall have immunity or other protection from liability of a scope and extent that is not less than the scope and extent of immunity or other protection from liability under applicable law accorded to such PSAP, employees, vendors, agents, and authorizing government entity, respective, in matters related to 911 or E–911 communications that are not provided via an IP-enabled voice service.

(h) DELEGATION PERMITTED.—The Commission may, in the regulations prescribed under this section, provide for the delegation to State commissions of authority to implement and enforce the requirements of this section and the regulations thereunder.

SEC. 3. MIGRATION TO IP–ENABLED EMERGENCY NETWORK.

Section 158 of the National Telecommunications and Information Administration Organization Act (as added by section 104 of the ENHANCE 911 Act of 2004) is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c) the following:

''(d) MIGRATION PLAN REQUIRED.—

''(1) NATIONAL PLAN REQUIRED.—No more than 18 months after the date of the enactment of the ENHANCE 911 Act of 2004, the Office shall develop and report to Congress on a national plan for migrating to a national IP-enabled emergency network capable of receiving and responding to all citizen activated emergency communications.

''(2) CONTENTS OF PLAN.—The plan required by paragraph (1) shall—

''(A) outline the potential benefits of such a migration;

''(B) identify barriers that must be overcome and funding mechanisms to address those barriers;

''(C) include a proposed timetable, an outline of costs and potential savings;

''(D) provide specific legislative language, if necessary, for achieving the plan; and

''(E) provide recommendations on any legislative changes, including updating definitions, to facilitate a national IP-enabled emergency network.

''(3) CONSULTATION.—In developing the plan required by paragraph (1), the Office shall consult with representatives of the public safety community, technology and telecommunications providers, and others it deems appropriate.''.

SEC. 4. DEFINITIONS.

(a) IN GENERAL.—For purposes of this Act:

(1) 911 AND E–911 SERVICES.—

(A) 911.—The term ''911'' means a service that allows a user, by dialing the three-digit code 911, to call a public safety answering point operated by a State, local government, Indian tribe, or authorized entity.

(B) E–911.—The term ''E–911 service'' means a 911 service that automatically delivers the 911 call to the appropriate public safety answering point, and provides automatic identification data, including the originating number of an emergency call, the physical location of the caller, and the capability for the public safety answering point to call the user back if the call is disconnected.

(2) IP-ENABLED VOICE SERVICE.—The term ''IP-enabled voice service'' means an IP-enabled service used for real-time 2-way or multidirectional voice communications offered to a customer that—

(A) uses North American Numbering Plan administered telephone numbers, or successor protocol; and

(B) has two-way interconnection or otherwise exchange traffic with the public switched telephone network.

(3) CUSTOMER.—The term ''customer'' includes a consumer of goods or services whether for a fee, in exchange for an explicit benefit, or provided for free.

(4) IP-ENABLED SERVICE.—The term ''IP-enabled service'' means the use of software, hardware, or network equipment that enable an end user to send or receive a communication over the public Internet or a private network utilizing Internet protocol, or any successor protocol, in whole or part, to connect users—

(A) regardless of whether the communication is voice, data, video, or other form; and

(B) notwithstanding —

(i) the underlying transmission technology used to transmit the communications;

(ii) whether the packetizing and depacketizing of the communications occurs at the customer premise or network level; or

(iii) the software, hardware, or network equipment used to connect users.

(5) PUBLIC SWITCHED TELEPHONE NETWORK.—The term ''public switched telephone network'' means any switched common carrier service that is interconnected with the traditional local exchange or interexchange switched network.

(6) PSAP.—The term ''public safety answering point'' or ''PSAP'' means a facility that has been designated to receive 911 calls.

(b) COMMON TERMINOLOGY.—Except as otherwise provided in subsection (a), terms used in this Act have the meanings provided under section 3 of the Communications Act of 1934.

By Mr. COCHRAN (for himself, Mr. KENNEDY, Mr. WARNER, Ms. CANTWELL, Ms. COLLINS, and Mr. DAYTON):

S. 1064. A bill to amend the Public Health Service Act to improve stroke prevention, diagnosis, treatment, and rehabilitation; to the Committee on Health, Education, Labor, and Pensions.

Mr. KENNEDY. Mr. President, the month of May is Stroke Awareness Month, and it is a privilege to join Senators COCHRAN, WARNER, CANTWELL, COLLINS, and DAYTON in introducing the Stroke Treatment and Ongoing Prevention Act of 2005. The STOP Stroke Act is a vital step in building a national network of effective care to diagnose and quickly treat victims of stroke and improve the quality of care for stroke patients across America.

For over 20 years, stroke has been the third leading cause of death in our country, affecting about 700,000 Americans a year and killing approximately 163,000 a year. Every 45 seconds, another American suffers a stroke. Every 3 minutes, another American dies. Few families today are untouched by this cruel, debilitating, and often fatal disease that strikes indiscriminately, and robs us of our loved ones. Even for those who survive, a stroke can have devastating consequences. Over half of all survivors are left with a disability.

Prompt treatment with clot-dissolving drugs within three hours of a stroke can dramatically improve these outcomes. Yet, only 2–3 percent of all stroke patients are treated with such a drug within those crucial first three hours. Few Americans recognize the symptoms of stroke, and crucial hours are often lost before a patient receives treatment. Emergency room staffs are often not trained to recognize and manage the symptoms, which further adds to the delay in treatment. Patients at hospitals with primary stroke centers have nearly five times greater chance of receiving clot-dissolving drugs.

Modern medicine is generating new scientific advances that increase the chance of survival and at least partial or even full recovery following a stroke. Physicians are learning to manage strokes more effectively, and they are also learning how to prevent them in the first place.

But science doesn't save lives and protect health by itself. We need to do more to bring new discoveries to the patient and new awareness to the public. That means educating as many people as possible about the warning signs of stroke, so that they know enough to seek medical attention. It means training doctors and nurses in the best techniques of care. It means finding better ways to treat victims as quickly and as effectively as possible—so that they have the best chance of full recovery.

Our bill provides grants to States to implement statewide systems of stroke care that will give health professionals the equipment and training they need to treat this disorder. It also establishes a continuing education program to make sure that medical professionals are well trained and well aware of the newest treatments and prevention strategies. The initial point of contact between a stroke patient and medical care is usually an emergency medical technician. Grants under this bill may be used to train these personnel to provide more effective care to stroke patients in the crucial first few moments after an attack.

The bill directs the Secretary of Health and Human Services to conduct a national media campaign to inform the public about the symptoms of stroke, so that more patients can recognize the symptoms and receive prompt medical care. The bill also authorizes the Secretary of HHS, acting through CDC, to operate the Paul Coverdell National Acute Stroke Registry, which will collect data about the care of stroke patients and assist in the development of more effective treatments.

The bill also provides new resources for states to improve the standard of care for stroke patients in hospitals, and to increase the quality of care in rural hospitals through improvements in telemedicine.

On Monday, the Wall Street Journal published an excellent article on the inadequate treatment that stroke patients often encounter when ambulances bring them to hospitals with staffs not trained in the early treatment of stroke or lacking the needed equipment to intervene early. Over twenty years ago, the survival of trauma victims was very much dependent on whether the ambulance took them to a hospital with a trauma care center, or to a hospital not equipped to treat traumatic injury. Congress passed the Trauma Care Systems Planning and Development Act of 1990 that revolutionized the treatment for accident victims. Now in 2005, it is long past time to see that state of the art care is made available to stroke patients as quickly as possible.

Stroke is a national tragedy that leaves no American community unscarred. Fortunately, if the right steps are taken during the brief window of time available, effective treatment can make all the difference between healthy survival and disability or death. We need to do all we can to see that those precious few hours are not wasted. The STOP Stroke Act is a significant step in reaching that goal. May is Stroke Awareness Month, and I urge Congress to act quickly on this legislation, and give stroke victims a far better chance for full recovery.

I ask unanimous consent that the full text of a Wall Street Journal article of May 9 on this issue be printed in the RECORD.

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

[From the Wall Street Journal, May 9, 2005]

STROKE VICTIMS ARE OFTEN TAKEN TO WRONG HOSPITAL

(By Thomas M. Burton)

Christina Mei suffered a stroke just before noon on Sept. 2, 2001. Within eight minutes, an ambulance arrived. Her medical fate may have been sealed by where the ambulance took her.

Ms. Mei's stroke, caused by a clot blocking blood flow to her brain, occurred while she was driving with her family south of San Francisco. Her car swerved, but she was able to pull over before slumping at the wheel. Paramedics saw the classic signs of a stroke: The 45-year-old driver couldn't speak or move the right side of her body.

Had Ms. Mei's stroke occurred a few miles to the south, she probably would have been taken to Stanford University Medical Center, one of the world's top stroke hospitals. There, a neurologist almost certainly would have seen her quickly and administered an intravenous drug to dissolve the clot. Stanford was 17 miles away, across a county line.

But paramedics, following county ambulance rules that stress proximity, took her 13 miles north, to Kaiser Permanente's South San Francisco Medical Center. There, despite her sudden inability to talk or walk and her facial droop, an emergency-room doctor concluded she was suffering from depression and stress. It was six hours before a neurologist saw her, and she never got the intravenous clot-dissolving drug.

In a legal action brought against Kaiser on Ms. Mei's behalf, an arbitrator found that her care had been negligent, and in some aspects ''incomprehensible.'' Today, Ms. Mei can't dress herself and walks unsteadily, says her lawyer, Richard C. Bennett. The fingers on her right hand are curled closed, and she has had to give up her main avocations: calligraphy, ceramics and other types of art. Kaiser declined to comment beyond saying that it settled the case under confidential terms ''based on some concerns raised in the litigation.''

Stroke is the nation's No. 1 cause of disability and No. 3 cause of death, killing 164,000 people a year. But far too many stroke victims, like Ms. Mel, get inadequate care thanks to deficient medical training and outdated ambulance rules that don't send patients to the best stroke hospitals.

Over the past decade, American medicine has learned how to save stroke patients' lives and keep them out of nursing homes. New techniques offer a better chance of complete recovery by dissolving blood clots and treating even more lethal strokes caused by burst blood vessels in the brain. But few patients receive this kind of treatment because most hospitals lack specialized staff and knowledge, stroke experts say. State and county rules generally require paramedics to take stroke patients to the nearest emergency room, regardless of that hospital's level of expertise with stroke.

Stroke care is positioned roughly where trauma care was a quarter-century ago. By 1975, surgeons expert at treating victims of car crashes and other major accidents realized that taking severely injured patients to the nearest emergency room could mean death. So the surgeons led a push to make selected regional hospitals into specialized trauma centers and to overhaul ambulance protocols so that paramedics would speed the most severely injured to those centers. Now, in many areas of the U.S., accident victims go quickly to a trauma center, and trauma specialists say this change has saved lives and lessened disability.

Eighty percent or more of the 700,000 stokes that Americans suffer annually are ''ischemic,'' meaning they are caused by blockage of an artery feeding the brain, usually a blood clot. Most of the rest are ''hemorrhagic'' strokes, resulting from burst blood vessels in or near the brain. Although they have different causes, both result in brain tissue dying by the minute.

Several factors have combined to prevent improvement in stroke care. In some areas, hospitals have resisted movement toward a system of specialized stroke centers because nondesignated institutions could lose business, according to neurologists who favor the

changes. In addition, stroke treatment has lacked an organized lobby to galvanize popular and political interest in the ailment.

DOCTOR IGNORANCE

A big reason for the backwardness of much stroke treatment is that many doctors know little about it. Even emergency physicians and internists likely to see stroke victims tend to receive scant neurology training in their internships and residencies according to stroke specialists.

''Surprisingly, you could go through your entire internal medicine rotation without training in neurology, and in emergency medicine it hasn't been emphasized,'' says James C. Grotta, director of the stroke program at the University of Texas Health Science Center at Houston.

Many hospitals don't have a neurologist ready to deal with emergencies. As a result, strokes aren't treated urgently there, even though short delays increase chance of severe disability or death. Even if doctors do react quickly, recent research has shown that many aren't sure what treatment to provide.

For example, a survey published in 2000 in the journal Stroke showed that 66 percent of hospitals in North Carolina lacked any protocol for treating stroke. About 82 percent couldn't rapidly identify patients with acute stroke.

As with other life-threatening conditions, stroke patients are better off going where doctors have had a lot of practice addressing their ailment. A seven-year analysis of surgery in New York state in the 1990s showed that patients with ruptured blood vessels in the brain were more than twice as likely to die—16% versus 7%—in hospitals doing few such operations, compared with those doing them regularly. A national study published last year in the Journal of Neurosurgery showed a similar disparity.

Another major shortcoming of most stroke treatment, according to many neurologists, is the failure to use the genetically engineered clot-dissolving drug known as tPA. Short for tissue plasminogen activator, tPA, which is made by Genentech Inc., has been shown to be a powerful treatment that can lessen disability for many patients. A study published in 2004 in The Lancet, a prominent medical journal, showed that the chances of returning to normal are about three times greater among patients getting tPA in the first 90 minutes after suffering a stroke, even after accounting for tPA's potential side effect of cerebral bleeding that can cause death. But several recent medical-journal articles have found that nationally, only 2% to 3% of strokes caused by clots are treated with tPA, which has no competitor on the market.

Some authors of studies supporting the use of tPA have had consultant or other financial relationships with Genentech. Skeptics of the drug point to these ties and stress tPA's side-effect danger. But among stroke neurologists, there is a strong consensus that the drug is effective.

One reason why many patients don't receive tPA is that they arrive at the hospital more than three hours after a stroke, the time period during which intravenous tPA should be given. But many hospitals and doctors don't use tPA at all, even though it has been available in the U.S. since 1996. The dissolving agent's relatively high cost—$2,000 or more per patient—is a barrier. Medicare pays hospital a flat reimbursement of about $6,700 for stroke treatment, regardless of whether tPA is used.

AIRPORT EMERGENCY

Glender Shelton of Houston had an ischemic stroke caused by a clot at Los Angeles International Airport on Dec. 30, 2003. In full view of other holiday travelers, Ms. Shelton, then 66, slumped over, and an ambulance was called. It was 4:45 p.m.

By 5:55 p.m., she arrived at what now is called Centinela Freeman Regional Medical Center, four miles away in Marina del Rey. Hospital records show that doctors thought Ms. Shelton had suffered an ''acute stroke.'' But she didn't get a CT scan, a recommended initial step, until 9 p.m. By then, she was already outside the three-hour window for safely administering intravenous tPA. Records also say she didn't receive the drug ''due to unavailability of neurologist until after the patient had been outside the three-hour time window.''

Ms. Shelton's daughter, Sandi Shaw, was until recently nurse-manager of the prestigious stroke unit at the University of Texas Health Science Center at Houston. Ms. Shaw says that at her unit, her mother would have had a CT scan within five minutes of arriving, and tPA probably would have been administered 30 or 35 minutes after that.

Today, according to her daughter, Ms. Shelton often can't come up with words or relatives' names, can't take care of her finances, and can't follow certain basic commands in neurological tests.

Kent Shoji, an emergency-room doctor at Centinela Freeman who handled Ms. Shelton's case, says, ''She was a possible candidate for tPA,'' but a CT scan was required first. ''The order was put in for a CT scan,'' Dr. Shoji says, ''I can't answer why it took so long.''

A Centinela Freeman spokeswoman says, ''We did not have 24/7 coverage with our CT scan, and we had to call, a technician to come in. That's pretty common with a community hospital.'' The hospital has since been acquired by a larger health system and now does have 24-hour CT capability.

'PAROCHIAL INTERESTS'

A hospital-accrediting group has begun designating hospitals as stroke centers, but that is only part of what is needed, stroke experts assert. They say hospitals typically have to come together to create local political momentum to change state or county rules to that ambulances actually take stroke patients to stroke centers, not the nearest ER. New York, Maryland and Massachusetts are moving toward creating stroke-care systems, and Florida recently passed a law creating stroke centers. But in many places, short-term economic interests impede change, some doctors say.

''There are still very parochial interests by hospitals and physicians to keep patients locally even if they're not equipped to handle them,'' says neurosurgeon Robert A. Solomon of New York Presbyterian Hospital/Columbia. ''Hospitals don't want to give up patients.''

The University of California at San Diego runs one of the leading stroke hospitals in the country. It and others in the area that are well prepared to treat stroke patients have sought for a decade to set up a regional system, but there has been little progress, says Patrick D. Lyden, UCSD's chief of neurology, ''Some hospitals are resisting losing stroke business,'' he says. ''We have the same political crap as in most communities. Paramedics still take people to the local ER.''

Among the opponents of the stroke-center concept during the 1990s was Richard Stennes, the ER director at Paradise Valley Hospital south of San Diego. In various public debates, Dr. Stennes recalls, he argued that many apparent stroke patients would be siphoned away from community hospitals even if they didn't turn out to have strokes. Also, he argued that tPA might cause more injury than it prevents. And then there was the economic issue: ''Those hospitals without all the equipment and stroke experts,'' he says, ''would be concerned about all the patients going to a stroke center and taking the patients away from us.'' Dr. Stennes has since retired.

''All hospitals and clinicians try to deliver the right care to patients, especially those with urgent medical needs,'' says Nancy E. Foster, vice president for quality of the American Hospital Association, which represents both large and small hospitals. ''Community hospitals may be equally good at delivering stroke care, and it would be important for patients to know how well prepared their local hospital is.''

Stroke experts aren't proposing that every hospital needs to specialize in stroke care but instead that in every population center there should be at least one that does. In Atlanta, Emory University's neuro-intensive care unit illustrates the special skills that make for top care. Owen B. Samuels, director of the unit, estimates that 20% to 30% of patients it treats received poor initial medical care before arriving at Emory, jeopardizing their futures or even lives. Brain hemorrhages, for example, are commonly misdiagnosed, even in patients who repeatedly showed up at emergency rooms with unusually severe headaches, Dr. Samuels says.

The Emory unit has 30 staff members, including two neuro-critical care doctors and five nurse practitioners. A team is on duty 24 hours a day. The unit handles about two dozen patients most days, keeping the staff busy. On the ward, nearly all patients are unconscious or sedated, so it's eerily silent. Patients generally need to rest their brains as they recover from stroke or surgery.

After a hemorrhagic stroke, blood pressure in the cranium builds as blood continues to seep out of the ruptured vessel. Pressure can be deadly, cutting off oxygen to the brain. Or escaped blood can cause a ''vasospasm,'' days after the original stroke, in which the brain reacts violently to seeped-out blood. In the worst case, the brain herniates, or squeezes out the base of the skull, causing death. To avoid this, nurses at Emory constantly monitor brain pressure and temperatures. They put in drain lines. They infuse medicines to dehydrate, depressurize and stop bleeding.

Since Emory launched the neuro-intensive unit seven years ago, 42% of patients with hemorrhagic strokes have become well enough to go home, compared with 27% before. Fewer need rehabilitation—31% versus 40%—and the death rate is down.

Damica Townsend-Head, 33, gave the Emory team a scare. After surgery last fall for a hemorrhagic stroke, her brain swelling was ''really out of control,'' Dr. Samuels says, raising questions about whether she would survive. The staff put a ''cooling catheter'' into a blood vessel, which allowed the circulation of ice water to bring down the temperature in her blood and brain. They intentionally dehydrated her brain to lower pressure. A month later, she woke up and recovered with minimal disability. She still walks with a cane and tires easily, but her speech is normal and she hopes to return soon to work. ''I consider her what we're in business for,'' Dr. Samuels says.

PUBLIC AWARENESS

The public's low awareness of stroke symptoms—and the need to respond immediately—can also hinder proper care. Ischemic strokes, those caused by clots or other artery blockage, cause symptoms such as muscle weakness or paralysis on one side, slurred speech, facial droop, severe dizziness, unstable gait and vision loss. People with this kind of stroke are sometimes mistaken for being drunk. In addition to intense head

pain, a hemorrhagic stroke often leads to nausea, vomiting or loss of balance or consciousness. Still, many people with some of these symptoms merely go to bed in hopes of improving overnight, doctors say. Instead, they should go immediately to a hospital and demand a CT scan as a first diagnostic step.

The well-funded American Heart Association, established in 1924, has made many people aware of heart attack symptoms and thereby saved many lives. In contrast, the American Stroke Association was started only in 1998 as a subsidiary of the heart association. The stroke association spent $162 million last year out of the heart association's $561 million overall budget.

Justin Zivin, another University of California at San Diego stroke expert, says the stroke association ''is a terribly ineffective bunch. When it comes to actual public education, I haven't seen anything.''

The stroke association counters that it is buying television and radio ads promoting awareness, similar to ones produced in 2003 and 2004. The group also sponsors research and education, including an annual international stroke-medicine conference.

It's not just the general public that fails to recognize stroke symptoms. Often, emergency-room doctors and nurses don't either. Gretchen Thiele of suburban Detroit began having horrible headaches last May, for the first time in her life. ''She wasn't one to complain, but she said, 'I can't even lift my head off the pillow.''' recalls her daughter, Erika Mazero. Ms. Thiele, 57, nearly passed out from the pain one night and suffered blurred vision. When the pain recurred in the morning, she went to the emergency room at nearby St. Joseph's Mercy of Macomb Hospital. Ms. Mazero says that during the six hours her mother spent there, she was given a CT scan, but not a spinal tap, which could definitively have shown she had a leaking brain aneurysm, meaning a ballooned and weakened artery in her brain. After the CT, Ms. Thiele was given a muscle relaxant and pain medicine and sent home, her daughter says.

Two months later, the blood vessel burst. Neurosurgeons at William Beaumont Hospital in Royal Oak, Mich., did emergency surgery, but Ms. Thiele suffered massive bleeding and died. Ali Bydon, one of the neurosurgeons at Beaumont, says a CT scan often is inadequate and that her condition could have been detected earlier with a spinal tap, also called a lumbar puncture. ''Had she had a lumbar puncture and perhaps an operation earlier, it might have saved her life,'' says Dr. Bydon. ''In general, a person who tells you, 'I usually don't get headaches, and this is the worst headache of my life,' is something that should alarm you.''

In addition, he says Ms. Thiele ''absolutely'' was experiencing smaller-scale bleeding in May that foreshadowed a more serious rupture. If doctors identify this kind of bleeding early, he says, chances of death are ''minimal.'' But when a rupture occurs, he says, ''25% of patients never make it to the hospital, 25% die in the hospital and 25% are severely disabled.''

A St. Joseph's hospital spokeswoman says the hospital has ''very aggressive standards for treatment, and we met this standard.'' declining to elaborate.

DETERMINED NURSE

Paramedics did the right thing after Chuck Toeniskoetter's stroke, but only because of some extraordinary intervention. Mr. Toeniskoetter, then 55, was on a ski trip, Dec. 23, 2000, at Bear Valley, near Los Angeles. He had just finished a run at 3:30 p.m. when, in the snowmobile shop, he began slurring his words and nearly fell over. Kathy Snyder, the nurse in the ski area's first-aid room quickly diagnosed stroke. She called a helicopter and an ambulance.

Ms. Snyder says she knew the closest hospital with a stroke team was Sutter Roseville Medical Center in Roseville, CA. The helicopter pilot was planning to take Mr. Toeniskoetter to a closer ER, but Ms. Snyder says she stood on the helicopter runners, demanding the patient go to Sutter. The pilot eventually relented. Mr. Toeniskoetter went to Sutter, where he promptly received tPA. Today, he has no disability and is back running a real estate-development business in the San Jose area. ''Trauma patients go to trauma centers, not the nearest hospital,'' he says. ''Stroke victims, too, require a real specialized sort of care.''

One-third of all strokes are suffered by people under 60, and hemorrhagic strokes in particular often strike young adults and children. Vance Bowers of Orlando, Fla., was 9 when he woke up screaming that his eyes hurt, shortly after 1 a.m. on Jan. 8, 2001. Malformed blood vessels in his brain were bleeding. He was in a coma by the time an ambulance delivered him at 1:57 a.m. to the nearest emergency room, at Florida Hospital East Orlando.

Emergency-room doctors soon realized Vance had a hemorrhagic stroke. But neurosurgery isn't performed at that hospital. A sister hospital 14 minutes away by ambulance, Florida Hospital Orlando, did have neurosurgical capability. But in part because of administrative tangles, Vance didn't get to the second hospital until 4:37 a.m., more than two hours after his arrival. Surgery began at 6:18 a.m. ''This delay may have cost this young man the possibility of a functional survival,'' Paul D. Sawin, the neurosurgeon who operated on Vance, said in a letter to the hospitals' joint administration.

Florida Hospital, an emergency-medicine group and an ER doctor recently agreed to settle a lawsuit filed against them in Orange County, Fla., Circuit Court by the Bowers family. The defendants agreed to pay a total of $800,000, court records show. Monica Reed, senior medical officer of the hospital, says the care Vance received was ''stellar'' and that any delays weren't medically significant. Vance's stroke, not the care he received, caused his injuries, she said.

Vance, now 13, survived but is mentally handicapped and suffers daily seizures, his mother, Brenda Bowers, says. Once a star baseball player, he goes by wheelchair to a class for disabled children. He speaks very slowly but not in a way that many people can understand. ''He remembers playing baseball with all of his friends,'' his mother says but they rarely come around any more. ''He really misses all that.''

By Mr. THUNE (for himself and Mrs. CLINTON):

S. 1065. A bill to amend title 10, United States Code, to extend child care eligibility for children of members of the Armed Forces who die in the line of duty; to the Committee on Armed Services.

Mr. THUNE. Mr. President, today I rise with my distinguished colleague from New York, Senator CLINTON, to introduce legislation that will provide a surviving spouse with two years of child care eligibility on any military instillation or Federal facility with a child care center. The legislation was inspired by our work on the Senate Armed Services Committee. In February the committee held an important hearing on improving survivor benefits and the government's role in helping survivors cope with the loss of a loved one. All too often surviving spouses are forced to make difficult, life changing decisions alone. Both Senator CLINTON and I are determined to provide as much help as possible to those who must bear the burden of loss, particularly those with young children. By providing two years of child care eligibility, our goal is to ensure that a surviving spouse has the time and tools necessary to make a healthy adjustment to life after the servicemember's death. Many decisions face survivors, most importantly, how to make a living. Often that means having to reenter the work force after years of being a working mother. The question of how to adequately care for young children while trying to find employment or restart a career should not be an issue. Further, we have expanded this eligibility to include access to child care centers in other Federal facilities. This will aide surviving spouses with children if they are in the process of relocating to an area of the country without a military base nearby, but in the proximity of a local Federal building. I am honored that Senator CLINTON is working with me on this legislation and I encourage my colleagues to support this important measure.

By Mr. VOINOVICH (for himself, Ms. STABENOW, Mr. BUNNING, Mr. LEVIN, Mr. ALEXANDER, Mr. DEWINE, Mr. MCCONNELL, and Mr. FRIST):

S. 1066. A bill to authorize the States (and subdivisions thereof), the District of Columbia, territories, and possessions of the United States to provide certain tax incentives to any person for economic development purposes; to the Committee on Finance.

Mr. VOINOVICH. Mr. President, I rise today to introduce the Economic Development Act of 2005 to authorize States to provide tax incentives for economic development purposes.

This legislation is crucial to preserve tax incentives as an important tool for State and local governments to promote economic development in the wake of last year's decision by the Sixth Circuit Court of Appeals in Cuno v. DaimlerChrysler.

In its decision in Cuno, the Sixth Circuit struck down Ohio's manufacturing machinery and equipment tax credit, which I helped enact while I was Governor of Ohio, on grounds that it violated the ''dormant'' Commerce Clause of the U.S. Constitution. The court ruled that the tax incentive violated the Commerce Clause of the U.S. Constitution because it granted preferential tax treatment to companies that invest within the State rather than in other States.

The Cuno decision has had severe repercussions across the country. The decision immediately cast doubt on the constitutionality of tax incentives presently offered by all fifty States. As

a result, States and businesses have been reluctant to go forward with new projects that depend on the availability of tax incentives out of concern that the Cuno decision may be used to invalidate those incentives. This legal uncertainty has worsened an already challenging economic environment. Furthermore, the decision threatens to undermine federalism by dramatically restricting the ability of States to craft their tax codes to promote economic development in the manner they determine is best. If left standing, this decision will handcuff the States in the Sixth Circuit, as well as States in other circuits where the court chooses to follow Cuno, in their efforts to promote economic growth and create jobs. Additionally, it will cripple their ability to compete internationally. In today's competitive economic environment, we can not afford to unilaterally discard the use of tax incentive to attract business to this country. As a former Governor who had to compete against Japan, Canada, China and Europe for new business projects, I know just how important a role tax incentives can play in attracting new businesses. I can assure you that our competitors are certainly not going to stop using tax incentives. Neither should we.

Fortunately, the U.S. Constitution gives Congress the power to determine which State actions violate the Commerce Clause. The purpose of the Economic Development Act of 2005 is therefore to have Congress override the decision in Cuno by authorizing States to provide tax incentives for economic development purposes. The legislation would remove the legal uncertainty surrounding tax incentives created by the Cuno decision and preserve the States' power to design their tax codes to promote economic development.

The history of the tax incentive struck down in Cuno demonstrates the important role tax incentives can play in promoting economic development. When I was Governor of Ohio, at my request and as part of my jobs incentive package, the Ohio Legislature enacted the manufacturing machinery and equipment tax incentive to encourage businesses to expand their operations in Ohio and to help draw new businesses to Ohio. It worked. Between 1993 and 1997, Ohio was ranked number one in the Nation by Site Selection and Industrial Development magazine three times for highest number of new facilities, expanded facilities, and new manufacturing plants. Since the program's inception, businesses have been eligible to claim a total of $2 billion in credits toward $34 billion in new equipment investments.

Currently, this incentive is part of an incentive package being offered to automobile manufacturer DaimlerChrysler in support of its plans for a $200 million expansion of their Jeep plant. The ruling by the Sixth Circuit in Cuno, however, puts that expansion in jeopardy and threatens to undermine Ohio's competitiveness in attracting new businesses.

In the Cuno decision, the Sixth Circuit ruled that the manufacturing machinery and equipment tax incentive, given by Ohio to DaimlerChrysler as part of its incentive package, violated the Commerce Clause of the U.S. Constitution because it discriminated against interstate commerce by granting preferential tax treatment to companies that expanded within the State rather than in other States.

The Cuno decision is troubling for several reasons. First, I believe the Sixth Circuit failed to appreciate the need for States to condition the availability of certain tax incentives on the undertaking of the specified economic activity within a State. In the case of the manufacturing machinery and equipment tax incentive, Ohio needed to limit the availability of the tax incentive to the investments undertaken in the State. Otherwise, Ohio would have been giving companies a tax incentive for activity that did not benefit the State. In other words, Ohio would have been effectively subsidizing investment in other States. We all know that in economics there is no free lunch and States should not be forced to provide a free lunch when they choose to give tax incentives. If Ohio or any other State is willing to forego tax revenue, it should be allowed to receive something in return, namely investment or other economic activity in the State. Accordingly, Ohio's tax incentive did not discriminate against interstate commerce. It merely required companies, if they chose to take advantage of the incentive, to undertake the investment in Ohio, the same State that would be foregoing tax revenue to provide the incentive.

There is also a little legal fiction present in the Cuno decision. The court states that Ohio could have provided a direct subsidy to companies that undertook investment in the State. Because Ohio decided to structure the program as a tax credit, however, the court said that it ran afoul of the Commerce Clause. I do not see how a direct subsidy does not violate the dormant Commerce Clause, but a tax credit does. They are economically the same.

If left standing, the Cuno decision will have a particularly detrimental effect on the U.S. manufacturing sector. From rising energy and health care costs to frivolous lawsuits and unfair international trade practices, the U.S. manufacturing sector and the hard working men and women who drive it are getting squeezed from all sides. Despite all they are up against, it's a testament to their ability and determination that they are still the most productive manufacturers in the world. This Sixth Circuit decision, however, is a new roadblock that threatens to take away one of the most effective and efficient means for assisting manufacturers who want to create new jobs here in America. The Economic Development Act of 2005 will make sure that manufacturers don't lose key tax incentives just when such incentives are needed the most.

The Cuno decision also sets a bad precedent that, if not checked, could upset our carefully balanced federal system. One of the most ingenious aspects of the U.S. Constitution is that it leaves a great deal of power with the States. It gives the States flexibility to devise their own solutions and, in the process, fosters innovation in government. Thus, the States are the laboratories of our democracy and an innovation they have developed to help create jobs and prosperity are programs that encourage new growth through tax incentives for training, job creation, and investment in new plants and equipment. The availability of tax incentives was critical to our success in Ohio and in being number one in new plant construction and expansion. Because Ohio had the ability to devise tax incentives that fit its economic development needs, we were able to create thousands of new jobs. My legislation will guarantee that the States remain our engines of innovation.

This legislation is something that Congress should have done a long time ago. The courts are not well-suited to making the often complex policy decisions regarding whether a tax incentive truly discriminates against interstate commerce and hinders the creation of a national market, or whether a tax incentive actually fosters innovation and job growth. Such decisions necessarily involve a careful weighing of competing and often mutually exclusive interests, and therefore should be made by Congress. Moreover, judicial decisions often fail to provide bright lines on which incentives run afoul of the dormant Commerce Clause, injecting uncertainty about the validity of certain tax incentives that makes businesses weary of relying on them and reduce their effectiveness. Indeed, the Supreme Court itself has called its dormant Commerce Clause jurisprudence a ''quagmire.'' Hence, it is time that Congress provide some clear rules on the treatment of tax incentives under the Commerce Clause.

As Supreme Court Justice Felix Frankfurter stated nearly a half-century ago:

> At best, this Court can only act negatively; it can determine whether a specific state tax is imposed in violation of the Commerce Clause. Such decisions must necessarily depend on the application of rough and ready legal concepts. We cannot make a detailed inquiry into the incidence of diverse economic burdens in order to determine the extent to which such burdens conflict with the necessities of national economic life. Neither can we devise appropriate standards for dividing up national revenue on the basis of more or less abstract principles of constitutional law, which cannot be responsive to the subtleties of the interrelated economies of Nation and State.
>
> The problem calls for solution by devising a congressional policy. Congress alone can provide for a full and thorough canvassing of the multitudinous and intricate factors which compose the problem of the taxing

freedom of the States and the needed limits on such state taxing power. Congressional committees can make studies and give the claims of the individual States adequate hearing before the ultimate legislative formulation of policy is made by the representatives of all the States. . . . Congress alone can formulate policies founded upon economic realities. . . .

The Economic Development Act of 2005 is a good first step toward providing the prudent and carefully considered legislation that Justice Frankfurter urged the Congress to pass nearly a half century ago.

At its core, the Economic Development Act of 2005 recognizes that decisions should be made, if possible, at the State and local level. States make and should make decisions about the programs and services they want to provide with their tax dollars, not the least of which are economic development programs. Highway funding, education funding, welfare funding, and funding for seniors programs all vary from state to state because State legislatures, acting on behalf of their citizens, make choices and set priorities. This has allowed government policy to reflect the diversity of interests in our great republic and results in better and more responsive government. Accordingly, states should be allowed to prioritize economic development in an effort to create jobs and prosperity for their citizens, and, yes, attract business from outside their State. If States choose to use tax incentives to promote economic development, then that is not a violation of the interstate commerce clause, that's simply their choice. It is called federalism, and it should not be thwarted by the courts.

There are a couple of points about this legislation that I would like to discuss. First, this legislation is carefully crafted to protect the most common and benign forms of tax incentives, but not to authorize those tax incentives that truly discriminate against interstate commerce. I believe this bill strikes the right balance between protecting States' tax rights and preserving long-established protections against truly discriminatory State tax practices. Second, this legislation does not invalidate any tax incentives. It only authorizes tax incentives. Any tax incentive not covered by the legislation's authorization is simply subject to the traditional dormant Commerce Clause review by the courts. Third, this legislation does not require any state to provide tax incentives. Although I had success using tax incentives to foster economic growth in Ohio while I was Governor, I recognize that some states have concerns about whether and how to offer tax incentives and therefore believe it should be left to the states to resolve these concerns.

I am pleased that this legislation is being co-sponsored by all of the Senators representing States in the Sixth Circuit. We all realize that the right of states to make their own decisions about the programs and services they offer within their boundaries is their own and should not be taken away. Moreover, if the Supreme Court fails to review the Cuno decision, then our States, the States in the Sixth Circuit, will be at a competitive disadvantage in attracting businesses against other states which are not affected by the Cuno decision and can offer tax incentives.

The bill has also been endorsed by Governor Bob Taft of Ohio, the National Governors Association, the National League of Cities, the National Association of Counties, the National Conference of Mayors and the Federation of Tax Administrators, as well as by broad-based business coalitions and the Teamsters.

I am hopeful that the seriousness of this issue, and the severity of the ruling's possible ramifications, will allow us to see quick and positive consideration of my bill. The States are in a crisis mode because of this ruling. In Ohio, as I'm sure is the case across the country, many important projects have been put on hold as we await the court's further action.

The challenges that manufacturers and workers face today are daunting but surmountable. The last thing we need, however, is an artificial legal hurdle that threatens to trip us up. I urge my colleagues to support the Economic Development Act of 2005 so that we can preserve the ability of the States to foster economic development and help put our economy, and especially our manufacturing industries, back on the road to recovery and prosperity.

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. 1066

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 ''Economic Development Act of 2005''.

SEC. 2. AUTHORIZATION.

Congress hereby exercises its power under Article I, Section 8, Clause 3 of the United States Constitution to regulate commerce among the several States by authorizing any State to provide to any person for economic development purposes tax incentives that otherwise would be the cause or source of discrimination against interstate commerce under the Commerce Clause of the United States Constitution, except as otherwise provided by law.

SEC. 3. LIMITATIONS.

(a) TAX INCENTIVES NOT SUBJECT TO PROTECTION UNDER THIS ACT.—Section 2 shall not apply to any State tax incentive which—

(1) is dependent upon State or country of incorporation, commercial domicile, or residence of an individual;

(2) requires the recipient of the tax incentive to acquire, lease, license, use, or provide services to property produced, manufactured, generated, assembled, developed, fabricated, or created in the State;

(3) is reduced or eliminated as a direct result of an increase in out-of-State activity by the recipient of the tax incentive;

(4) is reduced or eliminated as a result of an increase in out-of-State activity by a person other than the recipient of the tax incentive or as a result of such other person not having a taxable presence in the State;

(5) results in loss of a compensating tax system, because the tax on interstate commerce exceeds the tax on intrastate commerce;

(6) requires that other taxing jurisdictions offer reciprocal tax benefits; or

(7) requires that a tax incentive earned with respect to one tax can only be used to reduce a tax burden for or provide a tax benefit against any other tax that is not imposed on apportioned interstate activities.

(b) NO INFERENCE.—Nothing in this section shall be construed to create any inference with respect to the validity or invalidity under the Commerce Clause of the United States Constitution of any tax incentive described in this section.

SEC. 4. DEFINITIONS; RULE OF CONSTRUCTION.

(a) DEFINITIONS.—For purposes of this Act—

(1) COMPENSATING TAX SYSTEM.—The term ''compensating tax system'' means complementary taxes imposed on both interstate and intrastate commerce where the tax on interstate commerce does not exceed the tax on intrastate commerce and the taxes are imposed on substantially equivalent events.

(2) ECONOMIC DEVELOPMENT PURPOSES.—The term ''economic development purposes'' means all legally permitted activities for attracting, retaining, or expanding business activity, jobs, or investment in a State.

(3) IMPOSED ON APPORTIONED INTERSTATE ACTIVITIES.—The term ''imposed on apportioned interstate activities'' means, with respect to a tax, a tax levied on values that can arise out of interstate or foreign transactions or operations, including taxes on income, sales, use, gross receipts, net worth, and value added taxable bases. Such term shall not include taxes levied on property, transactions, or operations that are taxable only if they exist or occur exclusively inside the State, including any real property and severance taxes.

(4) PERSON.—The term ''person'' means any individual, corporation, partnership, limited liability company, association, or other organization that engages in any for profit or not-for-profit activities within a State .

(5) PROPERTY.—The term ''property'' means all forms of real, tangible, and intangible property.

(6) STATE.—The term ''State'' means each of the several States (or subdivision thereof), the District of Columbia, and any territory or possession of the United States.

(7) STATE TAX.—The term ''State tax'' means all taxes or fees imposed by a State.

(8) TAX BENEFIT.—The term ''tax benefit'' means all permanent and temporary tax savings, including applicable carrybacks and carryforwards, regardless of the taxable period in which the benefit is claimed, received, recognized, realized, or earned.

(9) TAX INCENTIVE.—The term ''tax incentive'' means any provision that reduces a State tax burden or provides a tax benefit as a result of any activity by a person that is enumerated or recognized by a State tax jurisdiction as a qualified activity for economic development purposes.

(b) RULE OF CONSTRUCTION.—It is the sense of Congress that the authorization provided in section 2 should be construed broadly and the limitations in section 3 should be construed narrowly.

SEC. 5. SEVERABILITY.

If any provision of this Act or the application of any provision of this Act to any person or circumstance is held to be unconstitutional, the remainder of this Act and the application of the provisions of this Act to any

person or circumstance shall not be affected by the holding.

SEC. 6. EFFECTIVE DATE.

This Act shall apply to any State tax incentive enacted before, on, or after the date of the enactment of this Act.

By Mr. HARKIN:

S. 1074. A bill to improve the health of Americans and reduce health care costs by reorienting the Nation's health care system toward prevention, wellness, and self care; to the Committee on Finance.

Mr. HARKIN. Mr. President, for more than a decade, I have spoken out about the need to fundamentally reorient our approach to health care in America—to reorient it towards prevention, wellness and self care.

I don't think you'll find too many people who would argue with the statement that if you get sick, the best place in the world to get the care you need is here in America. We have the best trained, highest-skilled health professionals in the world. We have cutting-edge, state-of-the-art equipment and technology. We have world-class health care facilities and research institutions.

But, when it comes to helping people stay healthy and stay out of the hospital, we fall woefully short. In the U.S., we spend in excess of $1.8 trillion a year on health care. Fully 75 percent of that total is accounted for by chronic diseases—things like heart disease, cancer, and diabetes. And what these diseases have in common is that—in so many cases—they are preventable.

In the United States, we fail to make an up-front investment in prevention. So we end up spending hundreds of billions on hospitalization, treatment, and disability. This is foolish—and, clearly, it is unsustainable. In fact, I've long said that we don't have a health care system here in America, we have a ''sick care'' system. And it is costing us dearly both in terms of health care costs and premature deaths.

Consider the cost of major chronic diseases—diseases that, as I said, are so often preventable.

For starters the annual cost of obesity is $117 billion. For cardiovascular disease is about $352 billion. For diabetes it's $132 billion. For smoking it's more than $75 billion. And for mental illness it's $150 billion; indeed, major depression is the leading cause of disability in the United States.

Now, if I bought a new car, drove that car off the lot, and never maintained it—never checked the oil, never checked the transmission fluid, never got it tuned up—you'd think I was crazy, not to mention grossly irresponsible. The common-sense principle with an automobile is: ''I pay a little now to keep the car maintained, or I pay a whole lot later.''

Well, it's the same with our national health priorities. Right now, our health care system is in a downward spiral. We are not paying a little now; so we are paying a whole lot later.

For example, we are failing to address the nation's growing obesity epidemic. Today 65 percent of our population is overweight or obese. Obesity is associated with numerous health problems and increased risks of diabetes, heart disease, stroke, and several types of cancer, to name just a few.

Another contributing factor to our health crisis is tobacco. We don't hear as much about the dangers of tobacco use, today, as we used to. That's because there is a perception that we've turned the corner—that we've done all that we need to do. But that perception is not accurate. In 2002, 46 million American adults regularly smoked cigarettes—that 26 percent of our population. Nearly 40 percent of college-aged students smoke. What this means is that after decades of education and efforts to stop tobacco use, more than one in every four Americans is still addicted to nicotine and smoking.

Mental health is another enormous challenge that we are grossly neglecting. Mental health and chronic disease are intertwined. They can trigger one another. It is about time we stop separating the mind and body when discussing health. Prevention and mental health promotion programs should be integrated into our schools, workplaces, and communities along with physical health screenings and education. Surely, at the outset of the 21st century, it's time to move beyond the lingering shame and stigma that often attend mental health.

Seventy percent of all deaths in the U.S. are now linked to chronic conditions such as heart disease, cancer, and diabetes. In so many cases, these chronic diseases are caused by poor nutrition, physical inactivity, tobacco use, and untreated mental illness. This is unacceptable.

After many months of meetings and discussions with Iowans and experts across the nation, today I am re-introducing comprehensive legislation designed to transform America's ''sick care'' system into a true health care system—one that emphasizes prevention and health promotion.

I am calling this bill the HeLP America Act, with HeLP as an acronym for Healthy Lifestyles and Prevention. The aim is to give individuals and communities the information and tools they need to take charge of their own health.

Because if we are serious about getting control of health-care costs and health-insurance premiums, then we must give people access to preventive care . . . and we must give people the tools they need to stay healthy and stay out of the hospital.

This will take a sustained commitment from government, schools, communities, employers, health officials, and the tobacco and food industries. But a sustained effort can have a huge payoff—for individuals and families, for employers, for society, for government budgets, and for the economy at large.

As I said, the HeLP America Act is comprehensive legislation. It a very complex, multifaceted bill. But, this afternoon, I'd just like to outline the bill's major elements:

The first component addresses healthy kids and schools. Prevention and the development of a healthy habits and lifestyles must begin in the early years, with our children. Unfortunately, today, we are heading in exactly the wrong direction. More and more children all across America are suffering from poor nutrition, physical inactivity, mental health issues, and tobacco use.

For example, just since the 1980s, the rates of obesity have doubled in children and tripled in teens. Even more alarming is the fact that a growing number of children are experiencing what used to be thought of primarily as adult health problems. Almost two-thirds—60 percent—of overweight children have at least one cardiovascular disease risk factor. Recent studies of children have shown that increasing weight, greater salt consumption from fast food, and poor eating habits have contributed to the rise in blood pressure, higher cholesterol levels, and a shockingly rapid increase in adult-onset diabetes.

The HeLP America Act will more than double funding for the successful PEP program, which promotes health and physical education programs in our public schools. I find it disturbing that more than one third of youngsters in grades 9 through 12 do not regularly engage in adequate physical activity. This is a shame, because studies show that regular physical activity boosts self-esteem and improves health.

The HeLP America Act will also expand the Harkin Fruit and Vegetable Program to provide more free fresh fruits and vegetables in more public schools. The bill will also encourage give schools incentives to create healthier environments, including goals for nutrition education and physical activity.

The HeLP America Act would also establish a grant program to provide mental health screenings and prevention programs in schools, along with training for school staff to help them recognize children exhibiting early warning signs. It will improve access to mental health services for students and their families.

New to the HeLP Act this year is a strong focus on breastfeeding promotion. Sound nutrition begins the moment a baby is born and there is a vast body of scientific evidence that shows beyond a shadow of a doubt that mom's milk is the ideal form of nutrition to promote child health. But in the U.S. we don't do enough to encourage breastfeeding. The HeLP America Act seeks to remove some of those barriers and to encourage new mothers to breastfeed.

The second broad component of the HeLP American Act addresses Healthy Communities and Workplaces. For example, the bill aims to create a healthier workforce by providing tax

credits to businesses that offer wellness programs and health club memberships. Studies show that, on average, every $1.00 that is invested in workplace wellness returns $3.00 in savings on health costs, absences from work, and so on.

At a field hearing in Iowa last year, I heard from Mr. Lynn Olson, CEO of Ottumwa Regional Health Center. The Center offers a comprehensive wellness program for its employees, including reduced health insurance premiums for those employees who meet individual health goals. The Center has seen tremendous savings from their investment in health promotion.

My bill also creates a grant program for communities, encouraging them to develop localized plans to promote healthier lifestyles. For example, we want to support efforts like those going on in Webster County and Mason City, IA, where mall walking programs have been expanded into community-wide initiatives to promote wellness.

At the same time, the bill provides new incentives for the construction of bike paths and sidewalks to encourage more physical activity, especially walking. It is shocking that, today, roughly one-quarter of walking trips take place on roads without sidewalks or shoulders. And bike lanes are available for only about 5 percent of bike trips.

As my colleagues know, I have been a longstanding advocate for the rights of people with disabilities. So I have given special attention to health-promotion programs and activities that include this population. I just mentioned the bill's incentives to create bike lanes and sidewalks on newly constructed roads. This will make a big difference to people with disabilities, who often are forced to travel in the street alongside cars because there are no sidewalks or bike lanes available for wheelchairs.

The Centers for Disease Control has funded a program called Living Well with a Disability, which has actually decreased secondary conditions and led to improved health for participants. The program is an eight-session workshop that teaches individuals with disabilities how to change their nutrition and level of physical activity. The program not only increases healthy activities for people with disabilities, but has also led to a 10 percent decline in the cost for medical services, particularly emergency-room care and hospital stays.

In addition, my bill includes a Working Well with a Disability program, which will build partnerships between employers and vocational rehabilitation offices with the aim of developing wellness programs in the workplace.

Mr. President, the third component of the HeLP America Act addresses Responsible Marketing and Consumer Awareness. Having accurate, readily available information about the nutritional value of the foods we eat is the first step toward improving overall nutrition. Unfortunately, because of all the gimmicks and hype that marketers use to entice us to buy their products, determining the nutritional value of the foods we buy can be problematic—especially in restaurants. This is why the HeLP America bill proposes to extend the nutritional labeling requirements of the National Labeling and Education Act, which currently covers the vast majority of retail foods, to restaurants foods as well, which were exempted from the NLEA when it first passed.

The marketing of junk food—especially to kids—is out of control. It was estimated that junk food marketers, alone, spent $15 billion in 2002 promoting their fare. And, I don't have to tell you, they are not advertising broccoli and apples. No, the majority of these ads are for candy and fast food—foods that are high in sugar, salt, fat, and calories.

Children—especially those under 8 years of age—do not always have the ability to distinguish fact from fiction. The number of TV ads that kids see over the course of their childhood has doubled from 20,000 to 40,000. The sad thing is that, way back in the 1970s, the Federal Trade Commission recommended banning TV advertising to kids. And what was Congress's response? We made it even harder for the FTC to regulate advertising for children than it is to regulate advertising for adults. My bill will restore the authority of the FTC to regulate marketing to kids, and it encourages the FTC to do so.

The fourth component of the HeLP American Act addresses Reimbursements for Prevention Services. Right now, our medical system is setup to pay doctors to perform a $20,000 gastric bypass instead of offering advice on how to avoid such risky procedures. The bill will reimburse and reward physicians for practicing prevention and screenings. It will also expand Medicare coverage to pay for counseling for nutrition and physical activity, mental health screenings, and smoking-cessation programs. It also would establish a demonstration project in the Medicare program, long overdue in my opinion, under which we can learn how best to use our health care dollars to prevent chronic diseases rather than just manage them once they've occurred. Frankly, it's a little embarrassing that we haven't done this before.

Finally, let me point out that the HeLP America Act will be paid for by creating a new National Health Promotion Trust Fund paid for through penalties on tobacco companies that fail to cut smoking rates among children, by ending the taxpayer subsidy of tobacco advertising, and also by reinstating the top income tax rates for wealthy Americans.

It's time for the Senate to lead America in a new direction. We need a new health care paradigm—a prevention paradigm.

Some will argue that avoiding obesity and preventable disease is strictly a matter of personal responsibility. Well, we all agree that individuals should act responsibly. I'm all for personal responsibility. But I also believe in government responsibility. Government has a responsibility to ensure that people have the information and tools and incentives they need to take charge of their health. And that is what the HeLP America Act is all about.

Of course, this description of my bill just scratches the surface. The HeLP America Act is comprehensive. It is ambitious. And I fully expect an uphill fight in some quarters of Congress.

But just as with the Americans with Disabilities Act 14 years ago, I am committed to doing whatever it takes—and for as long as it takes—to pass this critically needed legislation.

It's time to heed the Golden Rule of Holes, which says: When you are in a hole, stop digging. Well, we have dug one whopper of a hole by failing to emphasize prevention and wellness. And it's time to stop digging.

By Mr. THUNE (for himself, Ms. SNOWE, Mr. BINGAMAN, Ms. COLLINS, Mr. DOMENICI, Mr. GREGG, Mr. JOHNSON, Mr. LOTT, Ms. MURKOWSKI, Mr. STEVENS, and Mr. SUNUNU):

S. 1075. A bill to postpone the 2005 round of defense base closure and realignment; to the Committee on Armed Services.

Mr. THUNE. Mr. President, I rise today to introduce a bill that would delay the implementation of the 2005 round of the Defense Base Closure and Realignment report issued by the Department of Defense on May 13, 2005. The bill would postpone the execution of any decisions recommended in the report until certain anticipated events, having potentially large or unforeseen implications for our military force structure, have occurred, and both the department and Congress have had a chance to fully study the effects such events will have on our base requirements.

The bill identifies three principal actions that must occur before implementation of BRAC 2005. First, there must be a complete analysis and consideration of the recommendations of the Commission on Review of Overseas Military Structures. The overseas base commission has itself called upon the Department of Defense to ''slow down and take a breath'' before moving forward on basing decisions without knowing exactly where units will be returned and if those installations are prepared or equipped to support units that will return from garrisons in Europe, consisting of approximately 70,000 personnel.

Second, BRAC should not occur while this country is engaged in a major war and rotational deployments are still ongoing. We have seen enough disruption of both military and civilian institutions due to the logistical strain brought about by these constant rotations of units and personnel to Iraq and Afghanistan without, at the same time, initiating numerous base closures and the multiple transfer of units and missions from base to base. This is simply too much to ask of our military, our communities and the families of our

servicemen and women, already stretched and over-taxed. And frankly, our efforts right now must be devoted to winning the global war on terrorism, not packing up and moving units around the country.

Our bill would delay implementation of BRAC until the Secretary of Defense determines that substantially all major combat units and assets have been returned from deployment in the Iraq theater of operations, whenever that might occur.

Third, to review or implement the BRAC recommendations without having the benefit of either the Commission or Congress studying the Quadrennial Defense Review, due in 2006, and its long-term planning recommendations seems counter-intuitive and completely out of logical sequence. Therefore, the bill requires that Congress receive the QDR and have an opportunity to study its planning recommendations as one of the conditions before implementing BRAC 2005.

Fourth and Fifth: BRAC should not go forward until the implementation and development by the Secretaries of Defense and Homeland Security of the National Maritime Security Strategy; and the completion and implementation of Secretary of Defense's Homeland Defense and Civil Support Directive—only now being drafted. These two planning strategies should be key considerations before beginning any BRAC process.

Finally, once all these conditions have been met, the Secretary of Defense must submit to Congress, not later than one year after the occurrence of the last of these conditions, a report that assesses the relevant factors and recommendations identified by the Commission on Review of Overseas Base Structure; the return of our thousands of troops deployed in overseas garrisons that will return to domestic bases because of either overseas base reduction or the end of our deployments in the war; and, any relevant factors identified by the QDR that would impact, modify, negate or open to reconsideration any of the recommendations submitted by the Secretary of Defense for BRAC 2005.

This proposed delay only seems logical and fair. There is no need to rush into decisions, that in a few years from now, could turn out to be colossal mistakes. We can't afford to go back and rebuild installations or relocate high-cost support infrastructure at various points in this country once those installations have been closed or stripped of their valuable capacity to support critical missions. I, therefore, introduce this legislation today and call upon my colleagues to join us in supporting its passage.

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. 1075

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. POSTPONEMENT OF 2005 ROUND OF DEFENSE BASE CLOSURE AND REALIGNMENT.

(a) POSTPONEMENT.—Effective May 13, 2005, the Defense Base Closure and Realignment Act of 1990 (part A of title XXIX of Public Law 101–510; 10 U.S.C. 2687 note) is amended by adding at the end the following:

''SEC. 2915. POSTPONEMENT OF 2005 ROUND OF DEFENSE BASE CLOSURE AND REALIGNMENT.

''(a) IN GENERAL.—Notwithstanding any other provision of this part, the round of defense base closure and realignment otherwise scheduled to occur under this part in 2005 by reasons of sections 2912, 2913, and 2914 shall occur instead in the year following the year in which the last of the actions described in subsection (b) occurs (in this section referred to as the 'postponed closure round year').

''(b) ACTIONS REQUIRED BEFORE BASE CLOSURE ROUND.—(1) The actions referred to in subsection (a) are the following actions:

''(A) The complete analysis, consideration, and, where appropriate, implementation by the Secretary of Defense of the recommendations of the Commission on Review of Overseas Military Facility Structure of the United States.

''(B) The return from deployment in the Iraq theater of operations of substantially all (as determined by the Secretary of Defense) major combat units and assets of the Armed Forces.

''(C) The receipt by the Committees on Armed Services of the Senate and the House of Representatives of the report on the quadrennial defense review required to be submitted in 2006 by the Secretary of Defense under section 118(d) of title 10, United States Code.

''(D) The complete development and implementation by the Secretary of Defense and the Secretary of Homeland Security of the National Maritime Security Strategy.

''(E) The complete development and implementation by the Secretary of Defense of the Homeland Defense and Civil Support directive.

''(F) The receipt by the Committees on Armed Services of the Senate and the House of Representatives of a report submitted by the Secretary of Defense that assesses military installation needs taking into account—

''(i) relevant factors identified through the recommendations of the Commission on Review of Overseas Military Facility Structure of the United States;

''(ii) the return of the major combat units and assets described in subparagraph (B);

''(iii) relevant factors identified in the report on the 2005 quadrennial defense review;

''(iv) the National Maritime Security Strategy; and

''(v) the Homeland Defense and Civil Support directive.

''(2) The report required under subparagraph (F) of paragraph (1) shall be submitted not later than one year after the occurrence of the last action described in subparagraphs (A) through (E) of such paragraph.

''(c) ADMINISTRATION.—For purposes of sections 2912, 2913, and 2914, each date in a year that is specified in such sections shall be deemed to be the same date in the postponed closure round year, and each reference to a fiscal year in such sections shall be deemed to be a reference to the fiscal year that is the number of years after the original fiscal year that is equal to the number of years that the postponed closure round year is after 2005.''.

(b) INEFFECTIVENESS OF RECOMMENDATIONS FOR 2005 ROUND OF DEFENSE BASE CLOSURE AND REALIGNMENT.—Effective May 13, 2005, the list of military installations recommended for closure that the Secretary of Defense submitted pursuant to section 2914(a) of the Defense Base Closure and Realignment Act of 1990 shall have no further force and effect.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 145—DESIGNATING JUNE 2005 AS ''NATIONAL SAFETY MONTH''

Mr. DEWINE (for himself and Mrs. FEINSTEIN) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 145

Whereas the mission of the National Safety Council is to educate and influence society to adopt safety, health, and environmental policies, practices, and procedures that prevent and mitigate human suffering and economic losses arising from preventable causes;

Whereas the National Safety Council works to protect lives and promote health with innovative programs;

Whereas the National Safety Council, founded in 1913, is celebrating its 92nd anniversary in 2005 as the premier source of safety and health information, education, and training in the United States;

Whereas the National Safety Council was congressionally chartered in 1953, and is celebrating its 52nd anniversary in 2005 as a congressionally chartered organization;

Whereas even with advancements in safety that create a safer environment for the people of the United States, such as new legislation and improvements in technology, the unintentional-injury death toll is still unacceptable;

Whereas the National Safety Council has demonstrated leadership in educating the Nation in the prevention of injuries and deaths to senior citizens as a result of falls;

Whereas citizens deserve a solution to nationwide safety and health threats;

Whereas such a solution requires the cooperation of all levels of government, as well as the general public;

Whereas the summer season, traditionally a time of increased unintentional-injury fatalities, is an appropriate time to focus attention on both the problem and the solution to such safety and health threats; and

Whereas the theme of ''National Safety Month'' for 2005 is ''Safety: Where We Live, Work, and Play'': Now, therefore, be it

Resolved, That the Senate—

(1) designates June 2005 as ''National Safety Month''; and

(2) requests that the President issue a proclamation calling upon the people of the United States to observe the month with appropriate ceremonies and activities that promote acknowledgment, gratitude, and respect for the advances of the National Safety Council and its mission.

Mr. DEWINE. Mr. President, today I join with Senator FEINSTEIN to submit a resolution to designate June 2005 as ''National Safety Month.'' This year, the National Safety Council has selected ''Safety: Where We Live, Work, and Play'' as the theme for National Safety Month.

Public safety in our homes, communities, workplace, and on our roads and highways is a vital challenge that we must constantly address. According to