and taxation of commercial transaction on the Internet, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. HARKIN (for himself, Mr. CHAFEE, and Mr. GRAHAM):

S. 1889. A bill to reduce tobacco use by children and others through an increase in the cost of tobacco products, the imposition of advertising and marketing limitations, assuring appropriate tobacco industry oversight, expanding the availability of tobacco use cessation programs, and implementing a strong public health prevention and education strategy that involves the private sector, schools, States, and local communities; read the first time.

By Mr. DASCHLE (for himself, Mr. KENNEDY, Mrs. BOXER, Mr. DODD, Ms. MIKULSKI, Mrs. FEINSTEIN, Mr. DURBIN, Mr. REED, Mr. INOUYE, Mr. TORRICELLI, Mr. KERRY, Ms. MOSELEY-BRAUN, Mr. WYDEN, Mr. LAUTENBERG, Mr. ROCKEFELLER, Mr. CLELAND, Mr. LEAHY, Mrs. MURRAY, Mr. WELLSTONE, Mr. SARBANES, Mr. AKAKA, and Mr. BINGAMAN):

S. 1890. A bill to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; to the Committee on Labor and Human Resources.

By Mr. DASCHLE (for himself, Mr. KENNEDY, Mrs. BOXER, Mr. DODD, Ms. MIKULSKI, Mrs. FEINSTEIN, Mr. DURBIN, Mr. REED, Mr. INOUYE, Mr. TORRICELLI, Mr. KERRY, Ms. MOSELEY-BRAUN, Mr. WYDEN, Mr. LAUTENBERG, Mr. ROCKEFELLER, Mr. CLELAND, Mr. LEAHY, Mrs. MURRAY, Mr. WELLSTONE, Mr. SARBANES, Mr. AKAKA, and Mr. BINGAMAN):

S. 1891. A bill to amend the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage; to the Committee on Finance.

By Mr. KYL:

S. 1892. A bill to provide that a person closely related to a judge of a court exercising judicial power under article III of the United States Constitution (other than the Supreme Court) may not be appointed as a judge of the same court, and for other purposes; to the Committee on the Judiciary.

By Mr. DEWINE (for himself, Mr. HATCH, Mr. LEAHY, and Mr. SPECTER):

S. 1893. A Bill to establish a law enforcement block grant program; to the Committee on the Judiciary.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Mr. FRIST (for himself and Mr. THOMPSON):

S. Res. 203. A bill expressing the sense of the Senate that the University of Tennessee Lady Volunteers basketball team is the new dynasty in collegiate women's basketball; considered and agreed to.

By Mr. FORD (for himself and Mr. MCCONNELL):

S. Res. 204. A resolution to commend and congratulate the University of Kentucky on its men's basketball team winning its seventh National Collegiate Athletic Association championship; considered and agreed to.

By Mr. FAIRCLOTH (for himself, Mr. JEFFORDS, Mr. BOND, Mr. FRIST, Mr. CHAFEE, and Mr. INOUYE):

S. Res. 205. A resolution expressing the sense of the Senate that the Nation should recognize the contributions of public health and prevention services to this Nation and celebrate ''National Public Health Week'' during the week of April 6 through April 12, 1998; to the Committee on the Judiciary.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. ROBERTS:

S. 1884. A bill to amend the Commodity Exchange Act to remove the prohibition on agricultural trade options outside contract markets; to the Committee on Agriculture, Nutrition, and Forestry.

THE TRADE OPTIONS FOR FARMERS AND RANCHERS ACT

Mr. ROBERTS. Mr. President, today I am pleased to introduce the Trade Options for Farmers and Ranchers Act (TOFRA). This legislation will provide farmers and ranchers across the United States with new, improved and affordable risk management products to help producers succeed in the 21st century.

This bill fulfills a promise we made to America's farmers and ranchers during the 1996 farm bill debate. The far-reaching, market-oriented reforms contained in the Freedom to Farm Act have provided substantial financial benefits to agriculture producers throughout the country. At the same time, this policy must be buttressed by proper risk management tools, regulatory relief, tax changes and a consistent, strong export policy. As a result, while leading the fight to get the federal government out of producers' daily lives and pocket-books, I promised to fight for better tools to help manage the tremendous financial risk that is inherent in life on the farm today.

The TOFRA would repeal the Commodity Futures Trading Commission's prohibition on the sale of over-the-counter agriculture trade options. The CFTC ban dates to the Great Depression. It was put in place during a time when financial and commodity markets were viewed with both suspicion and fear. Today, we live in a time of mutual funds, computerized financial transactions and round-the-clock, global commodity trading. While we should never forget the important lessons of the Great Depression, we must not let the troubling memories of the past hold back our nation's farmers and ranchers when there is so much promise in the future.

The CFTC's agriculture option ban created a monopoly. Today, if a farmer or rancher wants to hedge his price risk with an agriculture option, he must purchase the option from a commodity exchange. Over the years, the exchanges have performed a valuable service to farmers and ranchers by giving them the opportunity to manage their price risk in a regulated environment. Despite their best efforts, organized exchanges—primarily as a result of excessive regulation—have not been able to keep up with the tremendous demand in Farm Country for newer, better alternatives to existing risk management tools.

I will continue to support legislative efforts to allow all interested parties—commodities exchanges included—to sell a wider variety of financial products. In fact, I continue to be frustrated with the CFTC's unwillingness to provide organized exchanges with the same basic business opportunities available to over-the-counter brokers. This bias is unfortunate and counter-productive to both buyers and sellers of commodities.

At the same time, overly restrictive regulations are preventing America's farmers and ranchers from receiving the new, innovative products they need. The CFTC ban on over-the-counter agriculture options has been maintained in order to ''save farmers from themselves.'' The argument here is that farmers, grain elevators and others in rural America don't understand how options work. Therefore, the federal government has seen fit to limit severely the development of, and competition in, financial instruments that would provide substantial benefits to producers who understand commodity marketing in order to protect the few remaining producers who have no interest in managing price risk. Basically, current federal policy in this area is targeted towards the 1930s instead of the 2030s.

Agriculture options are complex, expensive financial instruments. In order to use them properly, producers must have specialized knowledge of commodity marketing and the risks associated with participating in them. As a result, many producers may choose not to use the additional financial products made possible through this legislation. However, agriculture options should be readily available to those producers with the skill, knowledge and desire to use them.

It is important that agriculture options—whether sold on an organized commodity exchange or through an over-the-counter broker—be sufficiently regulated. This legislation will simply make agriculture options just like all other options. If you purchase an option on wheat, natural gas or common stock, the bookkeeping, registration and disclosure requirements should be the same. Similarly, strong protections against fraud and manipulation are included to help prevent and punish fly-by-night operations and bucket-shops. In short, this bill establishes a simple formula: provide business opportunity with limited, but vigorously enforced rules. With proper oversight, this bill will be good for producers, brokers, businesses and consumers alike.

I do want to thank the CFTC for recently submitting a proposed rule that would begin to lift its long-held ban on over-the-counter agriculture trade options. They have taken the initial step toward removing the ban on off-exchange agriculture options trading. Unfortunately, the CFTC's proposal is so limited, so burdened with red-tape and reporting requirements, that significant benefit is doubtful. No new

products, no improved products and no more competition to drive down the price of risk management for America's farmers and ranchers.

I am hopeful this legislation will renew CFTC interest in a workable regulation to govern agriculture option trading. I also urge the CFTC to act quickly to make these important tools available to America's farmers and ranchers. In conclusion, let me simply say this: if we give our producers a helping hand and appropriate safeguards, they will do the rest.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1884

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

SECTION 1. AGRICULTURAL TRADE OPTIONS OUTSIDE CONTRACT MARKETS.

The Commodity Exchange Act is amended by inserting after section 4p (7 U.S.C. 6p) the following:

"SEC. 4q. AGRICULTURAL TRADE OPTIONS OUTSIDE CONTRACT MARKETS.

''(a) DEFINITIONS.—In this section:

''(1) AGRICULTURAL TRADE OPTION OUTSIDE A CONTRACT MARKET.—The term 'agricultural trade option outside a contract market' means an agreement, contract, or transaction (or class thereof) entered into on other than a contract market for—

''(A) the purchase of an agricultural trade option involving a commodity by a person who is a producer, processor, commercial user, or merchant handler of the commodity;

''(B) the sale or transfer of an agricultural trade option involving a commodity; or

''(C) a purpose related to the business of a person referred to in subparagraph (A).

''(2) COMMODITY.—The term 'commodity' means an agricultural commodity referred to in section 1a(3).

''(b) AUTHORIZATION.—Subject to subsection (c), an agricultural trade option outside a contract market shall be permitted and shall be considered to be consistent with the other provisions of this Act.

''(c) REGULATION.—

''(1) SAFEGUARDS.—Subject to paragraph (2), an agricultural trade option outside a contract market shall, to the extent determined to be applicable by the Board, be subject to—

''(A) sections 4b and 4o;

''(B) the provisions of sections 6(c) and 9(a)(2), to the extent that the provisions prohibit manipulation of the market price of any commodity in interstate commerce for future delivery;

''(C) prohibitions against fraud or manipulation under section 4c(b);

''(D) registration requirements of the Commission administered by the National Futures Association;

''(E) a requirement that the person providing the option has a net worth of at least $50,000;

''(F) requirements for full disclosure of risks and responsibilities involved in the contract or agreement for the option; and

''(G) recordkeeping and reporting requirements of the Commission.

''(2) LIMITATIONS.—

''(A) TOTAL ASSETS.—Except for the fraud and manipulation provisions of the provisions of law referred to in subparagraphs (A), (B), and (C) of paragraph (1), paragraph (1) shall not apply to an agricultural trade option outside a contract market if the buyer and seller of the option each have assets of a value of at least $10,000,000.

''(B) PHYSICAL DELIVERY; STRUCTURE AND STRATEGIES.—An agricultural trade option outside a contract market shall not be subject to—

''(i) a requirement that the option, if exercised, be physically delivered; or

''(ii) a limitation on the structure of the option or trading strategies for the use of the option.

''(c) TERMINATION OF EFFECTIVENESS.—The authority provided by this section terminates effective September 30, 2002.''.

SEC. 2. CONFORMING AMENDMENTS.

(a) Section 4(a) of the Commodity Exchange Act (7 U.S.C. 6(a)) is amended—

(1) in paragraph (1), by inserting ''(A)'' after ''(1)'';

(2) by redesignating paragraphs (2) and (3) as subparagraphs (B) and (C), respectively;

(3) in subparagraph (C) (as so redesignated), by striking the period at the end and inserting ''; or''; and

(4) by adding at the end the following:

''(2) the contract is an agricultural trade option outside a contract market permitted under section 4q.''.

(b) Section 4c(b) of the Commodity Exchange Act (7 U.S.C. 6c(b)) is amended in the first sentence by striking ''No'' and inserting ''Except as provided in section 4q, no''.

SEC. 3. REGULATIONS.

Not later than 90 days after the date of enactment of this Act, the Commodity Futures Trading Commission shall issue such regulations as the Commission determines are necessary to carry out this Act and the amendments made by this Act.

By Mr. D'AMATO (for himself, Mr. ROCKEFELLER, Mrs. HUTCHISON, Mrs. FEINSTEIN, and Mrs. BOXER):

S. 1885. A bill to amend the Internal Revenue Code of 1986 to provide for a medical innovation tax credit for clinical testing research expenses attributable to academic medical centers and other qualified hospital research organizations; to the Committee on Finance.

THE MEDICAL INNOVATION TAX CREDIT ACT OF 1998

Mr. D'AMATO. Mr. President, I rise today to introduce legislation with my colleagues, Senators ROCKEFELLER, HUTCHISON, FEINSTEIN and BOXER, to create a new tax credit that will make it easier for medical schools, teaching hospitals, and non-for-profit research hospitals to invest in potentially life saving medical research. Our bill will add Section 41A to the Internal Revenue Code to establish a Medical Innovation Tax Credit. This new credit would apply to qualified medical innovation expenses for biopharmaceutical research activities, including clinical trials, at qualified academic institutions. The credit rate would be 20% of qualified expenses on research conducted in the United States. This tax incentive is necessary in order to assure that the United States maintains its position as the leading country for biomedical research.

The Medical Innovation Tax Credit will supplement the current law Research and Experimental Tax Credit (R&E) which has allowed biopharmaceutical companies to invest hundreds of billions of dollars in research for new drug therapies. Clinical trials are conducted by these drug companies in order to obtain FDA approval. However, these initial studies are only a fraction of the applied research needed to follow patients and to discover possible combinations of drugs which provide the most effective therapy. These post-approval studies are performed by clinical investigators and major academic medical centers.

Until recently, medical schools, teaching hospitals, and not-for-profit hospitals were able to fund research from their operating profits. Many physicians chose to practice at these hospitals at a reduced salary based on the opportunity to engage in teaching and clinical research. With the profound changes in the health care industry over the last few years, this profit no longer exists. In the era of managed care, many insurance companies are reimbursing physicians and hospitals at the cost of services. Combined with cuts in Medicare payments and reduced subsidies for graduate medical education, teaching hospitals can barely afford to pay their medical staff's salary, let alone fund its research.

These financing changes have had the largest impact on hospitals affiliated with academic medical centers. A recent study found a 22% decline in clinical research conducted at member hospitals of the Association of American Medical College's Council of Teaching Hospitals. This drop is alarming because it demonstrates that these hospitals no longer have the financial resources to contribute to the public's health. Traditionally, academic medical centers trained new doctors, supported applied biomedical research, and provided the bulk of uncompensated care for uninsured patients. Under this system medical residents had the opportunity to treat a wide spectrum of patients, regardless of their health insurance status. In addition, uninsured patients were able to receive the latest care within the scope of clinical trials performed at academic hospitals. With reductions in private and public funding these medical centers have been forced to reduce these social services to compete with for-profit-hospitals with no research agenda. This development promises only to stagnate the level of care and number of treatment options that the next generation of doctors can offer their patients.

Mr. President, my state of New York has 12 medical schools and 40 teaching hospitals, in addition to 8 designated cancer centers. Each of these institutions will be eligible for the Medical Innovation Tax Credit. Without continued funding of research at these institutions, many New Yorkers will recognize a profound effect upon the quality of their health care. Without the opportunity to conduct research many of the country's top doctors may leave to

practice in locations where they can earn more money. Such a move will also reduce the need for research specialists and their staffs. Patients will have to choose between hospitals that only recognize the bottom line while their children will not enjoy the same medical advances as they did. Many uninsured patients will not be able to receive uncompensated care and will not be able to receive the most advanced medicine possible.

And these changes aren't just particular to my state. Almost every state has a medical school which serves as the epicenter for a network of teaching hospitals which employ thousands of physicians, nurses, research specialists, and support staff. A large percentage of each state's economy is based on these medical centers. Thus, we all stand to recognize two main benefits from the Medical Innovation Tax Credit, more jobs and better health. Only by encouraging private investment in medical research can our health care infrastructure develop new and innovative ways to deliver the most advanced care to all citizens of our country.

We urge all of our colleagues to support this legislation that will restore to medical schools and teaching hospitals the ability to perform applied biomedical research to help treat and cure many of our pressing health needs such as cancer and heart disease. This is a targeted measure which has widespread benefits for all citizens.

Mrs. FEINSTEIN. Mr. President, I rise today to join Senator D'AMATO, Senator BOXER, Senator ROCKEFELLER and others in support of legislation to create the Medical Innovation Tax Credit. The proposed tax credit can be an effective complement to the existing research and experimentation tax credit. The new proposal will support additional medical research at fine research universities, like the University of California and Stanford University, assisting in the development of new products to improve health and save lives. I am pleased to support Senator D'AMATO's proposal.

Under the legislation, the Medical Innovation Tax Credit would provide a pharmaceutical or biotechnology company with a tax credit equal to 20% of their expenditures for human drug clinical trials conducted at medical schools, university teaching hospitals or non-profit research hospitals working in conjunction with the National Institutes of Health.

The proposal will provide an important incentive to conduct the research trials in the university hospital setting, improving academic training, health care and the development of new research and bio-medical products.

The legislation will assist medical schools and research institutions leverage additional private sector support for medical schools and teaching hospitals. Teaching hospitals have historically been an important site of research activity. However, partially because of the universities' broad education mission, teaching hospitals face a cost-disadvantage when compared to a ''for profit'' contract research organization. This new research credit will help level the playing field for medical schools and teaching hospitals.

The proposal will help provide, in an indirect manner, additional resources for medical research. The administration and Congress both enthusiastically support increasing federal support for medical research through the National Institutes of Health. However, with our acute budget needs, Congress may face difficulty in meeting our goals. Congress can provide new sources of revenue for these research hospitals by encouraging them to serve as sites for clinical trials. Only clinical research activities conducted in the United States can qualify for the credit, decreasing the economic incentive to move the research activities to lower cost facilities off-shore.

The support is appropriate because academic health centers address important societal priorities, accepting expenses other medical facilities may not have to incur.

University-based teaching hospitals provide a disproportionate share of high-cost, critical services to low-income or uninsured individuals.

University-based teaching hospitals carry a higher burden of necessary, but in many cases unprofitable, services, such as emergency trauma care and burn unit facilities. Academic health centers represent only 2% of all non-federal community hospitals, but have 33% of the trauma units and 50% of its burn units.

The credit will help provide, in an indirect manner, additional funds for medical research by encouraging them to serve as clinical trial sites. The infusion of research dollars will support their vital missions.

The proposal will help arrest the declining rate of clinical research trials conducted at these facilities.

The American Association of Medical Colleges, which supports the legislation, reports a 22% drop in clinical research at member hospitals.

A recent study of three pharmaceutical companies indicates that although pharmaceutical R&D is larger than the research funds of the National Institutes of Health, the level of university-based clinical trials has declined from 82% in 1989 to 68% in 1993.

This proposal can help schools arrest the steady, five year decline and make the most of their research dollars.

The credit will serve as an effective supplement to the current Research and Experimentation Credit and the Orphan Drug Tax Credit and provide a cost-effective incentive to encourage companies to pursue research in an academic setting. The credit will promote research at teaching hospitals, lead to the development of stronger research universities, contribute to new medical therapies and products and strengthen our world leadership in the important field of medical innovation. I am pleased to lend my support.

Mrs. BOXER. Mr. President, I want to take a few minutes to talk about an important piece of legislation which is being introduced today, the ''Medical Innovation Tax Credit.'' I am an original co-sponsor of this legislation.

The Medical Innovation Tax Credit will establish a new, free-standing credit in the Internal Revenue Code. The credit, modeled after a law in my home state of California, provides a targeted tax incentive for companies to increase clinical trials at medical schools and teaching hospitals. The California law has been successful in encouraging biotechnology and pharmaceutical companies to expand their pioneering research activities at medical schools and teaching hospitals throughout the state. The Medical Innovation Tax Credit will encourage and stimulate such pioneering research in California and throughout the country.

Many medical institutions today face significant financial pressures as a result of fundamental changes in the health care marketplace. With fewer funding sources available, medical schools, teaching hospitals, and charitable research hospitals designated as cancer centers by the National Cancer Institute (NCI), are having to cut back on their cutting-edge research activities.

The Medical Innovation Tax Credit will help alleviate some of these financial pressures by encouraging more clinical trials to be conducted at medical schools, hospitals and NCI-designated cancer centers; thus providing these institutions additional private sector resources to fund cutting-edge medical research projects which otherwise may not have been funded. These extra resources will also enhance research and training opportunities, thereby ensuring our nation's continued leadership in innovative medical research.

Moreover, the Medical Innovation Tax Credit encourages companies to conduct their research activities here in the United States since only domestic clinical trials are eligible for the credit. By decreasing the economic incentive to move such activities offshore, more clinical research projects will be conducted in the U.S. Such domestic based research will ultimately lead to increased jobs, investments and productivity here at home.

So, Mr. President, I am very proud to support this bill and I congratulate my colleague Senator D'AMATO for his hard work on this legislation. The enactment of this legislation will provide important resources for our nation's leading medical schools, teaching hospitals and NCI-designated cancer centers and it will help ensure America's continued preeminence in innovative medical research. I encourage my colleagues to join in supporting the Medical Innovation Tax Credit.

By Mr. DURBIN (for himself and Ms. MOSELEY-BRAUN):

S. 1886. A bill to designate the facility of the United States Postal Service

located at 3750 North Kedzie Avenue in Chicago, Illinois, as the ''Daniel J. Doffyn Post Office Building''; to the Committee on Governmental Affairs.

THE DANIEL J. DOFFYN POST OFFICE BUILDING DESIGNATION ACT OF 1998

Mr. DURBIN. Mr. President, I rise today together with my distinguished colleague, Senator CAROL MOSELEY-BRAUN, to introduce legislation to designate the United States Post Office facility at 3750 North Kedzie Avenue in Chicago, Illinois, as the ''Daniel J. Doffyn Post Office Building.''

This legislation honors the service and heroism of Daniel Doffyn, a 40-year-old rookie officer with the Chicago Police Department, who was fatally shot in the line of duty two years ago.

On the afternoon of March 8, 1995, Daniel Doffyn and his partner, Milan ''Mike'' Bubalo, who had just completed their regular shift, responded to a report of a burglary in progress. What they encountered, in broad daylight, just a few steps away from the Austin precinct house on Chicago's West Side, were three gun-wielding gang members hiding in an apartment. Believing the officers to be there to arrest them for their involvement in an earlier gang shooting, the trio panicked and tried to escape through a window.

After capturing one suspect, Doffyn was shot in the head and chest by a second man, who opened fire with a TEC-DC9 semiautomatic pistol, one of the 19 assault weapons banned under the 1994 Federal law. Officer Doffyn died in surgery later that evening. In the barrage of gunfire, Officer Bubalo was seriously wounded in the thigh, and has an artificial left hip as a result of the shooting.

Officer Doffyn tragically lost his life in the course of performing a job that he truly loved, less than a year after graduating from the Chicago Police Academy, following a three-year quest to fulfill a dream to protect and serve his community. If someone needed help, Danny Doffyn was the first one there. In the words of District Commander LeRoy O'Shield, ''he exemplified the very finest the police department has to offer. He was not assigned this job but responded to it.''

The post office sought to be designated is in the neighborhood where Officer Doffyn, who was posthumously awarded the Medal of Valor for his ultimate sacrifice, resided with his parents, bicycled and roller skated with his eight-year-old daughter, Brittany, and donned his blue uniform and police star #14030 with pride.

We trust our colleagues will agree that this designation is a worthy tribute to salute the life and courage of Daniel Doffyn, and to pay respect to the thousands of men and women in law enforcement careers who risk their lives every single day striving to keep our citizens, streets, and sidewalks safe.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1886

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

SECTION 1. DESIGNATION OF DANIEL J. DOFFYN POST OFFICE BUILDING.

(a) IN GENERAL.—The facility of the United States Postal Service located at 3750 North Kedzie Avenue in Chicago, Illinois, shall be known and designated as the ''Daniel J. Doffyn Post Office Building''.

(b) REFERENCES.—Any reference in a law, map, regulation, document, paper, or other record of the United States to the facility of the United States Postal Service referred to in subsection (a) shall be deemed to be a reference to the ''Daniel J. Doffyn Post Office Building''.

By Mr. HARKIN (for himself, Mr. CHAFEE, and Mr. GRAHAM):

S. 1889. A bill to reduce tobacco use by children and others through an increase in the cost of tobacco products, the imposition of advertising and marketing limitations, assuring appropriate tobacco industry oversight, expanding the availability of tobacco use cessation programs, and implementing a strong public health prevention and education strategy that involves the private sector, schools, States, and local communities; read the first time.

THE KIDS DESERVE FREEDOM FROM TOBACCO ACT OF 1998

Mr. HARKIN. Mr. President, today I am joined by my colleagues Senators JOHN CHAFEE, BOB GRAHAM in introducing the first bipartisan comprehensive proposal to cut youth smoking—The Kids Deserve Freedom From Tobacco Act, or simply, The KIDS Act. Today marks the turning point in the drive for tobacco reform this year.

Before I go further, I want to thank my partners in this effort, JOHN CHAFEE and BOB GRAHAM. They are real heroes in the fight to save kids from tobacco. They've taken significant risks in joining this effort. And they have done a terrific job in putting our proposal together. This has truly been a bipartisan team effort.

I also want thank the leaders of the public health community who have joined us to support our efforts. They will play a critical role in shaping the course of this historic tobacco reform effort in the coming months. And their support is vital to the success of The KIDS Act. Finally, I want to thank Dr. C. Everett Koop and Dr. David Kessler, for their help and counsel to us in crafting our proposal.

We are introducing this bill because we face a public health crisis affecting our children. 3,000 kids start smoking every day and fully 1,000 of them will die prematurely because of it. That's the equivalent of 3 jumbo jets packed with kids crashing every day. 400,000 Americans die every year of tobacco related illness at a cost of over $50 billion. And the tobacco industry has been engaged in a systematic campaign of distortion and deceit to hook kids and hide the facts from the American people.

Tobacco reform is the issue of 1998. It is the crown jewel of this Congress. And passing a tobacco bill like the KIDS Act is a once and a lifetime opportunity. Unfortunately, though, the tobacco debate so far has been largely partisan. That's why we've joined arms across party lines behind the KIDS Act. We hope and believe that the introduction of our bipartisan bill will change the debate and significantly increase the odds that reforms will be made.

The KIDS Act would cut tobacco use by kids in half over the next three years through aggressive and comprehensive reforms. That's the sharpest and fastest reduction achieved by any bill proposed to date. Our goal is to cut it by at least 65 percent shortly after that. The Food and Drug Administration has found that reducing the use of tobacco by children by 50 percent could prevent well over 60,000 premature deaths every year, and will save up to $43 billion annually in reduced medical costs and improved productivity.

Now is not the time for anything but the strongest, most effective bill possible.

Experts agree that a substantial price hike over a very short period of time is key to changing teen smoking behavior. If left unchanged, the Commerce Committee draft bill, which spreads a $1.10 price increase over 5 years will do little to impact teen smoking. In contrast, the KIDS Act increases the price by $1.50 in just two years, achieving a 50% reduction in just three years. That's the bottom line and anything less is just smoke and mirrors.

In addition, our bill gets tough on the individual companies that addict the most kids by imposing tough penalties if the company doesn't meet teen smoking reduction targets. I'm very concerned that the Commerce Committee proposes no company-specific penalty. Without a profit-based deterrent, the penalty will just be passed through to consumers, giving companies no incentive to cut youth smoking.

Finally, our bill caps the annual liability of the tobacco industry as part of a tough, comprehensive bill that dramatically reduces youth smoking. Without a tough public health bill, the annual liability cap is not acceptable.

As Drs. Koop and Kessler say in their letter, our bill is ''tough medicine for a tough problem.'' Our proposal sends a simple message to the tobacco industry: Keep away from our kids. Our plan will be a very, very bitter pill for the industry. And no doubt they will criticize us. But in the end, I believe they are going to have to swallow it.

Creating a more sensible policy toward tobacco has been a goal of mine for many years. It was in 1977, over 21

years ago, that I first introduced legislation calling for repeal of the tax deductibility of tobacco advertising and marketing.

Unfortunately, victories in the tobacco wars have come few and far between. In 1988, we finally changed federal law on smoking in airplanes. It was a full ten years later, and after failing one time, the Senate took its next step last September by passing the Harkin-Chafee plan to fully fund enforcement of the FDA youth ID check.

But I am more hopeful now than ever that we can pass a comprehensive plan that would once and for all change how this nation deals with tobacco and dramatically cut the number of our kids addicted to this deadly product. Mr. President, our goal is to be on the Senate floor three years from now announcing that indeed, child smoking has been cut in half. We're going to put all our energies into making that happen.

We urge our colleagues to review our proposal and join us in sponsoring it. We look forward to working with all our colleagues on a bicameral, bipartisan basis to make good on the historic opportunity we have this year.

Mr. President, I ask unanimous consent that a summary of the KIDS Act, letters of endorsement of our bill and copies of several editorials in support our the KIDS Act be included in the RECORD.

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

KID DESERVE FREEDOM FROM TOBACCO ACT OF 1998 ''THE KIDS ACT''

Principles

Congress has an historic opportunity to enact legislation this year which will significantly reduce tobacco use—especially among children. Nearly one in five deaths in America today is attributable to tobacco use, making it the single most preventable cause of premature death, disease and disability facing this country. These facts compel us to act now. However, to ensure the most effective result, legislation must embody the following principles:

It must be bipartisan and comprehensive—not piecemeal—to ensure a fundamental and lasting change in the way tobacco products are marketed and sold in this country.

It must attack the youth smoking epidemic as rapidly as possible by forcing the price of cigarettes to increase by $1.50 per pack within the first two years, and providing for comparable increases in other tobacco products.

It must preserve the rights of individuals and groups to sue tobacco manufacturers for the damages they have caused, while at the same time establishing a framework to ensure that funds are available to cover awards and settlements secured by successful claimants.

It must provide incentives to states, local communities, schools, research institutions, health professionals and other stakeholders to develop innovative strategies to discourage youth smoking, and to assist adult smokers in kicking the habit.

It must have as its primary purpose the promotion of aggressive anti-tobacco initiatives and public health improvements, including the provision of significant new resources for medical research.

Summary

The Kids Deserve Freedom From Tobacco Act of 1998 (''The KIDS Act'') significantly improves upon and strengthens the June 1997 Attorneys General Tobacco Settlement Agreement (''June 1997 Tobacco Agreement''). The legislation would substantially reduce youth tobacco use through a comprehensive set of policy changes. These include increasing the cost of tobacco products, curtailing advertising and marketing to children, assuring appropriate industry oversight, expanding the availability of smoking cessation programs, and implementing a strong public health prevention and education strategy involving the private sector, schools, states and local communities.

I. ECONOMIC INCENTIVES

Price Increase. Public health experts agree that the single most important component of a comprehensive plan to reduce youth tobacco use is to significantly increase the price of tobacco products over a short period of time. A gradual increase, phased in over 5 or more years, will not significantly reduce teen tobacco use. Therefore, our proposal would increase the price of a pack of cigarettes by $1.50 within two years ($1.00 the first year; $0.50 the second year). The price of other tobacco products with significant market shares would be increased by a comparable amount. These increases would be achieved through annual industry payments totaling $20 billion the first year and $25 billion per year thereafter (indexed to inflation).

Annual Youth Reduction Targets. There is clear and abundant evidence that the tobacco industry has tailored its marketing and advertising programs to attract and encourage children to smoke. Largely because of the industry's success in this regard, 3,000 children start smoking every day in America. Accordingly, the KIDS Act would make the tobacco industry accountable for promoting and achieving a significant reduction in tobacco use among children. Our proposal would set an ambitious, but realistic schedule for reducing the rate of youth smoking by 65 percent over the next ten years.

The schedule would follow the recommendations of the Final Report of the Advisory Committee on Tobacco Policy and Public Health, chaired by Dr. C. Everett Koop and Dr. David Kessler. The following targets would be set:

Year:	*Percent of reduction*
2	15
3	20
4	25
5	30
6	40
7	50
8	55
9	60
10	65
Beyond	65

(youth prevalence measured by monthly use)

Tough Look-back Penalties. The KIDS Act would impose up to an additional $10 billion per year in non tax-deductible penalties (indexed to inflation) on the tobacco industry for failure to meet these targets. First, and most importantly, company-specific penalties would be imposed to prevent individual manufacturers from achieving any financial reward from addicting children to their products. Second, industry-wide penalties would be assessed for failure to meet the above targets. Finally, unlike the June 1997 Tobacco Agreement, the KIDS Act would provide no abatement or rebate relief to tobacco companies.

Company-specific Penalties: The KIDS Act would impose the strongest possible incentives for individual tobacco companies to stop recruiting and addicting children. It sets up a system of tough and escalating penalties for those companies that miss youth reduction targets. This is crucial because, unlike industry-wide penalties which can be passed on to consumers equally by all companies without affecting market share, company-specific penalties directly tie company profits to reducing teen smoking.

Under the KIDS Act, for each percentage point a company misses between 0 and 10 percent, a penalty of 1 cent per pack is imposed. The penalty doubles for each percentage point missed between 11 and 20 percent and triples for each percentage point missed over 21 percent. For those companies that miss the targets by 20 percent or more for 3 consecutive years, this portion of the penalty is doubled to 6 cents per pack.

Industry-wide Penalties: The KIDS Act imposes a similarly tough penalty structure industry-wide if it fails to meet the youth reduction targets. In addition, if the industry fails to meet the targets for 3 consecutive years, the penalties are doubled.

No Anti-trust Immunity. Anti-trust laws are the most important safeguard we have against anti-competitive actions which hurt consumers and undermine the free market. As such, exceptions to these laws should be made only in rare circumstances, where important policy objectives outweigh the benefit of free market protections. The tobacco industry has not made a persuasive case for the grant of immunity it seeks. Therefore, unlike the June 1997 Tobacco Agreement, the KIDS Act would not extend any anti-trust exemptions to tobacco manufacturers.

State Performance Bonus Pool. The June 1997 Tobacco Agreement and pending legislative initiatives fail to provide strong economic incentives for states and communities to help decrease tobacco use among children. The KIDS Act would address this shortcoming by establishing a $500 million annual ''Performance Bonus Pool'' for states that meet or exceed the reduction targets within their own borders.

This would serve as an important incentive for states and localities to develop aggressive and innovative anti-smoking strategies suited to their own individual needs. State-specific baselines and targets would be developed using a standardized methodology determined by the Centers for Disease Control and Prevention. Furthermore, the KIDS Act would clarify the authority of states and local governments to encourage the enactment of stronger anti-tobacco policies.

II. CHANGING HOW TOBACCO PRODUCTS ARE SOLD

Marketing and Advertising Reforms. The tobacco industry spends an estimated $5 billion per year on marketing and promotional activities—much of it targeted to children. The KIDS Act would fundamentally alter tobacco marketing and advertising practices to eliminate this reprehensible practice.

Health Warning Labeling Reforms. Evidence suggests that the current warning label regime for tobacco product packaging fails to adequately convey to children the risks associated with tobacco use. For example, nearly half of the 8th graders in a 1993 study denied any great risk associated with pack-a-day smoking, despite the presence of health warnings on cigarette packaging. Moreover, consumer research indicates that alterations in format, composition and warning label content would make them far more effective in reaching children. Thus, the KIDS Act proposes to significantly strengthen warning labels on all tobacco products to improve their impact on the behavior of children. These messages would be regularly reviewed and updated by the Secretary of Health and Human Services to reflect

changes in public awareness and attitudes about tobacco use.

Minors' Access Reforms. Illegal sales to minors and shoplifting are the primary means by which children obtain tobacco products. An estimated 516 million packs of cigarettes per year are consumed by minors, of which at least half are obtained through direct, illegal sales to minors. Shoplifting is another serious concern. In Iowa alone, more than 4 million packs of cigarettes are shoplifted every year.

The KIDS Act would address these problems by banning self-service displays in stores that sell tobacco products, prohibiting vending machine sales in places children frequent, requiring retailers to verify age, and fining those vendors caught selling to children. In addition, the KIDS Act would require states to conduct spot checks of tobacco retailers to ensure compliance with minors' access provisions. If a retailer repeatedly violates the law, it could face suspension or revocation of their registration to sell tobacco products. These reforms would build upon those developed by the U.S. Food and Drug Administration (FDA), and those contained in the June 1997 Tobacco Agreement.

Importantly, the tobacco companies would be bound by enforceable consent decrees precluding them from challenging such restrictions in the courts, or providing any means of support to third parties for this purpose.

State Preemption. The KIDS Act would clarify the authority of states and local governments to regulate the sale and use of tobacco products by repealing the preemption clause in existing federal law. However, it would preserve the national requirement for uniform packaging and labeling standards to ensure the free flow of interstate commerce.

AT-A-GLANCE: CHANGING HOW TOBACCO PRODUCTS ARE SOLD

ADVERTISING

B&W text only (except in adult-only facilities and publications).

No human images or cartoon characters.[1]

No outdoor advertising.[1]

No advertising on the Internet.[1]

No self-service displays.

MARKETING

No ''trinkets & trash'' (caps, jackets, bags, etc.) or proof-of-purchase clubs.

No sponsorship of sporting events or other forms of entertainment.

No paid product placement in movies, TV shows, on Internet or video games.[1]

No free samples.

LABELING

Improved and updated warnings.

Increased size.

Rotating messages.

Statements of intended use.

Regularly reviewed and updated by HHS.

MINORS' ACCESS

No distribution or sales to minors under age 18.

Photo id required up to age 27.

Face-to-face sales required.

No single cigarettes sales.

No vending machines sales (except in adult-only facilities).

No self-service sales (except in adult-only facilities).

III. OVERSIGHT AND ENFORCEMENT

FDA Authority. Given the addictive, disease-causing nature of tobacco products, full and appropriate regulation is needed. Therefore, in addition to establishing new advertising and marketing restrictions, the KIDS Act would assure that FDA has the authority to effectively monitor and regulate the manufacture and distribution of tobacco products, promote the development of safer alternatives, and to conduct research. For these purposes, the KIDS Act would allocate $300 million over and above those provided in the annual appropriations process. Importantly, FDA would not be required to overcome special burdens or procedural hurdles in its regulatory activities—a major flaw of the June 1997 Tobacco Agreement. The KIDS Act would classify ''nicotine'' as a drug, and ''tobacco products'' as drug delivery devices (to include cigars, pipes and loose tobacco). In addition, our legislation would authorize FDA to implement a ''public health'' standard in its review of tobacco products.

The FDA's authority over tobacco products would be no more and no less than its authority over other drugs and devices. However, because of the addictive nature of tobacco products, and the high prevalence of their use, the KIDS Act would specifically prohibit the FDA from banning the sale of tobacco products to adults. Finally, the KIDS Act would ensure that FDA has adequate financial resources and appropriate access to tobacco industry documents to carry out its responsibilities.

Ingredient Disclosure. Evidence strongly suggests that tobacco companies design and manufacture their products to satisfy and enhance nicotine dependence. Therefore, increased information about the role and function of tobacco additives is essential to the effective regulation of such products. The KIDS Act would substantially strengthen current ingredient disclosure requirements for tobacco manufacturers. For example, each company would be required, by brand and content, to submit lists of all tobacco additives. Further, if the Secretary of Health and Human Services determines that any of these additives pose a particular risk to smokers or others exposed to tobacco smoke, this information will be fully and promptly disclosed to the public.

Reduced Risk. Much remains unknown about the feasibility and effectiveness of developing a less hazardous tobacco product. However, it is clear that tobacco manufacturers have the ability and knowledge to modify their products. Indeed, various forms of ''reduced risk'' nicotine delivery devices already have been introduced into the market. The KIDS Act would require tobacco companies to come forward with information in their possession about reduced risk products, and provide increased monitoring of new technologies. It would also stop tobacco companies from making misleading claims about these products.

Licensing. There are approximately one million tobacco outlets in the United States, and as recently as 1994, nearly three-fourths sold tobacco products to minors. These include supermarkets, newsstands, hotels, gas stations, convenience stores, and other types of vendors. Additionally, each year interstate cigarette smuggling costs states millions of dollars in lost excise tax revenues. To address these problems, the KIDS Act would establish minimum federal licensing standards for tobacco manufacturers, importers, exporters and distributors, and the registration of tobacco retail establishments. States could continue to impose additional licensing requirements, and would work closely with federal officials to enforce licensing and registration policies, just as they do with the distribution and sales of alcoholic beverages. By providing for the permanent revocation of tobacco licenses and registration permits for repeated violations of any provision of our law. The KIDS Act will put the worst offenders out of the business of making or selling tobacco products.

IV. STOPPING CHILDREN FROM SMOKING BEFORE THEY START

Prevention in Communities and Schools. In addition to economic incentives, changes in tobacco product advertising and marketing, and improved oversight of enforcement, experts agree that a comprehensive slate of public health activities is needed to stop children from taking up this deadly habit. For example, research-tested school programs have proven to consistently and significantly reduce adolescent smoking. Therefore, the KIDS Act would provide $1.25 billion to states for community and school-based prevention activities. These initiatives would be designed and implemented at the local level to ensure their effectiveness.

Because minority and low-income populations suffer a disproportionate burden of tobacco-related disease, and are among the greatest users of tobacco products, the KIDS Act would allocate a portion of the funding for community-based prevention activities to address their special needs. Funding also would be provided to assist Native American populations in their efforts to prevent and reduce youth smoking.

Counter Advertising. Research findings show that well-designed counter advertising initiatives do help to reduce teen smoking. Thus, an intensive, sustained media campaign at the state and federal level is needed to ''deglamorize'' tobacco use among young people. Accordingly, the KIDS Act would provide $650 million annually to fund a nationwide campaign with national, state, and local components. Preeminent advertising firms with proven expertise in the formulation of messages aimed at children would be charged with the development and implementation of ''deglamorization'' campaigns.

V. HELPING CURRENT SMOKERS KICK THE HABIT

Smoking Cessation. While the primary emphasis of our proposal is to reduce tobacco use among children, the more than 48 million adult Americans who currently smoke deserve and need help in kicking the habit. The KIDS Act would establish a coordinated federal and state-based initiative to increase access to, and awareness of, effective programs. When fully implemented, the legislation would provide $1.5 billion annually for programs designed to enhance existing employer-based initiatives, and those which target uninsured and underserved populations.

VI. EXPANDING RESEARCH

National Fund for Health Research. Tobacco products kill more than 400,000 Americans every year—more death than from AIDS, alcohol and drug abuse, car accidents, murders, suicides, and fires combined. To stop this epidemic, we must strengthen our national commitment to finding preventive measures and cures for diseases—especially those related to tobacco use, including cancer, heart disease, emphysema and stroke. Therefore, the KIDS Act would establish a National Fund for Health Research to allocate resources over and above those provided to the National Institutes of Health (NIH) in the annual appropriations process. The KIDS Act would allot $3.225 billion per year to the Fund.

Prevention and Cessation Research. While we know a great deal about reducing tobacco use, much remains unknown. Therefore, a significant expansion of prevention and cessation research is critical to the success of any comprehensive effort to reduce tobacco use. In particular, more information is needed on why people use tobacco and on what program interventions are most effective. Efforts must also be undertaken to increase our understanding of the health effects of tobacco use and exposure to second-hand

[1] Contained in consent decrees.

smoke. The KIDS Act would provide $600 million per year for a major new research effort.

VII. HELPING THE VICTIMS OF TOBACCO-RELATED DISEASES

The KIDS Act would fully preserve the rights of individuals and groups to utilize the civil justice system to recover tobacco-related damages. Unlike the June 1997 Tobacco Agreement and some of the legislation currently pending in Congress, the KIDS Act would not ban class action lawsuits or punitive damage awards, as the tobacco industry has sought.

Simply put, it would provide no immunity to the tobacco industry. Given the industry's behavior, such liability protections cannot be justified or condoned. Furthermore, our legislation would provide no protections from, or limitations on criminal prosecution of the tobacco industry.

National Victims' Compensation Fund. To ensure that resources are readily available for the victims of tobacco-related diseases, the KIDS Act would provide for the establishment of a prefunded National Victims' Compensation Fund (the ''Fund''), from which court awards and settlements would be paid. Furthermore, given the uncertainty of the legal environment surrounding tobacco litigation, an additional Contingency Reserve Account would be established within the Fund. The Fund and the annual cap would be indexed to medical inflation.

Annual Base Payment: At the beginning of each year, the tobacco industry would make a Base Payment of $4 billion into the Fund; awards and settlements would be paid from this base amount. At the end of every year, any unobligated funds from the Base Payments would be deposited into an interest-bearing Contingency Reserve Account.

Out-of-Pocket Supplement and Annual Cap: If awards and settlements exceed the Base Payment during any year, the industry would be liable for an additional $4 billion in out-of-pocket payments to cover the excess, for a total potential annual liability payment by the tobacco industry of $8 billion. This cap would not include payments made to states in settlement of existing Attorneys General suits, and would apply only to civil claims against past wrongdoing by the industry.

Contingency Reserve Account: As a further protection for claimants, the KIDS Act would establish a Contingency Reserve Account (the ''Account'') within the Victims' Compensation Fund. Any unobligated funds from the $4 billion Base Payment would be placed in the Account. For example, if awards and settlements paid in the first year amounted to $1 billion, the remaining $3 billion would be deposited into the account. Funds in the account would build up substantially in the early years as settlements and awards during this period are expected to be relatively small. For any year in which liability awards and settlements exceed $8 billion, the Account would be drawn down to make the excess payments. In the unlikely event that awards and settlements ever deplete the Account in any year, unpaid claims would be rolled over and paid from the Base Payment at the beginning of the following year.

If the Account accumulates a balance of $20 billion, the Attorney General, in conjunction with the Secretary of Health and Human Services, would determine whether to continue to deposit excess funds therein, or to redirect those funds to anti-smoking and other public health activities authorized under the legislation.

Small Claimant Protection: Under the KIDS Act, individuals and smaller classes of individuals would be given priority in disbursements from the Fund to ensure that large awards or settlements, paid to 3rd parties for example, would not deny smaller claimants timely payment of their claims.

Settlement of State Suits and Castano Class Action: Forty state Attorneys Generals have brought suits against the tobacco industry to recover costs incurred for tobacco-related illnesses and other damages. The KIDS Act would provide states the opportunity to settle their suits in exchange for funding from the National Tobacco Trust Fund established under this Act. In addition, the Castano Class Action lawsuits would be settled in return for the establishment of smoking cessation programs.

VIII. ENDING TOBACCO INDUSTRY SECRECY

For decades, to the severe detriment of the public health, the tobacco industry has concealed evidence of the consequences of tobacco use and deliberately misled the public. Moreover, tobacco manufacturers have broadly misused the doctrine of attorney-client privilege to cloak industry documents and research in a veil of secrecy.

Therefore, the KIDS Act would require tobacco companies to submit key documents relating to the health effects, safety, and marketing of products to children to a Tobacco Document Depository. Trade secret and attorney-client privilege claims would be scrutinized by a professional Tobacco Document Review Board. This reform would assist the victims of tobacco-related diseases in securing judgments against tobacco companies, and out-of-court settlements, without the traditional barriers and costs associated with document discovery. Manufacturers who make claims in bad faith will be subject to fines of up to $5 million per violation. Moreover, failure to comply with this section would result in license revocation and the waiver of the annual liability cap.

FDA to Obtain Needed Documents. Tobacco companies would be required to turn over to the FDA all documents the agency deemed necessary to carry out its regulatory responsibilities—including assessing the health effects of nicotine and other tobacco ingredients, the design and development of ''less hazardous'' or ''safer'' tobacco products, as well as the advertising, marketing and promotion of such products.

IX. TRANSITION ASSISTANCE TO FARMERS

Changes in national policy regarding tobacco products, and the expected decline in their consumption, will have ramifications for farming families, workers and communities in tobacco growing regions. The KIDS Act would provide $13.5 billion for compensation, income support and transitional assistance to tobacco farming families, and for economic development and related assistance in tobacco-dependent communities.

X. ASSURING CLEAN INDOOR AIR

Our knowledge is growing daily on the deleterious effects of exposure to Environmental Tobacco Smoke (ETS) in the home, the workplace and other public facilities. Annually, 3,000 Americans die of lung cancer caused by second-hand smoke, and 15,000 children under 18 months of age are hospitalized with respiratory infections related to ETS exposure.

While the ETS components of the KIDS Act are still a work in progress, our bill would place significant emphasis on reducing ETS exposure in the home—including such measures as pediatric outreach, public service announcements, and comprehensive media campaigns; $100 million from the counter advertising funds would be directed towards this purpose. The bill would also provide $100 million to help reduce exposure to ETS in workplaces and public facilities.

The KIDS Act would also require Congress to comply with the ''no smoking'' policies already in place throughout the Executive Branch. Furthermore, legislation would not preempt states and local governments from establishing even more stringent policies to protect individuals from ETS.

XI. STOPPING SMUGGLING AND SHOWING WORLD LEADERSHIP

In some countries, significant increases in cigarette prices have resulted in large-scale smuggling operations. Contraband cigarette trafficking can occur both at national borders and between states with wide disparities in tobacco excise taxes. Since 1992, this criminal activity has increased by more than 500% in the United States. Each year, interstate cigarette smuggling costs some states more than $100 million in lost excise tax revenue. As the price of cigarettes increases as a result of tobacco settlement legislation, actions must be taken to prevent the wide availability of contraband cigarettes.

Tough Anti-Smuggling Initiative. In addition to licensing all tobacco product sellers in the stream of commerce, the KIDS Act would allocate $100 million per year to implement an aggressive, well-coordinated anti-smuggling program aimed at stopping contraband tobacco products from entering or being sold in the United States. The bill would facilitate substantial coordination of international, federal and state law enforcement activities, as well as providing new resources to expedite the deployment of innovative anti-smuggling technologies.

Harsh New Penalties to Stop Smuggling. To further deter contraband trafficking in tobacco products, the KIDS Act would also establish harsh new criminal and monetary penalties for individuals convicted of such offenses. Violations by manufacturers, importers, exporters, or distributor or retailers could result in permanent revocation of their license or registration.

World Leadership. The World Health Organization (WHO) currently estimates that tobacco use causes three million deaths per year worldwide—a number which is expected to increase exponentially as the U.S.-based tobacco industry intensifies its global marketing and promotional activities. By the year 2023, WHO projects tobacco-related mortalities will jump to ten million, with nearly 70 percent occurring in developing countries. This troubling trend is expected to accelerate with the enactment of strong anti-tobacco policies in the United States.

Unlike the June 1997 Tobacco Agreement, our bill would provide clear leadership on international efforts to curb tobacco use. The KIDS Act would terminate all support for tobacco promotion overseas by the United States Government, provide $100 million per year to fund global education efforts, and encourage America's participation with other nations in efforts to harmonize tobacco policies worldwide.

XII. INDUSTRY CONSENT DECREES

Voluntary, but legally-binding consent decrees—signed by the federal government, state governments and tobacco manufacturers—are critical to the success of any comprehensive tobacco legislation aimed at significantly reducing tobacco use by children. Without these decrees, key provisions of such a law could be delayed by lengthy legal challenges. To help avoid this problem, the KIDS Act would require tobacco companies to sign legally-binding consent decrees in order to receive the benefits of the annual liability cap established under the legislation. Violation of any of the terms of the consent decrees would result in exclusion of that company from the annual liability cap. Among other things, the consent decrees—which would be enforceable by the U.S. Attorney General or State Attorneys General through federal and state courts—would

commit the companies to abide by the following agreements:

Not to directly or indirectly bring or support legal challenges to the implementation of any aspect of the KIDS Act, including existing or future FDA regulatory authority, document disclosure, youth look-back survey methodology and penalties, and advertising and marketing restrictions;

To pay and fully pass through the cost of annual industry payments and industry-wide look-back penalties, assuring that the price of cigarettes would increase by at least $1.50 per pack over 2 years, with comparable increases for other tobacco products;

All reforms related to the labeling, sale, advertising and promotion of tobacco products intended by this Act;

Not to directly, or through contractors, lobby federal, state or local governments against any provision of this Act;

To only do business with those retailers and distributors in full compliance with all provisions of this Act;

To dissolve the Tobacco Institute and other existing trade associations;

Not to advertise over the Internet; and,

To comply also with all of the marketing and advertising restrictions in both the FDA regulation and the proposed June 1997 Tobacco Agreement.

XIII. ANNUAL TOBACCO PAYMENTS AND SPENDING

Industry Payments: The KIDS Act would require a non-deductible industry payment of $10 billion immediately upon enactment. That payment would be used by states and local communities, as well as the federal government, to begin implementation of the strong anti-tobacco measures authorized under the Act.

One year after enactment the industry would make a payment of $20 billion to the National Tobacco Trust Fund. Each year thereafter the industry payment would be $25 billion, indexed to inflation. These payments would be assessed based upon each company's share of the overall tobacco market. Twenty-five percent of the payments would be deemed punitive, and therefore non-deductible.

Payments to States: As under the June 1997 Tobacco Agreement, $193.5 billion over the 25 year period would be reserved for state use. Of those funds, fifty percent would be distributed to the states to use at their discretion. The remaining fifty percent would be allocated to the states in the form of a Health, Human Services and Education block grant to be used to meet each State's particular needs in these areas.

Additionally, $500 million annually would be made available to states meeting or exceeding youth tobacco reduction targets.

Payments for National Programs: Under the KIDS Act, $4 billion of the industry's yearly payment would be directed to the National Victim's Compensation Fund as the Annual Base Payment. Remaining industry payments would be used exclusively for national anti-tobacco and public health purposes. These include funding for smoking cessation, counteradvertising, and community and school-based prevention programs, international education, health research, and other activities outlined in this summary.

March 11, 1998

Hon. TOM HARKIN,
Hon. JOHN CHAFEE,
Hon. BOB GRAHAM,
U.S. Senate,
Washington, DC.

DEAR SENATORS HARKIN, CHAFEE AND GRAHAM: We are sorry we are not able to be with you in person as you introduce your bill, but we wanted to offer our congratulations to you for crafting a very strong, comprehensive package of tobacco reforms.

We have carefully reviewed a detailed summary of your plan and strongly support its major features, with the exception of the concept of liability caps. While we await actual legislative language, it appears to us that if enacted, we believe your proposal includes many measures that would significantly reduce tobacco use and fundamentally alter the way America deals with tobacco. It is tough medicine for a tough problem. It would set national tobacco policy on to a course that would bring down nicotine addiction and the terrible health consequences of using tobacco.

You are to be especially commended for forging a bipartisan consensus on this difficult and complex issue. For a proposal to be successful in Congress, it must have bipartisan support. Yours is the first to meet that crucial test.

Your plan correctly deals with this public health crisis in a comprehensive manner, seeking to come as close as possible at this time to the ideals expressed last July in the report of the Advisory Committee on Tobacco Policy and Public Health. A piecemeal approach clearly won't work. We are especially pleased that you specify an increase in the cost of tobacco products within two years. This is vitally important for reducing tobacco use by young people. Protecting the FDA's authority, protecting a State's ability to develop and enforce stronger public health measures, and other such provisions make this proposal very attractive. We understand that you will address environmental tobacco smoke and we will be pleased to work with you on that. You are also to be commended for recognizing that the United States must play an enhanced role in promoting enlightened policies toward tobacco in other countries. We have a moral imperative to lead in this area as well as protecting the public health within the United States.

We look forward to continuing to work with you as you finalize this very promising proposal. There is much to be done this year, but the announcement of your bipartisan effort is a major step forward in our long battle for a tobacco policy.

Sincerely,

C. EVERETT KOOP, M.D., Sc.D.
DAVID A. KESSLER, M.D.

THE KIDS ACT ALLOCATION OF INDUSTRY PAYMENTS

The following amounts represent the annual maximum spending for each of the activities, assuming a 25% excise tax offset.

[In billions of dollars]

States—no strings	$3.000
States—Human Services Block Grant	3.000
States—bonus pool	0.500
States—total	6.500
Smoking Cessation	1.500
Counteradvertising	0.550
Community-based Prevention	1.000
School-based Prevention	0.300
Youth Database/Evaluation	0.175
Event Sponsorship Replacement	0.075
Tobacco Prevention Research	0.600
International Education	0.100
Native American Programs	0.200
Environmental Tobacco Smoke	0.200
FDA	0.300
Anti-Smuggling Efforts	0.100
Anti-Tobacco Program Total	5.100
NIH Research	3.225
Victim's Compensation Fund	4.000

Additionally, the KIDS Act would provide a total of $13.5 billion for transition assistance to farmers.

STATEMENT OF THE ENACT COALITION REGARDING THE INTRODUCTION OF KIDS DESERVE FREEDOM FROM TOBACCO ACT

(March 12, 1998)—The ENACT coalition of major public health organizations applauds today's introduction of the KIDS Deserve Freedom From Tobacco Act by Senators Harkin, Chafee and Graham. These Senators have exhibited courageous leadership in crafting a strong, comprehensive, bipartisan solution to the urgent problem of tobacco use.

This is the first bipartisan proposal which, based on the summary being released today, encompasses the key public health policies that ENACT has stated must be included in any effective tobacco control legislation. We support the public health features of this proposal because of their potential to save millions of lives and, therefore, welcome it as an important step forward.

The proposal contains strong and effective provisions regarding FDA authority over tobacco sales, manufacturing and advertising; significant price increases to deter use by kids; ''look-back'' penalties if sales to youth do not decrease; a vigorous crackdown on the illegal sale of tobacco to minors; protections from secondhand smoke; disclosure of tobacco industry documents; funding for tobacco-related health and cessation research; assistance to tobacco farmers; and support for efforts to reduce tobacco use internationally.

The KIDS Act also addresses issues relating to the tobacco industry's liability. It would make the internal documents the tobacco industry has been forced to produce available to plaintiffs and the general public. It would also require the tobacco industry to make a minimum annual tort-related payment of $4 billion a year, no matter what happens in the courts. It contains no limitations on class action or the rights of individuals to collect full compensatory or punitive awards from the industry, nor does it protect the industry from being held accountable for future misconduct. However, it does contain an annual cap of $8 billion a year on civil liability payments for the tobacco industry in suits based on past action.

While we await the receipt of the actual legislative language, we believe that this proposal would significantly reduce tobacco use, particularly among children, and would rein in the tobacco industry. We strongly support this proposal's major features with the exception of the liability cap. ENACT believes that only a comprehensive bill that meets our minimum criteria can adequately address the complex problem of tobacco use and reduce the number of kids who start using tobacco, and the number of adults who die each year. ENACT is committed to working with Senators Harkin, Chafee and Graham, as well as all Members of Congress from both parties, to enact a comprehensive, bipartisan, well-funded and sustainable tobacco control policy.

[From USA Today, Mar. 20, 1998]

BILLION-DOLLAR BLINDERS HIDE TOBACCO DEAL'S FLAWS

Big Tobacco has a politically enticing offer for lawmakers. Give us some legal protection against our past sins, and we'll pony up billions of dollars every year to fund your pet programs.

The offer proved too much for state attorneys general.

They signed a loophole-ridden settlement deal last June that gave a slap on the wrist to the industry and threw new roadblocks in front of the regulation of nicotine by the Food and Drug Administration (FDA)

Next week, Senate Commerce Committee Chairman John McCain will try to do better as his panel marks up a settlement plan. He's hoping to put together a tougher deal—one that will win the backing of health groups and members of both parties, and still secure the industry's consent. A delicate balancing act, to be sure, and one that comes amid fierce partisan wrangling, turf wars and general election-year money-grubbing.

Until last week, no proposals fit the bill. Either they were winners for the tobacco industry or they couldn't get support from across the aisle. Sens. Tom Harkin, John Chafee and Bob Graham broke the pattern with a bipartisan bill that has won over key health advocates.

Among their plan's virtues:

It would impose annual industry payments of $25 billion—two-thirds higher than the settlement. That would push up the price of a pack of cigarettes by $1.50, deterring smoking by children—the most important objective of any settlement.

Better yet, the deal would severely punish individual firms if they failed to meet company-specific teen smoking reduction targets—a clear incentive for each to join the effort to cut teen smoking. The industry as a whole could be fined up to $10 billion a year if teen smoking rates aren't cut by 65% within 10 years.

The measure preserves the FDA's ability to regulate tobacco. The industry had snookered the attorneys general by requiring the FDA to meet absurd burdens of proof.

Finally, there's no offer of blanket immunity on class-action suits, as the attorneys general allowed. People harmed by the industry could recover up to $8 billion a year from an industry-financed liability fund.

The offer to industry: Your total costs will be capped at $39 billion a year. Put in perspective, domestic cigarette sales are about $50 billion a year.

The two most prominent tobacco industry foes of recent years—former surgeon general C. Everett Koop and former FDA head David Kessler—both endorsed the Harkin-Chafee bill, calling it ''tough medicine for a tough problem.''

Whatever its merits, this is the minimum acceptable. Yet the risk that Congress will gut it and pass a flimsy substitute is enormously high. The industry is sure to throw its weight behind weaker bills; and with everyone in Washington salivating over the prospect of all that money to spend on pet programs in an election year, priorities easily will be warped.

There are already so many meat hooks in the funds that it would take several deals to appease all interests. President Clinton wants to fund everything from child care to Medicare with the money. Some Republicans want to use the tobacco funds to pay for tax cuts, others to pay for reforming the IRS. Advocacy groups see the chance to fund their cherished programs.

As the prospect of billions of dollars draws closer, even ardent health advocates might be tempted to dispense with sweating the details.

But the point of this exercise isn't to raise lots of money, boost the size of the federal government, or enrich a bunch of trial lawyers. The goal is to cut the horrendous human toll smoking imposes on society. The only effective way to do that is to stop the supply of new addicts.

That for the most part means keeping teens from taking up the habit. More than nine in 10 regular smokers started smoking before celebrating their 19th birthday. The Harkin proposal would give industry a strong push to help curb this trend despite the long-term consequences for the industry.

In the end, however, lawmakers must be willing to chuck a bad deal, even if that means killing the golden tobacco goose.

COMPARING THE SETTLEMENTS

The so-called KIDS Act toughens the June 1997 attorneys general settlement on several key fronts.

Annual payments

Settlement: Maximum of $15 billion a year for a total of $368.5 billion over the next 25 years.

KIDS Act: Maximum of $25 billion a year for a total of $630 billion over next 25 years.

Teen smoking

Settlement: 60% cut in smoking rates within 10 years.

KIDS Act: 65% cut in smoking rates within 10 years.

Failure to reduce teen smoking

Settlement penalty: Maximum of $2 billion a year.

KIDS Act: No; but does put an $8 billion annual cap on total damages.

Class-action lawsuit immuity

Settlement: Yes, but individuals could still sue.

KIDS Act: No; but does put an $8 billion annual cap on total damages.

FDA regulations

Settlement: Imposes new restrictions on FDA tobacco regulations.

KIDS Act: Preserves FDA authority.

Advertising

Settlement: Tough restrictions, including ban on human forms, Internet ads.

KIDS Act: Similar changes.

Source: USA Today research.

[From the Portland Press Herald, Mar. 28, 1998]

SENATE SHOULD PASS A BETTER TOBACCO DEAL

Legislation settling claims against the tobacco industry is now before the Senate Commerce Committee. The committee's chairman, Sen. John McCain, R-Ariz., is trying to forge a compromise among Democrats, Republicans and opponents and supporters of the tobacco lobby.

The starting point in this process is a settlement agreement negotiated last year between the tobacco companies and the attorneys general from 40 states. It is a deeply flawed document that gives up too much to big tobacco.

What that agreement lacks—and what any final agreement should have—is the approval of two men who have fought hard to reduce tobacco's deadly toll on the American people. C. Everett Koop, the former surgeon general, and David Kessler, former head of the Food and Drug Administration, have opposed the tobacco settlement as it is now.

Much of what Koop and Kessler seek is in a bipartisan proposal sponsored by Sens. Tom Harkin, D-Iowa, John Chafee, R-R.I. and Bob Graham, D-Fla. Maine Sens. Susan Collins, who sits on the commerce committee, and Olympia Snowe should back it or legislation that has the same basic elements.

The proposal would raise the price of cigarettes by $1.50 a pack, extracting $25 billion a year from the tobacco companies as payment for the huge costs imposed by these products on the government. Unlike the settlement negotiated with the states, it gives the FDA unfettered control over tobacco. It also has strong proposals for reducing youth smoking and sets up a system for processing claims against the tobacco companies without granting them immunity from future lawsuits.

In return, the tobacco companies would see their liabilities in civil suits capped at $8 billion a year. This is a far better approach than the blanket protection from future lawsuits contained in the agreement negotiated by the attorneys general.

Already, other ideas are surfacing. The committee seems settled on a $1.10-per-pack price increase for cigarettes and is discussing an annual liability cap ranging from $5 billion to $8 billion. FDA authority over tobacco, meanwhile, remains a sticking point.

The principles of the bipartisan bill are central to reaching a fair accord with the big tobacco companies over the immense harm they have caused the American people. As such, the bill should be taken seriously by Collins, Snowe and their Senate colleagues.

Mr. CHAFEE. Mr. President, over the course of the next month or two, the Senate will have the opportunity to debate how best to address the most significant, preventable public health problem confronting this nation today: the scourge of tobacco use by our young people. The Senate will face some difficult choices in this regard. The grim statistics about this epidemic, coupled with almost daily revelations of tobacco industry misdeeds, underscore the need for our earnest action.

We can all agree, where adults are concerned personal responsibility must be the rule; tobacco is a legal product and adults are free to make that choice. However, the same level of independent judgment cannot be said where fourteen year-olds are concerned. Bear in mind, only one in ten smokers takes up smoking after the age of eighteen; the remainder start well before that stage.

All of us—Democrats and Republicans—share a deep and abiding concern about this problem, and a recognition that now is the time for action. However, each of us has different thoughts on how best to attack this problem. The Commerce Committee draft bill offers a good beginning, but it must be strengthened. Senators HARKIN, GRAHAM and I believe that an aggressive, but responsible approach is essential if we are to be successful in reducing teen tobacco use.

This is why the KIDS Act would force the price of cigarettes up by $1.50 over the course of two—not four, five or six—years. The price hike must be significant and rapid in order to affect the purchasing behavior of children; the evidence solidly favors that position. Simply put, a smaller increase of only $1.10 over a longer period of time—in effect 20 cents per year in the Commerce Committee draft—will not achieve the desired result. As a result of our aggressive approach on price, the KIDS Act would halve teen smoking within just three years!

That is also why the KIDS Act contains very stiff so-called look-back'' penalties if the industry fails to meet the annual youth reduction targets specified in our bill. Unlike the Commerce Committee draft, the KIDS Act emphasizes company-specific penalties to ensure that the companies who do the addicting take the hit. Additionally, our annual penalties are capped at $10 billion per year, as opposed to $3.5 billion in the Commerce Committee draft. These look-back penalties are the very heart of our efforts to curb

youth tobacco use; if they miss the mark, the whole program is the weaker for it.

This is also why the KIDS Act provides roughly $5.1 billion per year for anti-tobacco programs, including counteradvertising, school and community-based prevention and education programs, cessation and other initiatives. For those who think this is too much spending, we spend a lot more money on addressing other ills which kill far fewer than 400,000 Americans per year.

Recognizing that the needs of each state are very different, the KIDS Act hands back $6 billion per year to the states in recognition of the costs and damages they have incurred in treating tobacco-related illnesses. Importantly, this funding could be used to meet the particular needs of each state; flexibility is the key with respect to the use of this funding. One pool of $3 billion per year could be used to meet any need; the other pool of $3 billion takes the form of a health, human services and education block grant to meet virtually any human need.

Our bill also includes a State Performance Bonus Pool to help incent and enlist states in the war against teen tobacco use, and we need all the stakeholders we can get! As a consequence of these provisions, the National Governors Association supports the state payment mechanism contained in the KIDS Act.

Some have pointed out that the draft Commerce Committee bill incorporates the cap on annual liability payments included in our bill—although at $6.5 billion, not $8 billion. My response is that the cap cannot be examined in isolation from the other parts of the legislation. If, for example, the youth smoking provisions are not as tough as they should be, than I question the appropriateness of a liability cap.

Now, some people have said our bill is too tough and could bankrupt the tobacco industry. Says who? The tobacco companies? I'm not sure we can rely upon their representations if past history is any judge. What about the securities analysts who understand the financial workings of the tobacco industry? Can we rely upon these individuals and firms when many of these same companies manage pension and mutual fund portfolios with significant investments in tobacco stocks? Frankly, I think the only reliable measure of what the industry can truly afford would be an independent audit—not an illogical request of an industry which seeks a virtually unprecedented deal with the federal government, the several states and the American people.

The KIDS Act would require the industry to pass along in the price of its products an annual payment of $25 billion. Given discussions we have had with a variety of experts, both inside and outside the government, we do not believe the payment requirements in our bill would jeopardize the profitability or future viability of the tobacco industry.

In closing, I urge my colleagues to examine the KIDS Act and to join with us in working to pass a strong, responsible tobacco bill as quickly as possible. We look forward to working with our respective Leaders, Senator MCCAIN, and our colleagues toward that end.

Mr. GRAHAM. Mr. President, I rise today with my colleagues, Senator JOHN CHAFEE and Senator TOM HARKIN, to introduce the Kids Deserve Freedom from Tobacco Act of 1998, legislation which if passed will have a monumental effect on the number one public health problem facing America's youth: underage smoking.

This legislation is the first bipartisan, comprehensive piece of legislation which has the support of the Administration and the public health community. Since the beginning of this school year, more than half a million kids have started smoking. If we don't act soon, another half million children will take up the habit by the start of the next school year. And by its inaction, Congress will have signed their death warrants.

In Florida alone, where minors purchase more than 12 million packs of cigarettes each year, 28% of high school students currently smoke cigarettes. Nationally, the number is closer to 35%. The KIDS Act takes a number of strong actions—all of which would be funded by the industry's annual $25 billion payment—to lower the rate of youth and teenage smoking. These include:

PRICE INCREASE

Because public health experts agree that substantially increasing the cost of cigarettes is the most effective way of keeping adolescents from buying them, the KIDS Act would force the tobacco industry to raise the price-per-pack of cigarettes and other tobacco products by $1.50 over the next two years.

In addition to raising the price of tobacco products, the KIDS Act would establish ambitious goals for the reduction of teenage tobacco use. The bill would mandate that the tobacco industry reduce youth smoking by 65 percent over the next ten years—or face as much as $10 billion in annual penalties. States, on the other hand, would be rewarded for reducing teen tobacco use. The KIDS Act would set aside $500 million of bonus money each year for states that meet or exceed annual smoking reduction targets.

MARKETING REFORMS

For decades, the tobacco industry has pushed its products on young Americans both overtly—on billboards and through the prominent sponsorship of sports like auto racing—and subtly, through characters like Joe Camel. Their efforts have been helped by the shockingly easy access that many minors have to tobacco products. Nationally, more than 62 percent of 12-to-17 year-old smokers report that they buy their own cigarettes. Nearly half of those minors were never asked to show proof of age.

The KIDS Act would dramatically change the rules governing tobacco advertising and sales. It would limit tobacco companies to black-and-white text advertisements—no more human images, cartoon characters, outdoor displays, sports and entertainment sponsorships, or product giveaways. It would also encourage illegal tobacco purchases by banning vending machines sales of cigarettes and requiring state licensing of tobacco retailers. Stores caught selling to minors would face severe financial penalties.

PAYMENTS TO STATES

In addition to the federal money it channels to states through bonus payments, incentives, grants, and federal programs, the KIDS Act would directly distribute almost $200 billion over 25 years—a third of the settlement money—to individual states to spend on a broad array of health and anti-tobacco programs.

As a former Governor, I strongly believe that states deserve to be recognized for their efforts to bring the tobacco industry to the table. Without state's efforts, Congress would not be in the position to introduce this bill today. Any legislation contemplated by this Congress must recognize the State crucial role in this process.

CAP ON ANNUAL INDUSTRY PAYMENTS

Unlike last year's national settlement, the KIDS Act would not safeguard the tobacco industry from future lawsuits. It ensures reliable industry payments, so that the industry cannot use the excuse of financial woes to avoid its annual $25 billion commitment. As such, it would require that tobacco firms deposit $4 billion/year into a ''National Victims Compensation Fund.'' Money from that fund would be used to pay victims who settle claims or win judgments against the industry. The industry would also have to pay up to $4 billion/year in any additional claims—a maximum total of $8 billion/year.

I want to stress that my colleagues, Senators CHAFEE and HARKIN, and I believe that this is our best and possibly our only chance to get this historic legislation passed. We cannot let this opportunity slip away. A half-hearted, piecemeal effort simply won't do.

By Mr. DASCHLE (for himself, Mr. KENNEDY, Mrs. BOXER, Mr. DODD, Ms. MIKULSKI, Mrs. FEINSTEIN, Mr. DURBIN, Mr. REED, Mr. INOUYE, Mr. TORRICELLI, Mr. KERRY, Ms. MOSELEY-BRAUN, Mr. WYDEN, Mr. LAUTENBERG, Mr. ROCKEFELLER, Mr. CLELAND, Mr. LEAHY, Mrs. MURRAY, Mr. WELLSTONE, Mr. SARBANES, Mr. AKAKA, and Mr. BINGAMAN):

S. 1891. A bill to amend the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage; to the Committee on Finance.

THE PATIENTS' BILL OF RIGHTS ACT OF 1998

Mr. DASCHLE. Mr. President, I join my colleagues in introducing the Patients' Bill of Rights Act of 1998. This legislation has been developed cooperatively with Democrats in the House and Senate to address a growing concern of the American public, the quality of care delivered by health plans and insurance companies. Today, three of every four working, insured Americans are in managed care plans, and far too many have experienced serious problems with their coverage. We all know someone with a horror story in that regard.

Today, David Garvey of Illinois told us the tragic story of his wife, who had taken a ''dream'' vacation to Hawaii with a few of her friends. When she arrived in Hawaii, she noticed some bruises on her body. She went to a clinic and was quickly admitted to the hospital. She was diagnosed with aplastic anemia. Her doctor in Hawaii began a course of treatment, and said that she would likely need a bone marrow transplant to save her life.

Several days into the treatment, her HMO called from Chicago and said she had to return to Chicago for the treatment and transplant. They insisted that she return, even over the strong objections of the doctor in Hawaii who said that she was not stable enough to travel and that her immune system could not fight infection. Mr. Garvey tried to talk to the decisionmakers in the plan, but they insisted that she return to Chicago or forego coverage. As the medical bills were adding up, Mrs. Garvey had no choice but to fly back to Chicago. During that flight, Mrs. Garvey had a stroke, and within days of her return, she developed a fungal infection. Ten days later, she died.

Mr. President, I am outraged by what happened to the Garveys and believe we need legislation to protect patients against medically inappropriate decisions by health plans that too often put the financial bottom line before patients' health care needs.

The bill I am introducing today would provide enforceable protections for millions of patients. It would ensure access to medically needed care, including coverage at emergency rooms. It would allow patients with serious conditions to see their specialist without asking permission each time and would allow women direct access to their ob/gyn.

The bill would allow patients denied benefits to appeal decisions both within the plan and to an independent, external reviewer. When a plan says no to a treatment that your doctor says you need, you should be able to appeal to an independent body that has no financial stake in the decision. This bill gives every patient that right and says the decision has to be made in a time frame that will not put the patient at risk.

The Patients' Bill of Rights provides protection for the provider-patient relationship by banning gag clauses and limiting inappropriate financial incentives to deny care. It also would put a stop to arbitrary decisions by plans to limit care, such as decisions to discharge mastectomy patients from the hospital before it is medically appropriate.

Finally, the bill would hold plans legally accountable for decisions to deny or delay care that result in harm to patients. Today, 125 million Americans who get their health care through their employer have little recourse if their plans' decisions harm them, even when the decisions lead to death. Doctors and hospitals are held accountable for their decisions, but health plans are not, and that is something that needs to change.

The Patients' Bill of Rights is an important proposal that has the backing of the American Medical Association, Consumers Union, Families USA, the National Association of Children's Hospitals and numerous other organizations that advocate for quality patient care.

I hope we can engage in productive debate on this issue in the coming months and pass legislation to improve the quality of health care for the American people.

Mr. KENNEDY. Mr. President, the time for action to protect patients and curb insurance company abuse has come. We face a crisis of confidence in health care. A recent survey found that an astonishing 80 percent of Americans now believe that their quality of care is often compromised by their insurance plan to save money. One reason for this concern is the explosive growth in managed care. In 1987, only 13 percent of privately insured Americans were enrolled in HMOs. Today 75 percent are in some form of managed care.

At its best, managed care offers the opportunity to achieve both greater efficiency and higher quality in health care. In too many cases, however, the priority has become higher profits, not better health. Conventional insurance companies, too, have abused the system by denying coverage for treatments that their customers need and that their faithful payment of premiums should have guaranteed.

And the issue is not just confidence. It goes to the heart of the issue of quality care and to the fundamental doctor-patient relationship. In California, a Kaiser Foundation study found that almost half of all consumers reported a problem with their health plan—and substantial proportions reported that the plan's misbehavior caused unnecessary pain and suffering, delayed their recovery, or even resulted in permanent disabilities. Projected to the national level, these results indicate that 30 million Americans actually developed additional health problems because of their plan's treatment of them, and a shocking 11 million developed permanent disabilities.

The list of those victimized by insurance company abuse grows every day.

A baby loses his hands and feet because his parents believe they have to take him to a distant emergency room rather than the one close to their home.

A Senate aide suffers a devastating stroke which might have been far milder if her HMO had not refused to send her to an emergency room—the HMO now refuses to pay for her wheelchair.

A doctor is denied future referrals because he tells a patient about an expensive treatment that could save her life.

A child suffering from a rare cancer is told that life-saving surgery should be performed by an unqualified doctor who happens to be on the plan's list, rather than by the nearby cancer specialty center equipped to provide quality care.

A San Diego paraplegic asks for referral to a rehabilitation specialist. Her HMO refuses, and she develops a severe pressure wound that a rehabilitation specialist would have routinely checked and treated. She is forced to undergo surgery, and has to be hospitalized for a year with round-the-clock nursing care.

A woman is forced to undergo a ''drive-by'' mastectomy and is sent home in pain, with tubes still dangling from her body.

The list goes on and on.

The opponents of action are already waging a calculated and well-financed campaign of disinformation arguing that protecting patient's rights is the same as massive government mandates and vastly increased costs. But the American people know better.

Opponents of the legislation try to create a false dichotomy between relying on competitive market forces and relying on regulatory standards. In fact, this amendment helps competition by establishing a level playing field between those who compete by providing quality care at a reasonable cost and those who try to compete by attracting only healthy enrollees and denying those who fall ill the care they have promised.

This legislation guarantees people the rights that every scrupulous insurance company already provides. These rights are common-sense statement of components of quality care that every family believes they have been promised when they signed up for coverage and faithfully paid their premiums.

Let me cite a few of these common-sense rights specified in our legislation. They include access to an appropriate specialist when your condition requires specialty care. They allow people with chronic illnesses or disabilities to have standing referrals to the specialists they need to see on a regular basis. They assure that patients who need a prescription drug to save their life or their health can have access to it even if it is not included in their plan's formulary.

They assure that a person suffering from serious symptoms can go to the nearest emergency room without worrying that their plan will deny coverage. No patient with the symptoms of a heart attack should be forced to

put their life at risk by driving past the emergency room down the street to the network provider an hour or more away. No patient with symptoms of stroke should be forced to delay the treatment to the point where paralysis and disability is permanent, because a clerk two thousand miles away does not respond promptly and appropriately. And no patient who goes to an emergency room with symptoms of a heart attack that proves to be a false alarm should suffer a real heart attack when a bill for thousands of dollars arrives that the health insurer has refused to pay.

This amendment also says that any reform worthy of the name must guarantee that insurance plans meet the special needs of women and children. Women should have access to gynecologists for needed services. No women with breast cancer should be forced to endure a ''drive-by'' mastectomy against the advice of her doctor.

No child with a rare childhood cancer should be told that the urologist who happens to be in the plan's network will treat him—even if that urologist has no experience or expertise with children or with that rare cancer.

Too many desperate patients—especially cancer patients—know that their only hope for survival is participation in a clinical trial. Such trials not only offer hope to patients, they also advance our knowledge and lead to better treatments for dread diseases. Many insurers have routinely paid for the medical costs associated with clinical trials, because they knew they offered benefits for patients and because the patients would incur medical costs in any event, even if they were not part of the trial. But today, many insurers are backing away from that constructive policy. Managed care plans, in particular, have often denied their patients the ability to participate in such trials.

Our legislation provides patients a right to participate in such trials if stringent conditions are met. There must be no standard treatment that is effective for the patient, and the patient must be suffering from a serious or life-threatening illness. The trial must be funded by the NIH or another government agency meeting NIH standards. And the trial must offer the patient a realistic hope for clinical benefit.

Patients need the right to appeal decisions on their plans to independent third parties. Today, if a health plan breaks its promise, the only recourse for most patients is to go to court—a time-consuming and costly process that may not provide relief in time to save a life or prevent a disability.

Independent review was recommended unanimously by the President's Commission. It has worked successfully in Medicare for four decades. Working families deserve the basic fairness that only an impartial appeal can provide. Without such a mechanism, any ''rights'' guaranteed to patients exist on paper only—and they are scarcely worth the paper on which they are written. When the issues are sickness and health—and often as serious as life and death—no health insurance company should be allowed to be both judge and jury.

When health plan misconduct results in serious injury or death, patients and their families should be able to obtain accountability. Every other industry in America can be held responsible for its actions. Why should health plans, whose decisions truly can mean life or death, enjoy this unique immunity?

Reforms must protect the integrity of the doctor-patient relationship. ''Gag clauses'' and improper incentive arrangements should have no place in American medicine.

And finally, everyone should agree that noncontroversial steps to improve quality and provide greater patient information should be part of reform.

This amendment should not be controversial for any member of the Senate who is serious about protecting patients from insurance company abuse. Its basic provisions were included in legislation introduced by Democrats in the House and Senate. That legislation is supported by the American Medical Association, the Consortium of Citizens with Disabilities, the National Alliance for the Mentally Ill, the National Partnership for Women and Families, the National Association of Children's Hospitals, the AFL–CIO, and many other groups representing physicians and other health care providers, children, women, families, consumers, persons with disabilities, Americans with serious illnesses, and working families.

It is rare for such a broad and diverse coalition to be assembled in support of any legislation. But ending these flagrant abuses will help every American family.

The choice is clear. The Senate should stand with patients, families, and physicians. We must not stand with the well-heeled special interests that put profits ahead of patients.

By Mr. DEWINE (for himself, Mr. HATCH, Mr. LEAHY, and Mr. SPECTER):

S. 1893. A Bill to establish a law enforcement block grant program; to the Committee on the Judiciary.

THE LOCAL LAW ENFORCEMENT BLOCK GRANT ACT OF 1998

Mr. DEWINE. Mr. President, today I rise to introduce the Local Law Enforcement Block Grants Act of 1998, which reauthorizes the very successful Local Law Enforcement Grant Program. This program gives local governments the resources to fight crime, without the ''Washington knows best'' strings attached. I believe it is a mistake for Washington to try to micromanage how local communities spend their law enforcement dollars. Instead Washington should play the role of partner with local law enforcement to improve the tools they use to fight crime.

My views on this issue are based on more than 20 years of experience in the criminal justice system: as a prosecutor in Greene County, Ohio; in the Ohio State Senate; as a United States Congressman on the Judiciary Committee; as Lieutenant Governor overseeing anti-crime and anti-drug efforts; and now, as a member on the Senate Judiciary Committee. I have had an opportunity to work on criminal justice issues from the local, state, and federal levels, and have been fortunate to see firsthand what Congress can do to help local communities be victors in the war on crime.

Because 90 percent of all criminal prosecution is local, the fight against crime will be won or lost by local law enforcement, local prosecutors and courts, and concerned citizens in every community. I believe the best way for the federal government to help local communities fight crime is to return more money to those communities, because in the final analysis, it is they who will get the job done. For too long the Federal Government has had all the money—and local communities all the crime. Local communities know what works—and they should have the resources.

From 1999–2003, this Act authorizes $750 million each year for direct grants to local law enforcement to reduce crime and improve public safety. Distributions are made by the Bureau of Justice Assistance on a formula basis, directly to local governments. Grants may include, but are not limited to, equipment and law enforcement personnel, enhancing school security measures, violent offender adjudication, drug courts, crime prevention programs and youth intervention programs.

One of the most frequent uses of this grant money in Ohio, and by local law enforcement across the country, has been for crime fighting technology. I believe there is a critical need to modernize the crime fighting tools used by local law enforcement, who have been fighting increasingly sophisticated criminals with outmoded tools. That's why I am expressly providing that funds may also be used for information and identification technology, such as criminal history information, fingerprint dissemination, and DNA and ballistics tests.

Let me underscore here that this Act leaves to local governments the decision regarding what their funding priorities should be, while at the same time requiring accountability as to how funds are ultimately used. Local advisory boards also have an opportunity to recommend how monies are spent as well. These funds will help local law enforcement meet the critical local needs, by letting them put the resources where they are needed most.

ADDITIONAL COSPONSORS

S. 71

At the request of Mr. DASCHLE, the names of the Senator from Connecticut