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Senate

(Legislative day of Monday, July 12, 1999)

The Senate met at 9:31 a.m., on the expiration of the recess, and was called to order by the President pro tempore [Mr. THURMOND].

PRAYER

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

Gracious God, You have shown us that there is no limit to the strength You give when we unite in the cause that You have guided. There is a wonderful sense of oneness when we call on Your help together. You are delighted when Your people work together in harmony to confront problems and discover Your solutions. Help us see that our task is not to defeat each other or simply to defend our points of view, but to discuss issues in a way that all aspects of truth are revealed and the best plan for America is agreed upon. So, together, Democrats and Republicans, we ask You to bless the debate on health care this week. Keep all the Senators united in the common goal of working through the issues until they can agree on what is best for all Americans. Keep them and all who work with them focused on positive solutions. Dear God, give us a win-win week for the good of America and for Your glory. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore. Senator BROWNBACK is designated to lead the Senate in the Pledge of Allegiance.

The Honorable SAM BROWNBACK, a Senator from the State of Kansas, led the Pledge of Allegiance, as follows:

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

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDING OFFICER (Mr. VOINOVICH). The acting majority leader is recognized.

SCHEDULE

Mr. BROWNBACK. Mr. President, today the Senate will immediately proceed to a period of morning business until 10 a.m. Following morning business, the Senate will resume consideration of the Patients' Bill of Rights. Debate will resume on the pending second-degree amendment regarding emergency medical care coverage. Further amendments are expected to be offered and debated during today's session, with votes to be scheduled for this afternoon. For the information of all Senators, the Senate will recess from 12:30 to 2:15 p.m. for the weekly party conference meetings. When the Senate reconvenes at 2:15 p.m., Senator SMITH of New Hampshire will be recognized for up to 45 minutes. I thank my colleagues for their attention.

MORNING BUSINESS

Mr. BROWNBACK. Mr. President, if I could go ahead and proceed this morning, Senator JOHN ASHCROFT, Senator KAY BAILEY HUTCHISON, and myself have reserved 20 minutes to discuss Chairman ROTH's tax package and the marriage penalty in particular. So I will begin that initial discussion in morning business.

TAX CUTS

Mr. BROWNBACK. Mr. President, the chairman of the Finance Committee will be coming out with his mark on tax cuts, and this is a critically important issue. It is an important one for the country. It is important, now that we are looking forward to having some surplus, that we say to the American people: You have been overpaying your taxes, and we want to give some of that back to you. This is over and above Social Security, the amount of the payroll tax that is going to Social Security. So we are setting aside the Social Security trust funds—a lockbox is what we call it, a lockbox for the Social Security surplus—and with the remainder talking about tax cuts, serious tax cuts.

One issue we want to discuss this morning is doing away with the marriage penalty. It seems extraordinary to me that we would have a tax policy in this country that actually penalizes people for getting married. With all the problems we have with families in our society, it seems, if anything, we would want to do just the opposite—we would want to give people a benefit for being married rather than taxing them for being married. And yet the way the code has evolved, today 21 million American married couples pay an average of $1,400 more in taxes just for the privilege of being married.

I think that is wrong. The Government should not use the coercive power of the Tax Code to erode one of the foundational units of our society, that of marriage. We should stop the taxation. We should put a stop to the marriage penalty tax. This year we can change that.

I am encouraged that the chairman of the Finance Committee, Senator ROTH, and his committee have put forward efforts to alleviate the marriage penalty. We have a unique opportunity to put that issue behind us.

I want to draw Senators' attention to another issue under the marriage penalty area which has not been talked about that much. That is the earned-income tax credit bias against married couples. A significant share of the marriage penalty occurs to low-income

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

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couples. It is caused by the loss of the earned-income tax credit when individuals' incomes are combined.

What happens is, you have two-wage-earner families that, if they were not married, if they were single and filing separately, would qualify for the earned-income tax credit. But if they get married and they earn over this mark, they get penalized again for being married.

Estimates by the CBO indicate that what we can do is double, for two-wage-earner families, the amount of income that can be received and still qualify for the earned-income tax credit. Virtually all the benefits of this adjustment in the earned-income tax credit would go to couples with incomes below $50,000. There are nearly 3.7 million couples in America today that do not receive the earned-income tax credit that would, if we double the amount that they can make, still qualify for the earned-income tax credit.

I point this out because people struggle mightily to raise families, and the notion that we would tax and then tax again low-income families, keeping them from receiving a benefit because they are married, makes absolutely no policy sense at all.

I don't see how on Earth anybody can argue this is a good idea or this is the right thing to do. I am hopeful the chairman of the Finance Committee has focused on this. We can do this. I hope the President will be willing to work with Members of Congress in both the House and the Senate in crafting a tax package we can all agree with, so the American people can stop overpaying their taxes—which they are currently doing.

The CBO is now projecting an onbudget surplus of $14 billion in fiscal year 2000, with the surplus growing to $996 billion over the 10-year period beginning in fiscal year 2000. We have this opportunity to eliminate the marriage penalty tax and to do away with paying the marriage penalty tax on upper-income levels and for those not being given the earned-income tax credit on the lower-income level.

Of course, the surging surplus I was discussing is as a result of payroll tax receipts. I continue to emphasize that.

The majority side wants to put a lockbox around any Social Security surplus and have that maintained only for Social Security. We can do these things. We need to work across the aisle. We need to work with the President. I hope he will be willing to work with Members as we move forward in dealing with the marriage penalty tax, which is a terrible signal to send across society, to send to people across America. We will be working with the chairman of the Finance Committee. I hope this is one tax that can find its death in this round of tax cuts. We will hopefully be going to reconciliation and discussing tax cuts this month. It is a very important topic we will discuss.

I encourage people paying a marriage penalty tax to contact Members regarding how the marriage penalty tax has directly impacted your lives. I have had any number of couples write saying: We wanted to get married but we found out we were going to pay this huge tax for getting married and we could not afford to do that; this is money we wanted to use for a down-payment of a house or to get a car that would work.

They were not able to do it because of the pernicious fiscal effect of the marriage penalty tax. It is a terrible signal we are sending across our society.

Senator HUTCHISON from Texas has been a leader on this issue of dealing with the marriage penalty tax. She has come to the floor, as well, to discuss what we can do. Now is the time to eliminate this marriage penalty tax.

I yield the floor.

VISIT TO THE SENATE BY THE HONORABLE JOHN HOWARD, PRIME MINISTER OF AUSTRALIA

Mr. HAGEL. Mr. President, I ask unanimous consent that Members of the Senate greet the Honorable John Howard, Prime Minister of Australia.

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

RECESS

Mr. HAGEL. Mr. President, I ask unanimous consent that the Senate now stand in recess for 5 minutes to greet the Honorable John Howard, Prime Minister of Australia.

There being no objection, the Senate, at 9:45 a.m., recessed until 9:52 a.m.; whereupon, the Senate reassembled when called to order by the Presiding Officer (Mr. VOINOVICH).

ORDER OF PROCEDURE

Mrs. HUTCHISON. Mr. President, I wonder how much time do we have remaining, with the added time based upon the Prime Minister's appearance?

The PRESIDING OFFICER. The Senator has 7 minutes.

Mrs. HUTCHISON. Mr. President, then I ask you to notify me at 3½ minutes. I intend to give the other 3½ minutes to Senator ASHCROFT.

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. I was very pleased to meet the Prime Minister from Australia. He asked me where I was from, what State I represented. I said, ''I represent the State that everyone says is just like Australia.'' He said, ''Texas?'' And I said, ''Absolutely.'' I had a wonderful visit with him. He has a wonderful personality. We are pleased to welcome him to the Senate.

TAX CUTS

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I thank Senator BROWNBACK.

Senator ASHCROFT from Missouri, Senator BROWNBACK, I, and many others have been talking about the marriage penalty tax for two sessions, and even a session before that.

We were stunned when we discovered 44 percent of married couples in the middle-income brackets—in the $40,000 to $60,000 range—were paying a penalty just for the privilege of being married.

We have introduced legislation to cut the marriage tax penalty. In fact, both the House and Senate have tax cut plans that we will be discussing over the next few months to try to determine what we can give back to the hard-working Americans who have been sending their money to Washington to fund our Government.

When we start talking about how we are going to give people their money back, I think we have to step back and talk about the basic argument, which is: What do we do with the surplus? And are tax cuts the right way to spend the surplus?

I will quote from a Ft. Worth Star-Telegram opinion piece by one of the editorial writers on that newspaper, Bill Thompson, from June 30, 1999.

He says there is only one question to ask about the budget surplus, and that is:

> How should we go about giving the money back to its rightful owners?
>
> And the rightful owners, surely even the biggest nitwit in Washington can understand, are the taxpayers of the United States of America.
>
> The federal government is not a private business that can do whatever it wants to with unexpected profits.

Because, in fact, we are more of a co-op. We are not a business that is trying to make a profit and then decide what to do with the profits.

> . . . [T]here should be no discussion about the fate of the money. . . .

If there is money left over, we give it back to the people who own that money. We in Washington, DC. do not own that money. The people who earned it own it. It is time we start giving them back the money they have earned.

We are doing what we should be doing. We are cutting back Government spending, so people can keep more of the money they earn. If we do not give it back to them, we will be abusing the power we have to tax the people. We are talking about giving the money back to the people who earn it, and the first place we ought to look is to people who are married who pay more taxes just because they are married. If they were each single they would be paying lower taxes, but because they got married the average is $1,400 in the marriage penalty tax. That is unconscionable.

Since 1969, we have seen the marriage tax penalty get worse and worse and worse. It was not meant to be that way. Congress did not intend to tax married people more. But because more women have gone into the workforce to make ends meet and to do better for

their families, the Tax Code has gotten skewed and the deductions have become unfair. So today we are saying the first priority should be to eliminate the tax that is more on married people than it would be if they were single.

I yield the remainder of my time to Senator ASHCROFT, who is working with me on this very important issue. We will give the taxes that people are paying to the Government back to them because it does not belong to us. It belongs to the people who earn it.

Mr. President, I ask unanimous consent the article by Bill Thompson be printed in the RECORD.

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

THE BUDGET SURPLUS: THERE'S ONLY ONE TOPIC THAT NEEDS DISCUSSING

(By Bill Thompson)

Nothing will get the politicians' juices flowing like an avalanche of money. Put large piles of cash in front of a herd of politicians, and the ensuing stampede will crush everything in its path.

Nowhere is this truer than in Washington, D.C., where the latest predictions of burgeoning federal budget surpluses have the president, Congress and everyone in between all but trampling one another in their fervor to dive into those irresistible mountains of money.

Not surprisingly, all the official and semi-official public pronouncements, all the expert analyses and all the wide-eyed speculation about the fate of the extra money seem to arrive at the same conclusion: The politicians will spend it.

In fact, the only question that anyone who's anyone seems to be asking about this ''windfall'' revenue is: How should we spend it?

Well, call me naive or simple-minded or just plain dumb—many readers do so on a regular basis, after all—but in my humble opinion the deep-thinkers are asking the wrong question. The only legitimate question that anybody should be asking about the federal budget surplus is: How should we go about giving the money back to its rightful owners?

And the rightful owners, surely even the biggest nitwit in Washington can understand, are the taxpayers of the United States of America.

The federal government is not a private business that can do whatever it wants to with unexpected profits. It's not even one of those publicly traded corporations that can choose among options such as reinvesting in the company sharing the profits with employees or distributing the money to stockholders by means of increased dividends.

Government collects money from citizens in the form of taxes and fees for the purpose of providing designated services to those very same citizens. If for some reason the government should happen to collect more money than it needs to provide the designated services, there should be no discussion about the fate of the money: It goes back to the taxpayers who worked it over in the first place.

For politicians and bureaucrats to suggest that they are so much as considering any other use of a budget surplus should be looked upon as the worst sort of fiscal malfeasance.

True enough, the idea of using some of the budget surplus to bail out fiscally endangered programs such as Social Security and Medicare sounds tempting. But there's a problem—two problems, actually.

Problem No. 1 is that these breathtaking estimates of budget surpluses totaling trillions of dollars over the next 15 years are just that—estimates. An unexpected downturn in the nation's economy could blow the projections sky high and leave the taxpayers with mind-boggling financial commitments to those programs—and no money to meet them.

Problem No. 2: The commitment of future budget surpluses to these expensive entitlements is a phony solution that distracts attention from the desperate need for fundamental reforms to programs whose escalating costs simply must be brought under control sooner or later.

President Clinton's proposal to dedicate a portion of any budget surplus to pay down the national debt seems reasonable enough at firs glance. But consider this: How can Clinton brag about cutting up Washington's credit card when his plan to pay off the card's outstanding balance hinges on projected income?

We should be paying off the debt with actual revenue that would be available for debt reduction if the government would cut expenses instead of constantly seeking new ways to spend the taxpayers' money.

No, this raging debate about how to spend the surplus is the wrong debate. The only question that politicians need to debate is whether to give the money back to the taxpayers in the form of a reduction in income tax rates, or through some sort of tax credit that enables taxpayers to deduct their share of the surplus from their tax bills.

The money belongs to the people. It should be returned to the people.

The PRESIDING OFFICER (Mr. CRAPO). The Senator from Missouri.

Mr. ASHCROFT. Mr. President, I thank the Senator from Texas for her kind remarks and for allowing me to speak on this important issue.

Americans are now paying taxes at a higher rate than ever before. The burden and cost of the government are more, and the Federal Government is responsible for the overwhelming lion's share. As a matter of fact, we are not just responsible for the Federal taxes, because we have mandated so many programs on State and local governments we are responsible for a lot of what they are taxing people. So we are being taxed at the highest rates in history—at the highest rates in history.

Now we announced, in spite of that, we are paying more in those taxes than it costs to run Government. We are paying more in than it costs to fund the programs we are getting. If you go to a grocery store and you are buying $8 worth of groceries and you give them a $10 bill, you are paying more than it costs for the service and they give you a couple of dollars in change.

There is a stunning debate in Washington. We are debating over whether or not to give people the change back. They are paying more than is required for the programs they have requested, and we are debating whether or not we are going to give them the change back. We ought to give the money back. They own it. They have overpaid.

No. 1, we are paying the highest taxes in history. No. 2, those taxes pay for more than what our programs cost; therefore, we are overpaying. No. 3, we ought to refund that overpayment to the American people.

I submit among those who ought to be the first in line to get money back are those who have been particularly abused, those who have been the subject of discrimination, those who have been the subject of wrongful taking of the money by Government. That is where you come to this class of people who are not normally thought of as being a special class. They are married people. Forty-two percent of all the married people in the United States end up penalized for being married. That is 21 million families. Mr. President, 21 million families pay an average of over $100 a month—that is $1,400 a year—because we have what is called the marriage penalty tax.

Before we decide on tax relief for the population generally, let's take some of these gross inequities out of the system, especially inequities that target one of the most important, if not the most important, components of the community we call America—our families. Our families are the most important department of social services, the most important department of education. The most important fundamental component of the culture is the family. It is where we will either succeed or fail in the next century. Our Tax Code has been focusing on those families and has been saying we are going to take from you more than we would take from anybody else.

This idea of penalizing people for being married is a bankrupt idea, and it is time to take the marriage penalty part of this law and administer the death penalty to the marriage tax.

I say it is time for us to end the marriage penalty. This will mean a substantial improvement in income for people who have been suffering discrimination because they are married. It is time for us to end the marriage penalty in the tax law.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. ASHCROFT. I thank the Chair.

ORDER OF PROCEDURE

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

Mr. REED. Mr. President, I yield myself 5 minutes of the allotted 10 minutes, and I yield the remaining 5 minutes to the Senator from Maryland, Ms. MIKULSKI.

The PRESIDING OFFICER. The Senator is recognized for 5 minutes.

CHILDREN'S HEALTH CARE

Mr. REED. Mr. President, we are engaged in a historic debate about the future of health care in the United States. I have tried very diligently to ensure that children are a large part of this debate.

In conjunction with those activities, yesterday I had the opportunity to visit with pediatricians and pediatric

specialists in my State of Rhode Island at Hasbro Children's Hospital, an extraordinary hospital in Rhode Island. I am very proud of it. While listening to those professionals, I got a sense of the real needs we have to address in this debate on the Patients' Bill of Rights.

First of all, there is tremendous frustration by these physicians and medical professionals about their ability to care for children, their ability to effectively provide the kind of care which parents assume they paid for when they enrolled in the HMO. They are frustrated by the mindless rules. For example, one physician related to me there is the standard practice of giving a child a complete examination at the age of 1. He had a situation where a child came in at 11 months 28 days. They performed the examination, and the insurance company refused to pay because, obviously, the child was not yet 1 year old. That is the type of incredible, mindless bureaucracy these physicians are facing every day.

I had another physician tell me—and this was startling to me—she was treating a child for botulism. She was told the company was refusing to pay after the second day. She called—again, here is a physician who is spending valuable time calling to find out why there is no reimbursement—and she was told simply by the reviewer—not a physician, the reviewer—that according to the guidelines of that HMO, no one can survive 2 days with a case of botulism; therefore, they were not paying for more than 2 days. Mercifully, the child survived, and eventually I hope they were paid for their efforts.

These are the kinds of frustrations they experience. This is throughout the entire system of health care. There are some very specific issues when it comes to children. One is the issue of developmental progress. An adult is generally fully developed in cognition, in mobility, in all the things that children are still evolving. Yet managed care plans seldom take into consideration the developmental consequences of a decision when it comes to children. Unless we require them to do that, they will continue to avoid that particular aspect. So a child can be denied services.

For example, special formulas for infants can be denied because the HMO will say: Well, it is not life-threatening; there is no serious, immediate health consequence. But the problem, of course, is, unless the child gets this special nutrient, that child is not going to develop in a healthy fashion. Five, six, seven, eight years from now, that child is going to have serious problems, but, in the view of an HMO, a dollar saved today is a dollar saved today. Oh, and by the way, that child probably will not even be in their health care system 5 years from now, the way parents and employers change coverage.

We have to focus on developmental issues. We also have to ensure children have access to pediatric specialists. There is the presumption that a rose is a rose is a rose, a cardiologist is a cardiologist is a cardiologist, when, in fact, a pediatric cardiologist is a very specific discipline requiring different insights and different skills.

We also have to recognize that many very talented pediatricians find themselves overwhelmed today with the young children they are seeing. I had one physician tell me he sees children who have problems with deficit disorders, problems with attention issues, and they have prescribed some very sophisticated pharmaceutical pills and prescriptions that he, frankly, has trouble managing because he is not a child psychiatrist. Yet they have difficulty getting access from the general practitioner to the specialist, the child psychologist to the child psychiatrist.

The other thing is, the system has been built upon adult standards. One of the great examples given to me is that there are new standards now to reimburse physicians when they are doing a physical, but they are based upon adult standards. The important things a physician has to do to evaluate a child are not even compensated because they are immaterial to an adult. Why would the company spend money paying a doctor to do that? This whole bias towards adults distorts the care for children in the United States.

The Democratic alternative which is being presented today recognizes these issues in a very pronounced and emphatic way. We do explicitly provide for access to pediatric specialists; we do specifically require, in making judgments about health care, the development of a child must be considered as part of the medical necessity test; and we also talk about developing standards, measurements, and evaluations of health care plans that are based on children and not just adults.

I urge all of my colleagues to endorse this concept. The best reason to pass this Democratic alternative is to help the children of America.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. REED. I thank the Chair.

The PRESIDING OFFICER. The Senator from Maryland is recognized for 5 minutes.

Ms. MIKULSKI. I thank the Chair.

ACCESS TO EMERGENCY CARE

Ms. MIKULSKI. Mr. President, I rise today to continue the discussion of the Patients' Bill of Rights and lend my voice to the Graham amendment for access to emergency care without penalty by an HMO when any prudent person presents their symptoms.

Before I do that, I congratulate the Senator from Rhode Island for his most eloquent and insightful remarks. For my colleagues, the Senator from Rhode Island has devoted his life to protecting the lives of Americans. As a West Point graduate serving in the U.S. military, he did that abroad, and now he does it in the Senate Chamber standing up for America's children. I thank him for his devotion and his gallantry. I am happy to be an able member of the Reed platoon.

I am pleased today to join with Senator BOB GRAHAM and other colleagues in speaking out about the people who go to an emergency room and want to be treated for their symptoms without fear of not having their visit covered by their HMO. When it comes to emergency care, people are afraid of both the symptoms they face as well as being denied coverage by their insurance company.

''ER'' is not just a TV show; it is a real-life situation which thousands of Americans face every day. Yet I hear countless stories from friends and neighbors and constituents, as well as from talking to ER docs in my own State, who tell me they are afraid to see their doctor or take their child or parent to the emergency room because they will not be reimbursed and will be saddled with debt.

Patients must be covered for emergency visits that any prudent person would make. That means if they have symptoms that any prudent person says could constitute a threat to their life and safety, they should be reimbursed. The prudent layperson standard is at the heart of this amendment. It is supported by the American College of Emergency Physicians which has stated that the way the Republican bill is written, it ''must be interpreted as constraints on a patient's use of the 'prudent layperson' standard.''

The Republican bill only goes part way. We need to restore common sense to our health care system.

Let me give an example, the case of Jackie, a resident of Bethesda, MD. She went hiking in the Shenandoah mountains. She lost her footing and fell off a 40-foot cliff. She had to be airlifted to a hospital. Thanks to our American medical system, she survived. After she regained consciousness and was being treated at the hospital for these severe injuries, Jackie learned that her HMO refused to pay her hospital bill because she did not get prior authorization. This is outrageous. Imagine falling off of a 40-foot cliff, waking up in a hospital and being told that your HMO will not cover your bills because you did not call while you were unconscious.

In America, we think if you need emergency care, you should be able to call 911, not your HMO's 800 number.

Incredibly, some of my colleagues in the Senate say that all these stories are anecdotes and they are horror stories. These are not anecdotes. We are talking about people's lives.

If you would come with me to the emergency rooms at Johns Hopkins Hospital, the University of Maryland, Salisbury General on a major highway on the Eastern Shore, all over the State, you would learn that many people come to the ER because of not only accidents but they are experiencing symptoms where they wonder if their life could be threatened or the life of

their child. The child is having acute breathing, and you do not know if that child is having an undetected asthma attack; or a man sitting at Oriole Park suddenly has shortness of breath, pains in his left side and leaves to go to the ER at the University of Maryland next to Camden Yards. Should they call 911 or should they call 800 HMO? I think they should call 911, and they should worry about themselves and their family and not about reimbursement.

So when we come to a vote, I really hope that we will pass the Graham amendment. The Republicans say they have an alternative. But it does not guarantee that a patient can go to the closest emergency room without financial penalty. Do not forget, it covers only 48 million Americans; it leaves out 113 million other Americans.

Let's do the right thing. Let's make sure that patients with insurance cannot be saddled with huge bills after emergency treatment.

I thank the Senate and yield the floor.

The PRESIDING OFFICER. The time of the Senator has expired.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

PATIENTS' BILL OF RIGHTS ACT OF 1999

The PRESIDING OFFICER. The Senate will now resume consideration of S. 1344, which the clerk will report.

The assistant legislative clerk read as follows:

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

Pending:

Daschle amendment No. 1232, in the nature of a substitute.

Daschle (for Kennedy) amendment No. 1233 (to Amendment No. 1232), to ensure that the protections provided for in the Patients' Bill of Rights apply to all patients with private health insurance.

Nickles (for Santorum) amendment No. 1234 (to Amendment No. 1233), to do no harm to Americans' health care coverage, and expand health care coverage in America.

Graham amendment No. 1235 (to amendment No. 1233), to provide for coverage of emergency medical care.

Mr. FRIST addressed the Chair.

The PRESIDING OFFICER. The Senator from Tennessee.

AMENDMENT NO. 1235

Mr. FRIST. Mr. President, I understand we are currently on the Graham amendment. Could you tell us how much time remains on either side?

The PRESIDING OFFICER. There are 33 minutes 8 seconds for the majority; and 7 minutes 59 seconds for the minority.

Mr. FRIST. Thank you.

Mr. President, today we will be talking about a number of issues that have to do with the Patients' Bill of Rights. Yesterday, the discussions began on what I regard as a very significant, important piece of legislation that is called the Patients' Bill of Rights. The debates that we will be having on the floor address really two underlying bills that were introduced formally yesterday: One is the Kennedy bill from the Democratic side, and the other is the Republican leadership bill. Both bills set out to accomplish what I think we all absolutely must keep in mind as we go through this process, and that is to make sure that we are focusing on the patients in improving the quality and the access of care for those patients and at the same time help this pendulum swing back to where patients and doctors are empowered once again; not to have this be so much in favor of managed care that, when it comes down to an individual patient versus managed care on certain issues, managed care enters into this realm of practicing medicine.

Again, I think if we keep coming back to focusing on the individual patient, we are going to end up with a very good bill.

We left off last night with the discussion of the Graham amendment which focuses on emergency services. In the Republican bill, basically there are a list of patient protections which include a prohibition of gag clauses, access to medical specialists, access to an emergency room, which is the real thrust of the Graham amendment, continuity of care—a range of issues that we call patient protections.

A second very important part of our bill focuses on quality and how we can improve quality for all Americans. I am very excited about that aspect of the bill. We will be discussing that later this week. That is our responsibility as the Federal Government, to invest in figuring out what good quality of care actually is. It is similar to investing in the National Institutes of Health: The research behind determining where the quality is, and spreading that information around the country so that excellent quality can be practiced and people can have access to that.

A third component of the Republican bill which I think is, again, very important that we will keep coming back to, is the access issue, the problem of 43 million people in this country who are uninsured. Some people say: No, that is a separate issue; we can put it off for another day.

But when you look at patient protections, you look at quality and you look at access. It is almost like a triangle. If you push patient protections too far you end up hurting access. If you push issues beyond what is necessary, to get that balance between coordinated care and managed care and fee for service and individual physicians' and patients' rights, if you get too far out of kilter, all of a sudden premiums go sky-high.

When premiums go sky-high in the private sector, employers, small employers start dropping that insurance. It becomes too expensive for an individual to go out and purchase a policy, and therefore instead of having 43 million uninsured, you will have 44 million, 45 million, or 46 million, all of which is totally unacceptable. As trustees to the American people, we simply cannot let that happen. Therefore, you will hear this quality and access and patient protection discussion go on over the course of the week.

Last night and today over the next 45 minutes or so we will be focusing on this patient access to emergency medical care. Let me just say that I have had the opportunity to work in emergency rooms in Massachusetts for years, in California on and off for about a year and a half, in Tennessee for about 6 years, and almost a year in Southampton, England.

Whether it is a laceration, whether it is a sore throat, whether it is chest pain, whether it is cardiogenic shock from a heart attack, access to emergency room care is critically important to all Americans.

We have certain Federal legislation which guarantees that access, but it is clear there are certain barriers that are felt today by individuals that their managed care plan is not going to allow them to go to a certain emergency room or, once they go, those services are not covered. That is the gist of what we have in the Republican bill—a very strong provision for patient access to emergency medical care.

This Republican provision, as reported out of the Health, Education, Labor, and Pension Committee where this was debated several months ago, requires group health plans, covered by the scope of our bill, to pay, without any prior authorization, for an emergency medical screening exam and stabilization of whatever that problem is—whether it is cardiogenic shock, whether it is a laceration or a broken bone or falling down the steps or a broken hip—to pay for that screening and that stabilization process with no questions asked—no authorization, no preauthorization, whether you are in the network or outside of the network.

The prudent layperson standard is very important for people to understand. The prudent layperson standard is at the heart of the Republican bill. We use the words ''prudent layperson.'' By prudent layperson, we define it as an individual who has an average knowledge of health and medicine. The example I have used before is, if you have a feeling in your chest, and you do not know if it is a heart attack or indigestion, and you go to the emergency room, a prudent layperson, an average person, would go to the emergency room in the event that that was a heart attack, and therefore is the standard that is at the heart of the Republican bill. Now, there are two issues that need to be addressed. We talked about them a little bit yesterday. One is what happens with the

poststabilization period. You are at home. You have this feeling in your chest. You go to the emergency room. Under our bill, you are screened; you are examined. Initial treatment stabilization of that condition is given.

Then the question is, What happens with poststabilization? This is where I have great concern in terms of what my colleague from Florida has proposed and what is in the underlying Kennedy bill. That is, once you get in the door, you can't open that door so widely that any condition is taken care of out of network. Why? Because it blows open the whole idea of having coordinated care, having a more managed approach to the delivery of health care.

This is a huge door you could get into. Then, once you get into that hospital door, you might say: Well, I have a little ache over here. Can you examine that and put me through all the diagnostic tests, regardless of what my health plan says and what I have contracted with my health plan to do?

That is where the concern is. The issue of poststabilization needs to be addressed; we need to talk more about it. Over the course of last night and, actually, the last several weeks, we have worked very hard to look at that poststabilization period. In just a minute, I will turn the floor over to my colleague from Arkansas to talk more about that.

The other issue is on cost sharing. We need to make sure there is no barrier there that would prevent somebody going to the closest emergency room or the emergency room of choice. It is an issue, I believe, we, as a body, Democrat and Republican, are obligated to address, to make sure that barrier is not there —again, returning to the patient so if the patient has any question at all, they don't have to think about payment and barriers and will they turn me away or, once I get in the emergency room, will they refuse to treat, but basically can I get the necessary care.

That is what is in the Republican bill. I am very proud of that. Can it be improved? Let's discuss it and see if there is anything we can do to make it better.

That is where we were yesterday, and that is where we are this morning. We will have a number of amendments as we go forward. Right now we are on the Graham amendment on emergency services.

At this juncture, on the amendment, I yield the time necessary to the Senator from Arkansas.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. I thank my colleague, the distinguished Senator from Tennessee. I express not only my appreciation but the appreciation of all Senators for the expertise that Senator FRIST brings to this important issue, as well as the care and compassion he has demonstrated throughout his career, even during his time in the Senate, in caring for other people in emergencies. He certainly brings a great deal of personal experience and expertise to this issue.

I rise to speak on this issue of access to emergency services and to explain why I believe my colleagues should oppose the Graham amendment. The amendment tree to which the Graham amendment was filed is now full. I alert my colleagues to an amendment I will be offering further along in the debate—I have been assured of the opportunity to do that—which will address the concerns raised by Senator Graham but, I think, addresses them in a far more responsible way.

Mr. GRAMM. That is GRAHAM of Florida.

Mr. HUTCHINSON. The Senator from Texas asks for that clarification.

I ask my colleagues to oppose the amendment by Senator GRAHAM of Florida, knowing they will have an opportunity to vote for a clarification amendment dealing with emergency services later on.

My amendment will remove the ambiguity that I think is so evident in the Graham amendment which will create such problems. The Republican provision, as reported out of the HELP Committee, requires group health plans covered by the scope of our bill to pay, without prior authorization, for an emergency medical screening exam and any additional emergency care required to stabilize the emergency condition for an individual who has sought emergency medical services as a prudent layperson.

As I listened to the comments of the distinguished Senator from Maryland, it is clear that what the Republican bill does and what my amendment will do needs clarification for my colleagues, because Jackie, the example that was given, would be covered, very clearly. The prior authorization issue is clearly covered. The closest emergency room issue is covered. The prudent layperson definition is repeatedly used.

Prudent layperson is defined as an individual who possesses an average knowledge of health and medicine. The purpose of this provision is to ensure that a person who has a reason to believe they are experiencing an emergency, according to the prudent layperson standard, will not, cannot, be denied coverage. If they are diagnosed with heartburn instead of a heart attack, they are still going to be covered under the prudent layperson definition.

In addition, by eliminating the requirement for prior authorization, no prior authorization will be required. Jackie doesn't have to make a phone call while she is unconscious; no one has to make a phone call asking for prior authorization. We ensure that individuals can go to the nearest emergency facility.

On the issue of cost sharing, plans may impose cost sharing on emergency services, but the cost-sharing requirement cannot be greater for out-of-network emergency services than they require for in-network services.

Mr. GRAHAM. Will the Senator yield for a question?

Mr. HUTCHINSON. I will be glad to yield when I conclude my comments. Let me go ahead because I think I may answer many of those questions as I go through.

An individual who has sought emergency services from a nonparticipating provider cannot be held liable for charges beyond what that individual would have paid for services from a participating provider.

Senator ENZI and I offered an amendment to this effect in the committee, and it was adopted by the committee. That amendment and the provision that is in the underlying Republican bill says that if a group health plan, other than a fully insured group health plan, provides any benefits with respect to emergency medical care as defined in subsection (c), the plan shall cover emergency medical care under the plan in a manner so that if such care is provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider. It is not going to cost the patient more if they go to a nonparticipating provider in that emergency room than they would if they went to one that was within their network.

As I think was pointed out by my colleague, Senator FRIST, and Senator GRAHAM of Florida last evening, the committee report language needs clarification on the committee's intention on cost sharing for in- and out-of-network emergency services. My amendment will certainly make that clarification.

My amendment will also improve the access to emergency services provision reported by the HELP Committee by requiring the plan to pay for necessary care provided in the emergency room to maintain medical stability following the stabilization of an emergency medical condition until the plan contacts the nonparticipating provider to arrange for transfer or discharge. If the plan fails to respond within a very narrow, specific time period, the plan is responsible for necessary stabilizing care in any setting, including in-patient admission.

We clearly state in the amendment which I will offer that these stabilizing services must be directly related to the emergency condition that has been stabilized. I think this was the point Senator FRIST made so very eloquently: If you do not make that connection, if you do not have the requirement that it has to be related to the emergency condition that has been stabilized, then you truly have a loophole. You open the door that totally undermines the concept of coordinated care.

To understand the true impact of the Republican access to emergency services provision as clarified and improved

by my amendment, let me offer the following scenarios and show how they are addressed by our provision in the bill.

Several examples have been repeated a number of times by my colleagues across the aisle. Let me use their examples. They specifically mentioned the case of a mother with a febrile child who called her health plan before going to the emergency room and was required to go to an in-network emergency facility, passing several nearby facilities on the way. Her child, tragically, had a serious infection which, due to the delay in care, resulted in amputation. There were very moving pictures of this particular child. Under our bill, a mother with a sick child will be able to access the closest emergency room, and she won't get stuck with the bill because she did not get prior authorization.

In a case referred to by my colleague from North Dakota, Senator DORGAN, if someone has taken a 40-foot fall and has been helicoptered to a hospital and delivered to an emergency room in a state of unconsciousness with fractured bones in three parts of her body, does that person have a right to emergency care under the Republican bill? The answer is yes, because we eliminate the prior authorization requirement. The case cited by my colleague from Montana, Mr. BAUCUS, where a woman came into an emergency room after falling and sustaining a complex fracture to her elbow, and the emergency physician diagnosed the problem and stabilized the patient. The stabilization process took less than 2 hours, but the patient's stay in the emergency room lasted for another 10 hours while the staff attempted to coordinate the care with the patient's health plan. The plan was unable to make a timely decision.

Under the Republican bill, the woman in this case will not have to wait hours on end for a response from her health plan. Under our provision, as improved by my amendment, the health plan must respond to the nonparticipating provider within a specific timeframe to arrange for further care.

Under the Democrats' bill, plans are required to pay, without prior authorization, for emergency services and ''maintenance and post stabilization services as defined by HCFA [Health Care Financing Administration] and Federal regulations to implement the Balanced Budget Act of 1997.'' I believe this is where the Democrat provision goes wrong and, quite frankly, it shows where we can make a much-needed improvement to the Balanced Budget Act language.

In the September 28th Federal Register, Volume 63, HCFA defines poststabilization as ''medically necessary, nonemergency services furnished to an enrollee after he or she is stabilized following an emergency medical condition.''

Now, that definition is completely vague and completely open-ended. I think it would be a serious mistake to take that language and to transport it into this very important bill.

Under this definition, a plan could conceivably be required to pay for services by a nonparticipating provider that are completely unrelated to the emergency conditions for which that patient was treated. To go in for one particular emergency, and while you are in that poststabilization period, to say: By the way, I also have a problem here and here; can you deal with that? And then require the plan to cover it, I think that would be a very serious mistake. The confusion and the ambiguity in the language is further perpetuated by conflicting statements on the meaning of ''poststabilization'' found in other places in the regulations.

So my amendment will provide for timely coordination of care. It ensures that the patient will receive the appropriate stabilizing services related to their emergency medical condition. The prudent layperson standard assures that a plan cannot retrospectively deny coverage for an event that was felt to be an emergency medical condition at the time the individual sought emergency care. It eliminates the prior authorization requirement so an individual can go to the nearest emergency facility and not have to worry about whether they are going to be covered if they go to a nonparticipating provider and that they might get stuck with the bill.

While my colleagues say they are simply adopting what was passed under Medicare, it is my contention that the provision I am offering will be an improvement on what is in Medicare because of the open-endedness and ambiguity of the language. I suggest that at some point we are going to have to revisit the Medicare provision and improve it as well.

In the meantime, I urge my colleagues to oppose the Graham of Florida emergency room amendment and vote for the amendment I will be offering later in the debate. Since this amendment tree is now full, I will have to offer that at a later point.

Mr. GRAHAM. Will the Senator from Arkansas yield?

Mr. HUTCHINSON. I will be glad to yield if I can yield on your time. We have limited time remaining on our side.

Mr. GRAHAM. I will try to ask short questions, and I will appreciate short answers.

One, you signed the committee report which, on page 29, says the committee believes it would be acceptable to have a differential cost sharing for in-network and out-of-network emergency charges. Are you saying that statement of explanation of the bill is incorrect?

Mr. HUTCHINSON. I believe that needs to be clarified, and my amendment will do that.

Mr. GRAHAM. When will you submit the language that will clarify what the committee report states?

Mr. HUTCHINSON. I will be glad to do that this morning.

Mr. GRAHAM. Two, with reference to poststabilization, what the current law for Medicare requires, and what this would require, is that the emergency room call the HMO and request the HMO's authorization as to what treatment to provide in the poststabilization environment. It is only when the HMO is unresponsive—in the case of Medicare, within 1 hour. If they fail to respond, then the emergency room has the right to do what it thinks is medically necessary for the patient.

Now, did the committee hear any testimony that there had been major abuses under the Medicare 1-hour-respond-to-call standard?

Mr. HUTCHINSON. What I suggest to the Senator is that my amendment will make that same requirement, only that the poststabilization services have to be related to the emergency room event.

Mr. GRAHAM. The question is, Was there any testimony to the kinds of abuses you have outlined under the current Medicare law?

Mr. HUTCHINSON. I am not certain at this point.

Mr. GRAHAM. Did the committee hold hearings on this bill, and did they not ask anybody what has happened under the 2½ years of experience we have had with Medicare and Medicaid?

Mr. HUTCHINSON. I say to the Senator from Florida that, in fact, there are abuses, I believe——

Mr. GRAHAM. Can the opponents of this amendment put into evidence before the full Senate and the American people what those abuses have been? We have had 2½ years of experience, covering 70 million Americans. If there have been abuses, they ought to be available and not just speculated about.

Mr. HUTCHINSON. In responding to the Senator, if there are no abuses, there should be no concern about clarifying language to ensure that, in fact, poststabilization treatment is related to the emergency room event. That is what I believe needs to be done. I think whether or not we can point to specific abuses in Medicare or not, the ambiguity in the language in Medicare is open to those kinds of abuses, and we will certainly see that occur if it is expanded to all managed care plans in the country. We certainly need to clarify that and ensure that the poststabilizations are related to the emergency room event.

Mr. GRAHAM. Let me go to a third issue. I discussed this yesterday. In the Republican bill, it states that while the person is stretched out in the emergency room under tremendous physical and emotional stress, they have the responsibility of monitoring the emergency room physician to determine if the type of diagnosis that the emergency room physician is rendering is appropriate. Could you explain how a person in an emergency room circumstance is supposed to provide that

kind of second-guessing of an emergency room physician?

Mr. HUTCHINSON. To the extent that the word ''appropriate'' should be removed, our amendment will, in fact, remove that. I don't believe that is an accurate reflection of what the Republican underlying bill would do.

Mr. GRAHAM. That is another defect. The use of the word ''appropriate'' is a gaping loophole.

Mr. HUTCHINSON. And which will be removed and clarified.

Mr. GRAHAM. I am concerned about the further provision which says that the patient is responsible for second-guessing the appropriateness of care rendered by the emergency room physician. Is that going to be taken care of?

Mr. HUTCHINSON. I do not believe that is an accurate reflection of that provision.

Mr. GRAHAM. I suggest that the Senator might read the bill and see that it is precisely what the bill says. I am concerned because we had a discussion last night with Dr. FRIST, and now today, which indicates that the Republican proposal has a number of admitted inconsistencies, inaccuracies, and gaping holes. Rather than us relying upon an amendment nobody has seen that is supposed to rectify those, why don't we vote for the Democratic amendment that would solve these problems?

Mr. HUTCHINSON. I think I have very clearly outlined what my amendment will do, and I have expressed very clearly my concerns about the Graham of Florida amendment. I will read right now, if you would like, the entire summary of the amendment and what it would do. I think it will respond to the concerns that many of my colleagues on the other side simply have misrepresented. What you call ''gaping holes'' simply need clarification, which my amendment will do. It will address it in a much more rational and responsible way than the very ambiguous language that I believe the Graham amendment contains.

Mr. GRAHAM. Well, I just offer a conclusion—not a question but a statement of fact. We have had 2½ years of experience with 70 million Americans. Our proposal will be available to all Americans in the instances of rampant abuse. I think it is incumbent upon those who make these charges to document it rather than just pontificate.

Mr. HUTCHINSON. Reclaiming my time, I reserve the remainder of my time.

Mr. REID. Mr. President, I yield 4 minutes to the Senator from North Dakota.

The PRESIDING OFFICER. The Senator from North Dakota is recognized.

PRIVILEGE OF THE FLOOR

Mr. DORGAN. I ask unanimous consent that Mina Addo, Leah Palmer, Jana Linderman, and Deborah Garcia be given floor privileges today.

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

Mr. DORGAN. Mr. President, yesterday I described a case dealing with emergency rooms which I understand my colleague referred to in his remarks. I want to go back to that case because I think it describes the difference between our two proposals with respect to protections for emergency room treatment for patients.

I described the case of little Jimmy Adams. This is a picture of Jimmy. This is a picture of a young, healthy Jimmy tugging on his big sister's shirt.

Here is a picture of Jimmy Adams after he lost both his hands and both his feet because he couldn't get care at the closest emergency room.

This is what happened. He was sick with a 104 degree fever. His mother called the family HMO. Officials there said you must go to a certain hospital in our network. So his parents loaded Jimmy up at 2 o'clock or so in the morning and started driving. They had to drive past the first hospital, the second hospital, and then drove past the third hospital. Finally they got to the hospital the HMO asked them to take Jimmy to. By that time, Jimmy's heart had stopped. They brought out the crash cart, intubated, and revived him. Regrettably, however, he suffered gangrene, and his hands and his feet had to be amputated.

Why didn't they stop at the first emergency room? Because they couldn't; the HMO said they won't pay for that. Why didn't they stop at the second hospital emergency room or the third? The HMO won't fully pay for that care. So they drove over an hour with a young, sick child who, because he didn't get medical treatment in time, lost his hands and his feet.

Now, my colleague says the Republican plan will solve little Jimmy's situation. Regrettably, it will not. Yes, the Republican plan will provide that that family could stop at that first hospital for emergency care, but it also allows the HMO to penalize the family financially for doing so. It allows the HMO to establish a financial penalty for this family to stop at out-of-network hospitals.

If their bill doesn't do that, I want to see it. As I read the Republican proposal, they say: We have protections here.

In fact, they don't have protections. In virtually every area of the two proposals on managed care, we see exactly the same thing. They have an emergency room provision. Is it better than currently exists? Yes, it is better. Does it solve the problem? No. This family would have been told: If you stop at the first emergency room with Jimmy, we will impose a penalty upon you. We have the right to impose a financial penalty for going to the nearest hospital emergency room.

If the other side wants to prevent that, I say, join us in supporting the Graham amendment, because we prevent that. We provide real protection for families with respect to emergency room treatment. Our amendment won't allow an HMO to say: Take that sick child to an emergency room but, by the way, you have to go to an emergency room four hospitals; if you stop sooner than that, we will penalize you.

That doesn't make any sense to me.

This issue is not about theory. It is about real people like Jimmy. It is about what the two pieces of legislation say regarding patient protection. My colleague from Florida, Senator GRAHAM, described the differences between the two bills on emergency care. He asked the questions and didn't get the answers, because satisfactory answers don't exist with respect to our opponents' proposal. Their proposal is, in fact, a shell. It does not offer the protections that we are offering in the proposal before the Senate.

Mr. MURRAY. Mr. President, I am pleased to join with Senator GRAHAM in support of access to emergency room care. During consideration of a Patients' Bill Rights in the Health, Education, Labor and Pensions Committee, I offered a similar amendment in an effort to prevent insurance companies from denying access to life saving emergency care. Unfortunately, my amendment was defeated on a straight party line vote.

I had offered the amendment because of problems that I have heard from emergency room doctors and administrators about creative ways insurance companies seek to deny access to emergency care. I offered the amendment because I have seen in my own state of Washington the inadequacy of simply saying care is provided if a prudent lay person deems it an emergency. We have a prudent lay person standard in the State yet we have seen where patients are turned away and reimbursement is denied.

The big flaw with the Republican bill regarding emergency room care is the lack of coverage of poststabilization care. This is the key different between our bill and that offered by the Republican leadership. We recognize the importance of not only administering emergency services but stabilizing the patient as well.

Let me give my colleagues an example of the important of poststabilization care; you rush your sick child to the emergency room with a fever close to 105. The fever escalates quickly and without warning. The emergency room doctors and nurses are able to control the fever and stabilize the child, but are concerned about determining the cause of the fever. They recommend poststabilization treatment to determine what caused the child to become so ill so quickly. The insurance company denies this treatment and the parents are told to take their child home and hope to get into see their own primary care physician the next day. Later that evening the child's fever escalates and the child begins to have seizures as a result. The child is then admitted to the hospital for more expensive acute care.

Why was follow-up poststabilization care not provided? What are the long-term effects on the child? Did the insurance company save a dime of the

premium paid by hard working Americans? No, in fact their callous behavior resulted in additional costs that could have been prevented.

I cannot imagine anything more frightening than holding a child who is experiencing uncontrollable seizures because their tiny body could not endure the impact of a high raging fever. Poststabilization is essential.

I urge any of my colleagues who think the Republican bill is sufficient to talk to ER doctors and nurses. Ask them how a patient is treated when brought into the ER. Let me give you another example that was discovered by the insurance commissioner's office in Washington state:

A 17-year-old victim of a beating suffered serious head injuries and was taken to an emergency room. A CAT scan ordered by an ER physician was rejected by the insurance company because there was no prior authorization for this test. In other words, we can stabilize the patient, but cannot do any post stabilization treatment to determine the extent of the injuries without seeking authorization from an insurance company hundreds of miles away.

Another example, in a state with a prudent lay person standard: The insurance commissioner's office found that an insurance company denied ER coverage for a 15-year-old child who was taken to the emergency room with a broken leg. The claim was denied by the insurer as they ruled the circumstances did not constitute an emergency. This is outrageous. A broken leg is not an emergency? By any standard, prudent lay person or medical standard, treatment of a broken leg would be considered an emergency.

I use these examples of real people and real cases to illustrate the flaws in the Republican bill. You can say you cover emergency room care and you can keep saying it hoping that it is true. But, unfortunately, the Republican bill does not provide adequate emergency room coverage.

I was disappointed in the HELP Committee markup when my amendment was defeated. I had truly hoped that we could reach a bipartisan agreement on emergency room care coverage. I had seen that we could reach a bipartisan agreement when it came to Medicare and Medicaid beneficiaries. We approved these very same provisions for these beneficiaries during consideration of the Balanced Budget Act of 1997. I had assumed that we would give the same protections to all insured Americans. It was a priority in 1997 and should be a priority in 1999.

We have spent a great deal of public and private resources to build an emergency health care and trauma care infrastructure that is the envy of the world. This infrastructure has saved millions of lives and provides a standard of care that is hard to beat. Yet policies focusing on restricting access to this care threaten the very infrastructure of which we are so proud. The ER doctor must be the one to administer care without fear of insurance company retaliation.

I urge my colleagues to support this amendment to provide 160 million insured Americans with access to state-of-the-art emergency room and trauma care. Please do not close the emergency room doors on these families.

Mr. HUTCHINSON. Mr. President, I inquire as to how much time remains on each side.

The PRESIDING OFFICER. The Senator has 10 minutes 43 seconds. The time has expired for the minority.

Mr. HUTCHINSON. Mr. President, I will make a couple of clarifications. I am puzzled by the reference to a penalty, the allegation, the insinuation, that the Republican bill somehow would allow a penalty to be charged.

S. 326 as reported by the committee requires plans to pay for screening and stabilizing emergency care under the prudent layperson standard without prior authorization, and the plan cannot impose cost sharing for out-of-network emergency care that would exceed the amount of cost sharing for similar in-network services. There is no differential. There can be no penalty charged under the Republican bill.

The amendment I will offer requires that the plans must pay for emergency services required. To maintain the medical stability in the emergency department plan, the plan contacts the nonparticipating provider to arrange for discharge of transfer. If the plan does not respond—as under Medicare, does not respond—to authorization of a request within a set time period, the plan must pay for services required to maintain stability in any setting, including an inpatient admission.

The great difference is that under the language of the Graham of Florida amendment, the emergency room could be required to not only provide services unrelated to the emergency event but that the health insurance plan would then be required to pay for and reimburse.

It is a glaring ambiguity. It in fact is the gaping hole in the language, and it is that which needs to be rejected. I will ask my colleagues to oppose the Graham of Florida amendment because of that ambiguity of language. Simply taking language from the Medicare balanced budget amendment, transporting that into this without any concern for the poorly defined ambiguous language that is used, I think my colleagues——

Mr. GRAHAM. Will the Senator yield?

Mr. HUTCHINSON. I think I have yielded quite enough. We have used quite a bit of our time in yielding.

I think it is very difficult to argue that treatment in an emergency room should be related to the emergency event. That is what we want to ensure.

We do not believe you can preserve any sense of coordinated care if you require health plans to pay for, in the poststabilization period, medical needs totally unrelated to the emergency that brought that patient to the emergency room.

That is sufficient for rejection of the Graham of Florida language.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

If no one yields time, the time running is the majority's time.

Mr. REID. That is because there is no time left on this side?

The PRESIDING OFFICER. That is correct.

Mr. GRAHAM. With the additional time that the majority has, would they respond to questions on their time? Would they at least cite in the bill the language that they believe is insufficient and creates an ambiguity?

Mr. NICKLES. Mr. President, I inform my colleagues, since we are on managed time, they are more than welcome to use time on the bill. They have that option, and I am sure the Senator from Nevada will yield to the Senator.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

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

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

Mr. REID. I say to my friend, we can't have quorum calls. The time should be running so that in 10 minutes you can offer your next amendment. A quorum call is not in keeping with what we are supposed to be doing.

Mr. NICKLES. Mr. President, to respond to my colleague, we have had almost no quorum calls since the debate has begun. I am preparing to offer an amendment in a moment. That amendment will be ready.

I will suggest the absence of a quorum and send the amendment to the desk momentarily.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

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

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, I want to take just one moment to respond to the question that was posed as to our specific concern about the language in the Graham of Florida amendment. The Graham of Florida amendment adopts the Medicare language. I will quote that Medicare language, from the September 28 Federal Register, volume 63. HCFA defines poststabilization, and I quote as I did before:

> . . . medically necessary nonemergency services furnished to an enrollee after he or she is stabilized following an emergency medical condition.

That is as vague and open-ended as any language I could conceive. It is, in

effect, a blank check for the emergency room, for the provider, for the patient. That is the language that needs clarification.

We believe the poststabilization medical services that are provided must be related to the emergency event that caused the individual to go to the emergency room. That is the clarification that is necessary. I will be delighted to once again go through the amendment summary that I will be offering, but that is a critical flaw in the Graham of Florida amendment. Because of that flaw in the language, I ask my colleagues to oppose the Graham of Florida amendment.

Mr. GRAHAM. Does the Senator from Arkansas yield? The Senator from Arkansas will not yield?

The PRESIDING OFFICER. All time has expired on the amendment. The question is on agreeing to the amendment.

The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I think we have some colleagues who are out right now. It is my anticipation the majority leader will want to have the vote afterwards. If my colleague wants me to pursue it, I can send an amendment to the desk or I can ask for a quorum call and we can talk to the leaders to determine what time we want to vote.

Mr. REID. I say to my friend, I think it would be appropriate. I think there has been a general agreement as of yesterday that we would vote sometime this afternoon at the agreement of the two leaders. So I think it would be better to offer an amendment and move this matter along.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, momentarily I will send an amendment to the desk. I ask consent the time be charged on this amendment.

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

AMENDMENT NO. 1236

(Purpose: To protect Americans from steep health care cost increases or loss of health care insurance coverage)

Mr. NICKLES. Mr. President, one of the big concerns many of us have with the underlying legislation of the so-called Kennedy bill is its cost. How much will it cost employers? How much will it cost employees? What will it cost employees in lost wages? If employers have to pay increased costs for health insurance, are they not paying their employees as much as they would pay them?

Health care costs a lot. Many of us would say health care already costs too much. It is unaffordable for millions of Americans. They would like to have it. We have 43 million uninsured Americans today. Most of those Americans, I imagine, would like to be insured but they cannot afford it. So health care already costs too much. Unfortunately, the bill proposed by Senator Kennedy and many of the Democrats would make it worse. They would make the insurance a lot more expensive and therefore less affordable. As a result, millions of Americans would probably lose their health care insurance. We think that would be a mistake.

I said yesterday we should make sure we do no harm. We should not increase the number of uninsured. I am afraid the Kennedy bill, with its estimated increase of cost of 6.1 percent over and above the inflation already expected, would increase the number of uninsured by what is estimated to be about 1.8 million persons. That is too many. That is far too many. So the amendment I will be sending to the desk, as soon as I get a copy of it, will say we should not increase the cost of health insurance by more than 1 percent. If we do, the provisions of the bill are null and void.

Let's not do any damage. Let's make sure at the outset we say very plainly we are not going to increase the cost of health care by more than 1 percent. Let's not increase the number of uninsured by over 100,000. If we do that, we have done harm, we have done damage, we have done more damage than good.

Mr. President, I send an amendment to the desk on behalf of myself, Senator GRAMM, and Senator COLLINS, and I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative assistant read as follows:

The Senator from Oklahoma [Mr. NICKLES], for himself, Mr. GRAMM, and Ms. COLLINS, proposes an amendment numbered 1236.

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

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

The amendment is as follows:

At the appropriate place, insert the following:

SEC. ___. EXEMPTIONS.

(a) IN GENERAL.—Notwithstanding any other provision of this Act, the provisions of this Act shall not apply with respect to a group health plan (or health insurance coverage offered in connection with the group health plan) if the provisions of this Act for a plan year during which this Act is fully implemented result in—

(1) a greater than 1 percent increase in the cost of the group health plan's premiums for the plan year, as determined under subsection (b); or

(2) a decrease, in the plan year, of 100,000 or more in the number of individuals in the United States with private health insurance, as determined under subsection (c).

(b) EXEMPTION FOR INCREASED COST.—For purposes of subsection (a)(1), if an actuary certified in accordance with generally recognized standards of actuarial practice by a member of the American Academy of Actuaries or by another individual whom the Secretary has determined to have an equivalent level of training and expertise certifies that the application of this Act to a group health plan (or health insurance coverage offered in connection with the group health plan) will result in the increase described in subsection (a)(1) for a plan year during which this Act is fully implemented, the provisions of this Act shall not apply with respect to the group health plan (or the coverage).

(c) EXEMPTION FOR DECREASED NUMBER OF INSURED PERSONS.—For purposes of subsection (a)(2), unless the Administrator of the Health Care Financing Administration certifies, on the basis of projections by the National Association of Insurance Commissioners, that the provisions of this Act will not result in the decrease described in subsection (a)(2) for a plan year during which this Act is fully implemented, the provisions of this Act shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan).

Mr. NICKLES. Mr. President, let me back up a little bit and bring our colleagues, and maybe the public, up to speed as far as where we are because, from a parliamentary procedure standpoint, this is getting maybe a little bit confusing.

The Republicans offered as the underlying vehicle the so-called Kennedy bill, S. 6, the Patients' Bill of Rights. We did it because we wanted to expose that it has a lot of expensive provisions that, frankly, need to be deleted.

The Democrats offered a substitute yesterday, the Republicans' Patients' Bill of Rights Plus that was reported out of the HELP Committee. They offered that as a substitute.

Then Senator DASCHLE, on behalf of Senator KENNEDY, offered a perfecting amendment to the substitute—''the substitute'' being the Republican bill—that said that should apply in scope to all plans. The Republican plan basically applies to self-insured plans. It does not duplicate State insurance, unlike the Democrats' bill that says we do not care what the States have done; we are going to insist you do everything we have dictated. They expanded the scope. That was a first-degree perfecting amendment.

The Republicans offered a second-degree amendment yesterday to the underlying first-degree amendment of the Democrats on scope that says two things: One, we think the primary function of regulating insurance should be maintained by the States. That was in the findings of the bill. And then in the legislative language: We should expand access and coverage to health care plans.

When the Democrats were so kind as to offer the Republican bill as a substitute, they forgot to offer our tax provisions. We included one of the tax provisions which we included in our Patients' Bill of Rights Plus, and that is 100 percent deductibility for the self-employed. We will be voting on that, and that will be the first vote this afternoon. We will probably be voting on that at the conclusion of Senator SMITH's statement or shortly thereafter. I expect that votes will occur on that sometime after 3 o'clock, maybe closer to 3:30.

The Democrats then were entitled to a second-degree amendment, and Senator GRAHAM of Florida offered a second-degree amendment dealing with emergency rooms. Senator HUTCHINSON and Senator FRIST debated against that and stated they would come up

with an alternative dealing with emergency rooms. That will be voted on at some later point in the debate.

This afternoon we will have a debate on the Republican amendment dealing with 100-percent deductibility of self-employed persons, and we will have a vote on the Graham amendment dealing with the emergency room provision, and then the next amendment we will actually vote on, depending on whether or not either of these second-degree amendments is adopted, will be to the amendment tree or the side to which I just sent an amendment.

I sent an amendment to the first-degree amendment on the so-called Kennedy bill. This amendment says, whatever we do, let's not increase health care costs by more than 1 percent or increase the number of uninsured by over 100,000. It is very simple and very plain: Congress, don't do it; whatever you do, whatever mandates you are considering—and we recognize and applaud everybody for having good intentions—let's do no harm; let's not increase health care costs by more than 1 percent; let's not increase the number of uninsured by over 100,000.

If the Secretary of Health and Human Services determines that it would increase costs by that amount or increase the number of uninsured by that amount, then the underlying bill will not take effect.

Those are the basic provisions of the bill. I hope and expect all of our colleagues will support this amendment. I urge its adoption.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. ENZI) Who yields time?

If neither side yields time, time runs equally.

The PRESIDING OFFICER. The Chair recognizes the Senator from Nevada.

Mr. REID. Mr. President, I yield the Senator from North Dakota 5 minutes.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, I have not seen the specifics of this amendment, but I have heard the description. It is interesting to hear this discussion of costs because we already have experience on this issue. The President has implemented the Patients' Bill of Rights for the Federal Employees Health Benefits Program. This is already in place for Federal employees around the country. And we know what it costs; we don't have to guess. It costs $1 a month. CBO says the patients' protection bill will cost $2 a month. We know it costs $1 a month in the Federal employees health insurance program.

The costs that are described by my friend from Oklahoma are inflated for reasons I do not understand. We know what it costs. It costs $1 a month in the Federal health benefits program, because it is already implemented, and the Congressional Budget Office says it will cost $2 a month for our Patients' Bill of Rights.

Let's talk about costs from a different angle for a moment. I find it interesting that, when people talk about costs, they do not talk about the costs that have been imposed upon American citizens who need health care but are denied it by their HMO even though they have paid their premiums in good faith. What about the costs imposed on this young boy who was taken past three hospitals to go to the fourth because the family's HMO would not allow him to stop at the first. What is the cost imposed on that young boy who lost his hands and feet or the young boy I described yesterday whose HMO denied him therapy because it said a 50-percent chance of walking by age 5 is a minimum benefit?

Or let's talk about other costs, costs on the HMO side.

Let me read a table of the 25 highest paid HMO executives. I wonder if there is any interest or concern about their salaries while we are withholding treatment for people under the aegis of cost cutting. Let me list some of the 25 highest paid CEO executives.

Annual compensation, 1997: one CEO makes $30.7 million, another has a $12 million salary, a $8.6 million salary, a $7.3 million salary, a $6.9 million salary—these are annual salaries—$5.7 million, $5.3 million, $5.2 million, $5.1 million, all the way down the list of the 25 highest salaries.

Mr. REID. Will the Senator yield?

Mr. DORGAN. I will be happy to yield.

Mr. REID. The Senator from North Dakota has talked about the salaries these executives make. Mr. President, he has not included the value of their stock, has he?

Mr. DORGAN. I have not. I have that on the next page. Let me describe that, starting at the top. Twenty-five companies: $61 million in unexercised stock options, on top of the salary, for one person in 1997, $32.7 million, $19.9 million, $19.0 million, $17 million—all the way down the list of 25.

It is interesting when people talk about costs. Is there any interest in this, any interest in talking about $35 million, $37 million, $38 million in unrealized stock options?

Mr. REID. Will the Senator yield for a question?

Mr. DORGAN. I will be happy to yield.

Mr. REID. Will the Senator add the stock options for that one individual and find out what it comes out to per year?

Mr. DORGAN. I do not have it listed quite that way, but I can tell my colleague that the average compensation plus stock options for these 25 executives is $16.7 million.

Mr. REID. It is fair to say it is a huge amount of money; isn't that true?

Mr. DORGAN. Oh, yes. One of them, for example, makes well over $30 million. Another is over $40 million. Of course that is a substantial amount of money.

The only point I am making is this: There is a lot of money and a lot of profit in this system. This has a lot to do with profits in for-profit medicine. On the other side, on the counterbalance, is the care for patients. Some people objected yesterday because we cited examples of patients who have been mistreated. They said this debate is not about individual patients. Of course it is. That is exactly what it is about. This debate is not about theory, it is about what kind of health care patients are going to get when they need it.

When your child is sick, what kind of treatment is your child going to get? Or if your spouse has breast cancer and your employer changes HMO plans, will someone say—I ask for 1 additional minute by consent—you cannot keep your same oncologist, you have to change doctors, even though you are in the midst of treatment? If your child needs to go to an emergency room, will someone say: We're sorry, you can't go to the one 2 miles away, you must go to the one 20 miles away? These are the kinds of issues, real people with real problems, that this debate is about. That is what this is about.

Every health organization in the country supports our bill. USA Today, in an editorial said: If you want a Patients' Bill of Rights from the Republican plan, you had better be patient because it doesn't provide a Patients' Bill of Rights.

There is a difference in these plans. At least we are on the right subject. But while we are on the subject of cost, let's talk a little about who is making the money here—$30 million, $20 million, $15 million in annual compensation—and then you talk to us about cost. We can't afford $1 a month to provide protection to Jimmy Adams so he can go to the nearest emergency room when he is desperately ill? Of course we can do that.

The PRESIDING OFFICER. The time has expired.

Ms. COLLINS addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Maine.

Who yields time?

Ms. COLLINS. I yield myself such time on this amendment as I may consume.

Mr. President, this amendment goes to the heart of this debate. All of us agree HMOs must be held accountable for providing the care that they have promised. All of us agree we need a strong appeals process so that anyone who is denied medical treatment or medical care has an avenue that is cost free, expeditious, and easy to appeal an adverse decision from an HMO. That is not what this debate is about.

The debate is whether we solve these problems in a way that is going to cause health insurance premiums to soar, thus jeopardizing the health insurance coverage of millions of Americans, or are we going to take the approach that the HELP Committee bill takes, which is to address these problems in a way that is sensible and that

addresses the concerns about quality, about unfair denial of care, without imposing such onerous and expensive Federal regulations that we drive up the cost of health insurance and cause some people to lose their coverage altogether.

That is the heart of this debate. That is the key difference between the bill advocated by my colleagues on the Democratic side of the aisle and the bill which we support.

This amendment is simple; it is straightforward. What this amendment says is, if the Kennedy bill, in fact, increases the cost of health insurance along the lines projected by the independent Congressional Budget Office, then it would be essentially no longer in effect for group health plans.

This is an important amendment. It recognizes that cost is the single biggest obstacle to providing health insurance. It addresses the issues the CBO has outlined in its report in which it warned about what would happen if the Kennedy bill goes into effect. What would happen is, under the Kennedy bill that is before us, 1.8 million Americans would most likely lose their health insurance; employers would drop coverage, particularly small businesses that may be operating on the margin already; self-employed individuals would find health insurance still further out of reach; and we would further exacerbate the problem of the growing number of uninsured in this Nation.

We have a record 43 million Americans without health insurance. We should not be increasing the number of uninsured.

So what our amendment does is very simple. It says if there is an increase in health insurance premiums beyond 1 percent, or if the number of uninsured Americans increases by more than 100,000 people, that we will take a second look, we will put a stop to the mandates that would be imposed by the Kennedy bill.

Surely, we should be able to come to an agreement that this is the right approach to take. If my colleagues on the Democratic side of the aisle believe that their bill will not have the kind of cost estimate that the independent CBO says it will have, then they should join with us in supporting this amendment because this amendment offers important safeguards.

It says the Senate should not be implementing, we should not be passing legislation that is going to drive up the cost of health insurance and further increase the number of uninsured Americans—a number that already stands far too high at 43 million people.

By contrast, the Republican approach seeks to expand, not contract, the number of Americans with insurance. We would do that, for example, by providing full deductibility for health insurance for self-employed individuals. This is a critical issue in my State of Maine where we have so many Mainers who are self-employed. Perhaps it is in keeping with the independent Yankee spirit of the State of Maine that we do have so many people who run their own businesses. We see them everywhere. It is the small businesses on Main Street of every town in Maine. It is our lobstermen, our fishermen, our gift shop owners, our electricians, our plumbers. We see it throughout our State. It would be the most important thing that we could do to help them to afford health insurance if we made their health insurance premium fully deductible.

So we have a very clear choice. Do we want the Kennedy approach, which is going to cause health insurance premiums to soar, causing small businesses to be unable to provide coverage at all and putting health insurance further out of reach for the 43 million uninsured Americans or do we want the approach that we have proposed through the HELP Committee bill?

Our legislation addresses the very real problems that do exist with managed care. Our approach would put treatment decisions back in the hands of physicians, not insurance company accountants, not trial lawyers. But our approach strikes that critical balance. We do so not by so overloading the system that we are going to drive up costs but, rather, by putting in commonsense safeguards that will solve the problems with managed care without jeopardizing the health insurance coverage of millions of Americans.

I urge my colleagues to join, I hope in a bipartisan way, in supporting this very important amendment. It is a way for the Senate to put itself on record as recognizing that cost is the single biggest obstacle to expanded health insurance coverage. I hope we will have bipartisan support for this amendment.

I thank my colleagues and yield the floor but reserve the remainder of our time.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Oklahoma.

Mr. NICKLES. Mr. President, I want to respond just a little bit to our colleague from North Dakota who said: Well, the Democrat bill would only increase costs by $1 a month. CBO says—I just read the CBO report. CBO does not say it. Or if my colleague would show me where it says that, I would be happy to maybe consume that page on the floor of the Senate. I don't know, but I read rather quickly. Maybe I missed it. I read fairly fast.

But the section I am looking at in CBO says—this is talking about the Patients' Bill of Rights, S. 6:

> Most of the provisions would reach their full effect within the first 3 years after enactment. CBO estimates the premiums for employer-sponsored health care plans would rise by an average of 6.1 percent in the absence of any compensating changes on the part of employers.

That is 6.1 percent. The annual premium for health insurance for a family, according to Peat Marwick, in 1998, in an employer survey, was $5,800. And 6.1 percent of that is $355 per year.

If you divide that by 12, it is almost $30 a month—not $1 a month; $30 a month. That is not even close.

So I make mention of this. Again, I think people are entitled to their own opinion; they are not entitled to their own facts.

If CBO says this Kennedy bill only increases costs by $1 a month, I would like to see where it is. I just read the report—April 23, 1999. It says: 6.1 percent.

That is a fairly big difference. When I am saying the cost is almost $30 a month—$29.50 a month—versus $1 a month, we have a little difference. I am using CBO. Maybe my colleague from North Dakota reads it a little differently.

I think that is a rather significant difference: $30 a month will price a lot of people out of health insurance. This additional 6-percent increase, on top of the 9-percent increase which is already projected, is going to put a lot of people in the uninsured category. We don't want to do that. We should do no harm. We shouldn't put millions of people in the uninsured category.

I refer, again, to the CBO report, because I heard my colleague from Massachusetts assert that this will only cost a family one Big Mac a month. I don't know if he is using CBO, but we are using CBO. CBO says S. 6, the Patients' Bill of Rights, the Kennedy bill, will increase health care premiums by 6.1 percent, resulting in an $8 billion reduction in Social Security payroll taxes over the next 10 years. This is in the report. If Social Security taxes are going down by $8 billion, that means total payroll goes down over that same period of time by $64 billion, total payroll reduction.

Employers are going to say: Wait a minute, if you are driving up my health care costs, I can't pay you as much. I am going to pay you less or we will offset this reduction.

That is CBO. That is not the Republican organization. That is not DON NICKLES penciling it in. This is CBO, a nonpartisan group, saying there is $64 billion in lost wages if we pass the Kennedy bill. That is a whole lot of Big Macs. That is 32 billion Big Macs, if they cost $2 apiece. That isn't one Big Mac. As Senator GRAMM said, you can buy the McDonald's franchises for that. I expect you could.

For people who say the cost impact of the Kennedy bill is trivial and it would do no damage, if they believe that, have them vote for this amendment. I hope they will vote for this amendment.

We should do no harm. We should not increase the cost of health care by more than 1 percent. Shame on us if we do. We should do no harm. We should not increase the number of uninsured. We should not be passing bills that make matters worse. Let's work on quality. Let's improve access. Let's make sure more people have health

care. Let's not do just the opposite. Let's not uninsure a couple million people by increasing the cost of health care so dramatically, as the Kennedy bill would do. That is the purpose of our amendment.

I compliment my colleague from Texas, who has been working on this amendment as the principal cosponsor with me, and also my colleague from Maine who spoke so eloquently on it earlier.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. REID. Mr. President, I yield, on the amendment, 5 minutes to the Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. Mr. President, virtually every provision in both versions of the Patients' Bill of Rights starts with a phrase similar to this: If a group health plan or health insurance coverage offered by a health insurer provides any benefits with respect to specialist care, emergency service care, primary care, then this is what they have to do. What does that say?

One, it says no health plan is required to offer virtually any of the services that are covered by this bill. It is all a matter of free contract between the HMO and those persons to whom an HMO contract is being sold. The analogy is, what is it that you buy when you sign an HMO contract that says you are going to get access to specialists.

To stay with the McDonald's example, the question is not what the hamburger costs. The question is whether there is any beef inside the hamburger or whether all you are paying for with your $2 is a couple of buns.

The fact is, if there is an increase in cost, it probably means people aren't getting the kind of services they think they are getting when they contract with an HMO. We found out, as it relates to Medicare, that 40 percent of the complaints by Medicare beneficiaries against their HMO were in the emergency room. They went to the emergency room, they got treatment, and then they were found not to have a heart attack, not to have the onset of a stroke. That was the good news. The bad news was the HMO said: Well, because you went to the emergency room and you didn't have a heart attack, we are not going to pay your bill.

Is that the way we want to hold down the cost of care, by having essentially a bait-and-switch process built into one of the most intimate aspects of an American family's relationships, and that is how their health care will be provided and paid for?

The issue is whether people are going to get what they contracted for. If they don't want to contract for these services and therefore have a lower cost product, they are at liberty to do so.

The irony is, to go back to the last discussion we were having on the emergency room, the very provision that apparently is going to be substantially altered, in the unseen, unread, unknown Republican amendment that is being offered as an alternative to my emergency room amendment, has to do with poststabilization care. According to the oldest and one of the largest HMOs in the country, Kaiser-Permanente, which has voluntarily adopted exactly the procedure we are suggesting should be the standard for emergency room contract provisions, their use of poststabilization has saved them money. How has that happened?

Take the case of a child who has a high fever. The parents take the child to the emergency room. It is determined the child does not have a life-threatening condition, but there is uncertainty as to why they have had this high fever.

Under the Kaiser plan, the emergency room calls the HMO and says: Here is what the situation is with this child. What do you think would be the appropriate medical treatment? The HMO, Kaiser, and the emergency room work out a coordinated plan of treatment. In many cases, what it says is the child can go back home if the child, at 9 o'clock in the morning, will come to Kaiser's primary care physician to be treated. That is why Kaiser says it is not only good health but also it saves money.

Ironically, the first amendment offered, after it is stated by the opposition that they are going to strip, dilute, adulterate this provision which has the potential of saving money, is to offer this saccharin amendment which says: Now we will put a limitation on increases in cost.

I think we are all concerned about cost. We are all concerned about making health care more affordable and reducing the number of uninsured. But we want people who contract with an HMO to get what they paid for, not to get the two buns but no beef in their McDonald's hamburger.

Mr. GRAMM addressed the Chair.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, I yield myself 15 minutes.

I have to say we often see people do 180 degree turns around here. It never ceases to amaze me to hear our Democrat colleagues savaging HMOs. Let us remember they are the people who have been in love with HMOs for 25 years.

In fact, they loved HMOs so much that in these bills virtually crushing this ancient desk—the 1994 Clinton health care bill and the two Kennedy variations of it—they loved HMOs so much they would have set up health care collectives all over the Nation, run by the Federal Government, and would have fined Americans $5,000 for refusing to join their health care collective. They loved HMOs so much in 1994, they would have imposed a $50,000 fine on a doctor who prescribed medical treatment that was not dictated or allowed by their Government-run HMO health care collective.

They loved HMOs so much in 1994, if a doctor provided treatment you needed for your baby that was not provided for in their Government-run health care collective, and you paid him for it, he could go to prison for 15 years. That was their vision of a health care future for America.

But having loved HMOs so much that they wanted to mandate that everybody in America be a member of one run by the Government, now all of a sudden they have done a public opinion survey. They have gotten focus groups together, and they have decided Americans are not as much in love with HMOs as they are. And so as a result, now they have a bill that doesn't say, as they said in 1994, HMOs are the answer to everything. They have a bill that now says HMOs are the problem.

What we try to do in our bill is fix the problems, but we do something they will not do: We empower Americans to fire their HMO. We allow Americans to buy medical savings accounts, where they have the right to choose for themselves.

Our Democrat colleagues are adamantly opposed to that freedom because they want the Government to run the health care system. And you can't get the Government running the health care system if you start giving people the power to fire their HMO. So they want to regulate the HMOs. They want to give you the ability to contact a bureaucrat if you are unhappy. They want to give you total freedom to hire a lawyer. You can hire whatever lawyer you want to hire.

But what they will not do is give you the ability to hire your doctor. Why don't they want to do it? Because this is simply one step in the direction of this health care bill that they want and love, and which we killed. But in their heart, they still want Government health care collectives, and they want people fined and imprisoned if they don't provide medicine exactly the way the Democrats want it provided.

Now they say, well, something is wrong with the Republican bill because they are not overriding State law. They think that somehow Senator KENNEDY and President Clinton know more about Texas than the people in the Texas Legislature and the Texas Governor. They believe we should trample State law and we ought to make every decision in Washington, DC. We don't agree. They say they want America to know the difference. Please know that this is the difference.

If Senator KENNEDY and President Clinton know so much about Texas, when President Clinton finishes in the White House, maybe he ought to move to Texas and run for some public office. It would be an educational experience, I can assure you, both for him and the people of Texas.

But the point is, I am not going to let Senator KENNEDY and President Clinton tell the people in Texas how to run

their State. I am not going to do it either. If I wanted to do that, I would run for the state legislature.

Let's get to the issue we are talking about here. The problem with the Kennedy bill is it drives up costs. The problem with the Kennedy bill is that the Congressional Budget Office has concluded that the Kennedy bill would drive up health care costs by 6.1 percent.

What that means is two things: One, 1.8 million Americans would lose their health insurance. Now, granted, if their bill passed, you would have the ability to pick up the phone book, look in the blue pages and call any government agency you wanted; you could hire any lawyer you wanted. But 1.8 million people would not have health insurance under this bill. Their bill would drive up health costs for those who got to keep their insurance by $72.7 billion over a 5-year period.

Let me convert that into something people understand. By 1.8 million people being denied health insurance because of the cost of all these lawyers and Government bureaucrats and therefore losing their insurance under the Kennedy bill, that would mean that in breast exams, 188,595 American women would lose breast exams that they would have under current law because Senator Kennedy's bill would drive up health insurance costs so much.

Because 1.8 million people would lose their health insurance under the Kennedy bill, there would be 52,973 fewer mammograms. Why? Is Senator Kennedy against mammograms? Of course he is not. But the point is, his bill, by driving up costs, by hiring all these bureaucrats and all these lawyers, where 60 percent of what comes out of these lawsuits goes to lawyers and not to people who have been damaged, hurt, or are sick—by imposing those new costs, 52,973 women per year would lose mammograms that they are getting, which are funded today under their health insurance policies.

Under Senator KENNEDY's bill, 135,122 women that get annual pap tests funded by their insurance policy would not get them because they would lose their insurance.

And so that no one thinks I am totally discriminating against men, prostate screenings would decline by 23,135. That's 23,135 men who would not get screened, who might die of prostate cancer because Senator KENNEDY thinks it is more important to be able to hire a lawyer than it is for people to have insurance so that they can get prostate screening.

Really, the bill before us is not about doctors. Nothing in Senator KENNEDY's bill lets you choose your doctor or fire your HMO. It lets you choose a lawyer and contact a bureaucrat. In doing so, it drives up costs by 6.1 percent and it denies 1.8 million people their health insurance. As a result, we get less care, not more; we get more expensive care, not cheaper. And anybody that believes that being able to hire a lawyer or contact a bureaucrat heals people clearly does not understand how medicine works.

The amendment before us is a very simple amendment. My guess is that after they pray over it a while, everybody will vote for it. It kills the Kennedy bill, no question about that. But I don't think they are going to want to vote against it because what this amendment says very simply is this: It sets up a triggering mechanism. It says that if this bill were to be adopted—which it won't be because we are going to defeat it this week because we have a better bill that works better—if it was found and certified that in any year, when fully implemented, this bill would drive up costs by more than 1 percent, the law would not go into effect. Or if in any year more than 100,000 people lost their health insurance as a result of the cost increase also imposed, then this bill would not be operative.

Now we know from CBO estimates that both of these things will occur. We have offered this amendment basically to point out the fact that the problem with the Kennedy bill is that it drives up costs, and it denies people health insurance.

Finally, let me say do I believe this is the end game? Suppose for a moment that we could pass their bill, if President Clinton could override every legislature and State, and we could have the Government decide, by law, what is the preferred service, what is the means of treating every disease so we would set by Federal statute all those things. Suppose that we did all those things and drove up health care costs, would the Democrats be happy? No, and neither would the American people.

Next year, they would come back with their old faithful, the Clinton health care bill, and they would say: Medical costs have risen by 6.1 percent, 1.8 million people have lost their health insurance, and there is only one solution. We have to have the Government take over the health care system. We will make everybody join an HMO. We will take their freedom completely away, and, in fact, we will fine them $5,000 if they refuse to do it, and we will make doctors practice medicine our way. We will fine them $50,000 if they give a treatment we don't approve, or we will put them in prison if they provide medical care that is not on our approved Federal list. That will be their answer to the problem they create with this bill. That is what this debate is about.

I am sure, having looked at their bill, they have done a poll, they have looked at a focus group, and they have determined that somehow they are going to gain some political points by the bill they put forward.

We have gone about it a little bit differently. We have spent 2 years with people such as BILL FRIST—who has actually practiced medicine; not only practiced, he is one of the premier doctors in America—putting together a bill that fixes the problems with HMOs, that doesn't write medical practice into law. If we had written medical practice into law 100 years ago, we would still be bleeding people for fevers.

We have put together a bill that tries to deal with abuses in HMOs so a final decision is made by an independent doctor as to what ''necessity'' is. We go a step further. We expand freedom so that people get a chance with our reforms, if they are not happy with their HMO, they can say something under our bill to the HMO that they can't say under Senator KENNEDY's bill. Under our bill, if all else fails, they can say to their HMO: You didn't do the job. You didn't take care of me, you didn't take care of my children, and you are fired. I'm going to get a medical savings account. I'm going to make my own decisions.

That is the difference between what Democrats call rights and what Republicans call freedom. Their rights are the right to more government, the right to more regulation, the right to look in the blue pages and call up a government bureaucrat, to look in the Yellow Pages under ''Attorney'' and call up a lawyer.

But their health care rights do not include the right to hire your own doctor or to fire your HMO. What kind of right is it when you have a right to complain and petition but you don't have a right to act?

Our bill is about freedom, the freedom to choose. That is the difference. Our Democrat colleagues don't support that freedom, because they want a government-run system.

Senator KENNEDY is not deterred. We may have killed the Clinton-Kennedy bill in 1994 taking over the health care system, but he dreams of bringing it back. If he can win on his bill this week, it is a step in that direction. But he is not going to be successful.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

If no time is yielded, the time is shared equally.

Mr. NICKLES. Mr. President, I want to make a couple more comments. I think some people have been loose with facts on saying the Kennedy bill would only cost $1 a month. One Member said it would only cost one Big Mac a month. That is absolutely, totally false.

I have been looking at the Congressional Budget Office cost estimate of the Kennedy bill, S. 6, the Patients' Bill of Rights of 1999. I will read a couple of provisions. If this report is wrong, I wish to be corrected. Members are making statements that it will only cost $2 a month, or one hamburger a month—unless they are buying that hamburger in Cape Cod or Hyannis Port. Maybe that is $30 a month. It is not a Big Mac in Oklahoma.

Page 3 of the CBO report says most of the provisions would reach the full effect within the first 3 years after enactment. CBO estimates the premiums for employer-sponsored health care plans would rise by an average of 6.1 percent in the absence of any compensating changes on the part of employers.

What would the compensating changes be? CBO says, on page 4, employers could drop health insurance entirely if we pass the Kennedy bill. Employers could drop health insurance entirely, which I am afraid many would do. They could reduce the generosity of the benefit package, according to CBO, increase the cost sharing by beneficiaries, or increase the employee's share of the premium.

This is CBO. This is not just DON NICKLES. This is not some right-wing conspiracy. They are saying if health care costs are increased this much, some employers will drop plans. Some employers will say employees have to pay a lot more. Some employers will come up with cheaper plans. CBO said some will reduce the generosity of the benefit package, come up with cheaper plans, not cover so much.

I thought the purpose of the bill was to improve health care quality, not come up with cheaper plans, not come up with fewer plans, not come up with greater uninsured. That is what CBO is saying increased costs would be.

How much would it cost? Again, I am a stickler for having facts. What is the estimated budgetary impact of the Kennedy bill? CBO says it would reduce Social Security payroll taxes by about $8 billion over the next 10 years, reducing Social Security payroll taxes by $8 billion. That means total payroll goes down by $64 billion. That is a big reduction. That is a lot of money coming out. That is a lot of money that people won't receive in wages, according to the CBO, because Congress passed a bill. Congress said: We know better; we should micromanage health care from Washington, DC. The net result is lost wages of $64 billion. That is not one Big Mac per month.

What is the cost per month? Family premium for health insurance, according to Peat Marwick: $5,826 in 1998; 6.1 percent of that is $355 per year. That is right at $30 per month an employer would pay. What does CBO say the employer would do if they were saddled with those kinds of increases? They would drop plans, drop health insurance entirely, reduce the generosity of the benefit package, increase cost sharing by beneficiaries, or increase the employees' share of the premium.

We should use facts. The cost of the Kennedy bill is not one Big Mac; it is about $30 a month for a family plan. According to CBO, I am afraid a couple of million people, at least 1.8 million people, would lose the insurance they already have. We should not do that. That would be a serious mistake.

Mr. FRIST. Will the Senator yield?

Mr. NICKLES. I am happy to yield.

Mr. FRIST. It is important for us to look at the CBO reports because they have obviously looked at various mandates in this bill. I ask the Senator if this is correct. It says:

> CBO finds the bill as introduced [Senator KENNEDY's bill] would increase the cost of health insurance premiums by 6.1 percent.

Is that correct?

Mr. NICKLES. That is correct.

Mr. FRIST. Does that 6.1-percent increase include the cost of inflation in health care? Or is that separate from that?

Mr. NICKLES. The Senator makes an excellent point. That is over and above whatever inflation is already anticipated for health care costs.

Mr. FRIST. So we have health care inflation. We know we worked hard to reduce it, but the rate of health care inflation already is two or three times that of general inflation. So that is already built into the equation. The increase, because of the Kennedy bill, is an additional 6.1 percent; is that correct?

Mr. NICKLES. That is correct.

Mr. FRIST. So we are talking about a potential increase of 9, 10, 11 percent in premiums?

Mr. NICKLES. Even higher than that. I think the estimate I have, that was done by the National Survey of the Employee-Sponsored Health Care Plans, Mercer, which is probably one of the biggest actuaries in health care, estimates a 9-percent increase for next year in health care costs. So if you put 6.1 percent on top of that, that is a 15-percent increase in health care costs for next year.

Mr. FRIST. So we have health care going to 10, 11, 12, 13, 14, 15 percent, possibly higher because of the bill, coupled with things we cannot control. Yet we know this bill is something we can control.

For every 1 percent increase in premiums—you say it is going to be 10, 12, 13, 14, 15—how many people are driven to the ranks of the uninsured?

Mr. NICKLES. Most of the professionals and actuaries usually estimate about 300,000.

Mr. FRIST. The reasons for that seem to me to be fairly obvious. With premiums going sky high, and you are a small employer and trying to do the very best to take care of your employees and offer them insurance and you are barely scraping by with your margins, as small businesspeople are working so hard to do, is it not correct that an 11-, 12-, 15-percent increase is enough to make you say I just cannot do it anymore?

Mr. NICKLES. Unfortunately, that is the case.

Mr. FRIST. Is it correct, what the CBO says, responding to, ''How will employers deal with these costs?'' Do you agree with what the CBO says:

> Employers could respond to premium increases in a variety of ways. They could drop health insurance entirely, reduce the generosity of the benefit package . . .

I tell you, as a physician, neither of those sound very attractive to me. We have to be very careful in this body that we don't cause them to drop their insurance or decrease their benefits package. I continue back with the quote:

> . . . increase cost sharing by beneficiaries . . .

As an aside, I am not sure we want to throw that increased cost sharing on our beneficiaries unless it is absolutely necessary.

> . . . increase the employees' share of the premium. CBO assumed employers would deflect about 60 percent of the increase in premiums through these strategies.

Mr. President, 60 percent, that is almost unconscionable unless these mandates are entirely necessary.

Mr. NICKLES. I thank my friend and colleague. He makes an excellent point. Again, this is CBO saying if we do this, employers are going to drop health insurance or they are going to drop the quality of the package. He makes an excellent point.

Mr. President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. FRIST. Mr. President, I yield myself 5 minutes.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Parliamentary inquiry. How much time remains?

The PRESIDING OFFICER. The Senator has 6 minutes 10 seconds.

Mr. FRIST. And on the other side?

The PRESIDING OFFICER. On the other side, 5 minutes 51 seconds.

Mr. FRIST. Mr. President, this Patients' Bill of Rights is critical. For us to come in and return the balance between physicians and patients in managed care—and I think managed care has gone too far—we need to absolutely make sure patients and physicians are empowered so the very best care is given to that patient. It means we in this body have to be very careful not to drive the cost just sky high, through the roof. Why? Because all the information, all the data presented to us is if we make these premiums skyrocket people are going to lose their insurance.

We have not talked about that very much. I mentioned it to my colleagues. Is very important to get some insurance coverage. Some coverage gets you into the door. That makes sure you have access to health care.

If we look at the President's own advisory commission on managed care, they were very careful to consider costs. I think we should be, just as they were, very careful.

This is one of their guiding principles of President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. They basically say:

> Costs matter . . . the commission has sought to balance the need for stronger consumer rights . . .

As an aside, we have to do that and accomplish that in this bill we have before us this week.

> . . . with the need to keep coverage affordable . . . Health coverage is the best consumer protection.

I agree with this. We need to come back to this guiding principle and consider cost.

We talk about the mandates. Let me say, because I mentioned the commission, we have a lot of mandates in the underlying Kennedy bill. I think we need to go through and see what other people have said about these mandates; are they necessary? Because we know unlimited mandates imposed on insurance companies, States, individuals, if they are not necessary, are going to drive costs up and decrease access. If we look at the Democratic mandates—and I just put a few on here to see whether or not President Clinton's Advisory Commission on Consumer Protection and Quality recommended them—you will find the following.

Under a medical necessities definition, something we will be debating over the next couple of days: Rejected under the President's commission.

Under the health plan liability, coming back to bringing the lawyers into the emergency room and suing everyone: Rejected; mandatory repeal of standardized data, rejected by President Clinton's commission; State-run ombudsman program, rejected by the President's commission; restriction on provider financial incentives, rejected by the President's commission. All of these are mandates in the Kennedy bill today, all of which were rejected by the President's own commission.

Rules for utilization review, section 115 in S. 6, the Kennedy bill: Rejected by the commission. Provider nondiscrimination based on licensure, rejected by the commission.

The point is not so much each of these and the sections I have enumerated here, 151, 302, 112, 151. The point is, in this body, as we go forward, we have to be very careful in all of the rhetoric and all of our commitment and all of our hard work, legitimately, on both sides, to protect patients. We have to be very careful not to go too far out of good intentions, to the point that it is unnecessary, if they do not need those rights, and it also drives the cost up.

So when you go through the Kennedy bill and see these mandates, President Clinton's own Advisory Commission on Consumer Protection and Quality looked at them, considered them, but rejected them.

Why? I cannot tell you for sure why because I was not in the room, but I think it comes back to the amendment we are talking about today and to what they have actually said in their guiding principles: Costs do matter.

The commission has sought to balance the need for stronger consumer rights——

Just as we are in our Republican Patients' Bill of Rights Plus bill——

with the need to keep coverage affordable. . . . Health coverage is the best consumer protection.

I look back at Tennessee. Looking at the uninsured and the costs associated with the underlying Kennedy bill, the number in Tennessee that we throw to the ranks of the uninsured would be 20,872. Again, we talked about the 1.8 million nationwide. Look to our own individual States.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. FRIST. Mr. President, I will close simply by saying I am very glad this amendment was brought to the floor because very early on it says this debate is more, it is in addition to just patient protections. Why? Because the ultimate patient protection means you get good quality of care and you have access to that care. So over the next several days our primary objective is to increase that quality of care, strong patient protections, but do all that without hurting people, without throwing them to the ranks of the uninsured.

That is our challenge. That is why I am very proud of our underlying Republican bill and look forward to supporting it and gathering more support as we go over the next several days.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

If neither side yields time, time will be charged equally.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Massachusetts.

Mr. KENNEDY. Mr. President, what is the time situation?

The PRESIDING OFFICER. The side of the Senator from Massachusetts has 35 minutes; the other side has used up all its time.

Mr. KENNEDY. It is our intention to respond to these arguments briefly and then offer an amendment. I yield myself 5 minutes.

Mr. President, as we see in this institution, there are amendments which are offered that are poison pill amendments. They are amendments that effectively kill legislation. That is really the purpose of this; we ought to be very clear about it. Senator GRAMM of Texas has indicated if that amendment is accepted, this whole debate comes to a halt and it ends any possibility of a Patients' Bill of Rights. That is what we are faced with at this time.

We will have an opportunity to judge whether the Senate wants to end any consideration of a Patients' Bill of Rights—or whether this is an issue that ought to be considered—when we vote on that particular amendment. We will have a chance to vote on the various amendments we have outlined and presented in different forms. We will continue to discuss these amendments over the course of this debate.

One of the techniques used in this institution—perhaps less so now than in the past—is to present the opposition's arguments with distortion and misrepresentation, and then differ with the distortions and misrepresentations. We saw a classic example of that with my good friend, the Senator from Texas, Mr. GRAMM. He went through this whole routine about what was in this bill and then he, in his wonderful way, differed with it, like only he had common sense and understanding of what is in that legislation.

Before responding to that, I start out with the basic core issues, which have been raised again and again by those who are opposed to our bill: One, costs; and, two, coverage.

When all is said and done and after we have listened to the distortions and misrepresentations of our good Republican friends, here is, majority leader TRENT LOTT on NBC ''Meet the Press'' saying: By the way, the Democrat's bill would add a 4.8 percent cost.

This is the Republican majority leader agreeing with the Congressional Budget Office figures. Maybe the other side gets a great deal of satisfaction—they certainly take a lot of time to distort and misrepresent the facts. But let's look at 4.8 percent—or even 5 percent—impact on a family's premium over 5 years. The family's premium might be $5,000 a year. Looking cumulatively at 5 percent—1 percent a year—that would be $250 for the total of 5 years, $50 a year.

You can misrepresent the figures, you can distort the figures, you can frighten the American people, which is a common technique; it was done on family and medical leave. Do you remember that argument put out by the Chamber of Commerce about the cost of family and medical leave to American business? They still cannot document it. Do you remember, when we had the minimum wage debate, claims about the cost to American business? They still cannot document it. As a matter of fact, Business Week even supports an increase in the minimum wage.

Now on the third issue, here it comes again, the bought-and-paid-for studies by the insurance industry. That is what these studies are all about. They are bought and paid for by the insurance companies, and they distort and misrepresent.

Mr. NICKLES. Will the Senator yield?

Mr. KENNEDY. I will not yield at this time. You would not yield last evening when I was trying to ask Republicans about particular provisions.

How many times did we hear from the other side: Let's rely on the Congressional Budget Office, they know what is best. We were just with the President of the United States. He said every time he sat down with the Republican leadership, they said: We will not do anything unless we get the CBO figures.

We have given you the CBO figure. The majority leader agrees with the CBO figure. Let's put that aside.

The second issue is coverage. The issue is whether more people will lose their health insurance coverage because we are going to do all of the things that Senator GRAMM talked about. I yield to no one on the passage of health care in order to expand coverage. The idea that the groups in support of this particular proposal would support a proposal which means that 2

million Americans would lose coverage is preposterous on its face. On the one hand, they are so busy over here saying: Look who is supporting your program, the AFL-CIO. Do you think they are going to support legislation—I yield myself 2 more minutes—that will cause 2 million Americans to lose coverage? Are we supposed to actually believe that? Or all the many groups—I will not take the time to enumerate them—that support a comprehensive program to expand coverage? That is poppycock. That is baloney. They even understand that in Texas. It is baloney.

The idea that 180,000 women are going to lose breast cancer screening, 52,000 a year are going to lose mammograms, 135,000 women in this country are going to lose Pap tests when the American Cancer Society supports us lock, stock, and barrel—come on, let's get real. Whom do you think you are talking to, the insurance companies again? Can you imagine a preposterous statement and comment like that coming from the Senator from Texas? That just goes beyond belief.

I will make a final comment or two about freedom. We heard a lot about freedom. Remember that, we heard all yesterday afternoon about freedom? We heard about freedom this morning. We heard about freedom: We are for freedom. The other side is not for freedom, but we are for freedom. Support our position, you will be for freedom.

The insurance companies want freedom from accountability. That is what they want, freedom to undermine good quality health care for children, for women who have cancer, for the disabled. That is what they want—freedom from accountability and responsibility.

That is baloney, too. We want accountability. I am surprised to hear from the other side all the time about how they want personal responsibility and accountability.

I ask for another 2 minutes.

They always want personal responsibility and accountability with the exception of HMOs. Sue your doctors, fine, but not your HMOs, not your insurance companies, not those that have paid $100 million and effectively bought this Republican bill—yes; that is right—those provisions are dictated by the insurance companies.

That is what we have. The American people are too smart to buy that.

I know there are others who want to speak. I yield back my time.

AMENDMENT NO. 1237 TO AMENDMENT NO. 1236

(Purpose: To provide coverage for certain items and services related to the treatment of breast cancer and to provide access to appropriate obstetrical and gynecological care, and to accelerate the deductibility of health insurance for the self-employed)

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

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative assistant read as follows:

The Senator from Massachusetts [Mr. KENNEDY], for Mr. ROBB, for himself, Mrs. MURRAY, Mrs. BOXER, Ms. MIKULSKI, Mr. KENNEDY, Mr. REID, Mr. DURBIN, Mr. FEINGOLD, Mrs. LINCOLN, Mr. DASCHLE and Mr. BYRD proposes an amendment numbered 1237 to amendment No. 1236.

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Parliamentary inquiry. That amendment is offered on behalf of Senator ROBB and others; is that so?

The PRESIDING OFFICER. Yes.

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

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

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

The PRESIDING OFFICER. Who yields time?

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. I would like to make a few comments. I will not address the amendment that was just sent to the desk, but I would like to respond to my colleague.

First, I started to call Senator FRIST. Sometimes I call him because we need help on the floor to debate things, such as medical necessity or other medical procedures. This time I thought I would call him because I thought we might need him because I was afraid somebody might have a heart attack getting so excited in the debate.

But let me just touch on a couple of comments that my good friend and colleague, Senator KENNEDY, made. He said: Enough about this cost stuff. He said: That was done by some study that was bought and paid for by the insurance companies.

Correct me if I am wrong, but I stand corrected if the Congressional Budget Office is bought and paid for by the insurance companies. If so, I would like to know it. I am not aware of that.

My colleague alluded to the fact that Republicans are bought and paid for. He was close to getting a rule invoked. I do not think he meant to say that. I will let that go.

I am not going to make allusions that trial lawyers have bought one side or that the unions have bought one side, although he did mention that the unions support his bill. It just happens to be that the unions are exempt from his bill. That is interesting. They are exempt for the duration of their contracts.

So his bill basically tells every private employer: You have to rewrite your contract next year, except for unions. Oh, if you have unions, you don't have to redo it until the end of your contract. If the contract is for 4 years, you don't have to touch it for 4 years. But anybody else, you rewrite it next year.

Maybe that is the reason the unions have signed on. Maybe there are other reasons or other special interest groups that have gotten into his bill.

But back to the cost. My colleague says: Well, it is only 1 percent per year. CBO says the cost would be 6 percent when it is fully implemented in 3 years—not 5 years. So Senator KENNEDY is able to say: Well, we think it is about 5 percent over 5 years; therefore, it is a 1-percent per year cost increase. And employees only pay 20 percent, which is how he gets his one Big Mac per month. It just does not work. It does not equate. The bill, when fully implemented, is 6.1 percent. That is in 3 years, and the cost is $355 per year.

If that happens, you are going to have a lot of people, according to CBO—not some study financed by the insurance companies—who are going to lose their coverage, a lot of people who are going to get less quality coverage, people who are going to have to pay a greater percentage of the coverage, people who are going to have to pay a greater percentage of the premiums if we pass the Kennedy bill. That is the bad news. The good news is we are not going to pass it.

But I think we have to stay with the facts. The facts are that the Kennedy bill increases costs dramatically and increases the number of uninsured dramatically. That would be a serious mistake. That is something we are not going to allow to happen.

Mr. President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, I yield 10 minutes to the Senator from Virginia.

The PRESIDING OFFICER. The Senator from Virginia.

Mr. WELLSTONE. Before the Senator speaks, may I do two quick things?

PRIVILEGE OF THE FLOOR

Mr. President, I ask unanimous consent that Renato Mariotti, an intern, be allowed on the floor during this debate today.

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

Mr. WELLSTONE. I ask unanimous consent that I follow Senator ROBB after we get back from caucuses, that I be first in order.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. ROBB addressed the Chair.

The PRESIDING OFFICER. The Senator from Virginia has 10 minutes.

Mr. ROBB. Thank you, Mr. President. And I thank my colleague from Massachusetts.

Mr. President, while I would concede that most Members of this body are very concerned about issues that have special relevance to women, we all too often leave much of the advocacy on those issues to women who are colleagues in the Senate. In a legislative body with only 9 women and 91 men, the amount of time focused on issues of special concern to women is often skewed. As someone who has always

prided himself on standing up for equality of opportunity, that seems profoundly unfair.

Women's health—and, specifically, the choices women have in our health care system—ought to be a special concern to everyone.

As a father of three daughters, I have come to better understand that the types of health care women need and the way they access it are often very different from the health care needs of men.

Unfortunately, our health care system has long ignored some important facts about women's health. During this important debate on the Patients' Bill of Rights, I have offered an amendment that would do something to correct that. I rise to explain the amendment which was just sent to the desk which will help women get the medical care they need.

The amendment has been crafted with Senators MURRAY, BOXER, and MIKULSKI and will remove two of the greatest obstacles to quality care that women face in our current system today: No. 1, inadequate access to obstetricians and gynecologists; and, No. 2, inadequate hospital care after a mastectomy.

We know today that for many women, their OB/GYN is the only physician they regularly see. While they have a special focus on women's reproductive health, obstetricians and gynecologists provide a full range of preventive health services to women, and many women consider their OB/GYN to be their primary care physician.

Unfortunately, some insurers have failed to recognize the ways in which women access health care services. Some managed care companies require a woman to first visit a primary care doctor before she is granted permission to see an obstetrician or gynecologist. Others will allow a woman to obtain some primary care services from her OB/GYN but then prohibit her from visiting any specialists to whom her OB/GYN refers her without first visiting a standard primary care physician. This isn't just cumbersome to women; it is bad for their health.

According to a survey by the Commonwealth Fund, women who regularly see an OB/GYN are more likely to have had a complete physical exam and other preventative services—like mammograms, cholesterol tests, and Pap smears.

At a time when we need to focus our health care dollars more toward prevention, allowing insurers to restrict access to health professionals most likely to offer women preventative care only increases the possibility that greater complications and greater expenditures arise down the road.

We ought to grant women the right to access medical care from obstetricians and gynecologists without any interference from remote insurance company representatives. This amendment is designed to do just that.

I offer this amendment on behalf of my colleagues because the Republican bill, which has been offered for the purposes of debate by Senator DASCHLE, will not grant women direct access to care.

First of all, their bill only covers a limited percentage of the women who have health care insurance in our country, leaving more than 113 million Americans without any basic floor for patient protections. Then, for the minority of patients that they do cover, the Republicans offer only a hollow set of protections but leave many women without direct access to the care they need. While their bill would allow a woman to obtain routine care from an OB/GYN, such as an annual checkup, the bill would not ensure that a woman can directly access important followup obstetrical or gynecological care after her initial visit. For example, if a woman were to have a Pap smear during a routine checkup at her gynecologist, and that Pap smear came back abnormal, the Republican bill would not guarantee that she could access important followup care from the same doctor.

Instead, their bill would allow insurers to force her to go back to a primary care gatekeeper physician to get permission for a followup visit to her gynecologist. This may sound unbelievable, but a recent survey showed that women face this obstacle 75 percent of the time. In addition, the Republican bill will now allow a woman to designate her OB/GYN as her primary care provider.

Their provision ignores one of the basic facts about the ways women receive health care in America today. While OB/GYNs have a special expertise on women's reproductive systems, they are also trained at primary care. For women, their OB/GYN is the only doctor that they see on a regular basis.

Because many of these women consider their OB/GYN to be their primary care physician, they depend on him or her for the full range of diagnostic and preventative services that are offered by other general practitioners. Statistics show that women are more likely to have had a physical from an OB/GYN in the past year than from any other doctor. One survey from the University of Maryland showed that OB/GYNs provide 57 percent of the general physical exams given to women. In another survey, when asked who they go to for primary care, 54 percent of the women said it is to their OB/GYN.

We know how women access primary care and we know that by allowing them to get this care, their health care will improve. Yet insurers often ignore the fact that many women rely on their OB/GYN for primary care, making it more difficult for them to access preventative care and other services.

Our amendment will grant women more direct access to health care professionals that they have come to depend upon.

The second piece of this amendment will address the inhumane treatment that some women have received after they have experienced the trauma of a mastectomy. Each year, millions of women are screened for cancer by mammogram and, sadly, nearly 200,000 of them are diagnosed with breast cancer.

The options women face in such circumstances are difficult, and in a time of great uncertainty, women ought not be forced to face unnecessary additional burdens. Unfortunately, some women have been told by their health insurer that a mastectomy will only be covered on an outpatient basis. Given the trauma that a woman faces with such major surgery, both physical and emotional, it is unconscionable that some insurers refuse to cover proper hospital care after a mastectomy. Much like the restrictions on access to obstetricians and gynecologists, these restrictions on hospital care after such traumatic surgery are simply bad for women's health. After a mastectomy, doctors tell us that hospitalization is often critical to foster proper healing, as well as to provide support to women who have just experienced the emotional trauma of such major surgery.

Our amendment will return control over this important medical decision to the medical professionals and ensure that doctors who actually know and examine their patients, not some distant, impersonal insurance company representative, make decisions about the length of stay in the hospital following a mastectomy. It would put into law the recommendations of the American Association of Health Plans, who said in 1996, that:

> The decision about whether outpatient or inpatient care best meets the needs of a woman undergoing removal of a breast should be made by the woman's physician after consultation with the patient . . . as a matter of practice, physicians should make all medical treatment decisions based on the best available scientific information and the unique characteristics of each patient.

Although this commonsense, important provision was included in legislation offered by the other side of the aisle last year, it has inexplicably been dropped from their bill this year. We cannot, however, retreat from our commitment to the health and well-being of the women of America.

Finally, this amendment would help self-employed women and, indeed, all self-employed Americans better access affordable health insurance by making the cost of their insurance fully tax deductible.

The PRESIDING OFFICER. The Senator's 10 minutes has expired.

Mr. ROBB. I ask for 1 additional minute.

Mr. KENNEDY. Fine. Are we still recessing at 12:30?

The PRESIDING OFFICER. Yes. That is the order.

Mr. ROBB. Finally, this amendment would help self-employed women and, indeed, all self-employed Americans better access affordable health care by making the cost of their insurance fully tax deductible. The current tax

system penalizes self-employed individuals, and this amendment will ensure they are treated equally.

I am concerned that the bill offered by the other side doesn't even cover 70 percent of Americans with health insurance. I am even more concerned, however, that the protections they offered to this limited number of Americans doesn't reflect the health needs of half of our population, the women in our population.

I know we can do better. We should do better. I urge my colleagues to support this amendment which recognizes the critical needs facing the women in this country today.

With that, I yield the floor, and I reserve any time remaining on my side.

The PRESIDING OFFICER. Under the previous unanimous consent, the Senator from Minnesota——

Mr. KENNEDY. Mr. President, I ask unanimous consent that that consent agreement be vacated.

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

Mr. KENNEDY. I yield 2½ minutes to the Senator from Washington and 2½ minutes to the Senator from Maryland.

The PRESIDING OFFICER. The Senator from Washington.

Mrs. MURRAY. Mr. President, I rise as a sponsor of this amendment to protect women's health. This amendment offers true security to women; it deals with women's access to health care and women's treatment when they receive that care. This amendment ensures women get more than just routine care when they visit their obstetrician/gynecologist and it protects women against the pain and danger of so-called drive-through mastectomies.

While the underlying Republican bill does allow access to OB/GYN care, the HELP Committee went to great lengths to ensure women only had access for routine care—and nothing more. Let me quote from the committee report, ''The purpose of this section is to provide women with access to routine OB/GYN care by removing any barriers that could deter women from seeking this type of preventive care.'' While the Republicans recognize the need for direct access, the language of their bill and their report makes it clear that direct access is guaranteed only for routine care.

Let me explain what that means. If during a routine examination, a woman's OB/GYN finds a lump or an inconsistency in her breast, the OB/GYN would not be allowed to refer the patient for further examination. Instead, the woman would have to go back to the gate keeper and hope that her primary care physician approved the referral. We should all agree this is a waste of time and energy—time and energy that would be better spent dealing with the potential breast cancer.

A recent study conducted by the American College of Obstetricians and Gynecologists shows that managed care plans are keeping women from receiving the health care they need and seeing the providers they choose. Sixty percent of all women who need gynecological care and 28 percent of all women who need obstetric care are either limited or barred from seeing their OB/GYNs without first getting permission from another physician. Once the patient is able to gain access to her own OB/GYN, she is forced to return to her primary care gate keeper for permission to allow her OB/GYN to provide necessary follow-up care almost 75 percent of the time.

What my Republican colleagues fail to understand is that women need OB/GYN care for much more than simple routine care. They also fail to understand the important relationship between a woman and her own OB/GYN. OB/GYN providers are often a women's only point of entry into the health care system.

Our amendment would allow women direct access to OB/GYN care and follow-up care as well. It would also allow a woman to designate an OB/GYN provider as her primary care physician. We know historically that women have not been treated equally in receiving health care. We know that some physicians do not treat women with the same aggressive strategies as they treat their male patients, especially when women complain about depression or stress.

What we do know is that OB/GYNs have traditionally been strong advocates for women's health. They understand the physical and emotional changes a women experiences throughout her life. The 1993 Commonwealth Fund Survey of Women's Health found the number of preventive services received by women, including a complete physical exam, blood pressure test, cholesterol test, breast exam, mammogram, pelvic exam, and pap smear, are higher for those whose regular physician is an OB/GYN than for those whose primary care doctor is not. Women are simply afforded greater access to preventive and aggressive health care services with OB/GYNs.

I am not sure why some of my Republican colleagues want to deny unobstructed access to important health care services for women. It cannot be about costs. The Congressional Budget Office estimated that the cost of direct access and primary care by OB/GYNs as only 0.1 percent of premiums. If my colleagues are so concerned about costs, can't they at least guarantee that women get the quality health care they pay for? This amendment ensures they will.

The other important provision in this amendment prohibits drive through mastectomies. It is outrageous that current trends in health care could force women to endure a mastectomy on an outpatient basis. It is wrong to send these women home to deal with the emotional and physical pain of the operation—as well as with the responsibility for draining surgical wounds and performing other post-surgical care. These women should not be abandoned during their time of need.

However, our amendment does not require a woman to stay in the hospital. Our amendment does not require a hospital stay for a set number of hours. Our amendment does require that the physician, in consultation with the patient, decides how long the woman should remain in the hospital. The physician determines what is medically necessary and what is in the patient's best interest.

I cannot believe there is anyone in this chamber who would want to see a loved one go through a mastectomy and be forced by her insurance company to go home immediately. If we have any compassion at all we should adopt this provision.

Let me respond to one criticism I've heard about this amendment from insurance companies. Some have claimed they do not have a policy of drive through mastectomies. I commend them and hope they would support this amendment to prohibit this cruel practice by other companies. I would also add that while most insurance companies may not engage in this kind of outrageous behavior today, how can we insure they will not tomorrow?

Our amendment is about protecting and improving women's health. For that reason, the College of Obstetricians and Gynecologists support it. If my colleagues truly consider themselves champions of women's health, they must vote for this amendment. I can assure you that women will not be fooled by the empty promises in the Republican bill. We know the difference between routine and comprehensive OB/GYN care. We know how traumatic and life-altering a mastectomy can be. We know we need real protection and this amendment provides it.

Mr. President, I especially thank Senator ROBB for his leadership on this issue.

He is right. There are only nine women in the Senate. We shouldn't have to rush to the floor to defend all of the women in this country every time an issue comes up that affects women's health. This is an issue that affects men as well. It affects their daughters, their wives and mothers, their aunts. I appreciate Senator ROBB and his leadership in making sure that women are protected when it comes to their health care.

Senator ROBB did an excellent job of outlining what our amendment does. It does two basic things:

It allows a woman the right to choose an OB/GYN as her primary care physician. As every woman in this country knows, their OB/GYN, their obstetrician/gynecologist, is the doctor they go to, whether it is for pregnancy, whether it is for breast cancer, whether it is for health care decisions that affect them later on in life. We want to make sure that women have access to those doctors without having to go back to a primary care physician.

When a woman is pregnant and she gets an ear infection, she may be treated dramatically different than someone

else who has an ear infection, for example. A woman needs to have access to the OB/GYN, and this amendment Senator ROBB and I and the other Democratic women are offering assures the woman that access.

Secondly, it deals with the so-called drive-through mastectomy legislation where too many HMOs today are telling a woman after this radical surgery——

The PRESIDING OFFICER. The time of the Senator has expired.

Mrs. MURRAY. I ask unanimous consent for an additional 30 seconds.

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

Mrs. MURRAY. Too many women today are told they need to go home before they are ready to take care of themselves or their families. This amendment doesn't designate a time. It says the doctor will determine whether that woman is ready to go home after this radical surgery.

I commend my colleagues for this issue. I urge the Members of the Senate to stand up, finally, for women's health and vote for this amendment.

The PRESIDING OFFICER. The Chair recognizes the Senator from Maryland.

Ms. MIKULSKI. I thank the Chair.

Mr. President, I thank Senator Robb and Senator KENNEDY for their support of this very crucial legislation. We, the women of the Senate, really turn to men we call the ''Galahads,'' who have stood with us and been advocates on very important issues concerning women's health.

Often we have had bipartisan support. I ask today that the good men on the other side of the aisle come together and support the ROBB amendment. We have raced for the cure together. We have done it on a bipartisan basis. Certainly, today we could pass this amendment. I challenge the other party to vote for this amendment because what it will do is absolutely save lives and save misery.

There are many things that a woman faces in her life, but one of the most terrible things that she fears is that she will go to visit her doctor and find out from her mammogram and her physician that she has breast cancer. The worst thing after that is that she needs a mastectomy. Make no mistake, a mastectomy is an amputation, and it has all of the horrible, terrible consequences of having an amputation. Therefore, when the woman is told she can come in and only stay a few hours—after this significant surgery that changes her body, changes the relationships in her family, she is told she is supposed to call a cab and go back home; it only adds to the trauma for her.

Well, the ROBB amendment, which many of us support, really says that it is the doctor and the patient that decides how long a woman should stay in the hospital after she has had the surgery. Certainly, we should leave this to the doctor and to the patient. An 80 year old is different than a 38 year old. This legislation parallels the D'AMATO legislation that had such tremendous support on both sides of the aisle. I say to my colleagues, if we are going to race for the cure, let's race to support this amendment.

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, Senator BYRD is on his way here. He has asked for 1 minute. If the Senator from Oklahoma would indulge me, he should be here momentarily. I ask unanimous consent that Senator BYRD be entitled to 1 minute when he gets here, which should be momentarily.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BYRD addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from West Virginia.

Mr. BYRD. Mr. President, how much time remains before the recess?

The PRESIDING OFFICER. The unanimous consent allows 1 minute.

Mr. BYRD. Mr. President, I ask unanimous consent that I may speak for not to exceed 3 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BYRD. Mr. President, I am pleased that the Senate is finally considering managed care reform legislation. I believe that the Democratic version of the Patients' Bill of Rights is the right vehicle on which to bring reform to the nation.

Our colleague from Virginia, Mr. ROBB, has offered an amendment that highlights an important aspect of managed care that needs to be fine-tuned, and that is women's access to health care. This amendment would allow a woman to designate her obstetrician/gynecologist (ob/gyn) as her primary care provider and to seek care from her ob/gyn without needing to get preauthorization from the plan or from her primary care provider. Even though many women consider their ob/gyn as their regular doctor, a number of plans require women to first see their primary care provider before seeing their ob/gyn. This means that a costly and potentially dangerous level of delay is built into the system for women. This amendment would allow a woman's ob/gyn to refer her to other specialists and order tests without jumping through the additional hoop of visiting the general practitioner.

This amendment would also address the care a woman receives when undergoing the traumatic surgery of mastectomy. This provision would leave the decision about how long a woman would stay in the hospital following a mastectomy up to the physician and the woman. Some plans have required that this major surgery be done on an outpatient basis. In other instances, women have been sent home shortly after the procedure with tubes still in their bodies and still feeling the effects of anesthesia. This should not be allowed to happen. Plans should not put concern about costs before the well-being of women.

The Republican bill does not provide women with sufficient access to care. Plans would not be required to allow women to choose their ob/gyn as their primary care provider. In addition, the Republican bill would allow health plans to limit women's direct access to her ob/gyn to routine care which could potentially be defined by a plan as one visit a year. In addition, ''drive-through mastectomies'' would not be prevented under their bill.

Mr. President, the Robb amendment contains commonsense protections women need and deserve. I urge my colleagues to support this important amendment.

I yield the floor.

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 having arrived, the Senate will now stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:36 p.m., recessed until 2:16 p.m.; whereupon the Senate reassembled when called to order by the Presiding Officer (Mr. BENNETT).

The PRESIDING OFFICER. Under the previous order, the Senator from New Hampshire is recognized to speak for up to 45 minutes.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. SMITH of New Hampshire. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. SMITH of New Hampshire. Mr. President, I ask I be recognized for a period of time, approximately 45 minutes.

The PRESIDING OFFICER. Under the order, the Senator from New Hampshire is recognized for 45 minutes.

LEAVING THE REPUBLICAN PARTY, A DECISION OF CONSCIENCE

Mr. SMITH of New Hampshire. Mr. President, as many of you know, it has been a very difficult period of time for me these past several days. I want to recognize the sacrifices of my wife and three children over the past several weeks as I agonized through this gut-wrenching political decision. My wife, Mary Jo, and my daughter, Jenny, and son, Bobby, and son, Jason, have had to endure the ups and the downs and the difficulties of making such a decision. I am deeply grateful to them for their support and comfort because, without

them, I could not really have gotten through it all.

My first political memories are of talking to my grandfather, who was a died-in-the-wool Republican. He always said he would vote for a gorilla on the Republican ticket if he had to. I remember conversations with him about the Dewey-Truman campaign. He was obviously for Dewey. It didn't work out very well. But I can also remember having conversations with my classmates, telling them that I, too, was for Dewey and explaining why I was for Dewey in that election.

At that time I was 7 years old. Years went by, and, in 1952, in the Eisenhower-Stevenson election, I was 11 years old. I bet a friend, who lived down the road and had a farm, a dollar versus a chicken that Eisenhower would win the election. I won, and my grandfather immediately drove me down to my neighbor's farm to pick up the chicken I had won. The young man's parents graciously acknowledged that I won the bet and provided me a nice barred rock hen that laid a lot of eggs over the next year or so.

In 1956, I volunteered to pass out literature for Eisenhower, and, as a college student, I worked for Nixon in 1964. But 1964 was the first election I voted in. Barry Goldwater's campaign was the one that really sparked my conservative passions. I worked as a volunteer in the Nixon campaigns in 1968 and 1972, but it wasn't like the Goldwater campaign. I remember walking into the booth, saying, this is a man I really believe in, and I said I really felt good about that vote.

In 1976, these conservative passions were again awakened while I worked for the conservative Ronald Reagan in the New Hampshire primaries against the incumbent President of the United States, Gerald Ford—not an easy thing to do for a lot of us who were basically grassroots idealists, if you will, who believed that Ronald Reagan should win that primary. In those days I was not a political operative; I was not a Senator; I was not a candidate; I was not an elected official. I was a teacher, a coach, a school board member, husband, father, small businessman—just an ordinary guy who cared about his country. I got involved because I cared, and I believed deeply in the Republican Party.

I came to this party on principle, pretty much initiating with Barry Goldwater but certainly finalized with Ronald Reagan. I was disappointed in Reagan's loss in 1976 because I believed that grassroots conservatives in the party, who had worked so hard for Reagan, lost to what I considered the party elitists, the establishment, who were there for Ford because he was President, not with the same passion that was out there for Reagan.

Watching that convention in 1976, I remember those enthusiastic grassroots party members who were unable to defeat that party machinery that was so firmly behind the incumbent President. I remember seeing the tears in their eyes, and the passion. It was a difficult decision. It was close, as we all remember—just a few delegates. That was 1976. At that time, as a result of the election, it inspired me to run for political office for the first time.

When Reagan sought the nomination again in 1980 I ran in the primary, hoping to be part of this great Reagan revolution. Reagan was pro-life. He was for strengthening our military. He was anti-Communist. He was patriotic. He brought the best out in the American people. I was excited. In all those years that Reagan was President, the criticism, the hostile questions, the political cheap shots, he rose above it all. And most of them, indeed probably all who criticized him, weren't qualified to kiss the hem of his garment. He rose above them all. He was the best.

As a result of that, I began a grassroots campaign in 1979, and I lost by about a thousand votes with seven or eight candidates in the race, including one candidate, ironically, who was from my hometown. It was tough, but I decided to come back again in 1982, after losing, because I still wanted so much to be a part of the Reagan revolution. So I did come back in 1982. And that, my colleagues and friends, is when I had the first taste of the Republican establishment.

I had a phone call that I thought was a great sign. I had a call from the National Republican Party. Boy, was I excited. They told me that some representatives wanted to come up to New Hampshire from Washington to meet with me. They came to New Hampshire. We sat down at a meeting. It was brief. They asked me to get out of the race, please, because my opponent in the primary had more money than I did and had a better chance to win. I had been a Republican all my life, a Republican in philosophy, but that was my first experience with what we would call the national Republican establishment. I did not get out of the race. I beat my wealthy opponent in the primary, and I received the highest vote percentage against the incumbent Democrat that any Republican had ever received against him, and it was 1982, which was a pretty bad year for Republicans, as you all remember.

In 1984, several candidates joined the Republican primary again for an open seat in the Reagan landslide. Now everybody wanted it because the seat was open. I was just a school board chairman from a small town of 1,500, no political power base, no money, but I beat, in that primary, the president of the State senate, who was well known, and an Under Secretary of Commerce who was well financed. They still do not know how I did it, but it was door to door, and I fulfilled my dream of coming to Washington as part of the Reagan revolution in Congress.

I then had successful reelections in 1986 and 1988 and, of course, was elected to the Senate in 1990 and 1996. In the Reagan era, as in the Goldwater era, the pragmatists took a back seat to those who stood on principle. Idealists ruled; those who stood up for the right to life, a strong national defense, the second amendment, less spending, less taxes, less government. Man, it was exciting. Even though we were a minority in the Congress, it was exciting because Reagan was there. Principles in, pragmatism out. Man, it was great to be a Republican.

In 1988, a skeptical—including me—conservative movement rallied behind the Vice President in hopes that he would continue the revolution.

The signal that this revolution was over was when the President broke his ''no new tax'' pledge. We let pragmatism prevail. We compromised our pledge to the voters and our core principles, and we allowed the Democrats to take over the Government.

In 1994, idealism again came back. The idealistic wing of the party took charge. Led by Newt Gingrich, we crafted an issues-based campaign embodied in the Contract With America. We put idealism over pragmatism, and we were rewarded with a tremendous electoral victory in 1994, none like I have ever seen. I remember sitting there seeing those results come in on the House. I was happy for the Senate, but I was a lot happier for the House. Those of us who were there know how it felt.

As we moved into the 1996 elections, we again began to see this tug-of-war between the principal ideals of the party and the pragmatism of those who said we need ''Republican'' victories. Conservatives became a problem: We have to keep the conservatives quiet; let's not antagonize the conservatives, while the pragmatists talked about how we must win more Republican seats. Conservatives should be grateful, we were told, because we were playing smart politics, we were broadening the case. Elect more Republicans to Congress, elect more Republicans to the Senate and win the White House. What do we get? Power. We are going to govern.

In meeting after meeting, conference after conference, the pollsters and the consultants—and I have been a part of all of this. Mea culpa, mea culpa, mea maxima culpa. I have been involved in it. I am not saying I have not, but the pollsters and consultants advised us not to debate the controversial issues. Ignore them. We can win elections if we do not talk about abortion and other controversial issues, even though past elections have proven that when we ignore our principles, we lose, and when we stick to our principles, we win. In spite of all this, we continued to listen to the pollsters and to the consultants who insisted day in and day out they were right. Harry Truman, a good Democrat—my grandfather did not like him, but I did—said, ''Party platforms are contracts with the people.'' Harry Truman was right.

Why did we change? We won the revolution on issues. We won the revolution

on principles. But the desire to stay in power caused us to start listening to the pollsters and the consultants again who are now telling us, for some inexplicable reason, that we need to walk away from the issues that got us here to remain in power. Maybe somebody can tell me why.

Some of the pollsters who are here now who we are listening to were here in 1984. Indeed, they were here in 1980 when I first ran. I had always thought the purpose of a party was to effect policy, to advocate principles, to elect candidates who generally support the values we espouse, but it is not.

Let me be very specific on where we are ignoring the core values of our party.

''We defend the constitutional right to keep and bear arms,'' says the platform of the Republican Party, but vote after vote, day after day, that right is eroded with Republican support. I announced my intention to filibuster the gun control bill. Not only does it violate the Republican platform, but it violates the Constitution itself, which I took an oath to support and defend.

Then I hear my own party is planning to work with the other side to allow more gun control to be steamrolled through the Congress which violates our platform. Not only does it violate our platform, it insults millions and millions of law-abiding, peaceful gun owners in this country whose rights we have an obligation to protect under the Constitution.

The Republican platform says:

> We will make further improvement of relations with Vietnam and North Korea contingent upon their cooperation in achieving a full and complete accounting of our POWs and MIAs from those Asian conflicts.

Sounds great. So I got up on the floor a short time ago and offered an amendment saying that ''further improvement of relations with Vietnam are contingent upon achieving a full and complete accounting of our POWs and MIAs. . .''—right out of the platform word for word. Thirty-three Republicans supported me. The amendment lost.

The platform says:

> Republicans will not subordinate the United States sovereignty to any international authority.

Only one—right here, BOB SMITH—voted against funding for the U.N. I can go through a litany—NAFTA, GATT, chemical weapons, and so forth. Vote after vote, with Republican support, the sovereignty of the United States takes a hit in violation of the platform of the Republican Party and the Constitution.

The establishment of our party and, indeed, the majority of our party voted to send $18 billion to the IMF. Let me make something very clear. I am not criticizing anybody's motives. Everybody has a right to make a vote here, and there is no argument from me on that. But I am talking about the relationship between the platform and those of us who serve.

This $18 billion came from the taxpayers of the United States of America, and it went to a faceless bureaucracy with no guarantee that it would be spent in the interest of the United States. We have no idea where this money will go and no control of it once it goes there.

Meanwhile, while $18 billion goes to the IMF, I drive into work and I find Vietnam veterans and other veterans lying homeless on the grates in Washington, DC, in the Capital of our Nation. How many of them could we take care of with a pittance of that $18 billion?

As Republicans who supposedly support tax relief for the American family, can we really say that $18 billion to IMF justifies taking the money out of the pocket of that farmer in Iowa who is trying to make his mortgage payment? Can we really say that? I do not think so.

Another quote out of the Republican platform:

> As a first step in reforming Government, we support elimination of the Departments of Commerce, Housing and Urban Development, Education, and Energy, the elimination, defunding or privatization of agencies which are obsolete, redundant, of limited value, or too regional in focus. Examples of agencies we seek to defund or privatize are the National Endowment for the Arts, the National Endowment for the Humanities, the Corporation for Public Broadcasting, and the Legal Services Corporation.

That is right out of the Republican platform. If I were to hold a vote today to eliminate any of these agencies, it would fail overwhelmingly, and it would be Republican votes that would take it down. Every Republican in this body knows it.

Can you imagine how much money we could save the taxpayers of this country if we eliminated those agencies and those Departments that the platform I just quoted calls for us to eliminate? It is not what I call for; it is what our party platform calls for. Why don't we do it? The answer is obvious why we don't do it: because we do not mean it, because the platform does not mean it. We do not mean it.

In education, our platform:

> Our formula is as simple as it is sweeping: The Federal Government has no constitutional authority to be involved in school curricula or to control jobs in the workplace. That is why we will abolish the Department of Education, end Federal meddling in our schools, and promote family choice at all levels of learning. We therefore call for prompt repeal of the Goals 2000 and the School to Work Act of 1994 which put new Federal controls, as well as unfunded mandates, on the States. We further urge that Federal attempts to impose outcome- or performance-based education on local schools be ended.

If I were to introduce a bill on the Senate floor to end the Department of Education, to abolish it, how many votes do you think I would get? How many Republican votes do you think I would get?

If, as Truman said, it is a contract, then we broke it. Where I went to school, breaking a contract is immoral, it is unethical, and it is unprincipled, and we ought not to write it if we are going to break it. Let's not have a platform.

Our party platform says also:

> We support the appointment of judges who respect traditional family values and the sanctity of innocent human life.

Listen carefully, I say to my colleagues.

In 1987, when President Ronald Reagan nominated Robert Bork to the Supreme Court, six Republicans voted against him, and he was rejected. What was Robert Bork's offense? That he stood up for what he believed in, that he was pro-life? He told us. He answered the questions in the hearing. God forbid he should do that. But when President Clinton nominated Ruth Bader Ginsburg, an ACLU lawyer who is stridently pro-abortion, only three Republicans voted no—Senator HELMS, Senator NICKLES, and myself.

Of course, all of the Republicans who voted against Bork voted for Ginsburg. I voted against Ginsburg because, as the Republican platform says, I want judges who respect the sanctity of innocent human life. I want my party to stand for something. Thirty-five million unborn children have died since that decision in 1973—35 million of our best—never to get a chance to be a Senator, to be a spectator in the gallery, to be a staff person, to be a teacher, to be a father, a mother—denied—35 million, one-ninth of the entire population of the United States of America. And we are going to do it for the next 25 years because we will not stand up. And I am not going to stand up any more as a Republican and allow it to happen. I am not going to do it.

Most interestingly, since that Roe V. Wade decision was written by a Republican, I might add, a Republican appointee, and upheld most recently in the Casey case, it is interesting there was only one Democrat appointee on the Court, Byron White, who voted pro-life. He voted with the four-Justice, pro-life minority. Five Republican appointments gave us that decision.

We are to blame. This is not a party. Maybe it is a party in the sense of wearing hats and blowing whistles, but it is not a political party that means anything.

About a week ago, my daughter, who works in my campaign office, told me the story of a 9-year-old girl whose dad called our office to say that his little daughter, 9-year-old Mary Frances—I will protect her privacy by giving only her first name—had said that she was born because of an aborted pregnancy, not an intentional one, an aborted pregnancy, a miscarriage at 22 weeks—22 weeks, 5½ months—and she lived.

She is 9 years old. She said: I want to empty my piggy bank, Senator SMITH, and send that to you because of your stand for life because I know that children who are 5½ months in the womb can live.

That is power.

Let me read from the pro-life plank of the Republican Party:

[W]e endorse legislation to make clear that the Fourteenth Amendment's protections apply to unborn children.

Anything complicated about that? Anything my colleagues don't understand about that?

We endorse legislation to make clear that the Fourteenth Amendment's protections apply to unborn children.

We are not going to apply any protections to unborn children. We will pass a few votes here, 50–49, if you can switch somebody at the last minute. I have been involved in those. Yes, we will do that, but we will not win. We are not going to commit to putting judges on the courts to get it done. Oh, no, we can't do that because we might lose some votes. So meanwhile another 35 million children are going to die.

This year I sponsored a bill out of the platform that says the 14th amendment's protections apply to unborn children. Do you want to know how many sponsors I have? You are looking at him. One. Me. That is it. Not one other Republican cosponsor.

In his letter to me—nice letter that it was—from Chairman Nicholson, he claims that ''every one of our Republican candidates shares your proven commitment to life''—he says. Gee, could have fooled me. Then how come every candidate isn't endorsing the bill or speaking out on the platform if they don't want to endorse the bill?

The party, to put it bluntly, is hypocritical. It criticizes Bill Clinton, a Democrat, for vetoing partial-birth abortion and for being pro-abortion, but it does not criticize our own. It does not criticize the Republicans who are pro-choice. So why criticize Bill Clinton? Or why criticize any Democrat? We cannot get it done. We don't say anything about those people.

How about the Governors who vetoed the bill, the partial-birth abortion bill? You know, there are a lot of fancy words in the Republican platform. Every 4 years we go to the convention and we fight over the wording. Sometimes even a nominee says: Well, I haven't read it. At least he is being honest. Or, which is probably more the truth, we just ignore it. It is a charade. And I am not going to take part in it any more. I am not going to take part in it any more.

In the movie ''Mr. Smith Goes to Washington,'' after his own political party has launched attacks on him for daring to raise an independent voice, Jimmy Stewart's character is seated on the steps of the Lincoln Memorial, and here is what he says: ''There are a lot of fancy words around this town. Some of them are carved in stone. Some of 'em, I guess, were put there so suckers like me can read 'em.''

You ought to watch the movie. It is a good movie. It will make you feel good.

Mr. President, I have come to the cold realization that the Republican Party is more interested in winning elections than supporting the principles of the platform. There is nothing wrong with winning elections. I am all for it. I have helped a few and I have won some myself, and there is nothing wrong with it. But what is wrong with it is when you put winning ahead of principle.

The Republican platform is a meaningless document that has been put out there so suckers like me and maybe suckers like you out there can read it. I did not come here for that reason. I did not come here to compromise my values to promote the interests of a political party.

I came here to promote the interests of my country. And after a lot of soul-searching, and no anger—no anger—I have decided to change my registration from Republican to Independent. There is no contempt; there is no anger. It is a decision of conscience.

Many of my colleagues have called me, and I deeply appreciate the conversations that I have had privately with many of you on both sides, but I ask my colleagues to respect this decision. It is a decision of conscience. Millions and millions of Independents and conservative Democrats and members of other political parties have already made this decision of conscience. As a matter of fact, there are more Independents than there are Republicans or Democrats.

I would ask you to give me the same respect that you give them when you ask them to vote for you in election after election. Indeed, we win elections because of Independents.

I found a poem, written by a man by the name of Edgar Guest, which my father, who was killed at the end of the Second World War, when I was 3 years old, had placed in his Navy scrapbook in 1941, just prior to going off to war in the Pacific—newly married about 2½ years. I can imagine what was going through his mind. But he placed it in his scrapbook and highlighted it.

I am just going to quote one excerpt. The poem is entitled, ''Plea for Strength.''

Grant me the fighting spirit and fashion me stout of will,
Arouse in me that strange something that fear cannot chill.
Let me not whimper at hardship.
This is the gift that I ask.
Not ease and escape from trial,
But strength for the difficult task.

Many have said that what I am doing is foolish. I have heard it from a lot of people—friends and colleagues. But you know what Mark Twain said—I think the Chaplain will like this:

I am a great and sublime fool. But, then I am God's fool. And all His works must be contemplated with respect.

I called Senator LOTT last week personally. It was the most difficult telephone call I think I had ever made.

I told him it was my intention to continue to vote in caucus with the Republicans, if he wanted me, provided that there was no retaliatory or punitive action taken against me. He was very gracious. He didn't like it—I don't blame him—but he was gracious. I appreciate his understanding, and I appreciate the compassion and understanding of many of my colleagues on both sides who have spoken with me these past few days.

I made another phone call, Mr. President. I called the chairman of the Republican Party, Mr. Jim Nicholson, last week to inform him of my decision and asked him if he could please maintain confidentiality until I had a chance to make my decision public. Before I had a chance to do that—indeed, about 20 hours after I had made the call—my home was staked out in New Hampshire. Where I was going to visit friends, their homes were staked out, sometimes until late into the evening, by the media, because the chairman put out a letter attacking me personally.

I am not going to dignify the letter by reading it here on the Senate floor. I do ask unanimous consent that the letter be printed into the RECORD.

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

REPUBLICAN NATIONAL COMMITTEE,
Washington, DC, July 9, 1999.

Hon. ROBERT C. SMITH,
Dirksen Senate Office Building,
Washington, DC.

DEAR SENATOR SMITH, I am writing concerning published reports that you have decided to abandon the Republican party and seek the Presidential nomination of a third party instead.

I believe this would be a serious mistake for you personally, with only a marginal political impact—and a counterproductive one, at that.

This would not be a case of the party leaving you, Bob, but rather of you leaving our party. Far from turning away from the conservative themes we both share, the party has championed them—and become America's majority party by doing so.

I truly believe, Bob, that your 1% standing in New Hampshire doesn't reflect Republican primary voters' rejection of your message, but rather its redundancy. Every one of our Republican candidates shares your proven commitment to life and to the goals of smaller government, lower taxes and less regulation of our lives and livelihoods—as does the party itself. In other words, I hope you do not confuse the success of our shared message with your own failure as its messenger.

I also urge that you reconsider turning your back on your many Republican friends and supporters, people who've always stood by you, even in the most difficult and challenging times. Most of all, I hope you will think of your legacy: it would be tragic for your decades of work in the conservative movement to be undone by a short-sighted decision whose only negligible impact would be to provide marginal help to Al Gore, the most extreme liberal in a generation.

Sincerely,

JIM NICHOLSON,
Chairman.

Mr. SMITH of New Hampshire. I will only characterize the letter in the following way: It is petty, it is vindictive, and it is insulting. It is beneath the dignity of the chairman of any political party. It is an affront to the millions of voters who choose not to carry

a Republican membership card but have given the party its margin of victory in election after election.

Remember that little girl I talked to you about a little while ago, Mary Frances? I do not know what she is going to grow up to be. She might be a Democrat. She might be a Republican. Maybe she will be an Independent. Maybe she won't vote. I don't know. But I'll tell you what, in the old baseball tradition, I wouldn't trade her for 1,000 Jim Nicholsons, not in a minute.

There was talk on the shows this weekend that I might be removed as chairman of the Ethics Committee. I must say, I was disappointed at the intensity of the attacks on me by unidentified sources, I might add, in the Republican Party. Interestingly, one of those reports was that the party is considering suing me for the money it spent during my reelection.

I want to make it very clear, because press reports were inaccurate on one point. Senator MCCONNELL called me personally yesterday to clarify that this particular report of a lawsuit is not true, and I accept his answer as absolute fact with no question. But some faceless party bureaucrat had a really good time writing that and then leaking it to the press. That is what is wrong with politics. He ought to be fired, but you will never find out who it is.

Another interesting report was that a different party operative presumed to suggest that ''Smith should be booted out of the conference altogether if he is not a Republican; he shouldn't be in the Republican caucus.'' I wonder how much he is being paid to sit up there using up the party faithful's contributions to write that kind of garbage.

The chairman of the New Hampshire Republican Party, where for 15 years I have been a member, went on ''Crossfire'' the other night to debate BOB SMITH, but BOB SMITH wasn't there to answer for himself. He took the anti-BOB position. He attacked me viciously, saying it was a selfish move and that it meant the end of my political career.

There is something a little strange in that. If it is selfish and I am throwing away my political career, maybe somebody can explain what he means. Not a mention of 15 years of service to the State and to the party. Even Bill Press said: Can't you find something nice to say about BOB?

That is what is wrong with politics. It is the ugly. It is the bad. It is the worst. It is the worst.

In 1866 Abraham Lincoln said this—it is a very famous quote:

> If I were to try to read, much less answer, all the attacks made on me, this shop might as well be closed for any other business. I do the very best I know how, the very best I can, and I am going to keep right on doing so until the end. If the end brings me out all right, what is said against me won't amount to anything. If the end brings me out wrong, 10 angels swearing I was right will make no difference.

Lincoln really knew how to say it. In a way, perhaps Chairman Duprey is right about my being selfish. I am putting my selfish desire to save my country ahead of the interests of the Republican Party, and some nameless, faceless bureaucrat in the party machinery decides to take off on me. I wish he would surface. I would like to meet him.

If that is selfish, then Duprey is right. If putting your country ahead of your party, if standing up for the principles you believe in is wrong, maybe it is time to get out of politics.

Over the past 15 years I have traveled all over America helping Republican candidates. I don't very often ask for help. I don't remember ever asking for help from the Republican Party to do it. I spent hours and hours on the phone raising money. And the party has helped me; I will be the first to admit it. Some have made a big deal out of that. They should help me. I think that is what the party is there for. I went to California, Louisiana, Iowa, Missouri, and North Carolina during the last year on behalf of Republican candidates. It had nothing to do with my Presidential campaign; it was entirely on behalf of other candidates. When the chairman of the senatorial committee asked Members to pony up money, he gave me a bill. He said: You have X in your account, and you owe me $25,000. I wrote him a check the next day. Everybody didn't do it though, did they, Mr. Chairman?

I have a bureaucrat out there somewhere in the party saying throw me out of the caucus. Frankly, I gave without hesitation because I believed things were changing. I don't take a back seat in my willingness as a Republican to help candidates in need. But oh, no, I have committed the unforgivable sin here in Washington; I have exposed the fraud. It is a fraud, and everybody in here knows it.

It is true in both parties that the party platform is not worth the paper it is written on. That is why I am an Independent. That is why I am going to stay an Independent, whatever happens in the future. I am still the same formula. I am still Classic Coke. I am not a new Coke. I am the same ingredients. I have merely redesigned the label. It is the same BOB SMITH. My colleagues over there looking for help, you are not going to get it. You know where my votes come from, so don't get excited.

In my travels, I have attended hundreds of Republican Party events, but the most consistent message I hear from the voters is one of frustration, deep frustration that the party is not standing on principle. Last year CQ published a list of leading scorers on party unity. This is a list they do every year, ranking the most loyal Republican votes.

It is interesting because I don't look at them as loyalty votes. I just make the votes. Well, guess what. Let's see—LARRY CRAIG was here. He is not here right now. LARRY CRAIG and I were No. 1—very interesting, when you look down the list. So I am No. 1 in party loyalty. How many major committee chairmen in the conference are on the list? Take a look at the list. I am not going to embarrass colleagues.

I am the most reliable Republican vote in the Senate, but I am attacked—not by colleagues, not by colleagues. It is obvious from these kinds of attacks that it is not about me. What it shows is a complete and final divorce between the party machinery and the principles for which it professes to stand. I say, with all due respect to my colleagues in the Senate, whether you are running a campaign for President or whether you are in the House or something else, we have to stop it. We have to get a handle on it. I think it is true in the other party as well.

We have to get a handle on it. They don't represent us well. It is an injustice to the candidates who run for and the people who serve in the Republican Party, and it has to stop. It is a cancer, and it is eating away at the two great political parties that rose to power; in this case, the Republican Party that rose to power on the moral opposition to slavery; and it killed the Whig Party, because it wouldn't stand up against slavery. It will kill the Republican Party if it doesn't stand up for what it believes in, especially against abortion.

I told you I watched the movie ''Mr. Smith Goes To Washington'' again over the weekend. I remember talking to Mike Mansfield, who was here a few weeks ago for one of the seminars that the leader puts on. He said that after he left the Senate was the first time he really went around and looked at the monuments; he read the writings; he took the time to smell the roses. He said: These just aren't hollow words or statues anymore; they have meaning to me.

This morning—I am not trying to be melodramatic—but I did it. I left early, about 5:45. I took Jimmy Stewart's example from the movie ''Mr. Smith Goes To Washington.''

I went to the Lincoln Memorial, the Jefferson Memorial, the Vietnam Wall, and the Arlington Cemetery where my parents are buried. I tried to smell the roses. Do you know what? These aren't memorials to people who fought for political parties. Lincoln helped to destroy his own political party. On that visit to Arlington this morning, I stopped at my parents' grave site. My father didn't fight for a political party. He didn't die for a political party. He fought for his country, as millions of others have done, and the ideals for which it was founded. I looked out at those stones all across Arlington Cemetery, and I didn't see any R's or D's next to their names. Then I went to the Vietnam Wall, and I didn't see any R's or D's next to anybody's name there. How about that?

Like Jimmy Stewart's character in the movie, I stand right here at the desk of Daniel Webster, one of the greatest lawyers of all time, one of the greatest Senators of all time, whose

picture is on statues everywhere. Most people probably could not even tell you what party he belonged to, unless you are a history buff. Who cares what party he belonged to? You will remember that he stood up against slavery, and his quote, ''Nothing is so powerful but the truth.'' And the opposite was John C. Calhoun, Henry Clay, the great orators of their time. You remember them for what they were and what they said, not for their party. Webster was an abolitionist and Calhoun the defender of slavery.

Calhoun said:

> The very essence of a free government consists in considering offices as public trusts, bestowed for the good of the country, and not for the benefit of an individual or a party.

We have lost sight of it. Man, there is so much history in this place. My wife conducts tours for people from New Hampshire and at times people she finds on the streets. If we would just take a few moments away from the bickering and the arguing and look around and enjoy it, do you know what. It would inspire us. It inspired me today. Maybe I should be doing it every day. Every year, a Senator is chosen to read Washington's Farewell Address. I have been here 9 years and was never asked. I never understood how that person gets picked, but they do. How many of us have actually taken the time to sit and listen to that Farewell Address? Well, Washington, in that Farewell Address, warns us that:

> The common and continual mischiefs of the spirit of party are sufficient to make it the interest and duty of a wise people to discourage and restrain it.

He spends a large part of his speech expounding on this point, and I encourage my colleagues to read it.

I ask unanimous consent that the relevant sections of Washington's Farewell Address be printed in the RECORD at the conclusion of my remarks.

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

(See Exhibit 1.)

Mr. SMITH of New Hampshire. In the spirit of what Washington is saying, I think we need to rid ourselves of the nastiness and the partisanship that has destroyed the comity of this great body and has become a barrier to a full and spirited discussion of the issues in America generally. You may say: That is pretty good coming from SMITH; he is as partisan as they come. There is a time and place for partisanship. HARRY REID knows when I put the partisanship at the door. He knows, as cochair of the Ethics Committee with me.

Americans deserve an honest debate, an honest exchange of ideas. They want us to put these partisan interests aside. It is not partisan if somebody is against abortion or is for abortion; it is issue generated.

Americans want people who will lead, not follow polls. The American people are losing the faith in their ability to effect change, and rightfully so.

Since I came to Washington, I have seen Senators and Congressmen come and go. Do you know what. I will tell you what doesn't go. I refer to the entrenched political industry that is here to stay. Oh, it changes a little bit at the top when somebody else becomes the chairman. But the entrenchment is still there. The pollsters, the spin doctors, and the campaign consultants are all there. They all have their hands in your pockets, and they are doing pretty well.

They run the show, for the most part. They don't directly choose candidates in the sense of a smoke-filled backroom, but they do influence it because they are the ones who tried to talk me out of running in 1980—the same ones.

Some of the pollsters in the party have been around since I first came to town. Every time there is a Republican retreat—and I assume it is the same for the other party—and often at Republican conferences here in the Senate, we hear from the professional consultants and pollsters. They tell us what the message should be. They tell us how to make ourselves look good and how to make the other guys look bad.

We need to get out the fumigation equipment. We need to clean out the pollsters, the consultants, the spin doctors, and the bloated staffs who tell us what to say, how to say it, when to say it, and how long to say it. The American people elected us. Isn't it time we start thinking for ourselves and leading?

This well-paid political industry, let me tell you, colleagues, is not interested in whether or not you believe in the issues of your party. Don't kid yourselves. This is about power, access, and jobs. I can have tea and crumpets with the President of the United States if I help him win it. As long as you look like a winner, it doesn't matter what you believe. Don't kid yourselves. They seek out the candidates who have the package they want—name ID, money, slickness. But, most importantly, they want candidates who won't make waves, or say anything controversial about an issue that might cost us a seat. They package you, wrap you up, put a little bow on it, tell you what to say, and then they sell you to the American voters.

The political professionals tell us all the time, ''Don't be controversial; it can cause you to lose your election.''

Why are we afraid of controversy? Was Lincoln afraid of it? Was FDR? Was Calhoun? Was Washington? With controversy comes change—positive change sometimes. Imagine Patrick Henry, striding up to the podium in 1773 before the Virginia Assembly, prepared to give his great speech: ''Give me liberty or give me . . .'' and then he turns to his pollster and says: I wonder whether they want liberty or death. I better take a poll and find out.

Let's not declare our independence; that is pretty controversial. They could have said that in 1776. Let's not abolish slavery; that is controversial.

In the 1850s, the great Whig Party said:

> Let's not talk about slavery, it's too controversial. Let's put the issue aside and focus on electing more Whigs.

But a loyal Whig Congressman named Abraham Lincoln thought otherwise.

The pollsters come into the hallowed Halls in meetings of Senators to tell us how we can talk to people, to all the men who are 35 and over, what to say to them; and women 25 and under, what to say to them; to Social Security people; to black people; and what we should say to Hispanics; or white people; what do we say to pro-choice or to pro-life. Pollsters, pollsters, pollsters.

We are looking at polls to decide whether or not to go to Kosovo. We take a poll to decide whether or not we should send our kids to die in a foreign country. Did Roosevelt do a poll on whether or not to retaliate against the Japanese? Partisanship is poisoning this town. The pollsters are poisoning this town. Help members of your own party and destroy the other guy.

My proudest moment in the Senate in the 9 years I have been here—other than some of the meetings HARRY REID and I have had together where we have to discuss the futures of some of you quietly—was when we went into the Old Senate Chamber and talked during the impeachment trial. You know it, all of you; it was the best moment we have had since we have been here. We took the hats off and we sat down and talked about things, and we did it the right way.

I wanted to have every caucus that we had on the impeachment trial bipartisan; I didn't want any separation. But we didn't get that. Boy, what a delight it would have been had we done that. I am not saying it would have made the difference; maybe it would not have. But that is not the purpose of bringing it up. It is my belief that if we had come together and looked at the evidence—you never know.

I am proudest of my service on the Senate Ethics Committee where six Senators, including my good friend, Senator REID, and I, discuss issues without one iota of partisanship.

When we investigated Bob Packwood, a fellow Republican came up to me after that vote in which we voted to expel a colleague, and he was angry. He was a powerful Republican, and this was not an easy conversation. He scolded me, saying, ''I can't believe that you would vote to expel a fellow Republican. It's outrageous. How can you do that?'' I said, ''You will have the opportunity to sustain or overrule that vote on the floor of the Senate very shortly.''

He came back later and said: Thank you for saving me a difficult vote.

We on the committee ignored the partisan mud balls. We did what was right.

I am not ashamed of being a member of a political party. The question is, Does party take precedence over principle? I want the 21st century to be remembered for debating important and

controversial issues in public: Abortion, taxes, size of government, restoring our sovereignty, gun control, moral decadence, freedom. Don't avoid these issues simply to help our own political fortunes or to destroy our opponents.

Lt. William Hobby, Jr., wrote a poem called ''The Navigator'' during the Second World War. I think it captures the vision and spirit of what I believe America should be.

The Morning Watch is mustered, and the middle watch withdrawn
Now Ghostlike glides the vessel in the hush before the dawn.
Friendly gleams polaris on the gently rolling sea,
He set the course for sailors and tonight he shines for me.

We have the opportunity to take America into the 21st century of freedom, morality, support for the Constitution, respect for life, respect for the sacrifices made for us by our founders and the millions of veterans who have given so much of their precious blood. Politics should be about each one of us joining together to rediscover our moral compass, to reignite the torch of freedom, to return to our navigational chart: The Constitution, the Declaration of Independence, and the Bible.

In conclusion, in the movie ''Mr. Smith Goes to Washington,'' Jimmy Stewart portrayed a U.S. Senator who believed that America was good, that politics was good, and that the American people deserve good, honest leaders. I agree.

Chaplain Ogilvie said to me a few weeks ago:

Our time in History is God's gift to us. What we do with it is our gift to him. Let's not squander it with petty partisan politics.

EXHIBIT 1

EXCERPTS FROM WASHINGTON'S FAREWELL ADDRESS

TO THE PEOPLE OF THE UNITED STATES

FRIENDS AND FELLOW CITIZENS: The period for a new election of a Citizen, to administer the Executive Government of the United States, being not far distant, and the time actually arrived, when your thoughts must be employed in designating the person, who is to be clothed with that important trust, it appears to me proper, especially as it may conduce to a more distinct expression of the public voice, that I should now apprise you of the resolution I have formed, to decline being considered among the number of those, out of whom a choice is to be made.

I beg you, at the same time to do me the justice to be assured, that this resolution has not been taken, without a strict regard to all the considerations appertaining to the relation, which binds a dutiful citizen to his country—and that, in withdrawing the tender of service which silence in my situation might imply, I am influenced by no diminution of zeal for your future interest, no deficiency of grateful respect for your past kindness; but am supported by a full conviction that the step is compatible with both.

The acceptance of, and continuance hitherto in, the office to which your suffrages have twice called me, have been a uniform sacrifice of inclination to the opinion of duty, and to a deference for what appeared to be your desire.—I constantly hoped, that it would have been much earlier in my power, consistently with motives, which I was not at liberty to disregard, to return to that retirement, from which I had been reluctantly drawn.—The strength of my inclination to do this, previous to the last election, had even led to the preparation of an address to declare it to you; but mature reflection on the then perplexed and critical posture of our affairs with foreign Nations, and the unanimous advice of persons entitled to my confidence, impelled me to abandon the idea.—

* * * * *

I have already intimated to you the danger of Parties in the State, with particular reference to the founding of them on Geographical discriminations.—Let me now take a more comprehensive view, and warn you in the most solemn manner against the baneful effects of the Spirit of Party, generally.

This Spirit, unfortunately, is inseparable from our nature, having its root in the strongest passions of the human mind.—It exists under different shapes in all Governments, more or less stifled, controuled, or repressed; but, in those of the popular form, it is seen in its greatest rankness, and is truly their worst enemy.—

The alternate domination of one faction over another, sharpened by the spirit of revenge natural to party dissension, which in different ages and countries has perpetrated the most horrid enormities, is itself a frightful despotism.—But this leads at length to a more formal and permanent despotism.—The disorders and miseries, which result, gradually incline the minds of men to seek security and repose in the absolute power of an Individual: and sooner or later the chief of some prevailing faction, more able or more fortunate than his competitors, turns this disposition to the purposes of his own elevation, on the ruins of Public Liberty.

Without looking forward to an extremity of this kind, (which nevertheless ought not to be entirely out of sight,) the common and continual mischiefs of the spirit of Party are sufficient to make it the interest and duty of a wise People to discourage and restrain it.—

It serves always to distract the Public Councils, and enfeeble the Public administration.—It agitates the community with ill-founded jealousies and false alarms, kindles the animosity of one part against another, foments occasionally by riot and insurrection.—It opens the doors to foreign influence and corruption, which find a facilitated access to the Government itself through the channels of party passions. Thus the policy and the will of one country, are subjected to the policy and will of another.

There is an opinion that parties in free countries are useful checks upon the Administration of the Government, and serve to keep alive the Spirit of Liberty.—This within certain limits is probably true—and in Governments of a Monarchical cast, Patriotism may look with indulgence, if not with favour, upon the spirit of party.—But in those of the popular character, in Governments purely elective, it is a spirit not to be encouraged.—From their natural tendency, it is certain there will always be enough of that spirit for every salutary purpose,—and there being constant danger of excess, the effort ought to be, by force of public opinion, to mitigate and assuage it.—A fire not to be quenched; it demands a uniform vigilance to prevent its bursting into a flame, lest, instead of warming, it should consume.—

It is important likewise, that the habits of thinking in a free country should inspire caution in those entrusted with its administration, to confine themselves within their respective constitutional spheres; avoiding in the exercise of the powers of one department to encroach upon another.—The spirit of encroachment tends to consolidate the powers of all the departments in one, and thus to create, whatever the form of government, a real despotism.—A just estimate of that love of power, and proneness to abuse it, which predominates in the human heart, is sufficient to satisfy us of the truth of this position.—The necessity of reciprocal checks in the exercise of political power, by dividing and distributing it into different depositories, and constituting each the Guardian of the Public Weal against invasions by the others, has been evinced by experiments ancient and modern; some of them in our country and under our own eyes.—To preserve them must be as necessary as to institute them. If in the opinion of the People, the distribution or modification of the Constitutional powers be in any particular wrong, let it be corrected by an amendment in the way which the Constitution designates.—But let there be no change by usurpation; for though this, in one instance, may be the instrument of good, it is the customary weapon by which free governments are destroyed.—The precedent must always greatly overbalance in permanent evil any partial or transient benefit which the use can at any time yield.—

Of all the dispositions and habits which lead to political prosperity, Religion and morality are indispensable supports.—In vain would that man claim the tribute of Patriotism, who should labor to subvert these great Pillars of human happiness, these firmest props of the duties of Men and Citizens.—The mere Politician, equally with the pious man, ought to respect and to cherish them.—A volume could not trace all their connexions with private and public felicity.—Let it simply

be asked where is the security for property, for reputation, for life, if the sense of religious obligation *desert* the oaths, which are the instruments of investigation in Courts of Justice? And let us with caution indulge the supposition, that morality can be maintained without religion.—Whatever may be conceded to the influence of refined education on minds of peculiar structure—reason and experience both forbid us to expect, that national morality can prevail in exclusion of religious principle.—

'T is substantially true, that virtue or morality is a necessary spring of popular government.—The rule indeed extends with more or less force to every species of Free Government.—Who that is a sincere friend to it, can look with indifference upon attempts to shake the foundation of the fabric?—

Promote, then, as an object of primary importance, institutions for the general diffusion of knowledge.—In proportion as the structure of a government gives force to public opinion, it is essential that the public opinion should be enlightened.—

* * * * *

Observe good faith and justice towards all Nations. Cultivate peace and harmony with all. Religion and Morality enjoin this conduct; and can it be that good policy does not equally enjoin it?—It will be worthy of a free, enlightened, and, at no distant period, a great nation, to give to mankind the magnanimous and too novel example of a People always guided by an exalted justice and benevolence.—Who can doubt that in the course of time and things, the fruits of such a plan would richly repay any temporary advantages, which might be lost by a steady adherence to it? Can it be, that Providence has not connected the permanent felicity of a Nation with its virtue? The experiment, at least, is recommended by every sentiment which ennobles human nature.—Alas! is it rendered impossible by its vices?

In the execution of such a plan nothing is more essential than that permanent, inveterate antipathies against particular nations and passionate attachment, for others should be excluded; and that in place of them just and amicable feelings towards all should be cultivated.—The Nation, which indulges towards another an habitual hatred or an habitual fondness, is in some degree a slave. It is a slave to its animosity or to its affection, either of which is sufficient to lead it astray from its duty and its interest.—Antipathy in one nation against another disposes each more readily to offer insult and injury, to lay hold of slight causes of umbrage, and to be haughty and intractable, when accidental or trifling occasions of dispute occur.—Hence frequent collisions, obstinate, envenomed and bloody contests.—The Nation prompted by ill-will and resentment sometimes impels to War the Government, contrary to the best calculations of policy.—The Government sometimes participates in the national propensity, and adopts through passion what reason would reject;—at other times, it makes the animosity of the Nation subservient to projects of hostility instigated by pride, ambition, and other sinister and pernicious motives.—The peace often, sometimes perhaps the Liberty, of Nations has been the victim.—

So likewise a passionate attachment of one Nation for another produces a variety of evils.—Sympathy for the favourite nation, facilitating the illusion of an imaginary common interest in cases where no real common interest exists, and infusing into one the enmities of the other, betrays the former into a participation in the quarrels and wars of the latter, without adequate inducement or justification: It leads also to concessions to the favourite Nation of privileges denied to others, which is apt doubly to injure the Nation making the concessions; by unnecessarily parting with what ought to have been retained, and by exciting jealously, ill-will, and a disposition to retaliate, in the parties from whom equal privileges are withheld; and it gives to ambitious, corrupted, or deluded citizens, (who devote themselves to the favourite Nation) facility to betray, or sacrifice the interests of their own country, without odium, sometimes even with popularity:—gilding with the appearances of a virtuous sense of obligation, a commendable deference for public opinion, or a laudable zeal for public good, the base or foolish compliances of ambition, corruption, or infatuation.

As avenues to foreign influence in innumerable ways, such attachments are particularly alarming to the truly enlightened and independent Patriot.—How many opportunities do they afford to tamper with domestic factions, to practise the arts of seduction, to mislead public opinion, to influence or awe the public councils! Such an attachment of a small or weak, towards a great and powerful nation, dooms the former to be the satellite of the latter.

* * * * *

Relying on its kindness in this as in other things, and actuated by that fervent love towards it, which is so natural to a man, who views in it the native soil of himself and his progenitors for several generations;—I anticipate with pleasing expectation that retreat, in which I promise myself to realize, without alloy, the sweet enjoyment of partaking, in the midst of my fellow-citizens, the benign influence of good Laws under a free Government,—the ever favourite object of my heart, and the happy reward, as I trust, of our mutual cares, labours and dangers.

GEO. WASHINGTON.

UNITED STATES,
17th September, 1796.

Mr. LOTT. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

PATIENTS' BILL OF RIGHTS ACT OF 1999

AMENDMENT NO. 1237

Mr. NICKLES. Mr. President, for the information of our colleagues, we were in the process of debating the Robb amendment dealing with mandatory length of stays for mastectomies. That is a second-degree amendment to an amendment I offered on behalf of myself, Senator GRAMM, and Senator COLLINS that had a limitation on the cost. The cost of the underlying bill cannot exceed 1 percent, nor could it increase the costs or increase the number of uninsured by over 100,000 or the bill would not be in effect.

Senator ROBB's amendment strikes the amendment that limits the 1-percent cost. It is our intention to finish the debate on the Robb amendment. We will vote on the Robb amendment, and it will be our intention for the Republican side to offer a second-degree amendment. We will debate that amendment and vote on it and work our way through the amendments that have been stacked today.

I ask the Parliamentarian how much time remains on the Robb amendment?

The PRESIDING OFFICER. The majority has 46 minutes remaining and the minority has 28 minutes remaining.

Mr. NICKLES. I yield the floor.

Mr. KENNEDY. I yield 5 minutes to the Senator from Maryland.

The PRESIDING OFFICER. The Senator from Maryland is recognized for 5 minutes.

Ms. MIKULSKI. Mr. President, what does a woman do in a few days before she is scheduled to have a mastectomy? How should she spend her time? What should she be doing? Should she be on the phone calling her HMO, trying to figure out what will happen to her after surgery? Who will take care of her, how long will she be in the hospital? Should she be on the phone, dealing with bureaucracy? Should she be dealing with paperwork? Should she be on the phone, dealing with an insurance gatekeeper?

No, I do not think that is what she should be doing and I think the Senate will agree with me. I think she should be with her family. I think she should be talking with her husband, because he is as scared as she is. He is terrified that she might die. He is wondering how can he support her when she comes home.

She needs to talk to her children so that they understand that even though she is going in for an operation, they know their mother will be there when she comes back home but she might not be quite the same. She needs to be with her family. She needs to be with her clergyman. She needs to be with those who love her and support her.

This is what we are voting on here today. Who should be in charge of this decision? When a woman has a mastectomy she needs to recover where she

can recover best. That should be decided by the doctor and the patient. We hear about these drive through mastectomies, where women are in and out in outpatient therapy. They are dumped back home, often sent home still groggy with anesthesia, sometimes with drainage tubes still in place or even at great risk for infection.

Make no mistake, we cannot practice cookbook medicine and insurance gatekeepers cannot give cookbook answers. An 80-year-old woman who needs a mastectomy needs a different type of care than a 38-year-old woman. And a 70-year-old woman whose spouse himself may be 80 might have different family resources than a 40-year-old woman.

Even the board of directors of the American Association of Health Plans states this: ''. . . the decision about whether outpatient or inpatient care meets the needs of a woman undergoing removal of a breast should be made by the woman's physician after consultation with the patient.''

As I said earlier, we go out there and we Race for the Cure. Now we have to race to support this amendment. Let's look at what we have done with our discoveries. We in America have discovered more medical and scientific breakthroughs than any other country in world history. It is America who knew how to handle infectious diseases. It is America who comes up with lifesaving pharmaceuticals.

We have been working together on a bipartisan basis to double the NIH budget. We have joined together on a bipartisan basis to have mammogram quality standards for women. Now we have to join together on a bipartisan basis and pass this amendment.

We must continue our discovery, we must continue our research, and we must continue to make sure that we have access to the discoveries we have made.

This is what this amendment is all about. It allows a woman and her physician to make this decision.

Some time ago very similar legislation was offered by the former Senator of New York, Mr. D'Amato. People on the other side of the aisle had cosponsored this bill. What we are saying here is, if you cosponsored it under Senator D'Amato, vote for it under the Robb-Mikulski-Boxer-Murray amendment. This should not be about partisan politics.

Let's put patients first. Let's understand what is going to happen to a woman. Let's understand what is going to happen to her family. And let the doctors decide. I told my colleagues a few weeks ago—I recalled a few months ago I had gall bladder surgery. I could stay overnight because it was medically necessary and medically appropriate. Surely if I can stay overnight for gall bladder surgery a woman should be able to stay overnight when she has had a mastectomy.

I yield the floor.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. KENNEDY. I yield 5 minutes to the Senator from California.

The PRESIDING OFFICER. The Senator from California is recognized for 5 minutes.

Mrs. BOXER. Mr. President, I thank Senator KENNEDY for his work on this, and Senator MIKULSKI for her inspirational talk, and Senator ROBB for offering an amendment that I think is crucial to the women of this country. I am eternally grateful to him for putting this amendment together.

Earlier, Senator SMITH made a very eloquent talk about the need to set aside politics and do what is right for the people. I think we have an extraordinary opportunity to do that on this Patients' Bill of Rights. It is really very simple to do. Whether we are Democrats or Republicans or Independents, we can set all that aside and follow this simple rule, asking every time we vote: What is best for the people of our Nation? That is it, the simple question: What is best for the children? What is best for the women? What is best for the men? What is best for the families, the old or the young, et cetera.

The Robb amendment is good for American women. As a matter of fact, the Robb amendment is crucially needed. It is desperately needed. The Senator from Maryland was eloquent on the point. Think about finding out you have breast cancer and learning you have to have a mastectomy. You do not need to be a genius to understand that you want a doctor making the decision as to how long you stay in the hospital.

It is very simple: Mastectomies are major surgery. Cancer is life-threatening and difficult. It is physical pain. It is mental anguish for you and your family. You don't want an accountant or a chief operating officer in an HMO telling you to leave after a few hours, with tubes running up and down you and being sick as a dog and throwing up and all the rest. I hate to be graphic about it, but we have to come to our senses in this debate. What is the argument against this? It is going to cost more? We know the CBO says it is maybe $2 a month to obtain all the benefits in the Patients' Bill of Rights. I think it is worth $2 a month to know a doctor makes the decision.

I want to talk about the CEOs of these HMOs. They make millions of dollars a year. They are skimming off the top, off of our health care quality, and putting it in their pockets. They make $10 million a year, $20 million a year, $30 million a year—one person. If his wife comes down with cancer and needs a mastectomy, do you think he is going to leave the decision to an accountant in an HMO? You know he is not. He is going to dig into his pocket, into his $30-million-a-year pocket, and pay for her to obtain good care.

What about the average woman? What about our aunts and our uncles and our neighbors? They deserve the same kind of attention and care. That is what the Robb amendment will do.

It will do something else. Again, I am so grateful to the Senator from Virginia on this point. Senator MURRAY had offered the mastectomy amendment in committee, and even Senators who were on the original Feinstein-D'Amato bill, Republican Senators, voted against her amendment in the committee. She is on the floor fighting for this.

Senator SNOWE and I, in a bipartisan way, introduced a bill that would require your OB/GYN, your obstetrician/gynecologist, to be your basic health care provider. Senator ROBB has included that in his amendment.

The reality is that a woman does consider her OB/GYN as her primary care physician. Let's make it a guarantee that her OB/GYN can refer her to a specialist. You do not have to jump through hoops.

Mr. President, 70 percent of the women in this country use their OB/GYN as their only physician from the time they are quite young. So the Robb amendment recognizes the reality.

Let me tell you why we should come together, both parties, on this amendment. Let's look at what happens to women who regularly see an OB/GYN. A woman whose OB/GYN is her regular doctor is more likely to have a complete physical exam, blood pressure readings, cholesterol test, clinical breast exam, mammogram, pelvic exam, and Pap test.

This is why it is so important. These are the threats to women.

The PRESIDING OFFICER. The Senator's 5 minutes have expired.

Mrs. BOXER. I ask unanimous consent for 1 additional minute.

Mr. KENNEDY. I yield 1 minute.

Mrs. BOXER. So you can see that the women who use their OB/GYN on a regular basis get what is necessary for them to stay healthy, to avoid the traumas, to avoid the problem of missing, for example, a breast cancer because they do not have that regular mammogram.

In conclusion, we have Senator ROBB who has long been a champion for women's health, and I can tell you chapter and verse that I have worked with him over these years and he has taken the most important issues to the women of this country and has rolled them into one, plus an additional part that deals with the deductibility of premiums if you are self-employed.

This is a wonderful amendment. This is not an amendment that responds to Democrats, Republicans, or any other party. It is for American women and their families. I urge us to support this fine amendment.

I yield back my time.

Mr. KENNEDY. Mr. President, I take 30 seconds to note that on Tuesday afternoon at 3:30 on the Patients' Bill of Rights, on an issue that is so basic and fundamental and important to American women, we have our Members who are prepared to debate this issue, an issue on which, if my colleagues on the other side have a difference, we ought to be debating. We

cannot even get an engagement of debate on this.

I do not know if that means they are willing to accept it. I would have thought they would have the respect at least for the position of several Members, led by our friend and colleague from Virginia, to speak to this issue.

I yield the Senator from Arkansas 3 minutes.

The PRESIDING OFFICER. The Senator from Arkansas is recognized.

Mrs. LINCOLN. I thank my colleague.

Mr. President, I rise today to make clear my position on such a very important issue. In the forefront of the managed care debate in the early nineties, I diligently supported the concept of trying to manage care, to control the cost of health care in this country in order to provide more health care to more Americans. When we did that, we in Congress never envisioned that medical decisions would be taken away from medical professionals or that an insurance company would circumvent a patient's access to specialists.

Again we are debating this issue of how to provide better health care for more Americans. Today we are talking about the Robb amendment which is absolutely essential to women across this country.

Managed care has been a very necessary and useful tool in our nationwide health care network. It has helped us cut the costs, especially in Medicare. But the issue of making sure women have the opportunity to choose as their primary care giver an OB/GYN is absolutely essential. Most women in this day and age go from a pediatrician to an OB/GYN. To have to go back through a primary care giver in order to see an OB/GYN is absolutely ridiculous.

It is so important to do more to see that women have access to quality care. The Robb amendment takes us in the right direction with three very important provisions. It provides women with direct access to an OB/GYN. They should not have to obtain permission from a gatekeeper. I have had staffers in the past who had awful experiences of having to go to a primary care giver and not even bothering to see their OB/GYN to get the speciality care they needed because it took so much time to go through a primary care giver. That is absolutely inexcusable in this day and age with the kind of speciality care, research, and knowledge we have in our medical professionals.

A great example: A lump is discovered in a woman's breast during a routine checkup. The OB/GYN ought to be able to refer that woman for a mammogram rather than sending her back to the primary care physician. The Robb amendment would designate the OB/GYN as the primary care giver. Most women try to do that already. They already view their OB/GYN as their primary physician.

It is especially important for women in rural areas. They are limited in their access and capability to get to their physicians, and if they cannot see an OB/GYN from a rural area, then they likely are never going to get the speciality care they need and deserve.

Most important, we have to make sure our physicians are able to make those medical decisions. One of the most frustrating comments I ever heard from my husband, who is a physician, is when he spent 1 hour 45 minutes on the telephone with an insurance adjustor after seeing one of his partner's patients who had come through surgery. She was still running a fever, and the nurse called him and said: We have to send this woman home because the insurance company said we had to.

He spent 1 hour 45 minutes on the phone with that insurance adjustor, and at the end of that conversation he finally said: If you can send me your medical diploma and if you will sign an affidavit that you will take complete responsibility for this woman's life, then, and only then, should I be able to discharge her from this hospital, because she is sick.

Yet they were not going to pay for it. He said: We are going to keep her in the hospital, and you are going to be responsible, you are going to pay for that bill, and we are going to ensure the woman is well taken care of.

It is so important for the women across this country to know they will have the primary care they need through their OB/GYN.

I appreciate my colleagues' involvement.

Mr. REID. Mr. President, will the Senator yield?

Mr. KENNEDY. I yield.

Mr. REID. Mr. President, I say to the Senator, the manager of the bill, can he indicate to me why no debate is taking place on the most important amendment we have had to the Patients' Bill of Rights in the 2 days we have been here? What has happened?

Mr. KENNEDY. The Senator raises a good question. We are not going to take advantage of the absence of our Republican colleagues. We are asking where they are. We know they are someplace. I can understand why they do not want to engage in this debate. We have a limited period of time. We are ready to debate. Our cosponsors are here and ready to debate this basic, very important issue. I believe they have made a very strong case.

I guess what they are waiting for is for us to run through the time and perhaps they will come out. Wherever they are, they will come out perhaps at least to try to defend their indefensible position on their legislation.

I note the Senator from Minnesota is here and wants to speak for 5 minutes.

The PRESIDING OFFICER. The Senator from Minnesota is recognized for 5 minutes.

Mr. WELLSTONE. Mr. President, I did not rise to defend the Republican Party position. I am sorry to disappoint my colleagues. I say to the good Senator from Virginia, I am not here to speak against his amendment.

I do find it interesting. I do not think I can repeat with the same eloquence and power what my colleagues have said about what this debate is about in personal terms when we are talking about women. But we could also be talking about a child having to get access to the services he or she needs. This is really a life-or-death issue. It is very important for people to make sure their loved ones, whether it be a wife, a husband, or children, get the care they need and deserve. That is what this debate is all about.

I notice that the insurance industry is spending millions and millions of dollars on all sorts of ads talking about how we are going to have 1.8 million more people lose coverage.

All of a sudden, the insurance industry is concerned about the cost of health care insurance. All of a sudden, the insurance industry in the United States of America is concerned about the uninsured. My colleague from Massachusetts says: Where are our colleagues on the other side of the aisle? Not too long ago, just a couple of hours ago, I heard colleagues come out on the Republican side and talk about how this patient protection was too expensive, families would lose their insurance company, the poor insurance industry—which is making record profits—cannot afford to provide this coverage. Where are they now?

As I look at the figures, 10 leading managed care companies recorded profits of $1.5 billion last year. United Health Care Corporation, $21 million to its CEO; CIGNA Corporation, $12 million to its CEO; and the figures go on and on. Yet we have colleagues coming out to this Chamber—apparently not now—trying to make the argument, even though the Congressional Budget Office says otherwise, even though independent studies say otherwise, that we cannot provide decent patient protection for women because it will be too expensive.

It is not going to be too expensive. What will be too expensive and what will be too costly is when women and children and our family members do not get the care they need and deserve and, as a result of that, maybe lose their lives, as a result of that they are sicker, as a result that there is more illness.

Where do the patients fit in? Where do the women fit in? Where do the children fit in? Where do the families fit in?

I say to Senator KENNEDY, we know where the insurance industry fits in. Here are their ads: Sure, the Kennedy-Dingell bill will change health care; people will lose coverage.

This is outrageous. The insurance industry thinks that by pouring $100 million, or whatever, into TV ads and scaring people, they are going to be able to defeat this effort. They are wrong. The vote on this amendment, and on other amendments, and on this

legislation, will be all about whether Senators belong to the insurance industry or Senators belong to the people who elected us. We should be here advocating for people, not for the insurance industry.

I yield the floor.

Mr. KENNEDY. How much time remains?

The PRESIDING OFFICER. The Senator has 7 minutes 14 seconds.

Mr. KENNEDY. I yield the Senator from Virginia 2 minutes.

The PRESIDING OFFICER. The Senator from Virginia.

Mr. ROBB. Mr. President, I thank you. And I thank our distinguished colleague from Massachusetts for his leadership on this whole bill.

I use this moment to simply commend our colleagues, who happen to be women, who have made the most passionate, persuasive case for this particular amendment that could be made.

Frankly, in listening to my colleague from Maryland about the agony women go through before they have to make a decision about a mastectomy, talking about the difficult choices that women have to make, and adding to it the bureaucracy, where we bounce them back and forth, and talking about money—for this particular amendment, I have heard one estimate that it will be 12 cents a year for the increased cost—we will probably, I suggest, save more money in the lack of administration and bureaucracy than it would cost if we allow women to have as their designated primary care provider their obstetrician or gynecologist. This is the person they go to right now to receive their health care, as pointed out so eloquently by the Senator from California.

As the Senator from Arkansas has noted, this is a very real problem. Her husband happens to practice this particular form of medicine. She gave us a compelling reason as to why we should not subject the women of America to this kind of burden.

I am very grateful to my colleague from Washington, who has long led the fight on this particular issue, and my colleague from Minnesota, and others who have spoken out.

I, frankly, do not understand the argument against this particular proposal. There is no one here to make that argument. I am, frankly, surprised. This makes sense for the women of America.

The PRESIDING OFFICER. The time has expired.

Mr. ROBB. Mr. President, with that, I yield back my time to the Senator from Massachusetts so we might hear again from the Senator from Washington.

Mr. KENNEDY. I yield 3 minutes to the Senator from Washington.

The PRESIDING OFFICER. The Senator from Washington.

Mrs. MURRAY. Thank you, Mr. President,

Again, I thank my colleague from Virginia, Senator ROBB, and all of the women and men on the Democratic side who have come out to speak for the Robb-Murray-Mikulski-Boxer amendment, which is so essential to women in this country.

I am astounded that the Republicans have fled the Chamber and have not returned to either agree with us in fighting for women's health or to explain why they are going to vote no.

I was astounded in committee when I offered this amendment and it was defeated on a partisan vote. Where are our colleagues on the Republican side who have come before us so many times and said that they are going to be there at the Race for the Cure? Where are the men of the Senate, when they have been there so many times, saying: You bet we stand for women's health.

This is a women's health issue. Young girls go to a pediatrician until they are 12, 13, or 14. At that time, they change doctors, not a primary care physician but an OB/GYN. Why should they be subjected now to HMO rules that say: We are going to change this, and you are going to have to go to a primary care physician in order to be sent to an OB/GYN? OB/GYNs are our primary care physicians.

As I stated this morning, if you are pregnant and have a serious cold or ear infection, or any other challenging problem that develops when you are pregnant, you will be given a different medication, a different procedure that you need to go through than if you are not pregnant.

Your OB/GYN is your primary care physician from the time you are a teenager until the time you reach menopause, whether you are there because you are pregnant or there because a physician is examining you to determine treatment. But you are there. The OB/GYN is your primary care physician. This amendment will guarantee it.

As Senator MIKULSKI so eloquently stated, a woman who has a mastectomy should not be sent home too soon whether she is 25 years old or 80 years old. In this country, on a daily basis, women are sent home too soon because it is considered, by HMOs, to be cosmetic surgery. This is not cosmetic surgery. A mastectomy is serious surgery. Women should be sent home when their doctor determines they are able to go home. That is what this amendment is about.

We urge our colleagues on the other side to vote with us, to join with us in being for women's health care.

I thank my colleagues who have been here to debate this issue. I especially thank Senator ROBB, who has been a champion for all of us. I look forward, obviously, to the adoption of this amendment since no one has spoken out against it.

The PRESIDING OFFICER. The Senator's side has 2 minutes remaining.

Mr. KENNEDY. Mr. President, we are reaching the final moments for considering this amendment. We, on this side, who have been strong supporters of the Patients' Bill of Rights, think this is one of the most important issues to be raised in the course of this debate. It is an extremely basic, fundamental, and important issue for women in this country.

Our outstanding colleagues have presented an absolutely powerful and indisputable case for our positions. We are troubled that we have had silence from the other side.

We listened yesterday about how beneficial the Republican bill was—when it refuses to provide protections to the millions of Americans our colleagues have talked about.

We are down to the most basic and fundamental purpose of our bill; that doctors and, in this case, women are going to make the decision on their health care needs, not the bureaucrats in the insurance industry.

This is one more example of the need for protections. Our colleagues have demonstrated what this issue is really all about. That is why I hope those Members on the other side that really care about women's health will support this amendment.

Mr. President, we are prepared to move ahead and vote on this amendment.

The PRESIDING OFFICER. Who yields time?

If neither side yields time, time runs equally against both sides.

Mr. KENNEDY. Do I have 1 minute left?

The PRESIDING OFFICER. Seventeen seconds.

Mr. JEFFORDS addressed the Chair.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. How much time do we have?

The PRESIDING OFFICER. Twenty-five minutes 15 seconds.

Mr. JEFFORDS. Mr. President, I know that my worthy opponents have made note of our absence. We are not ignoring this issue. We have a better answer. There will be a Snowe-Abraham amendment presented, probably tomorrow, that will handle this issue. I think the Members will agree that the approach we take will be preferable to the one being taken right now.

I would like to address my colleagues generally on the situation at this time. The Patients' Bill of Rights Act addresses those areas of health quality on which there is broad consensus. It is solid legislation that will result in a greatly improved health care system for all Americans.

The Committee on Health, Education, Labor, and Pensions, the HELP Committee, has been long dedicated to action in order to improve the quality of health care. Our commitment to developing appropriate managed care standards has been demonstrated by the 17 additional hearings related to health care quality. Senator FRIST's Public Health and Safety Subcommittee held three hearings on the work of the Agency for Health Care

Policy and Research, sometimes referred to as AHCPR. Each of these hearings helped us to develop the separate pieces of legislation that are reflected in S. 326, the Patients' Bill of Rights Act. People need to know what their plan will cover and how they will get their health care.

The Patients' Bill of Rights requires full disclosure by an employer about health plans it offers to employees. Patients also need to know how adverse decisions by a plan can be appealed, both internally—that is, within the HMO—and externally, through an independent medical reviewer. Under our bill, the reviewer's decision will be binding on the health plan. We are talking about an external, outside reviewer, and it is binding. There is no appeal. It is binding. They have to do it. However, the patient will retain his or her current rights to go to court.

Timely utilization decisions and a defined process for appealing such decisions are the keys to restoring trust in the health care system. Our legislation also provides Americans covered by health insurance with new rights to prevent discrimination based on predictive genetic information. This is a crucial provision. It ensures that medical decisions are made by physicians in consultation with their patients and are based on the best scientific evidence. That is the key phrase. We want to remember that one because you won't see it on the other side.

It provides a stronger emphasis on quality improvement in our health care system with a refocused role for AHCPR, taking advantage of all the abilities we have now to understand better what is going on with respect to health care in this country, to sift through the information that comes through AHCPR and make judgments on what the best medicine is.

Some believe that the answer to improving our Nation's health care quality is to allow greater access to the tort system, maybe a better lawsuit. However, you simply cannot sue your way to better health. We believe that patients must get the care they need when they need it. They ought not to have to go to court with a lawsuit. They ought to get it when they need it. It is a question of whether you want good health or you want a good lawsuit.

In the Patients' Bill of Rights, we make sure each patient is afforded every opportunity to have the right treatment decision made by health care professionals. In the event that does not occur, patients have the recourse of pursuing an outside appeal to get medical decisions by medical people to give them good medical treatment. Prevention, not litigation, is the best medicine.

Our bill creates new, enforceable Federal health standards to cover those 48 million people of the 124 million Americans covered by employer-sponsored plans. These are the very same people that the States, through their regulation of private health insurance companies, cannot protect. We will protect them.

What are these standards? They include, first, a prudent layperson standard for emergency care; second, a mandatory point of service option; direct access to OB/GYNs and pediatricians—that has not been recognized by the opposition—continuity of care; a prohibition on gag rules; access to medication; access to specialists; and self-pay for behavioral health.

It would be inappropriate to set Federal health insurance standards that duplicate the responsibility of the 50 State insurance departments.

Mr. KENNEDY. Will the Senator yield on that issue?

Mr. JEFFORDS. I am happy to yield.

Mr. KENNEDY. Can the Senator show us one State that has the patient protections included in our proposal? Is there just one State in this country, one State that provides those types of protections?

Mr. JEFFORDS. I believe Vermont does.

Mr. KENNEDY. All of the protections for the patients? I know the Senator understands his State well, but does the Senator know of any other State that provides these kinds of protections?

Mr. JEFFORDS. We are going to provide them with better protections.

Mr. KENNEDY. The scope of your legislation only includes a third of all the people who have private health coverage.

Mr. JEFFORDS. Well, in some areas we go beyond that, as the Senator well knows.

Mr. KENNEDY. No, I don't know. I don't know, because you talk about self-insured plans, and there are only 48 million Americans in those plans. You don't cover the 110 million Americans who have other health insurance plans.

Does the Senator know a single State that provides specialized care for children if they have a critical need for specialty care—one State in the country? We provide that kind of protection. Does the Senator know a single State that has that kind of protection?

Mr. JEFFORDS. I tell you, we have a better health care bill. That is all I am telling you. It will protect more people at less cost. Your bill is so expensive that you are going to affect a million people, and those people are the ones we want most to protect. Those are the people who are working low-income jobs and who will be torn off and removed from health care protection by your bill. We will not do that. We are going to protect those people who need the protection the most from being denied health insurance.

I take back the remainder of my time.

It would be inappropriate to set Federal health insurance standards that duplicate the responsibility of the 50 State insurance departments. As the National Association of Insurance Commissioners put it:

> We do not want States to be preempted by Congressional or administrative actions. . .Congress should focus attention on those consumers who have no protections in the self-funded ERISA plans.

Senator KENNEDY's approach would set health insurance standards that duplicate the responsibility of the 50 State insurance departments. Worse yet, it would mandate that the Health Care Financing Administration, HCFA, enforce them, if the State decides otherwise. It would be a disaster—HCFA can't even handle the small things they have with HIPAA, the Medicare and Medicaid problems—to get involved in the demands that would be placed upon them by the Democratic bill.

This past recess, Senator LEAHY and I held a meeting in Vermont to let New England home health providers meet with HCFA. It was a packed and angry house, with providers traveling from New Hampshire, Massachusetts, and Connecticut. That is who the Democrats would have enforce their bill. It is in no one's best interests to build a dual system of overlapping State and Federal health insurance regulation.

Increasing health insurance premiums causes significant losses in coverage. The Congressional Budget Office, CBO, pegged the cost of the Democratic bill at six times higher than S. 326. Based on our best estimates, passage of the Democratic bill would result in the loss of coverage for over 1.5 million working Americans and their families.

Now, why do you want to charge forward with that plan? To put this in perspective, this would mean they would have their family's coverage canceled under the Democratic bill—canceled. Let me repeat that. Adoption of the Democratic approach would cancel the insurance policies of almost 1.5 million Americans, CBO estimates. I cannot support legislation that would result in the loss of health insurance coverage for the combined population of the States of Virginia, Delaware, South Dakota, and Wyoming—no coverage.

Mrs. MURRAY. Will the Senator yield for a question?

Mr. JEFFORDS. Fortunately, we can provide the key protections that consumers want, at a minimal cost and without the disruption of coverage, if we apply these protections responsibly and where they are needed.

In sharp contrast to the Democratic alternative, our bill would actually increase coverage. With the additional Tax Code provisions of S. 326, the Patients' Bill of Rights Act, our bill allows for full deduction of health insurance for the self-employed, the full availability of medical savings accounts, and the carryover of unused benefits from flexible spending accounts.

Mrs. MURRAY. Will the Senator from Vermont yield for a question?

Mr. JEFFORDS. With the Patients' Bill of Rights Plus Act, we provide Americans with greater choice of more affordable health insurance.

Mrs. MURRAY. Will the Senator from Vermont yield for a question?

Mr. JEFFORDS. Yes.

Mrs. MURRAY. I thank the Senator.

I was listening to his discussion about the Republican bill. The current pending amendment, the Robb-Murray amendment, allows women access to OB/GYNs as their primary care physicians. Will the bill the Senator is discussing provide direct access for all of those women who are not in self-insured programs in this country?

Mr. JEFFORDS. We will have an amendment which will deal with that problem.

Mrs. MURRAY. All women in this country who are not in self-insured programs will have access under the amendment you are going to be offering?

Mr. JEFFORDS. First of all, we defer to the States in that regard.

Mrs. MURRAY. Then I can assume that the women who are not in self-insured programs will not be covered by the Republican amendment.

Mr. JEFFORDS. Our bill covers, as we intended to cover, those who need the coverage now who have no coverage and get the protection to those who need the protection. We will have an amendment that will take care of the problems that are——

Mrs. MURRAY. Not the self-employed. That is the answer.

Mrs. BOXER. Will the Senator yield for a question?

Mr. JEFFORDS. I think the Senator has her own time.

Mrs. BOXER. I wanted to ask the Senator one question.

Mr. JEFFORDS. Yes.

Mrs. BOXER. Is the Senator aware that when he talks about people losing their insurance, there is a $100 million effort going on by the HMOs to scare people into thinking that if the Democratic Patients' Bill of Rights passes—which is supported by all the health care advocate groups in the country—they will lose their insurance?

Is the Senator aware that his own Congressional Budget Office has clearly stated the maximum cost of the Democratic Patients' Bill of Rights is $2 a month?

And further, is the Senator aware that the President, by executive order, gave the Patients' Bill of Rights to Federal employees, and there has been no increase in the premium?

So what I am asking the Senator is, is he aware of this campaign by the HMOs? Has he seen the commercials? Does he believe the HMOs that who have an interest in this, the CEOs of which are getting $30 million a year, really have the interests of patients in their heart?

Mr. JEFFORDS. I say that the Senator was successful in stealing some time from me. Let me say that we have differences of opinions on these bills. There is no question that your bill is much more expensive, that it is going to cost 6 percent, and that CBO estimates 1.5 million people—all of which you say you care most about, I say to the Senator from California, the low-income people, the people who are just barely able to have plans right now, and small businesses that won't be able—1.5 million people will lose their health insurance if your plan is put in.

Mrs. BOXER. I say to the Senator——

The PRESIDING OFFICER. The Senator from Vermont has the floor.

Mr. JEFFORDS. S. 326, the Patients' Bill of Rights Plus Act, provides necessary consumer protections without adding significant new costs, without increasing litigation, and without micromanaging health plans.

Our goal is to give Americans the protections they want and need in a package they can afford and that we can enact. This is why I hope the Patients' Bill of Rights we are offering today will be enacted and signed into law by the President.

Mr. President, I yield to the Senator from Tennessee.

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

Mr. FRIST. Mr. President, I want to take a few minutes to return to the underlying amendment. It has taken me a while to read through the amendment. The first time I saw the amendment was 30 minutes ago. I have just read through the amendment offered by Senator KENNEDY and others which relates to certain breast cancer treatment and access to appropriate obstetrical and gynecological care.

I apologize for not being able to participate directly on in this issue earlier. At the outset, I will say that about 2 years ago, Senator Bradley from New Jersey and I had the opportunity to participate in writing an amendment that actually eventually became law which addressed the issue of postmaternity stay, postdelivery stay. We wrote that particular piece of legislation because we felt strongly that managed care had gone too far in dictating how long people stayed in the hospital and pushing them out after deliveries, and it was a little controversial, although I think a very good bill for the time, because it sent a message very loudly and clearly to the managed care industry that you need to leave those decisions, as much as possible, at the local level where physicians and patients, in consultation with each other, determine that type of care.

The amendment on the floor is different in that it focuses on another aspect of women's care and that is breast cancer treatment. As to the debate from the other side of the aisle, I agree with 98 percent of what was said in terms of the importance of having a woman be able to access her obstetrician and gynecologist in an appropriate manner, the need for looking at inpatient care, to some extent as it relates to breast disease. Yet I think the approach that Senator KENNEDY and others have put on the floor is a good start but has several problems. Therefore, I urge all of my colleagues to vote against that amendment, with the understanding we can take the good efforts from that amendment, correct the deficiencies, and address the very same issues that have been identified so eloquently by my colleagues across the aisle.

Now, in looking at the Kennedy-Robb amendment, on page 2, they talk about:

> . . . health insurance coverage, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in his or her professional judgment. . . .

So far, I agree wholeheartedly. But where I cannot vote in good conscience, or allow my colleagues to, without fully understanding the implications, is where they continue and say:

> . . . consistent with generally accepted medical standards, and the patient, to be medically appropriate following—(A) a mastectomy; (B) a lumpectomy; or (C) a lymph node dissection.

I agree with all of that and inpatient care. The part that bothers me is the ''consistent with generally accepted medical standards.'' This goes into the debate we will go into tomorrow, or the next day, on medical necessity and what medical necessity means.

When we talk about what is medically appropriate and medically necessary, you are going to hear me say again and again that we should not try to put that into law, Federal statute. We should not define ''medical necessity'' as generally accepted medical practices or standards. The reason is, as exemplified in this chart, nobody can define generally accepted medical standards. You will go up to a physician and a physician will say: That is what I do every day.

Well, that is not much of a definition, I don't think. Therefore, I am not sure we should use those terms and put them into a law and pass it as an amendment and make it part of the Patients' Bill of Rights.

This chart is a chart that shows the significant variation of the way medicine is practiced today, and that generally accepted medical standards has such huge variations that the definition means nothing. Therefore, I am not going to put into a Federal statute a definition that means very little because I think, downstream, that can cause some harm because maybe a bunch of bureaucrats will try to give that definition.

Mr. SANTORUM. If the Senator will yield, he is arguing that it doesn't mean anything. It means everything. Really it is sort of the opposite of that. It has such an expansive character to it that it can include inappropriate medicine, which is, I think, the point the Senator is making.

Mr. FRIST. I think that is right. My colleague said it much more clearly than I. The definition itself of ''medically necessary and appropriate'' is so important that we should not lock the definition into something that is so

small, so rigid, that we can't take into consideration the new advances that are coming along. That is why when we say generally accepted medical standards or practices, it leaves out the best evidence, the new types of discoveries that are coming on line. That decision should be made locally and should not be definitions put into a statute. Therefore, I am going to oppose this amendment.

Mr. ROBB. Will the Senator yield?

Mr. FRIST. Let me try to get through my presentation.

Mr. ROBB. Will the Senator yield?

Mr. FRIST. I will not yield.

Let me go through for my colleagues why the variation in medical practice has implications that may be unintended and therefore we cannot let the amendment pass.

Reviewing regional medical variations for breast-sparing surgery—basically for breast cancer today—I don't want to categorize this too much because the indications change a little bit. In a lumpectomy—taking out the lump itself and radiating because it is the least disfiguring—the outcome is equally good as doing a mastectomy and taking off the whole breast.

In my training—not that long ago, 25 years—the only treatment was mastectomy. As we learned more and more and radiation therapy became more powerful, we began to understand there are synergies in doing surgical operations and radiation therapy and chemotherapy. We didn't have to remove or disfigure the whole breast. The new therapy ended up being better for the patient but was not generally accepted medically. That sort of variation is shown in this chart.

In this chart, the very dark areas use lumpectomy versus mastectomy. Comparing the two, the high ratio of around 20 to 50 percent, versus going down to the light colors on the chart where this procedure is not used very much, there is tremendous variation. The different patterns of color on the chart demonstrate that a procedure generally accepted in one part of the country may be very different in another part of the country.

For example, in South Dakota, using this ratio of lumpectomy versus mastectomy, the ratio is only 1.4 percent.

In Paterson, NJ, the generally accepted medical standards in that community go up almost fortyfold to 37.8 percent—the relative use of one procedure, an older procedure, versus a newer procedure.

Which of those are generally accepted medical standards? That shows the definition itself has such huge variation that we have to be very careful when putting it into Federal statute. We will come back to that because it is a fundamentally important issue. Medicine is practiced differently around the country. Therefore, the words ''generally accepted medical standards'' have huge variations. We have to be careful what we write into law.

What I am about to say builds on the work of Senators SNOWE and ABRAHAM.

How much time do I have remaining?

The PRESIDING OFFICER. The Senator has 20 minutes 50 seconds.

Mr. FRIST. Again, Senators SNOWE and ABRAHAM will talk more about this a little bit later.

Instead of using language such as ''generally accepted medical standards,'' it has a built-in inherent danger because it defines what ''medical necessity and appropriate'' are.

We should be looking at words as follows: That provides a group health plan and a health insurance issuer providing health insurance coverage, that provides medical and surgical benefits, shall ensure that inpatient coverage—just like the Kennedy-Robb amendment with respect to the treatment of breast cancer—is provided for a period of time as determined by the attending physician, as the Kennedy-Robb amendment does, in consultation with the patient. I think this is ''in consultation with the patient.''

No, they do not have in their bill ''in consultation with the patient.'' I suggest ''in consultation with the patient'' should be part of their amendment.

We would put in ''in consultation with the patient'' to be ''medically necessary and appropriate,'' instead of using their words ''generally accepted medical standards,'' which has such huge variation.

Why not use the better terminology, ''medically necessary and appropriate''?

Use the same indications. Mastectomy is what we will propose, what they propose. Lumpectomy is what we propose, what they will propose. Lymph node dissection, we will use that language.

But ''generally accepted medical standards'' is dangerous. We ought to use such words as ''medically necessary and appropriate.'' Then we are not locked into the variation where there is a fortyfold difference in mastectomies versus lumpectomy, which shows the importance of being very careful before placing Federal definitions of what is ''medically necessary and appropriate'' in Federal law.

Mr. LEAHY. Mr. President, I was going to make a unanimous consent request.

Mr. FRIST. I yield to the unanimous consent request.

PRIVILEGE OF THE FLOOR

Mr. LEAHY. I ask unanimous consent that Alex Steele of my office be granted privilege of the floor today.

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

Mr. FRIST. In the Kennedy-Robb amendment is the issue of access.

Again, my colleagues on the other side hit it right on the head: Women today want to have access to their obstetrician. They don't want to go through gatekeepers to have to get to their obstetrician or gynecologist. That relationship is very special and very important when we are talking about women's health and women's diseases.

In the Kennedy-Robb amendment, the language is that the plan or insurer shall permit such an individual who is a female to designate a participating physician who specializes in obstetrics and gynecology as the individual's primary care provider.

It is true that in our underlying bill we don't say the plan has to say that all obstetricians and gynecologists are primary care providers. That is exactly right. The reasons for that are manyfold.

Let me share with Members what one person told me. Dr. Robert Yelverton, chairman of the American College of Obstetricians and Gynecologists' Primary Care Committee, stated:

> The vast majority of OB/GYNs in this country have opted to remain as specialists rather than act as primary care physicians.

He attributes this to the high standards that health plans have for primary care physicians, saying:

> None of us could really qualify as primary care physicians under most of the plans, and most OB/GYNs would have to go back to school for a year or more to do so.

You can argue whether that is good or bad, but it shows that automatically taking specialists and making them primary care physicians and putting it in Federal statute is a little bit like taking BILL FRIST, heart and lung transplant surgeon, and saying: You ought to take care of all of the primary care of anybody who walks into your office.

Mrs. BOXER. Will the Senator yield?

Mr. FRIST. I will finish my one presentation, and we will come back to this.

Mrs. BOXER. Will the Senator yield?

The PRESIDING OFFICER. The Senator does not yield.

Mrs. BOXER. Why do you not yield?

The PRESIDING OFFICER. The Senator did not agree to yield.

Mr. FRIST. I simply want the courtesy of completing my statement. I know people want to jump in and ask questions, but we have listened to the other side for 50 minutes on this very topic. I am trying to use our time in an instructive manner, point by point, if people could just wait a bit and allow me to get through my initial presentation of why I think this amendment must be defeated with a very good alternative.

I want to get into this issue of access to obstetricians and gynecologists. In our bill that has been introduced, we take care of this. I believe strongly we take care of it. We say, in section 723: The plan shall waive the referral requirement in the case of a female participant or beneficiary who seeks coverage for routine obstetrical care or routine gynecological care.

We are talking about routine women's health issues. We waive the referral process. There is not a gatekeeper. A patient goes straight to their obstetrician and gynecologist. That is what women tell me they want in terms of access to that particular specialized, trained individual.

It is written in our bill. Let me read what is in our bill.

The plan shall waive the referring requirement in the case of a female participant or beneficiary who seeks routine obstetrical care or routine gynecological care.

Therefore, I think the access provisions in the Kennedy-Robb amendment are unnecessary and are addressed in our underlying bill. Plus, they go one step further in saying that this specialist is the individual's primary care provider. I am just not sure of the total implications of that, especially after an obstetrician who is the chairman of the American College of Obstetrics and Gynecology very clearly states that merely assuming that a specialist is a good primary care physician is not necessarily correct.

Also, in our bill, beyond the routine care—this is in section 725 of our bill where we address access to specialists—we say:

A group health plan other than a fully insured health plan shall ensure that participants and beneficiaries have access to specialty care when such care is covered under the plan.

So they have access to specialty care when obstetrics care and gynecological care is part of that plan.

So both here and in the earlier provision of section 723, where we talk about routine obstetrical care, there is no gatekeeper; there is no barrier; a woman can go directly to her obstetrician and her gynecologist, which is what they want. Or, if you fall into the specialty category in provision 725, you have access to specialty care when such care is covered under the plan.

As I go through the Kennedy-Robb plan, and this is obviously the amendment that we are debating on the floor, there are a number of very reasonable issues in there. Again, I think the intent of the amendment is very good. I do notice secondary consultations in the amendment. I think, as we address the issue of women's health, obstetrical care, breast cancer treatment, access to appropriate care, which we plan on addressing and we will address, I believe, this is the amendment Senators SNOWE and ABRAHAM have been working on so diligently, the idea of secondary consultations.

About 2 months ago we did a women's health conference. It was wonderful. It was in Memphis, TN. It was on women's health issues. Maybe 200 or 300 people attended, focusing on women's health issues. We talked about the range of issues, whether it was breast cancer, cervical cancer, osteoporosis, diseases of the aging process, but an issue which came up was the issue of secondary consultations. Because it is dealing with something that is very personal to them, women say: Is there any way we can reach out in some way with health plans to lower the barriers for us to get a second opinion?

Why is that important? Part of that is important because of this huge variation. If you go to one doctor and he says do a mastectomy, which is very disfiguring, it is very clearly indicated—there are clear-cut indications for mastectomy or lumpectomy today. If you hear two different versions, you may want to get a secondary opinion or a secondary consultation.

What we are looking at in that regard is language similar to this: to provide coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields.

''Medical fields,'' I think we need to go a little bit further and focus on whether it is pathology or radiology or oncology or surgery to confirm—and I think it should be part of the language—to confirm or to refute the diagnosis itself. That is full coverage by the plan for secondary consultations for cancer as it deals with women's health issues.

I think that will be an important part to include as we address this very specific field. It is totally absent in the Kennedy-Robb amendment. I propose offering an amendment which does much of what they say in terms of inpatient care, changing this terminology from ''generally accepted medical standards,'' which I think is potentially dangerous, and move on to the language which I think should be used, which is ''medically necessary and appropriate.''

The access issue, I believe, we have developed. There are other issues in the bill that I will work with Senators ABRAHAM and SNOWE to address, in a systematically and well-thought-out way, so we can do what is best for women in this treatment of cancer, breast cancer, mastectomy, and access to obstetricians and gynecologists. That is something about which we need to ensure that no managed care plan says: No, you cannot go see your obstetrician; or, no, you cannot go see your gynecologist; or, no, you have to hop through a barrier; or, no, you have to go see a gatekeeper before you can see your obstetrician/gynecologist. We are going to stop that practice, and we are going to stop that in the Republican bill we put forward.

I have introduced the concept today—again, it is very important—of medical necessity and how we define what is medically necessary and appropriate. It is something critical. It is something we are going to come back to. I think with all the issues we are discussing, if we try to put in Federal law, Federal statute, a definition of what is medically necessary and appropriate instead of leaving it up to a physician who is trained in the field, a specialist, we are going in the wrong direction and have the potential for broadly harming people.

I urge defeat of this amendment with the understanding we are going to come back and very specifically address the issues I have talked about today.

I yield the floor.

Mr. LIEBERMAN. Mr. President, I rise today to express my support for the Robb-Murray amendment, which provides our mothers, wives, daughters and sisters with direct access to OB/GYN care and strengthens the ability of a woman and her doctor to make personal medical decisions.

The sponsors of this amendment, along with most women and most Americans, believe that a woman should have the choice and the freedom to select an OB/GYN physician as her primary care provider and to determine, in consultation with her doctor, how long she should stay in the hospital following surgery.

Those critical and deeply personal judgments should not be trumped by the arbitrary guidelines of managed care companies. The women in our lives deserve better than drive-by mastectomies. With the Robb-Murray amendment, we will say so in law, and ensure that women receive the services they need and the respect they are owed.

Studies show that when women have a primary care physician trained in OB/GYN, they receive more comprehensive care and greater personal satisfaction when they are treated by doctors trained in other specialties.

We should consider, too, that breast cancer is the second leading killer of women in this country. New cases of this disease occur more than twice as often as second most common type of cancer, lung cancer. More than 178,000 women in this country were diagnosed with breast cancer in 1998. I have no doubt we will someday find the origin and cure for this terrible malady. Until then, though, we have a duty to make the system charged with treating these women respectful and responsive to their needs.

Sadly, the evidence suggests we have a long way to go. We continue to receive disturbing reports about the insistence of some insurance companies to force women out of the hospital immediately after physically demanding and emotionally traumatic surgeries. We have been shocked by stories of women being sent home with drainage tubes still in their bodies and groggy from general anesthesia. This is distressing to me not just as a policymaker, but as a son, father, and husband.

Now, some critics of the Robb-Murray Amendment want to sidestep this problem, and suggest that we are legislating by body part. To that, I say:

Those who oppose this provision are wasting a valuable opportunity to increase the quality of physical health care for over half the population of the United States.

Those who oppose are ignoring the suffering and inconvenience of women throughout this country trying to receive the basic health care that they have every right to expect.

Those who oppose are failing to right a wrong that we have tolerated for too long.

Mr. President, women are being denied the quality of care they are paying for and to which they have a moral right. And this Senate has a chance today to begin fixing this inequity. I urge my colleagues to look beyond the rhetoric and see the very simple and fair logic that calls for the passage of this amendment, and join us in supporting it.

Several Senators addressed the Chair.

The PRESIDING OFFICER. Who yields time? The Senator from Oklahoma.

Mr. NICKLES. Mr. President, how much time remains on this amendment?

The PRESIDING OFFICER. There are 7 minutes and 26 seconds on the side of the Senator from Oklahoma. The other side has used all its time.

Mr. NICKLES. Mr. President, let me make a couple of comments. I heard my friend and colleague from Massachusetts say: Where is everybody in the debate? We have just received the amendment. I would like to look at it, and I had a chance to look at it while some of the debate was going on. I would like to make a couple of comments on it.

I found in the amendment—

Mr. KENNEDY. On that point, will the Senator yield?

Just on the point of the representation you just made. It is virtually the same amendment that was offered in the committee.

The PRESIDING OFFICER. Does the Senator yield?

Mr. NICKLES. No, I do not.

Mr. KENNEDY. It is not a surprise. It is the same amendment, effectively.

Mr. NICKLES. The Senator from Massachusetts says it is the same amendment offered in committee, but that is not factual. The Senator can correct me if I am wrong, but this amendment deals with Superfund. This amendment deals with transferring money from general revenue into Social Security. That was not offered in committee. There are few tax provisions in here. I asked somebody: What is this extension of taxes on page 17? My staff tells me it is a tax increase of $6.7 billion on Superfund. I don't know what that has to do with breast cancer, but it is a tax increase on Superfund.

I know we need to reauthorize Superfund. I didn't know we were going to do it on this bill. I stated in the past we are not going to pass the Superfund extension until we reauthorize it. We should do the two together. Why are we doing it on this bill?

So there are tax increases in here that nobody has looked at. They did not do that in the Labor Committee or the health committee, I do not think. I asked the Chairman of the committee. I don't think they passed tax increases on Superfund. That does not belong in the HELP Committee.

Certainly transferring money from the general revenue fund, as this bill does, into the Social Security trust fund, was not done in the HELP Committee, I do not think. It should not have been done. My guess is the Finance Committee might have some objections. Senator ROTH is going to be on the floor saying: Wait a minute, what is going on?

So there is a lot of mischief in these amendments. Some of us have not had enough time. One of the crazy things about this agreement is we are going to have amendments coming at us quickly. We have to have a little time to study them. Sometimes we find some things stuck in the amendments which some of us might have some objections with.

I want to make a couple of comments on the amendment. In addition to the big tax increases hidden in the bill, this amendment also strikes the underlying amendment that many of us have proposed on this side that says, whatever we should do we should do no harm. If we are going to increase premiums by over 1 percent; let us not do a bill. Maybe people forgot about that, but that is an amendment we offered earlier. This amendment, the Robb amendment, says, let's strike that provision. We do not care how much the Kennedy bill costs.

Some of us do care how much it costs. We do not want to put millions of people into the ranks of the uninsured. We do not want to do harm. Unfortunately, the amendment proposed by Senator ROBB and others would do that. It would strike that provision. It would eliminate that provision.

On the issue of breast cancer and mastectomy and lumpectomy and so on, Senator FRIST has addressed it a little bit. Senator SNOWE and others will be offering an amendment that is related and, I will tell you, far superior to the amendment we have on the floor.

I do not know if we will get to it tonight. Certainly, we will get to it tomorrow. It is a much better amendment. It is an amendment that has been thought out. It is an amendment that does not have Superfund taxes in it. It is an amendment that includes, as this bill does, transfers from the general revenue fund into the Social Security trust.

I urge my colleagues at the appropriate time to vote ''no'' on the Robb amendment, and then let's adopt the underlying amendment which says we should not increase health care costs by more than 1 percent; let's not do damage to the system; let's not put people into the ranks of uninsured by playing games, maybe trying to score points with one group or another group. Let's not do that. Let's not make those kinds of mistakes.

If people have serious concerns dealing with breast cancer and how that should be treated, again, Senator SNOWE, Senator ABRAHAM, and Senator FRIST have an amendment they have worked on for some time that I believe is much better drafted. It does not have Superfund taxes in it. It does not have a transfer of general revenue funds into the Social Security trust fund. It does not make these kinds of mistakes that we have, unfortunately, with this pending amendment.

Mr. GREGG. Will the Senator yield for a question?

Mr. NICKLES. I ask how much time we have?

The PRESIDING OFFICER. The Senator has 2½ minutes.

Mr. GREGG. As I understand it, by repealing the underlying amendment, which would limit the cost increase to 1 percent and would say, in the alternative, if 100,000 people are knocked off the rolls of insured, the bill will not go forward. If we repeal that and those 100,000 people are knocked off the rolls, they are not going to have any insurance for mastectomies; right?

Mr. NICKLES. The Senator is exactly right.

Mr. GREGG. Basically, the proposal of the Senator from Virginia, supported by Senator KENNEDY, uninsures potentially 100,000 women from any mastectomy coverage as a result of their amendment or any other coverage.

Mr. NICKLES. The Senator makes a good point, but probably not 100,000. Estimates would probably be much closer to 2 million people would be uninsured and have no coverage whatsoever in any insurance proposal if we adopt the underlying Kennedy amendment.

Mr. GREGG. Of those 2 million people, we can assume potentially half would be women. So we have approximately 1 million women who would not have insurance as a result of this amendment being put forward on the other side.

Mr. NICKLES. The Senator is correct.

Mr. SANTORUM. Mr. President, will the Senator from Oklahoma yield for a question? As a matter of fact, we have some information just provided to us that under the Kennedy legislation, S. 6, with 1.9 million people no longer being insured, you would have 188,595 fewer breast examinations. If people had their routine breast examinations, of those 1.9 million, a certain percentage would be women, that would be the number of breast exams that would no longer take place if this legislation passed.

We hear so much talk about ''in human terms,'' and they say this argument does not cut. These people are going to lose insurance. They will lose insurance. They will not get coverage so you do not have to worry about covering them for a mastectomy. They are going to find out, in many cases, unfortunately, far too late for even those kinds of treatments to be helpful. That is what we are trying to prevent in not passing a bill that drives up costs dramatically which drives people out of the insurance area.

Mr. NICKLES. I appreciate my colleague's comment. I yield back the remainder of my time and ask for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. KENNEDY. I yield myself 2 minutes on the bill.

The PRESIDING OFFICER. The Senator is recognized.

Mr. KENNEDY. Mr. President, the more we debate, the more confused our good colleagues on the other side, quite frankly, become. The underlying amendment dealing with the OB/GYN is the amendment that was offered in committee and that is no surprise.

The other provision the Senator from Oklahoma talks about is funding the self-insurance tax deduction introduced by the Senator from Oklahoma without paying for it. This would subject the bill to a point of order if it was carried all the way through. He did not pay for it.

It is a red herring. Time and time again we have put in the General Accounting Office document which states that the protections in this bill will enhance the number of people insured, not reduce the number.

Does the Senator from Pennsylvania actually believe we are endangering breast cancer tests for women, reducing Pap tests, reducing examinations for breast cancer and yet the breast cancer coalition supports our proposal? Is he suggesting any logic to his position?

Mr. President, I yield back the remainder of the time and look forward to the vote.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I yield myself 1 minute on the bill.

The Senator from Pennsylvania is right. The whole essence of the second-degree amendment is to kill the underlying amendment because the Senator from Massachusetts does not want to say we will not increase costs by more than 1 percent, because, frankly, he wants to, and expects to, increase costs by 5 or 6 percent. The net result of that will be to uninsure a couple million people, half of which could be women, half of which will not get those exams, half of which will not get those screenings, half of which will not get the care they need. That is the purpose of the amendment.

In the process, he also increases Superfund taxes and also comes up with general transfers of money from the general revenue fund to the Social Security fund. That is a mistake.

I urge my colleagues to vote no and keep in mind that in dealing with breast cancer, Senator SNOWE, Senator FRIST, and Senator ABRAHAM will offer a much better proposal later in this debate. I yield the floor.

The PRESIDING OFFICER. All time having been yielded back, the question is on agreeing to amendment No. 1237. The yeas and nays have been ordered. The clerk will call the roll.

The legislative assistant called the roll.

The result was announced—yeas 48, nays 52, as follows:

[Rollcall Vote No. 198 Leg.]

YEAS—48

Akaka	Edwards	Lieberman
Baucus	Feingold	Lincoln
Bayh	Feinstein	Mikulski
Biden	Graham	Moynihan
Bingaman	Harkin	Murray
Boxer	Hollings	Reed
Breaux	Inouye	Reid
Bryan	Johnson	Robb
Byrd	Kennedy	Rockefeller
Chafee	Kerrey	Sarbanes
Cleland	Kerry	Schumer
Conrad	Kohl	Specter
Daschle	Landrieu	Torricelli
Dodd	Lautenberg	Warner
Dorgan	Leahy	Wellstone
Durbin	Levin	Wyden

NAYS—52

Abraham	Frist	McConnell
Allard	Gorton	Murkowski
Ashcroft	Gramm	Nickles
Bennett	Grams	Roberts
Bond	Grassley	Roth
Brownback	Gregg	Santorum
Bunning	Hagel	Sessions
Burns	Hatch	Shelby
Campbell	Helms	Smith (NH)
Cochran	Hutchinson	Smith (OR)
Collins	Hutchison	Snowe
Coverdell	Inhofe	Stevens
Craig	Jeffords	Thomas
Crapo	Kyl	Thompson
DeWine	Lott	Thurmond
Domenici	Lugar	Voinovich
Enzi	Mack	
Fitzgerald	McCain	

The amendment (No. 1237) was rejected.

Mr. NICKLES. Mr. President, I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

AMENDMENT NO. 1238 TO AMENDMENT NO. 1236

(Purpose: To make health care plans accountable for their decisions, enhancing the quality of patients' care in America)

Mr. NICKLES. Mr. President, I send an amendment to the desk on behalf of Senator FRIST, Senator JEFFORDS, and others, and ask for its immediate consideration.

The PRESIDING OFFICER (Mr. HAGEL). The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Oklahoma [Mr. NICKLES], for Mr. FRIST, for himself and Mr. JEFFORDS, proposes an amendment numbered 1238 to amendment No. 1236.

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

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

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

Mr. NICKLES. Mr. President, for the information of our colleagues, we have now disposed of the Democrats' second-degree amendment to the first-degree amendment proposed by the Republicans, which first-degree amendment would limit the cost of the Kennedy health care bill to 1 percent. Now I have sent a second-degree amendment up under the unanimous consent agreement. Each side could offer a second-degree.

The amendment I sent to the desk on behalf of Senators FRIST, JEFFORDS, and others, is a very important amendment, so I hope all of our colleagues will listen to it. The amendment would strike the medical necessity definition that was in the Kennedy bill and replace it with the grievance/appeals process we have in our bill. In other words, it is a very significant amendment, one that we had significant discussion on last week. Some of our colleagues said they really wanted to vote on it last week. We will get to vote on it, depending on the majority leader's intention. If the time runs on this amendment, all time would be used, and we would probably be ready for a vote at about 6:40. Of course, it would be the majority leader's call whether or not to have a vote.

The amendment deals with medical necessity. It replaces the definition in the Kennedy bill with the grievance and appeals process that we have in the Republican package, which I think is a far superior package as far as improving the quality of care. I compliment Senator JEFFORDS, Senator FRIST, and others for putting this together.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. JEFFORDS. Mr. President, this is an extremely important amendment. I think everyone ought to understand exactly what we are trying to do.

We are entering into a new era with respect to the availability of health care, good health care, excellent health care. We have seen pharmaceuticals being devised which would do miraculous things. We are also having medical procedures designed and devices created. But what we have not seen is their being available everywhere, or a standard that will make them available in areas where they ought to be available.

What we are trying to do today is establish that every American is entitled to the best medical care available, not that which is generally available in your area; not be different from one end of the country to the other but that everyone is entitled to that health care, especially if you are in an HMO. They should be, and must be, aware of what is the best health care that would serve you to make you a well person.

For a couple of days now, we have heard many tragic stories about children who were born with birth defects or who were injured because the private health care system failed them in some manner. I know my colleagues on the other side of the aisle have a bill they believe would address these situations. The Republican health care bill addresses the concerns people have about their health care without causing new problems.

Americans want assurance that they will get the health care they need when they need it. I am going to describe exactly how the Republican bill does just that. I am also going to describe how the Republican bill will create new patient rights and protections which

would have prevented the tragic situations described by my colleagues on the other side of the aisle.

Finally, I want to talk about how the Republican bill achieves these goals in an accountable manner, without increasing health care costs, without a massive new Federal Government bureaucracy, and without taking health care insurance away from children and families. It doesn't cost money to increase your ability to make sure you are aware of what is available. The heart of the Republican Patients' Bill of Rights Plus Act is a fair process for independent external review that addresses consumer concerns about getting access to appropriate and timely medical care in a managed care plan.

The Republican bill establishes gateways that ensure medical disputes get heard by an independent, external reviewer. The plan does not have veto power in these decisions. Denials or disputes about medical necessity and appropriateness are eligible for review, period. If a plan considers a treatment to be experimental or investigational, it is eligible for external review. The reviewer is an independent physician of the same specialty as the treating physician. In addition, the reviewer must have adequate expertise and qualifications, including age-appropriate expertise in the patient's diagnosis.

So, in other words, a pediatrician must review a pediatric case and a cardiologist must review a cardiology case. In the Republican bill, only qualified physicians are permitted to overturn medical decisions by treating physicians. The reviewer then makes an independent medical decision based on the valid, relevant scientific and clinical evidence. This standard ensures that patients get medical care based on the most up-to-date science and technology.

The Kennedy bill describes medical necessity in the statute. It does not define it in a manner that ensures that patients will get the highest quality care and the most up-to-date technology.

The Republican bill ensures that physicians will make independent determinations based on the best available scientific evidence. That is the standard, the best available scientific evidence. It is that simple. Health plans cannot game the system and block access to external review. To ensure this is the case, I have asked the private law firm of Ivins, Phillips & Baker to analyze the Republican external review provision, asking two key questions: First, could a plan block a patient from getting access to external review in a manner that is inconsistent with the intent of our provision?

Second, is there any factor that would prevent the external reviewer from rendering a fair and independent medical decision?

I request that the letter be printed in the RECORD.

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

IVINS, PHILLIPS & BARKER,
Washington, DC, July 12, 1999.

Hon. JAMES M. JEFFORDS,
Chairman, Committee on Health, Education, Labor and Pensions, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: You have asked us to provide you with our opinion on the outcomes of certain medical claims denials under the bill reported out of your Committee, The Patients' Bill of Rights Act of 1999, S. 326 (the ''Bill'').

In each of these examples, a claim is made for coverage or reimbursements under an employer-provided health plan, and the claim is denied. You have specifically asked us to comment on whether the claims would be eligible for independent external review under the Bill, which provides the right to such review for denials of items that would be covered under the plan but for a determination that the item is not medically necessary and appropriate, or is experimental or investigational.

A. Bill's provisions for independent external review

If a participant or beneficiary in an employer-provided health plan makes a claim for coverage or reimbursement under the plan, and the claim is denied, the Bill amends the Employee Retirement Income Security Act of 1974 (ERISA) to provide that he or she has the right to written notice and internal appeal of the denial within certain time-frames set forth by statute.[1] If the adverse coverage determination is upheld on internal appeal, the Bill provides that the participant or beneficiary in certain cases has the right to independent external review.[2]

The right to independent external review exists for denial of an item or service that (1) would be a covered benefit when medically necessary and appropriate under the terms of the plan, and has been determined not to be medically necessary and appropriate; or (2) would be a covered benefit when not experimental or investigational under the terms of the plan, and has been determined to be experimental or investigational.[3]

A participant or beneficiary who seeks an independent external review must request one in writing, and the plan must select an entity qualified under the Bill to designate an independent external reviewer. Under the Bill's standard of review, the independent external reviewer must make an ''independent determination'' based on ''valid, relevant, scientific and clinical evidence'' to determine the medical necessity and appropriateness, or experimental or investigational nature of the proposed treatment.[5]

B. Fact patterns

You have asked us to review whether the following fact patterns would be eligible for external review under the terms of the Bill. You have also asked for our judgment on whether any factor in these examples would compromise the reviewer's ability to make an independent decision.

Fact Pattern 1: An employer contracts with an HMO. The HMO contract (the plan document) states that the ''HMO will cover everything that is medically necessary'' and that the ''HMO has the sole discretion to determine what is medically necessary.''

Question 1: Would any denial of coverage or treatment based on medical necessity be eligible for external review?

Answer: All claims denials would be eligible for independent external review under the Bill.

The hypothetical employer who drafted this plan may have thought that, by covering all ''medically necessary'' items, the plan incorporates medical necessity as one of the plan's terms. Under this apparent view, any coverage denial by the HMO at its sole discretion, would be a fiduciary act of plan interpretation, rather than a medical judgment. Under this view, then, all claims denials would be contract decisions rather than medical ones, and no denials would be eligible for independent external review.

The terms of the Bill clearly prevent this end-run around its intent. The Bill provides that the right of external review exists for any denial of an item that is covered but for a determination based on medical necessity, etc., ''under the terms of the plan.'' That is, the statutory language provides for external review of any determination of medical necessity, etc., even when that determination is intertwined with an interpretation of the plan's terms.

The report of your Committee clarifies that intent. The report explicitly notes that ''some coverage discussions involve an element of medical judgment or a determination of medical necessity.'' After walking through an example of a coverage decision which involves such a judgment, the report concludes that your Committee intends that such ''coverage denials that involved a determination about medical necessity and appropriateness'' would be eligible for independent external review.[5]

That is, under the Bill any interpretation of the plan's terms triggers independent external review when that interpretation involves an ''element of medical judgment.''

To further remove any ambiguity on this point, the Committee report states that any determination of medical necessity is eligible for independent external review, even if the criteria of medical necessity are partly included as plan terms requiring contract interpretation: ''The committee is interested in ensuring that, in cases where a plan document's coverage policy on experimental or investigational treatment is not explicit or is linked to another policy that requires interpretation, disputes arising out of these kinds of situations will be eligible for external review.''[6]

Thus, even assuming that the HMO's determinations in this example are plan interpretations by a fiduciary, they are not saved from independent external review under your bill. Any coverage determination by the HMO in this example involves ''an element of medical judgment or a determination of medical necessity,'' and is therefore eligible for independent external review under the Bill and Committee report. Moreover, the standard used by the HMO in this example for determining medical necessity is not ''explicit,'' and is therefore eligible for independent external review under the Bill and Committee report.

In short, under the hypothetical plan of this example, all claims would involve determinations of medical necessity, and all denials would be eligible for independent external review.

Question 2: Is there any factor that would prevent the reviewer from rendering an independent decision?

Answer. No. The reviewer's decision must be independent. Under the Bill, the reviewer shall consider the standards and evidence used by the plan, but is intended to use other appropriate standards as well. It is expressly intended that the review not defer to the plan's judgment under the deferential ''arbitrary and capricious'' standard of review.

Under the Bill, the independent external review must make an ''independent determination'' based on ''valid, relevant, scientific and clinical evidence,'' to determine medical necessity, etc. In making his or her determination, the independent external reviewer must ''take into consideration appropriate and available information,'' which includes any ''evidence based decision making

Footnotes at end of letter.

or clinical practice guidelines used by the group health plan,'' as well as timely evidence or information submitted by the plan, the patient or the patient's physician, the patient's medical record, expert consensus, and medical literature.[7]

That is, under the Bill the reviewer is instructed to consider standards and evidence used by the plan, but is intended to include other standards and evidence as well. The Committee report clarifies this by stating that the external review shall ''make an assessment that takes into account the *spectrum* of appropriate and available information.''[8] Fleshing out the above-cited list set forth in the statute, the report further clarifies that such information can include, for example, peer-reviewed scientific studies, literature, medical journals, and the research results of Federal agency studies.[9]

Moreover, the reviewer is not bound by the standard or evidence use by the plan, but must rather ''make an independent determination and not be bound by any one particular element.''[10] The Committee report further states that the independent reviewer should not use an ''arbitrary and capricious'' standard in reviewing the plan's decision.[11] That is, the reviewer is specifically prohibited from using the deferential standard now used by federal courts in reviewing certain coverage determinations by ERISA plan fiduciaries.

In short, the Bill provides that the reviewer shall use not only the standards and evidence considered by the plan, but other appropriate standards as well, in rendering its independent judgment.

Fact Pattern 2: A plan covers medically necessary procedures but specifically excludes cosmetic procedures. An infant born to a participant is born with a severe cleft palate. The infant's physician contends that plastic surgery to correct the cleft palate is necessary so the child can perform normal functions like eating and speaking. The plan denies the request on the grounds that it does not cover cosmetic surgery. The participant appeals the decision, arguing that the procedure is medically necessary. The treating physician provides supporting documentation that the procedure is medically necessary.

Question 1: Is the denial of surgery in this example eligible for external review?

Answer: Yes, the denial of surgery in this example is eligible for independent external review under the Bill.

The plan in this example covers surgery generally, but excludes ''cosmetic'' surgery. As with many plans, the term ''cosmetic'' is not defined. There is therefore no express basis in the plan's terms for inferring that ''cosmetic'' is defined as a procedure that is not ''medically necessary and appropriate.'' Does this mean that the claims denial in this example is merely an act of plan interpretation, without any determination of medical necessity? And if so, does this mean that the denial is not eligible for external review?

No. Under the terms of the Bill, any denial based on medical necessity, etc., is eligible for external review. This is so even if the denial is based on plan terms that do not expressly incorporate a reference to medical necessity, as long as interpretation of those terms involves ''an element of medical judgment.''

This intent is spelled out in the report of your Committee, which, as already noted, states that ''The committee recognizes that *some coverage determinations involve an element of medical judgment or a determination of medical necessity and appropriateness.*''[12] The report goes on to give an example: ''For instance, a plan might cover surgery that is medically necessary and appropriate, but exclude from coverage surgery that is performed solely to enhance physical appearance. In these cases, a plan must make a determination of medical necessity and appropriateness in order to determine whether the procedure is a covered benefit.''

The report concludes that, ''It is the committee's intention that coverage denials that involved a determination about medical necessity and appropriateness, such as the example above, would be eligible for external review.''

In the example discussed here, the plan's denial is based on its determination that the procedure is ''cosmetic'' under the terms of the plan. This interpretation of the plan includes a significant element of medical judgment. This is so despite the fact that plan uses the term ''cosmetic'' without an express reference to medical necessity. The essential element of medical judgment is evidenced in part by the fact that the treating physician provides documentation for his or her judgment that the treatment is necessary for certain basic life functions.

In short, the coverage dispute in this example turns on whether the procedure is cosmetic under the plan's terms. Under the Bill as amplified by the report of your Committee, this determination includes an ''element of medical judgment or determination of medical necessity.'' Therefore, the denial is eligible for independent external review under the Bill.

Question 2: Is there any factor that would prevent the reviewer from rendering an independent decision?

Answer: No, the reviewer's decision is independent, for the reasons set forth in our answer to this question in the above Fact Pattern 1. That is, under the Bill the reviewer shall use not only the standards and evidence considered by the plan, but other appropriate standards as well, in rendering its independent, nondeferential judgment as to whether the requested treatment is medically necessary and appropriate or experimental and investigational.

Fact Pattern 3: The employer contracts with an HMO that has a closed-panel network of providers which includes pediatricians. A baby born to a participant is born with a severe and rare heart defect. The infant's own network pediatrician, who is not a pediatric cardiologist (i.e., a pediatric subspecialist), recommends that the infant be treated by such a specialist. The network does not include a pediatric cardiologist. The plan denies coverage for a non-network pediatric sub-specialist, saying that one of the plan's network pediatricians can provide any medically necessary care for the infant.

Question 1: Is the denial in this case eligible for independent external review?

Answer: Yes, the denial of pediatric subspecialist care in this example is eligible for independent external review under the Bill.

The Bill requires that participants have access to specialty care if covered under the plan.[13] The report of your Committee explains that a health plan must ''ensure that plan enrollees have access to specialty care when such care is needed by an enrollee and covered under the plan and when such access is not otherwise available under the plan.''[14]

The bill defines specialty care with respect to a condition as ''care and treatment provided by a health care practitioner . . . that has adequate expertise (including age appropriate expertise) through appropriate training and experience.''[15]

In short, the Bill defines specialty care in terms of whether the care is ''needed'' by the enrollee, and by reference to whether the care is ''adequate,'' and the expertise ''appropriate.''

Under the terms of the Bill, then, a physician's determination that specialty care is required is by its terms a judgment based on the medical necessity and appropriateness of that care. Therefore, the treating physician's recommendation in this example that the infant be treated by a pediatric subspecialist is a judgment of medical necessity. The plan's denial of such specialty care is a denial of an otherwise covered service, based on a judgment of the medical necessity or appropriateness of that service. The denial is eligible for independent external review under the terms of the Bill.

Question 2: Is there any factor that would prevent the reviewer from rendering an independent decision in this case?

Answer: No, the reviewer's decision is independent, for the reasons set forth in our answer to this questions in the above Fact Patterns 1 and 2. That is, under the Bill the reviewer shall use not only the standards and evidence considered by the plan, but other appropriate standards as well, in rendering its independent judgment as to whether the requested treatment is medically necessary and appropriate or experimental and investigations.

Fact Pattern 4: A participant calls the plan to report that the participant's infant is very sick, and inquiries about emergency services. The plan representative pre-authorizes coverage in a participating emergency facility, which is 20 miles away. Alarmed by the infant's various severe symptoms, the participant instead takes the infant to a nearby emergency facility which is only 5 minutes away. Shortly after arrival, the baby is diagnosed as having spinal meningitis, and goes into respiratory arrest. The baby is immediately treated and stabilized, and tissue damage that might otherwise have resulted is avoided. The participant submits a claim to the plan for reimbursement of the emergency treatment. The claim for reimbursement is denied on the grounds that coverage was preauthorized only if provided in the more distant, in-network, emergency facility specified by the plan representative.

Question 1: Would the denial of reimbursement in this case be eligible for independent external review?

Answer: Yes, under the Bill the denial of reimbursement would be eligible for review by an independent external reviewer.

The Bill requires that if a plan covers emergency services, it must in some cases cover such services without pre-authorization, and without regard to whether the services are provide out-of-network.

Specifically, such coverage must be provided for ''appropriate emergency medical screening examinations'' and for additional medical care to ''stabilize the emergency medical condition,'' to the extent a ''prudent layperson who possesses an average knowledge of health and medicine'' would determine that an examination was needed to determine whether ''emergency medical care'' is needed.[16] ''Emergency medical care'' is defined as care to evaluate or stabilize a medical condition manifesting itself by ''acute symptoms of sufficient severity (including severe pain)'' such that a ''prudent layperson who possesses an average knowledge of health and medicine'' could reasonably expect the absence of medical care to endanger the health of the patient or result in serious impairment of a bodily function or serious dysfunction of any bodily organ or part.[17]

That is, under the Bill, reimbursement for the services in this example must be provided if the services satisfy the ''prudent layperson'' standard of the bill. The prudent layperson standard is met if an individual without specialized medical knowledge could reasonably reach the decision, based on the patient's symptoms, that lack of medical care could possibly result in severely worsened health or injury, and that expert medical observation is therefore necessary.

A determination made by the ''prudent layperson'' is therefore a determination of medical necessity or appropriateness—albeit one made under a nontechnical, nonexpert, standard. Under the Bill, a plan is required to incorporate this lower, non-expert or ''prudent layperson'' standard in evaluating whether to cover non-pre-authorized, out-of-network emergency medical care.

In this example, the participant's judgment, based on the baby's symptoms, that the baby should be observed as quickly as possible by medical experts at the nearer facility, is a judgment of medical necessity and appropriateness, made under this lower, non-expert standard. Likewise, the plan's denial of coverage in this case is based on the plan's determination that the participant's judgment concerning medical necessity was in error even under this lower standard.

In short, the coverage dispute in this case involves a judgment of medical necessity and appropriateness under the ''prudent layperson'' standard mandated by the Bill, and is therefore eligible for independent external review under the Bill.

Question 2: Is there any factor that would prevent the reviewer from rendering an independent decision?

Answer: No, the reviewer's decision is independent, for the reasons set forth in our answer to this question in the above Fact Patterns 1, 2 and 3. That is, under the Bill the reviewer shall use not only the standards and evidence considered by the plan, but other appropriate standards as well, in rendering its independent judgment as to whether the requested treatment is medically necessary and appropriate or experimental and investigational.

I hope this letter has been responsive to your request. Please do not hesitate to have your staff contact me for any questions with respect to the points here discussed.

Very truly yours,

ROSINA B. BARKER.

FOOTNOTES

[1] ERISA §§503(b), (d), as added by S. 326 §121(a).
[2] ERISA §503(e), as added by S. 326 §121(a).
[3] ERISA §503(e)(1)(A), as added by S. 326 §121(a).
[4] ERISA §503(e)(4), as added by S. 326 §121(a).
[5] S. Rep. No. 82, 106th Cong., 1st Sess. 46 (1999).
[6] *Id.* at 47.
[7] ERISA §503(e)(4), as added by S. 326 §121(a).
[8] S. Rep. No. 82, 106th Cong., 1st Sess. 48 (1999) [emphasis supplied].
[9] *Id.* at 49.
[10] *Id.* at 48.
[11] *Id.* at 48.
[12] *Id.* at 46 [emphasis supplied].
[13] ERISA §725(a), as added by S. 326 §101(a).
[14] S. Rep. No. 82, 106th Cong., 1st Sess. 32 (1999).
[15] ERISA §725(d), as added by S. 326 §101(a).
[16] ERISA §721(a), as added by S. 326 §101(a).
[17] ERISA §721(c), as added by S. 326 §101(a).

Mr. JEFFORDS. Let me provide examples of how our external review provisions ensure that patients and children get medical care.

Chart 1 illustrates under the Republican bill that the health plan cannot ''game the system'' by blocking access to external review or using some cleverly worded definition of ''medical necessity.'' The Republican provision ensures that people get the medical care they need.

Here is an example of an HMO that has a planned contract which says the HMO will cover ''medically necessary care'' but the HMO has the sole discretion to determine what is ''medically necessary.''

Of course, this is an extreme example. Let's see if it holds up under our external review provision. In this example, the patient and physician may not know the plan's rationale for denying a claim since it is the HMO's sole discretion to determine medical necessity. This can be frustrating for both the patient and the physician.

Under the Republican bill, a denied claim would be eligible for an outside independent medical review. In fact, all denied medical claims under this example would be eligible for review under our provision. This is confirmed by the outside legal analysis which I have submitted for the RECORD. The legal opinion says:

> The statutory language provides for external review of any determination of medical necessity and appropriateness, even when that determination is intertwined with an interpretation of the plan's terms.

The external reviewer would make an independent medical determination. There is nothing in the HMO contract or in the legislative provision that prevents the reviewer from making the best decision for the patient. If the patient needs the medical care, the reviewer will make this assessment. They will get the care. The independent reviewer's decision is binding on the plan.

Chart 2 is an example of a cleft palate. This chart illustrates that patients, and especially children, will get necessary health care services. Plans will not be able to deem a procedure as ''cosmetic'' and thus block access to external review. Only physicians can make coverage decisions involving medical judgment.

An example we have heard many times from our colleagues on the other side of the aisle is of an infant born with a cleft palate. The infant's physician recommends surgery so the child can perform normal daily functions, such as eating and speaking normally. The treating physician says this surgery is medically necessary and appropriate. In this example, the HMO planned contract states: ''The plan does not cover cosmetic surgery.'' It was denied as a claim, saying the child's surgery is not a covered benefit because it is a cosmetic procedure, despite the recommendations of the treating physician.

What does this mean? Does this mean this is the end of the road for this child's family? No. Under the Republican bill, this denial of coverage would be eligible for appeal because the decision involves an ''element of medical judgment.'' Under the Republican bill, medical decisions are made by physicians with appropriate expertise. In this case, it means an independent reviewer would be required to have pediatric expertise.

Finally, the independent medical reviewer would look at the range of appropriate clinical information and would have the ability to overturn the plan's decision. The child would receive the surgery to correct the cleft palate, and the plan would cover this procedure because the reviewer's decision is binding on the plan.

The next chart is on emergency room coverage. The primary point of this chart is that under the prudent layperson standard, parents can use their judgment and take their sick child to the nearest emergency room without worrying about whether the plan will deny coverage.

Another example we are all familiar with is of little Jimmy whose tragic story has been told by Senator DURBIN. His parents called the HMO when their baby fell ill. The HMO nurse recommended the parents take their sick child to a participating hospital an hour's drive away. During their long drive, the family passed several closer hospitals along the way. The child's symptoms grew worse and the baby went into respiratory arrest. By the time they got to the hospital, the one that the HMO said was covered by a plan, it was too late. The tissue damage resulted in the loss of a limb and little Jimmy had to endure a quadruple amputation. This is a horrible situation.

Let's look at what the Republican bill would do to address this type of tragic and unnecessary situation. First, under our prudent layperson standard, a parent would not have to call the HMO to get permission to go to the nearest emergency room. In this case, the parents could have gone to the closest emergency room and little Jimmy would not have gone into respiratory arrest. This tragedy would have been averted under the Republican provision because our bill ensures that emergency room services must be provided without preauthorization and without regard to whether the services are provided out of network.

Say for the sake of argument that the plan denies reimbursements after the hospital has provided the treatment. Under the Republican bill, little Jimmy's family would not be stuck with the hospital charges. They could appeal this decision to an outside reviewer because the decisions about whether care is medically necessary are eligible for external review.

The law firm of Ivins, Phillips & Baker says that under our provision:

> The coverage dispute in this case involves a judgment of medical necessity and appropriateness under the prudent layperson standard mandated by the bill, and therefore is eligible for independent external review under the bill.

This is a quote from the letter that has been previously printed in the RECORD.

Mr. SCHUMER. Will the Senator yield?

Mr. JEFFORDS. The independent medical reviewer can make an independent decision and overturn the plan denying reimbursement. This decision is binding on the plan and not appealable.

Mr. SCHUMER. Would the Senator from Vermont yield for a question?

Mr. JEFFORDS. Let me finish.

Mr. SCHUMER. I thank the Senator.

Mr. JEFFORDS. As Members can see from the examples on these charts, the

Republican Patients' Bill of Rights ensures patients get the medical care they need, that parents can be assured their children will be cared for by appropriate specialists, and that people can go forward to emergency rooms when they are sick, when the children are sick, and can do so with the assurance that their health plan will cover these services.

Establishing these important rights will help families avoid illness, injury, and improve the quality of health care. I believe this is why we are debating this issue today. You can't sue your way to health care. Congress can't create a definition of ''medical necessity'' that is better than letting physician experts make decisions on the best available science. They must practice the best available science.

However, we can improve access to health care services and ensure that people get timely access to the medical care they need. We can ensure that health care we provide is high quality health care. Most important, we can do all these things without increasing health care costs and causing more Americans to lose their coverage.

We accomplish all these goals with the Republican Patients' Bill of Rights.

I yield the floor.

The PRESIDING OFFICER. Who yields time? The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I yield myself 5 minutes.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, this amendment goes to the heart of the issue. I urge our colleagues to pay attention to the exchange we are going to have on the floor of the Senate.

Let us look, first, at what is in the Democratic bill. In the Democratic bill, ''medical necessity,'' as defined on page 86, is ''medically necessary or appropriate.'' That is the standard definition medicine has used for 200 years. It is the standard recommended by none other than the Health Insurance Association of America itself, on page 269:

> Medical necessity. Term used by insurers to describe medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice.

Our legislation does what the Health Insurance Association of America recommended. This is the standard that has been used for 200 years. This is the standard that is supported by the medical profession.

The Republican plan knocks that standard out. It knocks it out. What do they put in as a substitute? As a substitute, on page 148, they say ''medical necessity'' used in making coverage determinations is determined ''by each plan.'' ''By each plan.'' The plan can define medical necessity any way it wants.

In their appeals procedure we find that medical necessity issues can be appealed, but medical necessity is defined by the HMO.

That sounds complicated. What does it mean in real terms? Let me read you a few examples of how HMOs have defined medical necessity. Here is a company—I will not give its name—and their definition. The company:

> . . . will have the sole discretion to determine whether care is medically necessary. The fact that care has been recommended, provided, prescribed or approved by a physician or other provider will not establish the care is medically necessary.

In other words, medical necessity is whatever the HMO says. Whatever the HMO says.

Here is an example of Aetna U.S. Health Care, the provision in their Texas contract:

> The least costly of alternative supplies. . . .

Here is another HMO:

> The shortest, least expensive, or least intensive level. . . .

They throw out the medical necessity standard used for 200 years and say, medical necessity will be whatever the HMO wants it to be. That is the heart of this issue.

What do we find when the HMO uses their own medical necessity definition? Who makes the judgment? It is an insurance company bureaucrat. That is what this amendment is all about.

Finally, when you see the appeals procedures which will be addressed by my other colleagues, all you have to do is look at the Consumers Union and many other consumer groups. The consumer groups believe their appeals procedure does not provide adequate protections.

The American Bar Association believes basic consumer protections are not met. The American Arbitration Association makes the same judgment.

This is a status quo amendment. If you want to do nothing about the pain and injury being experienced by children, women, and family members in our country, go ahead and support this program. It is an industry protection amendment. It will protect the profits of the industry; it puts the profits of the industry ahead of protecting patients.

I yield 5 minutes to the Senator from California.

The PRESIDING OFFICER. The Senator from California.

Mrs. FEINSTEIN. Mr. President, the Senator from Massachusetts is absolutely correct. This amendment essentially puts into the bill the basic premise of the Republican plan, which is to let the HMO define what is medically necessary, decide what the treatment should be, what the length of hospitalization should be for a patient, not based on that patient, not based on medical necessity, but based on standards that individuals who have not even seen the patient determine.

I must tell you I have a very real problem with that. The insurance plan would determine medical necessity, not the physician who sees the patient. It would substitute an independent review process for the knowledge and the skill of the independent physician who is actually seeing the patient, who has done the diagnosis, who knows the patient, the patient's history the patient's problems.

This past week I spent a good deal of time in California talking with physicians and patients up and down the State. I probably talked with more than 50 people, including patients, hospital administrators, county medical societies of many different counties as well as the California Medical Association. What I found was a dispirited, demoralized medical profession because medical decisionmaking was being taken out of their hands. I learned that a physician would prescribe medication, the patient would go to the druggist to have the medication filled and the druggist would make a substitution, often without even the doctor knowing. The patient would say: I cannot take this drug. And the pharmacist would have to say: We cannot furnish what your physician prescribed because it was not on your plan's list. This is what we mean by medical necessity—the most appropriate medical treatment for that particular patient in the judgment of the treating physician.

I contend there is not anyone who has not seen a patient, who doesn't know what patient is all about, who can adequately prescribe for that individual. That, in fact, is what is happening.

Let me read a statement by someone who testified before a congressional House committee a couple of years ago in a hearing. This individual was the reviewer for an HMO. As an HMO reviewer, she countermanded a physician. Let me read her words:

> Since that day I have lived with this act and many others eating into my heart and soul. For me, a physician is the professional charged with the care of healing of his or her fellow human beings. The primary ethical norm is, 'Do no harm.' I did worse. I caused death.
>
> Instead of using a clumsy weapon, I used the simplest, cleanest of tools, my words. This man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for this moment. When any moral qualms arose I was to remember I am not denying care, I am only denying payment.

That is why this Republican amendment is so fallacious. Let me read the actual language in the bill:

> A review of an appeal under this subsection relating to a determination to deny coverage based on a lack of medical necessity and appropriateness, or based on a experimental or investigational treatment, shall be made only by a physician with appropriate expertise including age appropriate expertise, who was not involved in the initial determination.

My father, chief of surgery at the University of California, would turn over in his grave with this kind of language. That is not what someone goes to medical school and does a residency, does a surgical residency, does graduate school work for, to get overturned

by an insurance company reviewer who has not even seen the patient. This amendment, I contend, is in the worst of medical practice because it allows a panel that has never seen the patient to make the determination of whether a patient gets a lifesaving operation, gets a drug that might make them well, gets a treatment from which the physician thinks they might benefit.

The PRESIDING OFFICER. The time of the Senator has expired.

Mrs. FEINSTEIN. I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. Mr. President, I would like to answer my good friend from California. I do not believe she was listening to my explanation of what this bill does. In fact, we do throw out 200 years of law practice. That shakes the legal community up a bit because they have to learn what is going on in modern medical situations. They have to become aware of how they find out what the best medicine is, not necessarily what is used in that area. It is the best medicine available.

We set a higher standard, and that is why the legal profession is a little bit upset. They do not want to have to learn all this medical stuff. They want to go back to the good old days when they could just call the local doctor and say: What is the general medical practice? And whatever that doctor does is the general medical practice. That is the present standard. We say that is not good enough now.

We are going to make sure that every person in an HMO has the right to the best medical care available, and that is what we explained with chart 1, chart 2, and chart 3. The decision is made by the external reviewer who says: Look, you can use this treatment now, you can use this pharmacy prescription, and that can be cured. You did not use it, you are not going to use it—that is wrong. Give them that care.

Mrs. FEINSTEIN. Will the Senator yield for a question?

Mr. JEFFORDS. Certainly.

Mrs. FEINSTEIN. Does the Senator from Vermont really believe the best treatment can be provided by a reviewer who has never seen the patient?

Mr. JEFFORDS. There is nothing that says the reviewer never sees the patient. The reviewer is an expert. He is the one who is qualified in that profession to know, who reviews the records. There is nothing that says he cannot also see the patient and interview the patient. This is not going to be a judgment done in some courthouse with a jury determining something. This is going to be done by an expert in the field who is dealing with a patient to make sure that patient gets the best available health care, the best of medicine that is available.

Mrs. FEINSTEIN. Will the Senator yield to me a moment?

I met some of the reviewers this past week. They did not see the patient. They made the decisions based on their insurance companies' definitions of medical necessity, not based on the particular needs of the individual patients.

Mr. JEFFORDS. This is new. This does not exist anywhere. We are creating a new policy to ensure the best health care possible for every American.

Mr. President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Massachusetts.

Mr. KENNEDY. I want to ask the Senator from California a question. Where in the earlier response does it say they will use the best practices?

Mrs. FEINSTEIN. It does not.

Mr. KENNEDY. It does not say that. To the contrary, does the Senator not agree that we have example after example where HMOs have used definition based on lowest cost?

Mrs. FEINSTEIN. As a matter of fact, I can read terminology right out of insurance contracts, which I was going to read had my amendment been able to come to the floor. As the Senator knows, the purpose of this amendment is essentially to defeat the amendment I was going to offer, that I did offer to the Agriculture Appropriations bill and that I said last week that I was going to offer to this bill, to allow the physician to give the treatment and prevent the HMO from arbitrarily interfering with or altering the treating physician's decision, whether it be the treatment or the hospital length of stay.

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

The PRESIDING OFFICER. The Senator from New York.

Mr. SCHUMER. Mr. President, I thank the Senator from Massachusetts.

There are two pernicious parts to this amendment. One is removing the accurate definition of medical necessity, as the Senators from Massachusetts and California have pointed out, and the second is putting in an appeals process that is nothing short of bogus in a whole variety of ways. When you look at the appeals process that is being substituted by the Senator from Vermont, you understand how grudging it is, how imperfect it is, how it will not do the job. Let me give a few examples.

First, there is no timeliness. The HMO can initiate the appeals process whenever it wants. It could wait 3 months or 6 months or 9 months before review. Our amendment, which the Senator from North Carolina and I will offer, requires the review process to start when the patient asks.

Second, there is no requirement that the appeals process, after it is finished, be implemented. The HMO can appeal and appeal and appeal.

The two I want to focus on this afternoon are these: First, it is much more limited in scope. I say to my friends and my fellow Americans who are watching this debate, this is not two competing bills; this is one bill that does the job and one bill that seeks to please the insurance industry and still make it look as if the job is being done.

One of the main issues is scope: 160 million covered versus 48 million covered for emergency room, for medical necessity, and for other things. Thirty-eight million people would be included in the Schumer-Edwards amendment who are excluded by this amendment.

Perhaps the greatest area where this amendment is a false promise, is a hoax, is the independent review. The Senator from Vermont said the review is independent. Not so. In the amendment offered by the Senator from Vermont, the reviewer is appointed by the HMO. The reviewer is not even required to have no financial relationship with the HMO. Theoretically, under this proposal, the HMO could pay an ''independent'' reviewer. If we want an independent external review, why shouldn't that reviewer have no ties to the HMO?

How can we tell people that an independent review is independent when the insurer selects the reviewer? If you have ever heard of the fox guarding the chicken coop, here it is. An independent review, as in the amendment we will be voting on in the next few days, requires that the HMO not pick the reviewer. I know the Senator from Vermont has stressed that a pediatrician would review a child's case. I say to my colleagues, if I were a member of an HMO, I would not want a pediatrician who has a financial relationship with the HMO to review the case.

Mr. JEFFORDS. Will the Senator yield for a question?

Mr. SCHUMER. The Senator did not yield to me. I will wait until his time to answer a question.

What I am saying is this: If you want a real review, and hundreds of thousands of Americans want such a review, then vote against this amendment, wait for the Schumer-Edwards amendment, and you will get a true independent review.

In conclusion, this is not so different from the gun debate we had a month and a half ago, where we had a powerful special interest on one side and the American people on the other side, and there were a series of proposals put forward that the powerful special interests liked but were intended to make the American people believe we were making progress.

I cannot tell you how or where or when, but just as in the gun debate, the American people will not be fooled. They want, they demand, a real Patients' Bill of Rights, one that covers 160 million Americans, not 48 million, one that has a real review process, not a sham review process where the reviewer can be paid by the HMO. Please vote down this amendment.

The PRESIDING OFFICER. The Senator's 5 minutes has expired.

Who yields time to the Senator from Pennsylvania?

Mr. JEFFORDS. I yield the Senator from Pennsylvania 10 minutes.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. I thank the Chair.

Mr. President, it is extraordinarily complex to work your way through the various provisions. Representations are being made on both sides of the aisle which are contradictory.

The Senator from New York has just made a contention that the independent reviewer is not independent at all. My reading of the provisions in S. 326 at page 177 set forth the qualified entities as the reviewers and the designation of independent and external reviewer by the external appeals entity which specifies independence.

I will not take the time now to read it. But that reference, I think, would establish the true independence of the reviewer.

My principal purpose in seeking recognition was to deal with the comparison of the standards for ''medical necessity,'' which is the core of the argument at the present time.

The pending amendment seeks to strike the language of the Kennedy amendment, which defines medical necessity as ''medical necessity or appropriate means with respect to a service or benefit which is consistent with generally accepted principles of professional medical practice.''

The language of the pending amendment, which would be substituted, provides for a standard of review as follows, at pages 179 and 180:

> IN GENERAL.—An independent external reviewer shall—
>
> (I) make an independent determination based on the valid, relevant, scientific and clinical evidence to determine the medical necessity, appropriateness, experimental or investigational nature of the proposed treatment; and
>
> (ii) take into consideration appropriate and available information, including any evidence-based decision making or clinical practice guidelines used by the group health plan or health insurance issuer; timely evidence or information submitted by the plan, issuer, patient or patient's physician; the patient's medical record; expert consensus; and medical literature . . .

The accompanying report amplifies ''expert consensus'' as ''including both what is generally accepted medical practice and recognized best practice'' so that the language of the statute itself is more expansive in defining ''medical necessity.'' The commentary goes on to include generally accepted medical practice and adds to it: the recognized best practice.

There is no doubt that in the articulation of these competing provisions, an effort is being made by one side of the aisle to top the other side of the aisle. It is a little hard, candidly, to follow the intricacies of these provisions because, as is our practice in the Senate, an amendment can be offered at any time, and to work through the sections and subsections is a very challenging undertaking.

Mr. SCHUMER. Would the Senator from Pennsylvania yield?

Mr. SPECTER. No, I will not, but I will yield in a minute. I will not now because I am right in the middle of my train of thought. I will be glad to yield in a moment and respond to whatever question the Senator from New York may have.

I supported the Robb amendment, the last vote, because the Robb amendment had provided a standard for medical necessity, generally accepted medical principles, important operative procedures. At this stage of the record, without that definition of the requirement, as articulated in the Robb amendment, I thought that was improvement.

Now we are fencing. To say that the air is filled with politics in this Chamber today would be a vast understatement. But in at least my effort to try to understand what is going on and to make an informed judgment, I am prepared to make a judgment for the Robb amendment or the Kennedy amendment or the Schumer amendment contrasted with the Nickles amendment or the Jeffords amendment. It requires a lot of analysis.

But as I read these plans, I believe that Senator JEFFORDS, Senator FRIST, and Senator NICKLES are correct, that when you take a look at the language they are substituting, it places a higher standard on the HMO, the managed care operation, than does the provision in the Kennedy amendment which they are striking.

Now I would be glad to yield to the Senator from New York on his time.

Mr. SCHUMER. I thank the Senator for yielding.

Mr. SPECTER. I am yielding for a question.

Mr. SCHUMER. I appreciate the Senator searching to come up with the right solution here. I would ask him—he is an excellent lawyer, far better than I am—on page 179 of the bill, (iv), says:

> receive only reasonable and customary compensation from the group health plan or health insurance issuer in connection with the independent external review . . .

It seems to me—and I ask the Senator the question—that the plan proposed in the substitute envisions the insurer paying the reviewer. That seems to me not to be an independent review.

Mr. SPECTER. I ask the Senator, where are you reading from?

Mr. SCHUMER. This is S. 326, page 179. That is, as I understand it, the exact language of the amendment offered by the Senator from Vermont.

Mr. SPECTER. Would the Senator restate the question?

Mr. SCHUMER. Yes. My question is, given that the amendment envisions the insurer paying the reviewer, as listed in little number (iv) on page 179, how can we say the review in the Jeffords amendment is independent?

Mr. SPECTER. The fact that the insurer pays the reviewer does not impugn or impinge upon the reviewer's objectivity when there are specific standards for the selection of the reviewer and specific standards that the reviewer has to follow.

If I could use an analogy from a practice that I engaged in for a long time as district attorney of Philadelphia, the State paid the fee for the defendant in first-degree murder cases. But there was no doubt that notwithstanding the fact that the Commonwealth of Pennsylvania paid defense counsel, the defense counsel worked in the interests of the defendant.

When you have a determination as to what the HMO ought to be doing, that is something they ought to pay for. But there ought to be a structure to guarantee objectivity by the decision-maker.

Similarly, if I can amplify, if you have a Federal judge paid by the Federal Government, and the Federal Government is a party to the process, nobody would say that Federal judge is going to be biased toward the Federal Government simply because the Federal Government pays his salary.

Mr. SCHUMER. Would the Senator yield for a question?

Mr. SPECTER. I do.

Mr. SCHUMER. If we could give these reviewers lifetime appointments and salary, I might agree with the analogy of a federal judge. But, of course, these reviewers could be immediately——

Mr. SPECTER. The defense lawyers do not have lifetime appointments.

Mr. SCHUMER. I understand.

The second question: On page 175, this reviewer is selected by the HMO, whereas in our plan there is an independent selection process. Again, I rely on the Senator's much greater knowledge of the law. If the reviewer were not selected by the HMO, they would obviously be more independent. That is on page 175.

Mr. SPECTER. If I may respond, on page 177, the qualified entities are defined, and they are the ones that make the determination of the independent reviewer. And a qualified entity is defined to be:

> (I) an independent external review entity licensed or accredited by a State;
>
> (II) a State agency established for the purpose of conducting independent external reviews;
>
> (III) any entity under contract with the Federal Government to provide independent external review services;
>
> (IV) any entity accredited as an independent external review entity by an accrediting body recognized by the Secretary for such purpose; or
>
> (V) any other entity meeting criteria established by the Secretary for purposes of this subparagraph.

I think that language answers the question of the Senator from New York about independence and expertise.

Mr. SCHUMER. I ask the Senator, wouldn't we be better in guaranteeing independence by having the selection of the review panel be made independently of the HMO, given that the HMO—I understand there are some criteria here, but if we are trying to get a truly independent process, it strikes me that it would be a lot better to have the selection be made truly independently, not by the HMO, which obviously has an interest, albeit, as the Senator certainly recognizes and pointed out, with a bunch of criteria.

Mr. SPECTER. Mr. President, if I may respond, I don't understand the question. The reason I don't understand the question is that the specification of independence here is so comprehensive that it guarantees independence.

Mr. SCHUMER. I thank the Senator.

Mr. KENNEDY. Mr. President, I yield 8 minutes to the Senator from North Carolina.

Mr. EDWARDS. Mr. President, if the Senator from Pennsylvania will respond to a question.

Mr. SPECTER. I am glad to respond to a question at this time.

Mr. EDWARDS. I am looking at page 30 of the actual amendment that has been offered. Looking under subsection (B)(ii), this is the designation of independent external reviewer, which goes to the very heart of whether the review is independent or, in fact, is not independent. In subsection (ii) it says there is a requirement that the reviewer ''not have any material, professional, familial, or financial affiliation with the case under review.''

My question to the Senator is—and I would like to see the language in the actual amendment, if he could point to it—what is it that requires that the reviewer not have an ongoing financial relationship with the health insurance company or with the HMO, which would in fact, as the Senator I am sure would recognize, make them not independent?

Mr. SPECTER. Well, I believe that that is provided by the high level of independence specified in the preceding section (3)(A)(ii) which establishes the independence of the qualified entity which selects the independent reviewer.

Mr. EDWARDS. My question is, Can you point to specific language in the bill that requires that the reviewer, in order to be independent, not have an ongoing financial relationship with the health insurance company?

Mr. SPECTER. Well, there is no suggestion that there would be that kind of a relationship. The language which the Senator from North Carolina cited takes care of one category of potential conflict of interest, that they will not have any material, professional, familial, or financial affiliation with the case under review, the participant or beneficiary involved, the treating health care professional, the institution where the treatment would take place, or the manufacturer of any drug, device, procedure, or other therapy proposed for the participant or beneficiary whose treatment is under review.

If your question is, Would there be a triple firewall if you also specify the HMO? I would be inclined to have all the firewalls I could, as I do when I draft documents, as my distinguished colleague did when he practiced law.

Mr. EDWARDS. I thank the Senator very much, and I reclaim the remainder of my time.

Mr. President, there are two fundamental problems with this amendment that go to the very heart of this debate. First, as my colleague from New York pointed out, this review is not an independent review. It is not an independent review by any definition of independence. The reason is, No. 1, the health insurance company, the HMO, chooses the entity which chooses the reviewer. I want to be precise here. That is exactly what the bill provides. The health insurance company chooses an entity; that entity chooses the reviewer. So the health insurance company has control over who ultimately does the review.

No. 2, the only requirement with respect to financial independence or professional independence is the requirement that I just read to the Senator from Pennsylvania, that the reviewing entity not have a financial or professional relationship with the very specific case under review, which means there is nothing to prohibit a reviewer, the so-called independent reviewing body under their amendment, from being somebody who has a longstanding, ongoing relationship with the health insurance company or with the HMO.

Nobody in America, certainly none of my colleagues in the Senate, would believe that an independent review could be conducted by somebody who has an ongoing contractual relationship and receives money from the health insurance company. There is absolutely nothing in this bill which prohibits that. That is why the Senator from New York and I have proposed an amendment that makes it very clear that there is a truly independent reviewing body. That independence is critical and to the very heart of the review process. It is why we need it.

I notice both the junior and the senior Senators from Pennsylvania are on the floor now. In Pennsylvania, these reviews are conducted by a State regulatory body. They are not conducted by some person chosen by an HMO or a health insurance company. Second, in terms of what can be reviewed under the State law of Pennsylvania, any consumer grievance can be reviewed. It is not, as this bill is, limited to what constitutes medical necessity.

Third, under the law of the State of Pennsylvania, the review is de novo, which is absolutely not what this amendment provides.

Let me go back and summarize where we are. No. 1, we don't have, under this amendment, an independent review. We don't have it for two fundamental reasons: No. 1, the health insurance company, the HMO, is allowed to select the body that picks the reviewer. No. 2, the reviewing body is allowed to have a longstanding professional or financial relationship with the HMO that has denied the claim. There is absolutely nothing to prohibit that under this bill. Our amendment, which will be considered at a later time, would not allow that. So there is no independent review.

The second problem is—and this goes to the amendment offered by my colleague from California—this review process is meaningless so long as the reviewing body is bound by the definition of medical necessity contained and written by the HMO. It is absolutely bound by the language of the HMO.

I will add, in committee—I see my colleagues from Massachusetts and Tennessee are here—Senator KENNEDY asked a question to Senator FRIST. The question was:

> Would the Senator accept language that mentions that the decision would be made independent of the words of the contract?

The question Senator KENNEDY posed was: Would you agree that in the appeals process, the determination could be made without regard to the HMO-written definition of medical necessity?

Senator FRIST's answer was: ''No, sir,'' in the committee. So he would not concur to not be bound by the language in the HMO or health insurance contract.

So there are two fundamental problems, and they work in concert to be devastating and to make this amendment devastating to the whole concept of the Patients' Bill of Rights.

No. 1, there is no independent review. The people are picked by the HMO, and they are allowed to have an ongoing financial relationship with the HMO. No. 2, they are bound by an HMO-written definition of medical necessity. That is the very heart of the amendment of my colleague from California, because what this debate is ultimately about is whether health care decisions are going to be made by medical professionals, doctors, or whether they are going to be made by insurance company bureaucrats.

Mrs. FEINSTEIN. Will the Senator yield?

The PRESIDING OFFICER. The Senator's 8 minutes have expired.

Who yields time?

Mr. KENNEDY. Mr. President, I yield 10 minutes to the Senator from Rhode Island.

Mr. CHAFEE. I thank the Chair.

First of all, it is with deep regret that I find myself on the opposite side of an issue from my good friend, the senior Senator from Vermont.

The question before us this afternoon is medical necessity. I believe this medical necessity provision is one of the most widely misunderstood issues in this entire debate.

I think what we want to make clear is what we are not talking about this afternoon. We are not talking about erasing the gains managed care has made in bringing down costs. We are not talking about forcing plans to cover unnecessary, outmoded, or harmful practices. We are not talking about forcing plans to pay for any service or treatment which is not already a covered benefit. This is absolutely not about giving doctors a blank check. What we are talking about is making sure that patients get what they pay for with their premium dollars. It is

about ensuring that an objective standard of what constitutes prudent medical care is used to guide physicians and insurers in making treatment and coverage decisions.

This provision is about making sure that an infant suffering from chronic ear infections gets drainage tubes to ameliorate his or her condition. It is about making sure that a patient with a broken hip is not relegated to a wheelchair in perpetuity but, rather, given the hip replacement surgery that prudent medical practice dictates.

Although some would have us believe that ''medical necessity'' would undo managed care by giving doctors the power to dictate what treatments and services insurers must cover, this isn't accurate. The real issue is, how will questions of coverage and treatment be decided?

S. 1344—a bipartisan bill that I have had the privilege of introducing earlier this year with Senators GRAHAM, LIEBERMAN, SPECTER, BAUCUS, ROBB, and BAYH—would codify the professional standard of medical necessity.

As defined, medically necessary services are those ''services or benefits which are consistent with generally accepted principles of professional medical practice.'' This means the care that a prudent practitioner would give. The medical necessity standard is a well-settled principle of legal jurisprudence which has been used by the courts to adjudicate health law cases for nearly a century.

Many insurance contracts in force today contain some version of this standard. In fact, remarkably similar language is found in contracts written by Prudential and Blue Cross and Blue Shield, to name a few. The contractual definition of medical necessity from a Blue Cross contract is care which is ''. . . consistent with standards of good medical practice in the U.S.''

One of the reasons managed care plans are so adamantly opposed to putting this standard into the law is that some in the industry are beginning to move in a very troubling direction, away from this standard. Here is how an insurance regulator in the State of Missouri explained this very alarming trend:

> Increasingly, insurance regulators in my State are finding that insurers are writing ''sole discretion'' clauses into their contracts—meaning that it is solely up to the insurer to determine whether treatment is medically necessary. Therefore, without an objective standard of what constitutes medically necessary care, and a requirement that treatment and coverage decisions are supported by credible medical evidence, any external appeals process is meaningless.

If an insurance contract gives the plan sole discretion to determine what constitutes medically necessary care, an external review panel's hands are tied; it will have no choice but to enforce the terms of the contract, even if the coverage decision in question is completely irresponsible. Thus, if we don't codify the professional standard, any external review provision we pass in the Senate could be entirely meaningless.

I have a chart here. This includes the actual medical necessity provision from an insurance contract in force today. I have eliminated the company's name, but this tells the whole story. If a plan has the sole discretion to determine what is medically necessary care, it can ignore the doctor's recommendations, the patient's medical record, and any other evidence it cares to overlook in making its determination. You will see it here. Here is the name of the company. That company will have the sole discretion to determine whether the care is medically necessary. The fact that the care has been recommended, provided, described, or approved by a physician or other provider will not establish that care is medically necessary. In other words, talk about putting the fox in charge of the chicken coop. This is it. Here we have the company deciding whether care is medically necessary, and they have the final decision.

Let me give you a real world example of what can happen when a plan has an imprudent definition of medical necessity. A child named Ethan Bedrick was born with cerebral palsy and needed physical therapy to maintain some degree of mobility. The insurer paid for the physical therapy for a while but one day cut off payment for the services—which, by the way, were covered as an unlimited benefit under the plan's contract. The child's doctor thought the care was medically necessary to prevent further deterioration in Ethan's condition, and physical therapy is routinely provided to patients with cerebral palsy.

When the plan was questioned in court as to why the care had been denied, the response was given that it was not medically necessary because, under the plan's definition, medically necessary care is that which will restore a person to ''full normalcy.'' Well, this child has cerebral palsy and he is not going to be restored to full normalcy.

If we do not include an objective standard of medical necessity in this legislation, insurers will be able to bait and switch when it comes to the delivery of services, just as they tried to do with Ethan Bedrick.

The professional objective standard—and not an insurer's practice guidelines or opinions—should be used to determine if care is medically necessary. Without the objective standard, what measure would an appeals body use to determine whether a treatment or coverage decision was accurate or appropriate? Let me deal with two arguments used by those against this medical necessity provision.

First, they say it will prevent ''best practices'' and will force plans to practice substandard care. I have trouble with that. Since the professional standard of medical necessity has been the standard used by the courts for over a hundred years and it is a feature of many insurance contracts today, why hasn't this already had the effect of preventing ''best practice'' medicine? In other words, I don't get the argument that somehow you are not going to practice the best medicine because you have to use what is medically necessary. The fact is that this standard does not lock in the state of medical practice today. Why do we make these giant strides forward? Because we are not locked in, as has been suggested.

Second, it is suggested that adopting this standard is tantamount to giving doctors a blank check and will force plans to cover a whole array of services which are not covered benefits, such as aromatherapy.

The plain fact is, if a plan excludes aromatherapy, or any other service, that is the end of the story. It excludes it. It is out. There is no fuss after that. If it is written in there, it is out. A patient would have no basis for an external appeal in a case where a denied service was clearly excluded.

In summary, I urge colleagues not to be swayed by the health insurance industry. Both Democrats and Republicans alike acknowledge the need for an external appeals process. But make no mistake about it, without a provision to ensure that plans are held to an objective standard of professional medical practice, legislation giving patients access to the external process will be ineffective.

I thank the Chair and the managers of the legislation.

The PRESIDING OFFICER. Who yields time?

Mr. FRIST. Mr. President, I yield myself 5 minutes, and then I will yield 5 minutes to the Senator from Maine.

My amendment is pending. I will review where we are today. My amendment does two things. No. 1, it strikes certain provisions that we believe will be harmful to the quality of health care, and it goes back to medical necessity and defining medical necessity in Federal statute. We will come back and talk about that. My colleagues will talk further about that shortly. We also strike certain provisions that will increase cost and ultimately reduce access to health insurance coverage. Again, people have heard me again and again going back to the patients. We can simply not do anything. I believe it diminishes quality and at the same time diminishes access to make ourselves feel good.

Now, what we have done, we struck that and we replaced that part of the bill—the accountability provisions, the provisions on internal appeal, on external appeal, the issues we have been talking about in the last 15 or 20 minutes—although there is a lot of misconception that we need to straighten out before we actually vote on this bill, because the internal appeals process and external appeals process, which in many ways are the heart of the Patients' Bill of Rights bill, are important to ensure that patients do get the medical care they need and ensure that

ultimately it is physicians, not trial lawyers, not bureaucrats, who make the coverage decisions regarding medical necessity. That is what this amendment is all about. I want to steer the discussion right there.

To simplify things, so we will know how the process works, if you are a doctor and you are a patient, and you say that a particular procedure should be covered, and your plan for some reason says no, well, you need an appeals process if that is what you really believe is appropriate to get that sort of care. What you do under our bill is go to an internal appeals process and work through. That is something in the managed care network. It might be going to another physician within the network. It is a process that has to be set up by each and every managed care plan. That is what we call an internal appeals process.

The bill on the other side of the aisle also had an internal appeals process. If the doctor and patient and the managed care internally could not come to an agreement after going through a specified process, at that point the doctor and patient can go outside the plan. This is where the accountability is so important: Should my plan cover what is medically necessary and appropriate? Outside the external appeals process is where much of the discussion has taken place.

Our bill has that final decision of whether or not something is covered, whether or not it is medically necessary or appropriate, made by a medical specialist—these are words actually in the bill—independent medical specialist, physician making the final decision, not some bureaucrat, not some health care plan, not some trial lawyer. An independent medical specialist is making the final decision in this external process.

Mr. President, 20 minutes ago we had discussed that the external reviewer has to be independent—it is written into the bill that way—has to be a medical person from the same field, a specialist, if necessary. Are they part of the Health Maintenance Organization? Does the Health Maintenance Organization actually hire that person to make a decision?

We have not talked about what our bill does. Our bill says in this external review process there has to be a designated entity. Nobody has talked about that today. Words such as ''unbiased, external entity'' are in the bill. This unbiased entity is regulated by either the Secretary of Health and Human Services in Washington, DC, by the Federal Government, or by the State government. They regulate that entity, not the plan itself.

What about the independent reviewer? Where do they come from? The impression which I have heard again and again is the independent reviewer has ties to the medical care plan and will give a biased view. No; the independent medical specialist making the binding final decision is appointed by the third party entity—not the plan itself but this third party entity regulated by the Federal Government, State government, or signed off for by the Secretary of Health and Human Services. This independence from plan to entity has to be unbiased. That is No. 1, to assure independence.

No. 2, the entity is regulated by the Federal Government or the State government or the Secretary of Health and Human Services.

No. 3, it is written in the bill that that entity does the appointment of the independent medical specialist who makes the final decision.

What information does that medical specialist use to make the final decision? We don't limit the information. In fact, we encourage them to consider all information. It is very specifically written in the bill that the ''independent medical specialist will make an independent determination based on the valid relevant scientific and clinical evidence to determine the medical necessity, appropriateness, experimental or investigational nature of the proposed treatment.'' They will take into consideration ''all appropriate and available information, including any evidence-based decisionmaking or clinical practice guidelines.''

The point is this external review person is independent and separate from the entity and separate from the HMO.

I yield 5 minutes to the Senator from Maine.

Ms. COLLINS. First, I commend the Senator from Tennessee for his very lucid explanation clearing up a lot of the misinformation about what is in the Republican package with regard to the independent, impartial, unbiased external review.

This is a very complicated issue. On the surface, the Kennedy bill appears to have a great deal of appeal. It sounds so simple. It reminds me of that expression by H.L. Mencken when he said that for every complicated problem there is a solution that is simple, easy, and invariably wrong.

That fits the Kennedy bill on medical necessity.

Physicians clearly must play a central role in care decisions. No one disputes or wants to minimize the critical role of treating physicians in the process of determining what is medically appropriate and necessary care. However, the very same patient can go to different physicians, be told different things, and receive markedly different care.

This chart illustrates the problem. The Washington Family Physicians Collaborative Research Network studied how physicians treat bladder infections for adult women. This is the second most common problem seen in a physician's office. Mr. President, 137 treating physicians were asked to describe their treatment recommendations for a 30-year-old woman with a 1-day history of the infection and an uncomplicated urinary tract infection. They responded with 82 different treatment options.

Which of these is the prudent physician? Which of these 82 different treatments is the generally accepted principle of medical practice as provided by the Kennedy bill? The Kennedy bill would require health plans to cover all 82 different treatments without any thought being given to what is the best treatment, what is the most effective treatment, what is the newest treatment based on the latest in medical research.

Even if something is consistent with generally accepted principles and professional practice, it may not necessarily be the medically best treatment for that patient. Dr. Jack Wennberg is Dartmouth's premier expert in studying quality and medical outcomes. He testified before our committee recently that medical necessity in one community is unnecessary care in another.

Let me give an example from my home State of Maine. The Maine Medical Assessment Foundation conducts peer review and studies area variations in practice patterns in an effort to identify cases in which too many procedures being performed, unnecessarily putting patients at risk. They did a study that showed that physicians in one city in Maine were performing a disproportionately high rate of hysterectomies. They counseled the physicians in that city and were able to lower the rate, thus saving women from being exposed to unnecessary risks of surgery.

I ask my friends on the other side of the aisle, wasn't that review appropriate? Wasn't that review necessary? Wasn't that review a good idea to save these women from undergoing unnecessary hysterectomies?

Let me give some other examples. The Centers for Disease Control estimates that physicians performed 349,000 unnecessary C sections in 1991. Again, these women were placed at risk for unnecessary surgery. Isn't it a good idea to question in some of these cases the decision of the physician to order this unnecessary surgery?

Let me give yet another example. Despite solid evidence that women who undergo breast-sparing surgery followed by chemotherapy or radiation and women who undergo total mastectomies have similar survival rates, regional preferences—as opposed to medical necessity—still prevail in determining treatment.

There was a recent article in the New York Times which showed that the rate of mastectomies was 35 times higher for Medicare patients in one region of the country than in another. According to another study at Dartmouth, women in Rapid City, SD, were 33 times less likely to have breast-sparing surgery than women in a similar city in Ohio.

Yet another example involves children. Today, treatment for frequent ear infections includes the implantation of tubes. I have a nephew who had this procedure, and I am sure many of

my colleagues have children who have gone through this as well. In fact, almost 700,000 children in the United States have had this procedure. According to a 1994 study published in the Journal of the American Medical Association, however, this treatment is inappropriate for more than a quarter of these children.

The PRESIDING OFFICER. The Senator has used her time.

Mr. FRIST. Mr. President, I yield an additional 3 minutes.

The PRESIDING OFFICER. The Senator from Maine is recognized for an additional 3 minutes.

Ms. COLLINS. In another 41 percent of the cases reviewed, the clinical indications for having the tubes implanted were inconclusive at best.

A 1997 study showed that only 21 percent of elderly patients were treated with beta blockers after a heart attack, despite evidence that mortality rates are 75 percent higher for those not receiving treatment.

I would note, in contrast, that HMO members in plans that submit data to the National Committee on Quality Assurance are 2½ times more likely than members of fee-for-service plans to receive beta blockers.

I could go on and on and on. Perhaps the President's own commission said it best. It concluded that excessive procedures—procedures that lack scientific justification—could account for as much as 30 percent of our Nation's medical bills.

Not to mention posing unnecessary risks as well as pain an suffering for those who undergo these unnecessary procedures.

As we can see by these examples and countless more, there may well be valid, indeed, very worthwhile. In fact, there may be very good reasons for the health plan, in some cases, to suggest an alternative treatment to the one the treating physician has initially selected. It may be far better for the patient than the initial recommendation of his or her physician. These examples show that, even if something is consistent with generally accepted principles of professional medical practice, it is not necessarily appropriate high quality care. That should be our goal. Our goal should be to put the patient first and to provide the best quality care to that patient.

The Republican bill deals with the issue of medical necessity through a strong, independent, external appeals process. That is the way to deal with disputes about medical coverage. A Federal statutory definition of medical necessity is unwarranted and unwise.

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

The PRESIDING OFFICER. Who yields time? The Senator from Oklahoma.

Mr. NICKLES. Mr. President, how much time remains on both sides?

The PRESIDING OFFICER. The Senator has 5 minutes 30 seconds; the Senator from Massachusetts has 13 minutes 30 seconds.

Mr. NICKLES. Mr. President, that means there is about 20 minutes remaining. Just for the information of our colleagues, I think they can expect a rollcall vote on this and subsequent amendments to begin at about 6:45. So those offices should notify their Senators to expect rollcall votes beginning about 6:45.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, I yield 5 minutes to the Senator from California.

The PRESIDING OFFICER. The Senator from California is recognized for 5 minutes.

Mrs. FEINSTEIN. Mr. President, if this definition, the definitions we have been debating on what is medical necessity—if the Republican definitions were supported by medical organizations, I might think they are pretty good. But there is virtually no physician-oriented organization anywhere in the United States that I know of that supports this particular definition of medical necessity. Every single one of them supports the definition in the Daschle bill.

I think the Senator from Rhode Island and the Senator from North Carolina spoke eloquently as to why. Since the Senator from North Carolina remains on the floor, I would like to ask him this question. The Senator from Rhode Island read the definition from a particular insurer. Let me reread it:

> [This company] will have the sole discretion to determine whether care is medically necessary. The fact that care has been recommended, provided, prescribed or approved by a physician or other provider will not establish that the care is medically necessary.

Then, in view of that, if you read on the top of page 180, in the bill, which sets out the guidelines for the standard of review for the independent reviewer, at the top of the page and the bottom of page 179:

> The independent reviewer will take into consideration appropriate and available information including any evidence-based decisionmaking or clinical practice guidelines used by the group health plan or insurance issuer.

How would an independent reviewer make a decision?

Mr. EDWARDS. Under the definition the Senator has just read—and I might point out the appeals process that is contained in this amendment is completely controlled by the HMO or health insurance company's definition of medical necessity. Throughout the process it is totally controlled by it.

Mrs. FEINSTEIN. Then if I understand you correctly, if an insurer had in its plan that they will use the least costly alternative available, the independent reviewer would have to find for the least costly alternative?

Mr. EDWARDS. That is absolutely correct.

Let's suppose we had a young child who needed a particular kind of care and every physician who had treated that child recommended the care for the child. But there was a less costly procedure that could be used, so the care was denied. Throughout the appeals process, the determination of whether it ought to be reversed or not would be based on what is the least costly, because it is totally controlled by the definition written by the HMO.

In the language the Senator from California has just read to me, where it says it shall be within the ''sole discretion,'' what that ultimately means is whatever appealing body is deciding, which is bound by that definition, which they are by this amendment—if they are bound by that definition, every appealing body would be left with no alternative but to affirm the decision because the contract says it is left within the sole discretion of the HMO.

It goes to the very heart of the Senator's amendment. It goes to the very heart of this debate. The whole question is, Are health insurance bureaucrats going to make health care decisions or are health care decisions going to be made by doctors and health care professionals?

Mrs. FEINSTEIN. I just read the language. There is no language in this that says the independent reviewer, even in a case of life or death, would necessarily see the patient.

Mr. EDWARDS. That is absolutely correct. There is nothing that requires the independent reviewer to see the patient. You could have some doctor who is nothing but a bureaucrat, who has not seen the patient, does not know what the patient needs, making the decision.

If I could add one thing, another problem with this so-called independent review process is the HMO, the health insurance company, are the ones that are determining. Remember, they choose this entity that chooses the reviewer. They determine who is biased or unbiased.

Mrs. FEINSTEIN. And the entity pays the reviewer as well.

Mr. EDWARDS. They pay the reviewer. We have said it now five different times, but talk about putting the fox in charge of the chicken coop. What we need to be doing is to have some truly independent body making these determinations. They need to be able to make the determination based upon what the patient, in my example the child, really needs, based on what the doctor says the child needs.

Mr. NICKLES. Will the Senator yield?

Mr. EDWARDS. No, I will not.

It is not based on what some insurance company has written into a HMO or health insurance contract.

Mrs. FEINSTEIN. So, in other words——

Mr. NICKLES. Mr. President, regular order.

Mrs. FEINSTEIN. I believe I have the floor, Mr. President.

Mr. NICKLES. Parliamentary inquiry. Aren't Senators supposed to go through the Chair?

Mr. KENNEDY. Regular order. Senators are permitted to inquire and ask questions. That is the regular order, Mr. President. I insist on the regular order, not the interruption of the Senator from North Carolina. Whose time is this on, Mr. President?

Mr. NICKLES. The Senator from North Carolina——

The PRESIDING OFFICER. The time right now, at this point, is not being charged. The Senator from California had 5 minutes that she was controlling after it was allotted by the Senator from Massachusetts.

Mr. KENNEDY. Parliamentary inquiry. Can the Senator be inquired of by a Member of the Senate and answer a question?

The PRESIDING OFFICER. The questions are most appropriately addressed through the Chair.

Mr. KENNEDY. But the Senator is entitled, the Senator from North Carolina, to inquire of the Senator from California, is he not?

Mrs. FEINSTEIN. Or vice versa.

The PRESIDING OFFICER. If he does so through the Chair.

Mr. KENNEDY. I thank the Chair.

Mrs. FEINSTEIN. I inquire of the Senator from North Carolina, through the Chair, if I were a woman suffering from ovarian cancer and I have this policy that I read from, and my physician said there is a small chance a bone marrow transplant might help you——

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. KENNEDY. I yield an additional 3 minutes.

Mrs. FEINSTEIN. But there is a small chance a bone marrow transplant might help you, I would advise that you have it, and if the health plan with this language turned it down, I would have no opportunity to have that bone marrow transplant?

Mr. EDWARDS. You would have absolutely no opportunity and no opportunity to have the decision reversed. I might add, there is a double whammy in this amendment. The double whammy is that the only thing that can be appealed is the determination of what is medically necessary, and what is medically necessary, under the language of their bill is—and I am reading now from the bill—''when medically necessary and appropriate under the terms and conditions of the plan,'' which is what the HMO and the health insurance company's contract says.

People are getting whammied twice: No. 1, you cannot appeal but one thing, which is: Is it medically necessary? No. 2, that determination is based on what the health insurance company or the HMO wrote into the plan.

Mrs. FEINSTEIN. In other words, if I may, through the Chair, if this amendment were to be adopted, every enrollee of an HMO plan would have to read the fine print very carefully, because all an HMO would have to do is put in a disclaimer, either medical necessity based on least cost or medical necessity based on the fact that the plan would have the ultimate say on how medical necessity is defined.

Mr. EDWARDS. The Senator is correct, and the patient would be stuck with that decision initially by the HMO and would be stuck with it throughout the entire appeals process and would have absolutely—it goes to the very heart of this debate: Do we want health insurance companies deciding what is medically necessary, or do we want health care providers, doctors, and patients making the decisions?

Mrs. FEINSTEIN. Who have seen the patient.

Mr. EDWARDS. Absolutely, doctors who have seen the patients. We believe doctors ought to make the decisions.

Mrs. FEINSTEIN. I thank the Senator very much. This has been a helpful clarification. I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. NICKLES. Mr. President, I yield myself 5 minutes on the bill.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized for 5 minutes on the bill.

Mr. NICKLES. Mr. President, I was trying to make sure our colleagues understand the procedure in the Senate. When you have colloquies, you go through the Chair. I have noticed some colloquies on this side have bypassed the Chair. Some colloquies on that side have bypassed the Chair. That is not the rule of the Senate. It is important we have discussions according to the rules of the Senate. That is the way we should do it. That way, we do not freeze out other colleagues who want to participate in colloquies. I was not trying to get under my colleagues' skin. It is important we follow the rules of the Senate.

I want to point out that a couple of the statements made by our colleagues are actually very inaccurate. Actually who pays for the plans and entities are very similar in both bills. Under the Democrat bill, S. 6, on page 66: A plan or insurer shall be conducted under contract between the plan or insurer in one or more qualified external appeals entities.

That is page 66.

Under the Republican bill, it is the same thing, the plan selects the entity. They do not select the person who does the review, they select the entity. The entity is licensed by the State, or it is a State agency established for that purpose, or it is an entity with a contract with the Federal Government and they have the reviewers.

My point is, both the Democrat plan and the Republican plan select the entities. They are the same. For them to say, oh, the Republican plan selects the reviewer is false. The Democrat plan, as well as the Republican plan pay for the entities, they select the entities, and the entities themselves are independent, and the entities select the individual reviewer.

There is a little—I do not want to use the word ''hypocrisy''; it is not a word I often use on the floor. But to be railing against the Republican plan, not stating the facts, and then say, oh, by the way; oh, the Democrat plan, the plan selects the entities as well, I just find it to be very inconsistent.

I urge my colleagues to see that in the Republican plan, the proposal we have before us, we say the plans select the entity, and the entity is a qualified entity if it is an independent external reviewer and credentialed by the State or a State agency established for the purpose of conducting the external review, or it is an entity under contract with the Federal Government, or it is an entity accredited as an independent external review entity by an accrediting body recognized by the Secretary of HHS.

I just mention that. It is important we be consistent and that people understand on both sides, the Democrat proposal selects an entity very similar to that of the Republican proposal.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. I yield 1 minute to the Senator from California and then 1 minute to the Senator from North Carolina.

Mrs. FEINSTEIN. Mr. President, I must respond to the Senator from Oklahoma because he mischaracterizes the Democratic plan. His statement might be correct if it were taken in an isolated sense. But if you take it with the medical necessity definitions on page 85 of the Democratic plan, you will see that ''a group health plan and a health insurer, in connection with a provision of health insurance coverage, may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or setting in which particular services are delivered if the services are medically necessary or appropriate for treatment.''

Then it goes on to define medical necessity as a service or benefit which is consistent with generally accepted principles of professional medical practice. It does not give the plan the opportunity in its fine print to throw out medical necessity.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. KENNEDY. I yield the Senator 2 minutes.

The PRESIDING OFFICER. The Senator from North Carolina is recognized for 2 minutes.

Mr. EDWARDS. Mr. President, I say respectfully in response to my colleague from Oklahoma that there are two things about which I fundamentally disagree with him. No. 1, under our proposal, the State—totally independent—chooses the reviewing body. If my colleagues are really looking for an independent review, I ask them whether they would agree to allow the State to choose the reviewing body instead of the health insurance company, instead of the HMO choosing the entity that chooses the reviewing body. I cannot imagine how they would disagree

with that if they are looking for a truly independent review.

Secondly, the entire issue revolves around what is medical necessity. I say to my colleagues, would they agree to change the language of this amendment so that the initial decision and every appeals decision of the appeals deciding body is not bound by the definition of ''medical necessity'' contained in the insurance written contract? Because so long as the appeals process is controlled by what the HMO wrote, what the health insurance company wrote at the beginning and all the way through the process, the patient does not have a chance. They will never have a chance. My question is to my colleagues——

Mr. GREGG. Will the Senator yield?

Mr. EDWARDS. I will give the Senator an opportunity to respond. My question is whether they will agree, No. 1, with the State choosing a truly independent reviewing body, and, No. 2, whether they will agree that the reviewing body is not bound by a definition written by the health insurance or HMO company.

I yield for a question.

The PRESIDING OFFICER. The Senator's time has expired.

Who yields time?

Mr. GREGG. We have no time.

Mr. FRIST. We have 5 minutes.

Mr. KENNEDY. I yield 1 minute to the Senator for a question.

Mr. GREGG. I appreciate that.

Mr. KENNEDY. Does the Senator still have time left?

The PRESIDING OFFICER. The majority side controls 5 minutes 20 seconds, the minority side, 5 minutes 4 seconds.

Mr. GREGG. Mr. President, I have a question for the Senator from North Carolina which is in reference to the Kennedy bill, section 133, subsection (1)(ii), on page 67:

If an applicable authority permits—

That will be the State authority—

more than one entity to qualify as a qualified external appeals entity with respect to a group health plan or health insurer issuer, then the plan or issuer may select among such qualified entities the applicable plan.

So basically if the State picks two or three different reviewers, under your plan, then the plan gets to choose; isn't that correct?

Mr. FRIST. Whose time is this on?

The PRESIDING OFFICER. On the majority side.

Mr. FRIST. I yield another 30 seconds.

Mr. GREGG. So there is an option under your proposal where plans would have a choice because that is what the language says?

The PRESIDING OFFICER. Who yields time?

Mr. EDWARDS. Am I allowed to respond?

Mr. KENNEDY. I yield the Senator 1 minute.

The PRESIDING OFFICER. The Senator is recognized for 1 minute.

Mr. EDWARDS. My response is very simple.

The language on the preceding page requires that the independent external review entity be designated by the State. That is, if I am reading the language correctly, contained on the preceding page. That is designated by the State. In fact, we say—this is at page 11, I say to the Senator—that ''No party to the dispute shall be permitted to select the entity conducting the review.''

So there are two things operating, I think, in combination in our bill. No. 1, the State has to designate an independent body, and, No. 2, we specifically require that no party to the dispute be involved in designating the reviewing entity.

I might add to that, I think it is also critically important who determines what is medically necessary and what the appeal decision body is bound by in terms of what is medically necessary because I think all of this becomes meaningless if they are bound by what the HMO or health insurance company wrote.

The PRESIDING OFFICER. The time has expired.

Mr. GREGG. Will the Senator yield me another 30 seconds?

Mr. FRIST. How much time do we have?

The PRESIDING OFFICER. Four minutes 20 seconds. The minority has 4 minutes.

Mr. FRIST. I yield 30 seconds to the Senator.

Mr. GREGG. I, therefore, take it in the Kennedy plan, when it says, ''the plan or issuer may select among such qualified entities,'' that that language is not operative, that that does not exist, that that language is a nonfactor.

Let's get serious. This is what your bill says. It says the plans can be selected from the qualified entities. You can pick two or three plans, that the States have chosen to qualify two or three plans, and the people pick the plans. So you are totally inconsistent with your argument.

Mr. EDWARDS. May I respond?

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. I yield the Senator 30 seconds.

The PRESIDING OFFICER. The Senator from North Carolina is recognized for 30 seconds.

Mr. EDWARDS. There is a very simple, straightforward answer to the question. I understand the Senator is reading the old bill. He is not reading the bill that is presently before the Senate.

The PRESIDING OFFICER. Who yields time?

Mr. FRIST. Mr. President, I yield 4½ minutes—how much time is remaining?

The PRESIDING OFFICER. The majority side controls 4 minutes on the amendment.

Mr. FRIST. Mr. President, I yield the remaining time to the Senator from Wyoming.

Mr. GREGG. Would the Senator yield me 10 seconds? Because a misstatement was made.

Mr. FRIST. I yield another 30 seconds to the Senator from New Hampshire.

Mr. GREGG. I am reading from S. 6. That is the bill that was laid down. That is the bill we are debating.

The PRESIDING OFFICER. Who yields time?

Mr. FRIST. I yield 4½ minutes to the Senator from Wyoming.

The PRESIDING OFFICER. There are only 3 minutes 50 seconds remaining on the majority side. The Senator from Wyoming is recognized for that time.

Mr. ENZI. Mr. President, I rise in strong support of improved, reliable quality care for all Americans. To that end, I am pleased to join my colleagues in debating the dangerous concept of putting into law a definition of medical necessity.

The minority argues that putting a definition of medical necessity into the law would assure health care providers absolute autonomy in making all treatment decisions for their patients. They say that is exactly what they want. It is their prescription for high quality health care.

Well then, when asked what patients and providers would use as a guide for the choice of treatment options and delivery of care, particularly in such a dynamic and constantly innovating field such as health care, the minority relies squarely on ''generally accepted medical practice.''

The Democrat plan is a trial lawyer's dream. ''Generally accepted medical practice'' is lawsuit bait. But I can tell you that with the Democrat plan ''medical necessity'' would be absolutely necessary because it is the only way to bridge the bureaucracy.

This is the bill we are looking at from the Democrats. Who can follow the lines? Each one of those lines represent a lawsuit trap. This is lawsuit bait.

Unfortunately, for patients, ''generally accepted medical practice'' is the strict application of medical opinion versus the combination of your doctor's good judgment or opinion and the prevailing evidence-based practice of medicine. The minority approach turns its back on the scientific foundation of medicine. But what other solid ground is there upon which we could build greater quality into our health care system?

The minority, for the first time in Federal law, wants to carve this variability into law, and that law will be followed by rule and regulation—more lawsuit bait. This is a Federal one-size-fits-all budget-busting bureaucracy with lots of lawsuit bait and difficulty in following the whole process.

Let me share with my colleagues the language from the minority bill. Under the subtitle of ''Promoting Good Medical Practice,''—a good title—lies a provision which, in my estimation, would have the exact opposite effect. The bill reads:

A group health plan, and a health insurance issuer in connection with the provision

of health insurance coverage, may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or setting in which particular services are delivered if the services are medically necessary or appropriate for treatment or diagnosis to the extent that such treatment or diagnosis is otherwise a covered benefit.

Now, let me loop through the rest of their proposal to demonstrate how they essentially ''ban'' the use of trustworthy science and evidence-based medicine. At the end of the same subtitle, we are offered a definition of medical necessity or appropriateness. It reads, ''medically necessary or appropriate means, with respect to a service or benefit, a service or benefit which is consistent with generally accepted principles of professional medical practice.''

To recap the minority policy proposal, they've suggested that doctors make decisions about their patients based just on opinion, and that health plans would, by law, have to cover any and every treatment opinion prescribed by providers. The minority may argue that their proposal limits what plans must pay for to the terms of the contract. However, their plan requires plans to cover all treatments deemed medically necessary, so this provision would, in fact, encompass the universe of health care, heedless of quality and contract alike.

It's my opinion, and a major thrust of the Republican bill, that we should be doing everything we can to help health care providers in their efforts to provide the highest possible quality of care to patients. The minority tells doctors, who are now busier than ever and doing their best to stay atop the innovations in medicine, that ''it's all on you.''

Mr. President, since there has been an effort to infuse real life examples into this debate, it might be helpful for all of the health care consumers at home if we talk about how medical science versus ''generally accepted practices'' actually translates into real life. In the following examples, you'll begin to understand that ''generally accepted practices'' vary from town to town, and the gap gets wider from state to state. This basically means that the quality of your health care may depend more on where you live than on what the prevailing best medical science is on your illness.

Here's an example where I can use my home state of Wyoming. The average number of days spent in the hospital during the last 6 months of life for people living in Wyoming was between 4.4 days and 8 days. In contrast, the average number of days spent in the hospital for the last 6 months of life for people living in New York was between 12 and 22 days. This means that there is nearly a 250 percent variation among States for hospital length-of-stay at the end of life. Who's responsible for this variation and what does it mean about the quality of care we're receiving?

More importantly, how does this jibe with legislating a definition of medical necessity? Remember, the minority want us, for the first time, to carve this variability into law. The law will be followed by rule and regulation. Does this mean that for health plans that have beneficiaries in Wyoming and in New York that what might be determined a medically appropriate treatment for a New Yorker would be deemed medically inappropriate for a patient in Wyoming?

This variation is comprehensive, going beyond hospital lengths-of-stay, from the use of drug therapies to surgical practices. One of the most disheartening and horrifying statistic is regarding women with breast cancer. Despite the solid evidence that women who undergo breast-sparing surgery followed by chemotherapy or radiation and women who undergo radical mastectomies have similar survival rates, it is regional preferences, that is, the general practices of a region, that still prevail in determining a woman's course of treatment. In 1996, women with breast cancer in Rapid City, SD were 33 times less likely to have breast-sparing surgery than women in Elyria, OH. How can anybody look at these variations and view them as the only answer to good medicine?

These inconsistencies in the medical care Americans receive are something we all need to address; that includes health plans and doctors, and ourselves. Make no mistake about our potential as Congress to derail the efforts at quality improvement in American's health care if we're not very careful and very thoughtful about what it is we're doing here today.

On a positive note, we are seeing signs of improvement when it comes to doctors and health plans working together to improve the consistency and overall quality of health care. For example, according to a 1997 Quality Compass report by the National Committee on Quality Assurance, over 50 percent of elderly heart attack patients in HMOs that submitted data were treated with beta blockers, which can reduce mortality rates by 75 percent in those patients. In the same year, patients in regular fee-for-service plans received beta blocker only 21 percent of the time. This is almost a three-fold difference when you compare a coordinated approach to care with a ''generally accepted practices'' approach.

I am very concerned that we need to pass a proposal that responds to these ''consistent inconsistencies'' in the quality and practice of medicine in this country, while also guarding the doctor-patient relationship. After all, outside of family, many of us view our relationship with our doctor as our most trusted.

The solution lies in building on the doctor-patient relationship and infusing our health care system with evidence-based medicine. Our bill does that. Our bill does not turn a blind eye to either the strengths or the weaknesses of today's health care system. Our bill takes a look at what we need to preserve and what we need to improve upon, and offers a responsible solution to enhancing quality and ensuring access.

Our bill will provide patients and their doctors with a new, iron clad support system that will insure access to medically necessary care. An independent, external appeals process will be available for patients whose plan has initially denied a treatment request that the patient and doctor have decided is necessary. In other words, our bill gets patients the right treatment, right away. And it's based on the independent decision of a medical professional who is expert in the patient's health care needs. In rendering a decision on the medical necessity of the treatment request, the expert review will consider the patient's medical record, evidence offered by the patient's doctor and any other documents introduced during the internal review. This covers the ''generally accepted practice'' standard that the minority offers as a singular solution.

Our bill goes further, capturing the other half of good quality health care, which is the evidence-based medicine rooted in science that I spoke about earlier. We would require the expert reviewer to also consider expert consensus and peer-reviewed literature and evidence-based medical practices. Let me say that again; evidence-based medicine, not the varied, town-by-town, tried but not necessarily true, general practice of medicine.

Because we feel so strongly about preserving the trusted relationship between doctors and patients by providing them with the best evidence-based medicine in making treatment decisions, we've included another lynchpin in our bill. We establish the Agency for Healthcare Research and Quality, whose purpose it is to foster overall improvement in health care quality, firmly bridging the gap between what we know about good medicine and what we actually do in health care today. The Agency is built on the platform of the current Agency for Health Care Policy and Research, but is refocused and enhanced to become the hub and driving force of Federal efforts to improve the quality of health care in all practice environments.

The Agency will assist, not burden physicians, by aggressively supporting state-of-the-art information systems for health care quality. This is in stark contrast to the minority proposal, which would require the Secretary of Health and Human Services to Mandate a new, onerous data collection bureaucracy. The Agency would support research in primary care delivery, priority populations and, critical to my state of Wyoming, access in underserved areas. Most important with regard to this research, is that it would target quality improvement in all types of health care, not just managed care. The Agency would also conduct

statistically and scientifically accurate, sample-based surveys, using existing structures, to provide high quality, reliable data on health outcomes. Last, the Agency would achieve its mission of promoting quality by sharing information with doctors, health plans and the public, not tying it up in the knots of an expanded Federal bureaucracy. We need to assist the providers on the front lines. Their job is to make clinical decisions. We need to give them the tools to make these medical decisions based on the proven medical advances made every day through our investment in medical research. It would be a huge mistake to put the Secretary and a Federal bureaucracy between doctors and patients.

Clearly, medical necessity is a long and complicated issue. It is also where the rubber meets the road on improving the quality of medicine in the purest sense. This is where we all must pony up on the true intent of our proposals regarding medical necessity. This is where we peel away the rhetoric and reveal the true implications of our vastly different standards regarding the quality of care we are willing to demand for Americans. I, for one, am demanding that my constituents get the best care possible, with a solid basis in proven, quality, evidence-based medicine and timely access to the advancements and innovations in health care.

Mr. President, I understand and greatly respect the role of doctors and all health care providers in this country. It is for that very reason that I support the creation of a new, independent appeals mechanism to support their efforts in treating their patients. This, in conjunction with strengthening the health care system through strong Federal support for access to evidence-based medicine.

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

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, much of this debate may seem technical, but the definition of medical necessity and a fair and independent appeals process are at the heart of any serious effort to end insurance company abuse. Our plan has it; their program does not. That is why Consumers Union—the outfit that publishes Consumer Reports—calls the Republican program ''woefully inadequate'' and ''far from independent.''

No one supports their program but the insurance companies and the HMOs, the very organizations that profit from the abuses of the status quo. Their program is opposed by the American Cancer Society, and virtually every cancer organization in the country. It is opposed by the American Heart Association. It is opposed by the disability community. It is opposed by the women's community, and the people who represent children. These are the patient groups that have the most to lose from low quality and the most to gain from high quality. And they lose under the Republican program.

This amendment will determine whether Senators stand with the patients or with the HMOs.

We yield back the remainder of our time and are prepared to vote.

Mr. NICKLES addressed the Chair.

Mr. KENNEDY. I reserve my time.

Mr. NICKLES. Just to clarify, I think my colleague from Massachusetts spoke incorrectly. The insurance industry does not support our amendment. I think he said that they do. He happens to be factually wrong. I would like to have the RECORD be clear. We ought to be stating facts and we ought to be stating the truth. What he said was not correct. They do not like our bill, either. They have not supported our bill.

My colleague from Massachusetts earlier said they wrote our bill. He is absolutely wrong. I just want to make sure people have the facts.

Mr. President, I will yield back the remainder of our time.

First, I ask unanimous consent that at the expiration of debate time on the pending amendment, votes occur on the following pending amendments: amendment No. 1238, medical necessity, that is the pending amendment; the next amendment would be amendment No. 1236, which is the cost cap, limiting it to 1 percent; the next amendment would be amendment No. 1235 which deals with emergency rooms, by Senator GRAHAM; the next amendment would be amendment No. 1234, deductibility for the self-employed; and the next amendment would be amendment No. 1233, dealing with the scope.

I further ask unanimous consent that following the first vote, there be 4 minutes equally divided for closing remarks prior to the beginning of each vote.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Reserving the right to object, and I will not object, just in response to the Senator's earlier statement, I wonder why the insurance companies are spending more than $2 million opposing our program.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. Is there objection?

Mr. KENNEDY. Mr. President, I reserve the right to object. Unless I am entitled to speak, I will object, Mr. President.

Mr. CHAFEE addressed the Chair.

Mr. KENNEDY. Mr. President, I withdraw my objection.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. CHAFEE. I wonder if we could have an agreement that on the successive votes the Senator from Oklahoma outlined there be a 10-minute break, or whatever he suggests, in there.

Mr. NICKLES. I think our friend from Rhode Island has made a good suggestion. I suggested possibly doing that. I think we will possibly do that after the first vote.

The PRESIDING OFFICER. Is there an objection to the request? Without objection, it is so ordered.

Mr. NICKLES. For the information of all of our colleagues, we are now getting ready to begin a series of votes, beginning with the first vote dealing with medical necessity. We expect there will be four votes tonight, so I encourage all our colleagues to come to the floor to vote.

I encourage all of our colleagues to stay on the floor because it is our intention to reduce the time allotted to each vote to 10 minutes after the first vote.

Mr. REID. Reserving the right to object——

Mr. NICKLES. I did not make a UC.

Mr. REID. Are we going to allow a minute of explanation? Is that in the unanimous consent request?

Mr. NICKLES. Under the unanimous consent that has already been agreed to, we have 4 minutes equally divided.

Mr. REID. I missed that. I apologize.

The PRESIDING OFFICER. Does the Senator from Massachusetts yield back the remainder of his time?

Mr. KENNEDY. Just 30 seconds of the time to point out, in response to the comments of the Senator from Oklahoma, the insurance industry has just spent $2 million in opposition to our program, which basically includes the provisions so eloquently commented on by the Senators from California and North Carolina. Zero has been spent by the insurance companies in opposition, to my best understanding, to the Republican proposal. If it looks like a duck and quacks like a duck, it is a duck.

This is the insurance company's proposal, the HMO proposal. They are the ones that will gain if this amendment of the Republicans is accepted. There is no question about that. It is the disabled, the cancer groups, and the children who will gain if our proposal prevails.

I yield back the remainder of the time.

Mr. NICKLES. Mr. President, I yield back the remainder of my time.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 1238.

The yeas and nays have not been ordered.

Mr. NICKLES. Mr. President, I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 1238. The yeas and nays have been ordered. The clerk will call the roll.

The result was announced—yeas 52, nays 48, as follows:

[Rollcall Vote No. 199 Leg.]

YEAS—52

Allard	Gramm	Nickles
Ashcroft	Grams	Roberts
Bennett	Grassley	Roth
Bond	Gregg	Santorum
Brownback	Hagel	Sessions
Bunning	Hatch	Shelby
Burns	Helms	Smith (NH)
Campbell	Hutchinson	Smith (OR)
Cochran	Hutchison	Snowe
Collins	Inhofe	Specter
Coverdell	Jeffords	Stevens
Craig	Kyl	Thomas
Crapo	Lott	Thompson
DeWine	Lugar	Thurmond
Domenici	Mack	Voinovich
Enzi	McCain	Warner
Frist	McConnell	
Gorton	Murkowski	

NAYS—48

Abraham	Durbin	Leahy
Akaka	Edwards	Levin
Baucus	Feingold	Lieberman
Bayh	Feinstein	Lincoln
Biden	Fitzgerald	Mikulski
Bingaman	Graham	Moynihan
Boxer	Harkin	Murray
Breaux	Hollings	Reed
Bryan	Inouye	Reid
Byrd	Johnson	Robb
Chafee	Kennedy	Rockefeller
Cleland	Kerrey	Sarbanes
Conrad	Kerry	Schumer
Daschle	Kohl	Torricelli
Dodd	Landrieu	Wellstone
Dorgan	Lautenberg	Wyden

The amendment (No. 1238) was agreed to.

Mr. LOTT. I move to reconsider the vote.

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

Mr. LOTT. Mr. President, I ask unanimous consent that remaining votes in this series be limited to 10 minutes in length. I urge Senators to stay in the Senate Chamber or not to go any farther than the cloakrooms so we can actually hold these next three votes to 10 minutes. Please do so. Senator DASCHLE and I intend to cut off the vote after about 10 or 11 minutes. Please stay in the Chamber.

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

AMENDMENT NO. 1236

The PRESIDING OFFICER. There are 4 minutes equally divided.

Mr. NICKLES. Mr. President, I yield the Senator from Texas 1 minute.

Mr. GRAMM. Mr. President, the Kennedy Patients' Bill of Rights drives up health care costs by 6.1 percent. It causes 1.8 million Americans to lose their health insurance. It raises the cost of health care for those who don't lose their health insurance by $72.5 billion. By driving up labor costs, it would destroy 194,041 jobs in the American economy by the year 2003. These are not our numbers. These are numbers based on estimates done by the CBO and private research firms that have used those numbers to project the economic impact.

Our amendment simply says if the Kennedy bill drives up health care costs by more than 1 percent when it is fully implemented, or if it pushes more than 100,000 Americans off the private insurance rolls by driving up cost, then the law will not go into effect; it will be suspended.

The PRESIDING OFFICER. Who yields time?

Mr. REID. The Senator from Rhode Island is yielded 2 minutes.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Mr. President, once again we hear the same old misestimate of the costs associated with the legislation. The true cost calculated by the Congressional Budget Office is 4.87 percent over 5 years. That is exactly what Senator LOTT said on ''Meet The Press'' on July 11. In his words, ''By the way, the Democratic bill would add 4.8 percent cost. That is less than 1 percent a year.''

Mr. GRAMM. Mr. President, may we have order. I can't hear the Senator.

The PRESIDING OFFICER. The Senate will be in order. Those of you who have conversations, please take them to the Cloakroom. This is important debate.

The Senator from Rhode Island.

Mr. REED. I thank the Chair.

As I indicated, the true cost is 4.8 percent over 5 years. ''That is less than 1 percent a year.'' That is what Senator LOTT said on ''Meet The Press.'' Indeed, if you calculate that down to a monthly cost, it is about $2 extra a month to the average family paying health care premiums. It is not going to cause a huge eruption of costs.

It is also to me somewhat disconcerting to think that the insurance industry is worried about people losing their health care coverage. They raise costs every day. They will raise costs to protect their profits.

What this legislation wants to do is guarantee that there is quality in the American health care system.

Make no mistake, this amendment is calculated and designed to undercut all the protections in the Patients' Bill of Rights. It is calculated within 2 years to undercut and remove all of the protections that are so necessary to the American family, which we are fighting for.

This would be a recipe also to reward those companies that have excessive costs, and it would be virtually impossible to figure out what costs are associated with their need for profits versus what costs are associated with the increase in quality in the system. They would be doing the audits. They would essentially be exempting themselves. We are giving them a key to let them out of the responsibilities to their patients and to their consumers. We can't do that.

This is just another red herring, another ruse, and another device to prevent the American people from achieving what they definitely want—rights in the health care system.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Oklahoma.

Mr. NICKLES. Mr. President, just to correct my colleague from Rhode Island, he said the cost of the Kennedy bill is about $2 a month. That is not correct. That is not in CBO's report. CBO says most of the provisions would take full effect within the first 3 years, not 5 years; not 1 percent, but a total of 6.1 percent. That is S. 6. That is what we are debating. That is what we are amending.

We are saying that costs shouldn't increase by more than 1 percent.

The Congressional Budget Office says the total costs would be $8 billion in lost Social Security taxes and total lost wages would be $64 billion. That is not a McDonald's hamburger. That is $64 billion in lost wages, according to the Congressional Budget Office. That is not a Republican insurance study. That was the Congressional Budget Office that said people would lose $64 billion in lost wages.

They also said as a result of the Kennedy amendment that people would drop insurance entirely; would reduce the generosity of health benefit packages; they would increase cost sharing by beneficiaries.

I urge my colleagues to vote for this amendment.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. NICKLES. I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to Amendment No. 1236, as amended. On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The legislative clerk called the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The result was announced—yeas 52, nays 48, as follows:

[Rollcall Vote No. 200 Leg.]

YEAS—52

Abraham	Gorton	Murkowski
Allard	Gramm	Nickles
Ashcroft	Grams	Roberts
Bennett	Grassley	Roth
Bond	Gregg	Santorum
Brownback	Hagel	Sessions
Bunning	Hatch	Shelby
Burns	Helms	Smith (NH)
Campbell	Hutchinson	Smith (OR)
Cochran	Hutchison	Snowe
Collins	Inhofe	Stevens
Coverdell	Jeffords	Thomas
Craig	Kyl	Thompson
Crapo	Lott	Thurmond
DeWine	Lugar	Voinovich
Domenici	Mack	Warner
Enzi	McCain	
Frist	McConnell	

NAYS—48

Akaka	Edwards	Levin
Baucus	Feingold	Lieberman
Bayh	Feinstein	Lincoln
Biden	Fitzgerald	Mikulski
Bingaman	Graham	Moynihan
Boxer	Harkin	Murray
Breaux	Hollings	Reed
Bryan	Inouye	Reid
Byrd	Johnson	Robb
Chafee	Kennedy	Rockefeller
Cleland	Kerrey	Sarbanes
Conrad	Kerry	Schumer
Daschle	Kohl	Specter
Dodd	Landrieu	Torricelli
Dorgan	Lautenberg	Wellstone
Durbin	Leahy	Wyden

The amendment (No. 1236), as amended, was agreed to.

Mr. NICKLES. Mr. President, I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

AMENDMENT NO. 1235

The PRESIDING OFFICER. The question is on the Graham of Florida amendment. There are 4 minutes equally divided.

The Senator from Florida is recognized.

Mr. GRAHAM. Mr. President, most of us here have already voted in favor of the amendment which is before us. In 1997 we adopted virtually this identical language as it relates to the 70 million Americans who are covered either by Medicare or Medicaid. So the question before us is, Should we adopt a different standard of emergency room care for the rest, for the other 190 million Americans?

There are two principal differences between the current law for Medicare and Medicaid and what the Republican alternative would propose. First, as to access to the nearest available emergency room, the current Medicare/Medicaid law says you have the right to go to the nearest emergency room without any additional charge. That is the same provision that is in this amendment. The Republican provision says that a differential charge can be made so you would have to pay more if it happened that the closest emergency room was not an emergency room affiliated with your health maintenance organization.

The second difference is poststabilization care. What is poststabilization care? I quote the language from the Medicare regulations:

> Poststabilization care means medically necessary nonemergency services needed to assure that the enrollee remains stabilized from the time that the treating hospital requests authorization from the health maintenance organization.

Medicare and Medicaid beneficiaries get the benefit of poststabilization care. Our amendment would make that benefit available to all 190 million non-Medicare/Medicaid Americans. The Republican bill would not. It would not say that you are entitled to medically necessary services to continue you in a stabilized condition after you had contacted your HMO and received authorization to do so.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. GRAHAM. Mr. President, there is no reason why all Americans should not have the same benefits that we voted less than 3 years ago to make available to the 70 million Medicare and Medicaid beneficiaries.

Mr. NICKLES. Mr. President, may we have order in the Senate.

The PRESIDING OFFICER. The Senate will come to order.

Mr. NICKLES. I yield 2 minutes to the Senator from Arkansas.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, I say to my colleagues, in the area of emergency group services, both bills eliminate prior authorization, and they should. You should not have to call your insurance company before you go to the emergency room. Both bills establish a process for timely coordination of care, including services to maintain stability of the patient.

I will be offering an amendment that will make it perfectly clear in the Republican bill that there can be no greater costs charged for those going to an out-of-network emergency room as those going to an in-network emergency room. There should not be a differential. I will make very certain in my amendment that there is no such differential.

The Graham amendment is flawed, and it is seriously flawed because it uses language that is confusing for patients, confusing for plans and providers, it is vague and ambiguous, and it does not ensure that poststabilization services are related to the emergency condition. That is a gaping loophole. It is a blank check to say you have to provide services for a condition that is absolutely unrelated to the reason you went to the emergency room.

My amendment I will be offering will fix that vague and ambiguous language to be sure that what is provided in the emergency room for poststabilization services are related to the condition for which the patient went to the emergency room.

This is a very dangerous amendment in that it is vague and ambiguous and leaves a blank check, a gaping loophole that needs to be fixed. I ask my colleagues to reject the Graham amendment.

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

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 1235. The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 47, nays 53, as follows:

[Rollcall Vote No. 201 Leg.]

YEAS—47

Akaka	Edwards	Lieberman
Baucus	Feingold	Lincoln
Bayh	Feinstein	Mikulski
Biden	Graham	Moynihan
Bingaman	Harkin	Murray
Boxer	Hollings	Reed
Breaux	Inouye	Reid
Bryan	Johnson	Robb
Byrd	Kennedy	Rockefeller
Chafee	Kerrey	Sarbanes
Cleland	Kerry	Schumer
Conrad	Kohl	Specter
Daschle	Landrieu	Torricelli
Dodd	Lautenberg	Wellstone
Dorgan	Leahy	Wyden
Durbin	Levin	

NAYS—53

Abraham	Frist	McConnell
Allard	Gorton	Murkowski
Ashcroft	Gramm	Nickles
Bennett	Grams	Roberts
Bond	Grassley	Roth
Brownback	Gregg	Santorum
Bunning	Hagel	Sessions
Burns	Hatch	Shelby
Campbell	Helms	Smith (NH)
Cochran	Hutchinson	Smith (OR)
Collins	Hutchison	Snowe
Coverdell	Inhofe	Stevens
Craig	Jeffords	Thomas
Crapo	Kyl	Thompson
DeWine	Lott	Thurmond
Domenici	Lugar	Voinovich
Enzi	Mack	Warner
Fitzgerald	McCain	

The amendment (No. 1235) was rejected.

Mr. NICKLES. I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

AMENDMENT NO. 1234

The PRESIDING OFFICER. The question is on amendment No. 1234 by Senator NICKLES for Senator SANTORUM. There are 4 minutes equally divided. Who seeks recognition?

Mr. NICKLES. Mr. President, I yield the principal sponsor of the amendment, Senator SANTORUM, 1 minute.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. SANTORUM. Mr. President, I rise in strong support and encourage all my colleagues to support this amendment. The amendment does basically two things. No. 1, it establishes 100-percent deductibility for the self-employed, something for which I know many Members of both sides of the aisle have been striving. One of the things we have said about our health care proposal is that ours is much more comprehensive than the Democratic plan. It looks at the issue of access.

Mr. NICKLES. Could we have order?

The PRESIDING OFFICER. The Senate will please come to order. Again, this is an important debate.

The Senator from Pennsylvania is recognized.

Mr. SANTORUM. As I said, our bill is much more comprehensive. We looked at the question of access and making health insurance more affordable to cover more people, to bring them into the insurance market. Our bill, with this amendment, does that.

The other thing we do is we emphasize that we do not want the Federal Government, the Health Care Financing Administration, to oversee State-regulated plans. Almost all 50 States have passed a Patients' Bill of Rights. They traditionally regulate health insurance. They are doing a very good job. We do not need to impose HCFA regulations and HCFA control over every State insurance department. It is the wrong approach. It is Washington getting its teeth into the State pie. That is unnecessary.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DASCHLE. I yield 1 minute to the distinguished Senator from Massachusetts.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, this vote is directly related to whether the Senate is really interested in covering all Americans who have insurance or whether whatever passes applies to only the 48 million persons who are included in the Republican bill.

In the House of Representatives, all of the leading Republican legislation applies to all patients with insurance through their private employers—the whole 123 million here. The proposals put forward by the House Republicans who happen to be doctors also cover the people in the individual market. But not the Senate Republican bill.

It is an extraordinary irony, but HMOs are found in all of these other categories—under the 75 million, the 15 million, the 25 million—not in self-funded employer plans. So the Republican bill does not even cover the individuals who first raised the whole question of whether their current coverage is adequate. Whatever we are going to do, Republican program or Democrat, let's make sure we provide protections to all patients. Every category here on this chart. That is what our amendment does.

But their amendment would leave out more than 100 million Americans like Frank Raffa, a fire fighter for the city of Worcester, Massachusetts. He puts his life on the line every day, but he and millions of others are left out and left behind with the Republican program. Let's make sure we are going to cover all of them, all the workers in this country.

The PRESIDING OFFICER. The time has expired.

Who yields time?

Mr. NICKLES. Mr. President, I yield 1 minute to the Senator from Missouri, Senator BOND.

The PRESIDING OFFICER. Before the Senator from Missouri starts, the Senate will be in order.

The Senator from Missouri.

Mr. BOND. Mr. President, the opponents of this amendment overlook the fact that the States are involved. The States do regulate health insurance. The States are taking care of those they can cover.

This amendment says we should not wipe out State regulation. It also completes the job of ending the tremendous inequity in our health care system which said formerly that self-employed people could only deduct 25 percent of their health insurance premiums. Thanks to the bipartisan support we have had, we say now, by 2003, that there will be 100-percent deductibility. Right now, however, there are 5.1 million uninsured, 1.3 million children. For the woman who is starting a new business, the fastest growing sector of our economy, she starts up an information technology business and she is not able to deduct 100 percent of health care insurance for herself and her family until 2003. She cannot afford to wait to get sick until 2003.

I urge my colleagues to support immediate deductibility.

The PRESIDING OFFICER (Mr. GORTON). The distinguished minority leader is recognized.

Mr. DASCHLE. Mr. President, I think the distinguished Senator from Pennsylvania had it right. We all support 100-percent deductibility for the self-employed. We just voted for it an hour or so ago. There is no question all of the Senate supports it. We are on record in support of it. The question is whether we should accelerate it. We just voted to accelerate it on this side on the Robb amendment. That isn't the question on this amendment. This amendment is about whether or not we offer 100 million additional Americans the patient protections under the Patients' Bill of Rights.

In order to clarify that, I ask unanimous consent that the deductibility language be added to both the Republican bill, S. 1344, and the Daschle substitute.

Mr. NICKLES. I object.

Mr. DASCHLE. I ask unanimous consent that at least the deductibility amendment be allowed as part of the Kennedy amendment as well.

Mr. NICKLES. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. DASCHLE. That makes it very clear. This vote is about denying millions of Americans the right to patient protections, not about health and deductibility for self-employed businessmen.

I yield the floor.

The PRESIDING OFFICER. All time has expired.

Mr. NICKLES. Mr. President, I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 1234. The yeas and nays have been ordered. The clerk will call the roll.

The assistant legislative clerk called the roll.

The result was announced—yeas 53, nays 47, as follows:

[Rollcall Vote No. 202 Leg.]

YEAS—53

Abraham	Frist	McConnell
Allard	Gorton	Murkowski
Ashcroft	Gramm	Nickles
Bennett	Grams	Roberts
Bond	Grassley	Roth
Brownback	Gregg	Santorum
Bunning	Hagel	Sessions
Burns	Hatch	Shelby
Campbell	Helms	Smith (NH)
Cochran	Hutchinson	Smith (OR)
Collins	Hutchison	Snowe
Coverdell	Inhofe	Stevens
Craig	Jeffords	Thomas
Crapo	Kyl	Thompson
DeWine	Lott	Thurmond
Domenici	Lugar	Voinovich
Enzi	Mack	Warner
Fitzgerald	McCain	

NAYS—47

Akaka	Edwards	Lieberman
Baucus	Feingold	Lincoln
Bayh	Feinstein	Mikulski
Biden	Graham	Moynihan
Bingaman	Harkin	Murray
Boxer	Hollings	Reed
Breaux	Inouye	Reid
Bryan	Johnson	Robb
Byrd	Kennedy	Rockefeller
Chafee	Kerrey	Sarbanes
Cleland	Kerry	Schumer
Conrad	Kohl	Specter
Daschle	Landrieu	Torricelli
Dodd	Lautenberg	Wellstone
Dorgan	Leahy	Wyden
Durbin	Levin	

The amendment (No. 1234) was agreed to.

Mr. NICKLES. Mr. President, I move to reconsider the vote.

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

The motion to lay on the table was agreed to.

AMENDMENT NO. 1233, AS AMENDED

The PRESIDING OFFICER. The question now is on agreeing to amendment No. 1233, as amended.

The amendment (No. 1233), as amended, was agreed to.

Mr. DODD addressed the Chair.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

AMENDMENT NO. 1239 TO AMENDMENT NO. 1232

(Purpose: To provide coverage for individuals participating in approved clinical trials and for approved drugs and medical devices)

Mr. DODD. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Connecticut [Mr. DODD] for himself, Mrs. BOXER, Mr. HARKIN, Mr. KENNEDY, Mr. REID, Mrs. MURRAY, Mr. DURBIN, Mr. ROCKEFELLER, Mr. FEINGOLD, Mrs. FEINSTEIN, and Mr. DASCHLE, proposes an amendment numbered 1239 to amendment No. 1232.

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

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

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

Mr. DODD. Mr. President, I offer this amendment on behalf of myself, Senators HARKIN, BOXER, FEINGOLD, FEINSTEIN, JOHNSON, ROCKEFELLER, KENNEDY, MURRAY, and REID of Nevada.

As I understand it, we will debate it briefly this evening, and then it will be one of the first orders of business tomorrow morning.

This amendment has two parts to it. It would ensure that patients have access to the best possible care in two areas—cutting edge clinical trials and medically necessary prescription drugs.

Until recently, health plans routinely paid for the doctor and hospital costs associated with clinical trials, and many still do. But a growing number of insurance plans are now refusing to pay, disrupting an arrangement that

immediately benefited individual patients and advanced our ability to treat future patients.

As my colleague from Vermont will recall from our debate in the Health and Education Committee, which he chairs, this amendment is a moderate one. It would require insurance plans to cover the costs of a patient's participation in clinical trials in only those circumstances that meet the following criteria: One, the clinical trial must be sponsored or funded by the National Institutes of Health, the Department of Defense, or the Veterans' Administration; two, the patient must fit the trial protocol; three, there is no other effective standard treatment available for the patient; four, the patient has a serious or life-threatening illness.

It seems to me that if a patient's situation meets those criteria, insurance plans ought not to deny access to clinical trials. This ought not to be a controversial proposal.

Let me lastly add that the plan's obligation is to pay only for the routine patient costs, not for the costs of running the trial that ought to be paid for by the sponsor of the trial—such as the experimental drug or medical device.

The cost of providing coverage for clinical trials is negligible. After all, similar routine patient costs for blood tests, physicians' visits, and hospital stays are covered for standard treatment anyway.

The Congressional Budget Office found that this patient protection would increase premiums a mere four-tenths of a percent over the next 10 years. That is less than 12 cents per person per month.

Many researchers believe even this minuscule amount is a dramatic overstatement of the cost. In fact, when the Memorial Sloan-Kettering Cancer Center, and the MD Anderson Cancer Center compared the cost of clinical trials to standard cancer therapies, both of these world-renowned cancer centers found that the average cost per patient actually was lower for those patients enrolled in clinical trials. So it actually can save money to give patients access to clinical trials, if you believe Sloan-Kettering and the Anderson Cancer Center.

The American Association of Health Plans—the trade association for the managed care plans—has urged its members to allow patients to participate in clinical trials and to pay the associated doctor and hospital costs. Let me quote from a news release of the American Association of Health Plans. They said:

> AAHP supports patients having access to NIH-approved clinical studies, and supports individual health plan linkages with NIH-sponsored clinical trials. AAHP also believes that it is appropriate for health plans choosing to participate in NIH research studies to pay the routine patient-care costs associated with these trials.

This is the very trade association of the insurance plans urging its members to allow access to clinical trials and suggesting they ought to pick up the cost

The release goes on to cite the benefits of participating in clinical trials for patients and for the advancement of medicine.

We are asking that health plans do nothing more than what they already said they want and they intend to do.

The Republican proposal? What do they say about the clinical trials? They say the managed care bill should study this issue further. With all due respect, further studies will only cause unnecessary delays. We already have answers to many of the questions they want to study. We know what hinders a patient's participation in clinical trials. It is the plans' refusal to pay for them. We know what the costs are. They are minuscule. And plans presumably have figured out how to differentiate between costs of running the trials and costs of patient care since many of them already are doing it.

All we would get from another year of delay is more patients with life-threatening conditions being denied access to research that can save their lives.

I know this does not have to be a partisan issue. Republicans have not only supported related legislation but some—including Senator MACK, and my colleague, Senator SNOWE who is on the floor, and Senator FRIST—have been leaders on this issue. Our good friend and colleague from Maine, Senator SNOWE, has authored excellent legislation widely supported, I might add, by patient groups which would broadly provide access to almost all clinical trials for all privately ensured patients. I commend her for that bill. Thirteen of our Republican colleagues have cosponsored the Mack-Rockefeller bill that would require Medicare to cover the cost of cancer clinical trials. The Representative from my State, Republican Congresswoman NANCY JOHNSON, has introduced a companion bill with several Republican cosponsors.

What I am offering has broad bipartisan support in a variety of legislative proposals. All we are saying is this Patients' Bill of Rights ought to include it.

Clearly, there is bipartisan interest in making sure patients all over this country with breast cancer, colon cancer, liver cancer, congestive heart failure, lupus, Alzheimer's, Parkinson's, diabetes, AIDS, along with a host of other deadly illnesses, have access to cutting-edge treatments. To allow a plan to deny a patient access to clinical trials is an outrage.

I hope this body will find it in its good judgment to adopt this amendment tomorrow when it comes up for a vote and to allow people to have access to these critical clinical trials.

The second part of this amendment deals with prescription drugs.

Nearly all HMOs and other insurance plans use a preferred list called a formulary to extract discounts from drug companies and to save on drug costs. Many of the best plans already take steps to ensure these formularies aren't unreasonably rigid by putting processes in place that allows patients access to nonformulary medicines when their own doctors say those drugs are absolutely needed. In fact, the HMO trade association supports this practice as part of its Code of Conduct for member plans.

Why would a patient need a drug that is not in the plan's formulary? Patients have allergies in some cases to drugs on the formulary. They may be taking medications that would have bad interactions with the plan's preferred drugs, or simply have a medical need for access to some product that is not listed in the formulary—rather commonsensical reasons.

Without access to a reasonable process for making exceptions to the formulary, patients may be forced to try two or three different types of older, less effective medications and demonstrate that those drugs don't work or have negative side effects before the plan would allow access to offer formulary prescription drugs.

No patient, in my view, should be exposed to dangerous side effects, or ineffective treatment, just because the cheaper drug in their plan that was chosen does not work as well as the one their doctor would recommend.

I was pleased that during our committee markup our chairman, who is on the floor, and our Republican colleagues agreed to support a portion of the protection in the Democratic Patients' Bill of Rights plan that relates to access to prescription drugs. I will point out that, as with the majority of provisions in the Republican bill, even its limited protection would be denied to more than 100 million Americans whose employers don't self-insure their own health care coverage.

In addition, their provision contains a significant loophole that needs to be corrected. The Republican proposal requires plans to provide access to drugs off the formulary. However, it also says that the insurers can charge patients whatever they want to get those off-formulary products, even if they are medically necessary, and even if the drug is the only drug that can save that patient's life.

This subverts the purported intent of the very provision the Republican bill proposes; and that is to ensure that patients have access to medically necessary care. If a determination has been made by a doctor and the plan that a patient needs that specific drug and no other, why should that patient be subjected to higher costs—conceivably even a 99-percent copay?

The issue is not about patients simply preferring one brand over another. Our concern is for patients for whom a certain product is medically necessary. It is inconceivable they should be charged more for the care they need just because it doesn't make the plans formulary. This amendment would remedy that situation.

Lastly, our amendment would also address another roadblock that patients encounter trying to get life-saving prescription drugs. That is the practice of a plan issuing blanket denials on the ground that a drug is experimental even when it is an FDA-approved product.

If there is any question in your mind why the plans would resort to such a practice, I think it's useful to listen to their own explanation. In a letter to the majority leader in July of last year, the American Association of Health Plans, Blue Cross and Blue Shield, and the Health Insurance Association of America wrote:

> If health plans are not allowed to deny coverage on the basis that the device is investigational, the health plans would have to perform a much more costly case-by-case review on the basis of ''medical necessity''.

They state the case for me.

In other words, according to the health plans themselves, their fear is that if they are prevented from issuing blanket, unfounded denials they might actually have to look at an individual patient's medical needs.

These two provisions of this amendment are critically important. Patients need access to clinical trials and they need access to prescription drugs. It doesn't get more basic than that.

Denying access to clinical trials doesn't just deny good care to the patient today who is desperately in need of a cure, but it denies state of the art health care to future patients as well, by impeding the development of knowledge about new therapies.

Senator MACK, Senator SNOWE, and many others have strongly supported legislation in this area. Some of their bills go further than my amendment does.

I hope tomorrow when the vote occurs we will have the support of a broad bipartisan coalition.

Mr. REID. Will the Senator yield?

Mr. DODD. I am happy to yield to the Senator.

Mr. REID. I say to my friend from Connecticut, isn't it true we spend billions of dollars at the National Institutes of Health, the Veterans' Administration, and the Department of Defense on medical research that can only be made effective if they have clinical trials?

Mr. DODD. That is correct. The process of finding cures starts with an unknown product first being tested in the laboratory. The second place it is tested is with animals. Third is the clinical trial before it is on the market for general use.

If insurers impede enrollment in clinical trials that phase of research development will be adversely affected and valuable, life-saving products will be delayed from getting on the market for general use by the public.

It is an excellent question.

Mr. REID. I say to my friend, all the money, the billions and billions of dollars, spent by the entities I previously talked about, the money we spend is basically worthless unless we can have clinical trials.

Mr. DODD. To answer my colleague from Nevada, the Senator is absolutely correct. This is a tremendous waste of taxpayer money. There are those, I suppose, who are only concerned about that issue. I appreciate the Senator raising the point because it is indeed a waste of money.

It is also a waste of human lives. I think that people watching this debate here on the floor of the Senate will ask the question: What did the Senate do when it had a chance to protect my family, my child, my wife or my husband, to give them access to the cutting edge technologies when my insurer says no. I think they will be outraged if we don't provide them this protection.

In addition to the monetary cost issue, which our distinguished friend from Nevada has raised, to cause a human life to be lost because we denied access to clinical trials, I argue, is an even greater loss.

Mr. REID. There have been some who say it is too expensive. The Senator is aware of plans that have cut off clinical trials because it is ''too expensive.''

What I hear my friend saying is, the real expense is in the pain and suffering of the families who suffer from Parkinson's, Alzheimer's, lupus, and all the other diseases that the Senator has outlined so clearly.

Is it not true that is where the real suffering comes and that is where the expense comes—in the pain and suffering to those people—if we don't allow the clinical trials?

Mr. DODD. I appreciate the question of my colleague.

He is absolutely correct. I will make a dollars-and-cents case. The cost is 12 cents per patient per month, a negligible cost.

As I mentioned in earlier remarks, when Sloan-Kettering Cancer Institute and the MD Anderson Cancer Center examined the issue of cost—two world-class cancer research centers—their conclusion was that clinical trials are actually less costly than the standard care that will be used in the absence of clinical trials. ''Less costly'' is their conclusion.

If your argument is we cannot do this because it costs too much, one estimate suggests 12 cents per patient per month, and two of the world-class cancer centers in the world think it is actually a lower cost using the clinical trials.

Mr. REID. The final question I ask my friend from Connecticut: Isn't it true that huge amounts of money will be saved if these clinical trials are proved effective? The Senator knows that half the people in our rest and extended care facilities are there because of Parkinson's and Alzheimer's.

Assume, for example, that these clinical trials would delay the onset of one of these two diseases or if some miracle would occur we could cure those diseases. Would that save this country money?

Mr. DODD. The cost in savings would be astronomical.

When we delay a product going from the research phase to general use because patients are shut out of clinical trials, not only do patients today suffer, but future patients suffer, and the costs to the health care system as a whole go up.

AIDS is a wonderful example of this—the AIDS clinical trials have saved literally thousands of lives. People are working today who would not have been able to do so had it not been for clinical trials that helped to develop powerful new drugs. Imagine if the treatments that exist today existed a few years ago, what a different world it would be and how many lives would not have been lost—productive citizens today who would make a contribution to our society.

I reserve the remainder of our time.

Mr. JEFFORDS. Mr. President, I commend my good friend on the committee for the work he has done in this area. This is an area where we have joined together. It will ensure that we have a change, a positive change in the clinical trial aspect. I want to work together with the Senator in that regard.

I also want to say this bill is not finished yet. We have places to go and time to spend to bring it to a better form than it is now. I look forward to continuing to work to improve the bill.

I reserve the remainder of my time.

Mr. DODD. How much time remains?

The PRESIDING OFFICER. The Senator from Connecticut has 29 minutes 33 seconds, and the Senator from Vermont has 49 minutes 15 seconds.

Mr. REID. Mr. President, I think we are ready to do wrap-up.

Mr. JEFFORDS. That is my intention.

Mr. REID. The time has stopped running on the bill for both the majority and minority.

Mr. McCAIN. Mr. President, this evening I cast several difficult votes regarding core principles facing this body as we work to ensure the health care rights of Americans are protected.

I voted for an amendment creating an external appeals process for patients who are denied medical care by their health plan. While I strongly support this initiative, I am concerned that this specific proposal needs further strengthening ensuring that the individual health care rights of Americans are the priority. I will be working with my colleagues on both sides of the aisle to strengthen the external appeals process, including access to reasonable legal remedies while ensuring that the external review process is conducted by unbiased and independent entities whose sole purpose is to protect the rights of American patients.

In addition, I support guaranteeing an individual medical care in an emergency room without prior approval from their HMO if the person believes that it is an emergency situation. However, I was forced to vote against an

amendment which provided this protection but then superseded state rights and created an opportunity for emergency rooms to begin providing a litany of treatments outside of the realm of the perceived emergency which could have negative financial repercussions.

Finally, I support providing American women with direct access to OB/GYNs and ensuring they receive quality health care while battling breast cancer. However, I was forced to vote against an amendment providing this critical access because it eliminated an important provision ensuring that health care costs do not skyrocket thereby causing thousands, if not millions of new Americans to lose their health care coverage.

Mr. CAMPBELL. Mr. President, today I take this opportunity to comment on the pending bill.

In my view, what we are discussing today is the most costly big-government health care plan since the Clinton health care reform plan was debated earlier this decade. We all know the fate of that attempt, and it is my hope we might now allow common sense to play a part in creating a Patients' Bill of Rights.

The demands on our health care system have changed dramatically in the past decade. So has our health care system. But, those changes have not affected all people evenly, and it's clear many people have had unfortunate experiences.

Going from the traditional doctor-patient relationship into a system where all aspects of care are subject to approval and authorization is understandably difficult. But, as the cost of quality care became an obstacle to access, the concept of managing care has evolved as the predominate method of insured medical service.

While health care in America, and our advances in medical technology remain the envy of the world, it would be a serious mistake to pretend that all are well-served by our present health care system.

The Federal Government, in an effort to give all Americans access to affordable care, has, in fact, encouraged participation in managed care plans. All federally-sponsored health care, which includes Medicare, Medicaid, the Federal Employees Health Benefit program and military health care, has experienced the emergence of managed care. Now we must deal with the issue of ensuring health care quality as a first priority. And we must do it in a way that will not raise costs of care or cause employers to stop offering health insurance.

While managed care has become the dominant delivery method of cost-effective healthcare in our nation, what is missing are standards that will ensure fairness to both patients and providers, and clarify what are often confusing medical and legal terms and hidden rules for both parties. The question before us now is how best to protect these patients while giving the health care industry incentives for finding efficient methods of delivering care.

All of us expect the highest quality health care for the citizens of this country, but, that care must be affordable. Anyone that believes having Congress dictate a costly, one-size-fits-all mandate will make health care more affordable or more available is, I believe, severely out of touch with reality.

That is why I am concerned about the pending legislation. This bill mandates new regulations which would increase premiums by 6.1 percent, not including inflation. It could raise the cost of a typical family's health insurance policy by more than $300 per year. That is not logical, responsible or acceptable. We have been down this road before with the ''catastrophic health'' bill of 10 years ago. The Senate passed it because people were told premium increases would be minimal. Then people got their bill. This pending bill will drive up the number of uninsured Americans. In my State of Colorado, it is estimated that this legislation would add more than 32,000 persons to the rolls of the uninsured. Our biggest health care problem already is that there are currently 43.5 million uninsured Americans. Who pays for their inevitable medical care? You, I, and every other taxpayer. It is clear that increased mandates increase costs, and that those increased costs reduce coverage.

It is no secret that higher health insurance premiums will force employers to drop optional medical coverage they offer employees. That should not be the intention of this legislation, but it is the reality. Every time a mandate raises the cost of insurance by one percent, more than 200,000 Americans lose their coverage.

Small businesses would drop coverage if exposed to the pending bill's liability provisions. Canceling coverage leaves patients exposed to expensive medical bills. That's not patient protection. We cannot pass legislation that forces employers to provide health care. They will close shop, because they can't afford it. The pending bill will lead to government-run health care. The bill's mandates could cost the private sector more than $56 billion, greatly exceeding the annual threshold established in the Unfunded Mandates Reform Act, which most Members of this body voted for.

Many States are currently developing patient-protection legislation through their State legislatures and assemblies. My State of Colorado has already established mandates concerning an independent external review process for denied claims, a ban on gag clauses, and direct access to OB-GYN services.

Despite that fact, the pending bill, in an attempt to tighten federal control over the entire U.S. health system, applies federal mandates to all health insurance products.

Mr. President, I believe it is time to put the brakes on the runaway one-size-fits-all mandates which are inflicting hardship on our most vulnerable citizens and legitimate health care providers. The time to protect patients and providers is before costly mandates are enacted into law.

Let us think ahead. We have already seen through our experience with the Balanced Budget Act of 1997, that well-intentioned solutions enacted by Congress can turn into unworkable, burdensome regulations when imposed on the entire health care system. We are discussing sweeping legislation which, if passed and enacted, will have significant consequences for all Americans and their health care. I believe we can best protect these Americans by making reasonable changes which give them more choices. Let's provide access to affordable, quality care without inventing unnecessary new federal mandates for an already top-heavy health care structure.

I believe the Republican Patients' Bill of Rights Plus will do just that. It will improve quality of care and expand consumer choice as well as protect patients' rights.

It will hold HMOs accountable for providing the care they promised. It places treatment decisions in the hands of doctors, not lawyers. And, patients have the right to coverage for emergency care that a prudent lay-person would consider medically necessary.

The purpose of our bill is to solve problems when care is needed, not later after harm has occurred. Common sense demands we act reasonably. More importantly, the future health care of hundreds of millions of Americans demands we act with their interests in mind.

I thank the Chair.

Mr. ALLARD. Mr. President, in the 1970s, the State of Colorado adopted a well-child care law, legislation concerning the treatment of alcoholism and mental health, as well as legislation concerning insurance coverage of psychologists. In the 1980s home health care, hospice care, and mammography screening legislation was passed into law. In the 1990s, those who represent the people of Colorado in the State House saw fit to pass laws concerning the coverage of nurses, nurse midwives, nurse anesthetists, nurse practitioners, psychiatric nurses, the continuation of coverage for dependents and employees, and conversion to non-group health care.

This decade the Colorado Legislature also passed consumer grievance procedures, children's dental anesthesia and general dental provisions, direct access to OB–GYN, direct access to midwives for OB–GYN, emergency room services legislation, a ban on gag clauses, prostate cancer screening, breast reconstruction, maternity stay, and mental health parity legislation. Last, but certainly not least, among State laws enacted in my home State is a law concerning independent external appeals

for patients and a comprehensive Patients' Bill of Rights, passed in 1997.

I am proud to have served in the Colorado State Senate, and I am proud to say that today I represent a state that has been responsive and aggressive in addressing health care issues and patients' rights.

At the same time, Mr. President, I am deeply troubled that there are those in this body who are advocates of Senator KENNEDY's Patients' Bill of Rights that would preempt a number of the laws that I just mentioned in the State of Colorado. In this country of 260 million Americans throughout the fifty states I believe that the people of those States are in the best position to make these specific decisions. I come from our nation's 8th largest State with a population of just 3.9 million people. I will not assume that any federal entity is more prepared to develop policy for Colorado than the people of Colorado, nor would I impose the policies unique to Colorado's needs on another State.

Something I find equally troubling is that in addition to infringing on the laws of the State of Colorado, the legislation that Senator KENNEDY and the Democrats have developed has the potential to increase health care costs, deprive 1.9 million Americans of health insurance who are currently covered, and cast heavy mandates down on individual states who are in a far better position to make these decisions for themselves.

I will speak today about a number of things I believe will enhance the quality of health care, increase access to care, and provide important protections for patients without unnecessarily placing mandates on individual states. These provisions are all part of a comprehensive package called the Patients' Bill of Rights Plus Act, which I feel properly addresses the needs of America's patients, physicians and health care providers.

The Patients' Bill of Rights Plus Act establishes consumer protection standards for self-funded plans currently governed by the Employee Retirement and Income Security Act (ERISA). 48 million Americans are currently covered by plans governed by ERISA—these are American health care consumers who are not under the jurisdiction of state laws.

Our bill would eliminate gag rule clauses in providers' contracts and ensure that patients have access to specialty care. The legislation also requires that health plans that use formularies to provide prescription medications ensure the participation of doctors and pharmacists in the construction of the formulary. Further addressing patient choice and access, health plans would be required to allow women direct access to obstetricians and gynecologists, and direct access to pediatricians for children, without referrals from general practitioners.

These provisions are important steps in removing barriers that may prevent patients covered under ERISA from receiving necessary and proper treatment in a timely manner.

As a former small business owner I have a keen understanding of the issues that confront the self-employed. I also have experience in balancing the wages and benefits you extend to an employee with a healthy bottom line. I think it is important that we remember throughout the course of this debate that employers provide health care benefits as a voluntary form of compensation for their employees. We must be wary of legislation that will increase costs and liability for employers in a way that may reduce the quality and scope of benefit packages for employees.

Our bill, the Patients' Bill of Rights Plus, would make health insurance deductible for the self-employed and increase the availability of medical savings accounts. I believe that each of these provisions would give greater power to the individual and make private insurance more affordable for families and individuals. Large corporations can claim a 100 percent deduction for health care and small business should be treated the same.

Medical savings accounts, otherwise known as MSAs, combine a high deductible and low cost catastrophic policy with tax free savings that can be used for routine medical expenses. We should increase the availability to all families who desire MSAs. These efforts will prove particularly helpful to those individuals working for small business, and those in transition from one job to another since MSAs are fully portable.

I want to stress that our legislation will not mandate these accounts for everyone, but will simply establish the accounts as an option to those who feel they will be best served by MSAs. I believe that medical savings accounts are particularly important for uninsured, lower income Americans. Allowing consumers to pay for medical expenses through these affordable tax-deductible plans, tailored to their needs, is a viable free-market approach to decreasing the number of uninsured in America. This is a question of providing greater choice for health care consumers.

The Patients' Bill of Rights Plus Act would also permit the carryover of unused benefits from flexible spending accounts, again increasing the number of options available to the consumers of health care.

In keeping with presenting more options to the consumer, The Patients' Bill of Rights Plus Act includes language that would require all group health plans to provide a wide range of comparative information about the health coverage they provide. This information would include descriptions of health insurance coverage and the networks who provide care so that consumers covered by self insured and fully insured group health plans can make the best decisions based on their needs and preferences.

One of the most contentious issues in health care has been the issue of malpractice liability, grievance procedures and the mechanism for the appeal of decisions made by managed care companies. My colleagues across the aisle are interested in taking the grievance procedure into a court of law, allowing a patient greater access to litigation as a means of challenging a managed care organization's decision.

Lawsuits and the increased threat of litigation will demand that more money to be funneled into non-medical administration and away from what patients really want—quality health care. Furthermore, making the courts a de facto arbiter of health care decisions seems to me to be less efficient and less effective in dealing with the interests of the patient. The Kennedy bill is an enormous gift for the trial lawyers in America who stand to profit by high cost, long-term cases. Patients, not lawyers, will fare far better under the Patients' Bill of Rights Plus.

I am also concerned that expanding medical malpractice liability will lead to more defensive medical decisions regardless of the merit of a particular treatment. High liability exposure and cost has driven countless physicians from their profession for years, particularly in high-need rural areas.

This is not a provision we can afford in rural areas of western States like Colorado that are already underserved.

Rather than take health care out of the doctor's office and into the courts, the Patients' Bill of Rights Plus Act establishes strict time frames for internal and external appeals for the 124 million Americans who receive care from self insured and fully insured group plans. Routine requests would need to be completed within 30 days, or 72 hours in specific cases when a delay would be detrimental to the patient. Rather than use the courts in cases of health care appeals our legislation would establish a system of independent, internal and external review by physicians with appropriate expertise. We are talking about doctors with years of experience and medical training making health care decisions, not legal arguments.

I believe that such a system will be more responsive and more tailored to the needs of every individual patient—and it will do so without creating unnecessary bureaucracy. It is also important to note that these internal and external appeals will cost patients and employers considerably less than the alternative proposal that is heavy on lawsuits, lawyers and litigation.

Another area of concern that I believe needs to be incorporated in any sensible managed care reform legislation is the inclusion of protections for patients from genetic discrimination. The Patients' Bill of Rights Plus Act would prohibit all group health plans and insurers from denying coverage or adjusting premiums based on predictive genetic information. The protected genetic information includes an

individual's genetic tests, genetic tests of family members, or information about the medical history of family members.

No one should live in fear of being without health care based on genetic traits that may not develop into a health problem.

Mr. President, I believe these provisions will empower the individual, not the lawyers or bureaucracies. I am committed to the notion that each individual American consumer of health care is in the best position to chose where his or her health care dollar is best spent.

An administrative issue involved in this debate that I am very concerned with is the effort to attempt to force all health plans—not just HMOs—to report the medical outcomes of their subscribers and the physicians who treat them. This makes sense for a managed care plan such as an HMO, but it would be virtually impossible for a PPO or indemnity plan to monitor and classify this data without becoming involved in individual medical cases.

I believe that if we require all health plans to collect and report data like this we will be requiring all plans to be organized like an HMO. This would significantly reduce the number of choices consumers and employers currently enjoy in selecting their health care.

The Congressional Budget Office recently determined that if S. 6, the Kennedy version of the Patients' Bill of Rights, were to pass that this country would see private health insurance premiums increase 6.1 percent above inflation. What appears to be a minor increase to health care premiums would have disastrous and immediate consequences around the country, adding 1.9 million Americans to the ranks of the uninsured. In my home state that translates to 32,384 people. In Colorado the average household would lose $203 in wages and 2,989 jobs would be lost by 2003 for this ''minor'' increase.

We are talking about people in Colorado losing their jobs and their health care coverage because Washington wants to do what the State of Colorado has been working on for the last thirty years.

The Congressional Budget Office determined that our bill, the Patients' Bill of Rights Plus Act, would increase costs by less than 1 percent. While I urge my colleagues to be wary of any potential increase in costs for the American people, I also believe that the Patients' Bill of Rights Plus, and not the current Kennedy bill, directly addresses health care quality issues and increases choice for consumers with a minimal cost.

Mr. AKAKA. Mr. President, I rise today to speak on a very important piece of legislation—legislation that is vital to the future of health care in this country, the Patients' Bill of Rights. Democrats have fought long and hard to debate this bill on the floor of the Senate and I am thankful for the opportunity to speak in support of the underlying measure.

Today more than 160 million Americans, over 75 percent of the insured population, obtain health coverage through some form of managed care. Managed care arrangements can and do provide affordable, quality health care to large numbers of people. Yet reports of financial consideration taking precedence over patients health needs deserve our attention. We hear stories and read news articles about people who have paid for health insurance or received employer-sponsored insurance, became ill, only to discover that their insurance does not provide coverage. Recent surveys indicate that Americans are increasingly worried about their health care coverage. 115 million Americans report having a bad experience with a health insurance company or knowing someone who has. This undermining of confidence in our health care system must be addressed. We must act to restore the peace of mind of families in knowing that their health insurance will be there when they need it most. We can accomplish this by establishing real consumer protections, restoring the doctors decision-making authority, and ensuring that patients get the care they need.

Some of the important issues that we are debating include the scope of coverage, definition of who determines ''medically necessity,'' protecting the doctor/patient relationship, access to care, and accountability.

True managed care reform cannot come from a narrow bill that covers only a certain segment of the population. Today much of the regulation of managed care plans comes form the states. However, federal laws such as the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act, combined with the various state regulations, form a patchwork of regulation for managed care plans. Some in this chamber believe that the protections we are considering should only apply to ERISA-covered plans and not to the 113 million Americans who have private insurance that is regulated by the states. They argue that these issues should be left to the states to address. Democrats believe that everyone deserves equal protection, regardless of where they may live or work. The Patients' Bill of Rights would not interfere with patient protection laws passed by the states, it would simply extend these patient protection rights to all Americans.

As managed care has grown, so has the pressure on doctors and other health care providers to control costs. Complaints receiving widespread attention include denials of necessary care, lack of accountability, limited choice of providers, inadequate access to care, and deficient information disclosure for consumers to make informed plan decisions. Mr. President, a strong Patients' Bill of Rights should address the shortcomings of managed care. S. 6 takes a comprehensive approach in dealing with these issues, which is why I am a cosponsor of the measure.

The dominance of managed care has undermined the doctor-patient relationship. Often tools are used to restrain doctors from communicating freely with patients or providing them with incentives to limit care. We need to ensure that insurers cannot arbitrarily interfere in the medical decision making. The Patients' Bill of Rights includes a number of provisions to prevent arbitrary interference by insurers. Our bill establishes an independent definition of medical necessity, prohibits gag clauses on physicians and other restrictions on medical communications, and protects providers from retaliation if they advocate for their patients.

The issue of who decides what is medically necessary is probably the most fundamental issue of this debate. We must empower patients so they receive appropriate medical treatment, not necessarily the cheapest treatment, not necessarily the treatment that an insurance company determines is appropriate, but the best treatment. Currently, many doctors are finding insurance plans second-guessing and overriding their medical decisions. Democrats believe that the ''medical necessity'' of patient care should be determined by physicians, consistent with generally accepted standards of medical practice. Doctors are trained to diagnose and make treatment decisions based on the best professional medical practice. We need to keep the medical decisions in the hands of doctors and not insurance company bureaucrats.

Families in managed care plans often face numerous obstacles when seeking access to doctors and health care services. Some of these barriers include restrictions on access to emergency room services, specialists, needed drugs, and clinical trials. S. 6 would ensure access to the closest emergency room, without requiring prior authorization. It would provide access to qualified specialists, including providers outside of the network if the managed care company's choices are inadequate, and direct access to obstetricians and gynecologists for women and pediatricians for children. S. 6 would also ensure access to drugs not included in a managed care plan's covered list when medically indicated and provide access to quality clinical trials.

Finally, the underlying bill allows consumers to hold managed care companies accountable for medical negligence. Currently, insurers make decisions with almost no accountability. Patients deserve the right to a timely internal appeal and an unbiased external review process when they disagree with a decision made by the insurer. Patients also deserve recourse when the misconduct of managed care plans results in serious injury or death. However, under ERISA plans, patients have no right to obtain remedy under state

law. These patients are limited to the narrow federal remedy under ERISA, which covers only the cost of the procedure the plan failed to pay for. S. 6 would ensure that managed care companies can be held accountable for their actions. It does not establish a right to sue, but prevents federal law from blocking what the states deem to be appropriate remedies. A strong legal liability provision will discourage insurers from improper treatment denials or delays and result in better health care.

Mr. President, only a comprehensive bill will guarantee patient protection with access to quality, affordable health care. We should not miss this important opportunity to enact meaningful legislation that is federally enforceable and will improve care and restore confidence in our health care system.

MORNING BUSINESS

Mr. JEFFORDS. Mr. President, I now ask unanimous consent that the Senate now proceed to a period of morning business with Senators permitted to speak for up to 10 minutes each.

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

TRIBUTE TO DR. MARY E. STUCKEY, THE 1999 ELSIE M. HOOD OUTSTANDING TEACHER

Mr. LOTT. Mr. President, it is with great pleasure that I pay tribute to The University of Mississippi's 1999 Outstanding Teacher of the Year, Dr. Mary E. Stuckey.

Each year my alma mater The University of Mississippi, known as Ole Miss, recognizes excellence in the classroom with the Elsie M. Hood Outstanding Teacher Award during its Honors Day Convocation. Nominations for this honor are accepted from students, alumni, and faculty. A committee of former recipients then selects the faculty member who best demonstrates enthusiasm and engages students intellectually.

Dr. Mary E. Stuckey is an Associate Professor of Political Science. An 11-year veteran of the Ole Miss Political Science Department, Dr. Stuckey's teaching interests include the Presidency and political communications as well as American Indian politics. Her research focuses on Presidential rhetoric, media coverage of the President, and institutional aspects of Presidential communication. Dr. Stuckey is also working on several projects regarding depictions of American Indians in the media and in national politics. In addition to these areas of interest, she also teaches in the McDonnell-Barksdale Honors College.

Dr. Stuckey's research has earned her several prestigious grants. These include the President Gerald R. Ford Library, the C–SPAN in the Classroom Faculty Development, a National Endowment for the Humanities Fellowship, and the Canadian Studies Faculty Research. She has also published several studies such as ''The President as Interpreter-in-Chief'' and ''Strategic Failures in the Modern Presidency.''

A native of southern California, Dr. Stuckey earned a bachelor's degree in political science from the University of California at Davis. She then completed her graduate studies at the University of Notre Dame and joined the Ole Miss faculty in 1987.

Now, Mr. President, let me tell you that Dr. Stuckey and I probably will not agree on much when it comes to political issues. But three members of my current staff, Steven Wall, Beth Miller, and Brian Wilson, tell me she is outstanding in the classroom. They all agree that she is an equal opportunity challenger, regardless of political views, when it comes to the study of politics. She requires her students to use logic rather than emotions when advocating any viewpoint. Dr. Stuckey does not penalize her students when they don't share her views; rather she rewards academic scholarship.

The study of political science is essential to any society. And I believe it is even more incumbent on us, as Americans, to do so. Thomas Jefferson once said, ''Self-government is not possible unless the citizens are educated sufficiently to enable them to exercise oversight.'' He was right. Universities are an important institution to help instill in each generation an appreciation for the unique and honorable character required for our democratic republic. Americans want to learn from their past mistakes so they can strive to build a better society for their children and grandchildren. Dedicated and inspiring teachers, such as Dr. Mary E. Stuckey, this year's Elsie M. Hood Award recipient, are key to ensuring that our next generation of political leaders will have the necessary knowledge and character to make America strong.

ECONOMIC REFORMS IN RUSSIA

Mr. KERREY. Mr. President, I draw my colleagues' attention to an article that appeared earlier this year in Economic Reform Today. I ask unanimous consent that the full text of ''Safeguarding Russian Investors: Securities Chief Speaks Out'' be printed at the end of my statement.

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

(See exhibit 1.)

Mr. KERREY. Mr. President, Economic Reform Today is a quarterly magazine published by the Center for International Private Investment. CIPE is one of the core grantees of the National Endowment for Democracy and is dedicated to promoting democratic governance and market oriented economic reform. Their work has been particularly important in assisting the ongoing transition to free markets in the former communist countries of Eastern Europe and the former Soviet Union.

The article I will include in the RECORD, highlights Russia's continuing effort to implement political and economic reforms. This has been a painful process in Russia. However, it is my firm belief that Russia's transition to a free-market democracy will be measured in decades, not years. During this important time—CIPE and the other NED grantees—have been working to ensure that the Russian people have access to the information and resources necessary to make a successful transition.

Again, I encourage my colleagues to read this important article.

EXHIBIT 1

SAFEGUARDING RUSSIAN INVESTORS: SECURITIES CHIEF SPEAKS OUT

(If Russia is to gain economic stability and attract foreign investors it will need to respond better to the needs and concerns of investors. Dmitry Vasiliyev has made this the chief reform priority of the securities commission that he heads. He is one of the strongest voices in Russia today calling for more efficient and transparent markets to provide the necessary foreign and domestic capital to jump start Russia's newly privatized enterprises. In this interview with Economic Reform Today, Vasiliyev underscores the importance of establishing strong shareholders' rights as a cornerstone of economic reform)

ERT: You have made upholding shareholder rights one of the top priorities of the Federal Securities Commission (FSC). Why is this so important?

Mr. Vasiliyev: Protecting investors' rights is an important prerequisite for attracting foreign investment, and, unfortunately, Russia faces serious problems in this area. Although we are gradually improving the quality of corporate governance, Russia is losing billions of dollars in investments because of poor investor safeguards, both in corporate and government securities. This is reflected in the lower value of Russian stock prices as compared with those of other emerging market countries. Better protection of investors' rights will attract more investors and allow companies to raise more capital and lead to the development of new technologies and more production.

ERT: Can you gauge the damage that denying these shareholder rights inflicts on the Russian economy?

Mr. Vasiliyev: The Russian economy faces serious consequences unless it can offer adequate safeguards. Not only are foreigners reluctant to invest in Russia, but Russians do not trust it either. People are putting their savings into dollars because other forms of investment don't offer enough protection.

That's why we have concentrated our efforts on protecting the market from low-quality securities. Last year we denied registration to 2,600 issues; that is, we turned down 14% of all submitted prospectuses. That means we prevented 2,600 possible violations of shareholder rights. Of course we also had to cancel some issues that were already registered; for example, the well-publicized cases involving the largest Russian oil companies, such as Sidanko and Sibneft. Last week the Commission launched an investigation into the case of Yukos. We are determined to use all measure necessary to defend minority shareholders. In some cases the exchange or brokers themselves violate shareholder rights through manipulation. Our investigations have increased sevenfold in the last two years. We recognize, however, that we are only at the beginning of a long process.

A responsible government should observe a strict financial policy and minimize its borrowing, including issuing government bonds. The crisis over the past year was also a crisis of sovereign debt: the crash of the GKO (government bond) pyramid caused tremendous losses to the real economy and to the financial sector. As a result, the government is developing twelve new laws aimed at protecting investors. In March, Parliament adopted one of these laws, which protects investors in the securities markets. We also need to improve our joint stock company law in order to reduce share dilution and asset stripping, as well as to allow shareholders to dismiss management and stop asset theft. We also want to change the criminal code and make nondisclosure to investors and crime. I believe that we can learn from other countries' experiences, including the United States, in this area.

There are several typical violations of shareholder rights in Russia. The first is share dilution, which we have been trying to counter by denying issue registrations. The bill approved in March also introduces stricter procedures that should protect against share dilution.

The second is nondisclosure or provision of false information. We have begun to address this issue through the same bill, which allows the FSC to fine issuers of securities if they provide insufficient disclosure or misleading data. For example, if a prospectus contains false information, those who have signed it—the CEO, the auditor and the independent appraiser—bear a subsidiary responsibility if investors lost money because the information was false. Of course this is only the first step; we still have to iron out how to enforce the law and other procedural matters. In the West, for instance, you have ''class action'' suits, but courts do not hear such cases in Russia.

Another typical violation is transfer pricing abuse; that is, when commodities or securities are sold at artificial prices between or among affiliated companies. Here, as in the case of asset stripping, shareholders need to have stricter control over the actions of management. The FSC is trying to prevent the execution of large transactions without prior shareholders' approval. While we do not always succeed, we are trying to close this important loophole.

The issue of share conversion between a holding company and its subsidiaries is very serious. Shareholders of both the holding company and the subsidiaries must insist on a fair and independent appraisal of assets and establishment of a fair conversion rate. Government officials cannot solve this question; it's a matter for management and the shareholders and points up the importance of appropriate procedures for corporate decision making. For example, in some cases, such as Lukoil's, the share conversion process went pretty smoothly because Lukoil management took a balanced and well-conceived position. Other cases, such as Sibneft, resulted in huge scandals. This is a long-term process and the FSC will be focusing on this issue indefinitely.

ERT: Financial industrial groups have a very strong presence in the Russian economy. Experts argue that they need to be reformed or regulated. In your view, what type of regulation is necessary?

Mr. Vasiliyev: The economic crisis last year delivered a very serious blow to financial industrial groups (FIGs). It destroyed many of them, and weakened many of the so-called ''oligarchs,'' who were forced to sell off parts of their empires. Yukos is just one example of the troubles facing these groups.

I believe that FIGs are not the most efficient way to achieve economic development. Equity or investment financing through the securities market and the banking system should be kept—and regulated—as separate systems. The experiences of other countries, including the US, show that heavy investment in industry by banks and financial institutions can have catastrophic consequences. Back in 1997, I was already insisting that Russia needs banks to stay away from risky speculative operations, not to hold stock in companies and not to invest in industry. What we had in the August 1998 crisis was the collapse of the settlement system.

At the same time we need investment banks involved in corporate finance, but investors know that many Russian banks are used for speculative operations not for settlement purposes. Russia's President Yeltsin recently sent a message to the Federation Council stating that the country needs both ''settlement'' banks and ''investment'' banks. The fact that President Yeltsin highlighted this critical issue is an encouraging sign for the ailing banking sector.

Creditors' rights also need to be protected. In Russia creditors are not offered adequate protection. The banks say that they need a controlling interest in a company in order to be able to lend money to it. Creditors' rights should be protected, but the solution to that is for banks not to participate in a company's equity capital. If banks would lend to companies rather than invest in government bonds, they would not be so involved in speculation and not be so dependent on getting controlling interest in companies.

State involvement in the economy should be minimal, but today it is still very high. Sweeping privatization is not the most important objective; the goal should be to privatize the land held by industrial companies so they can use it as collateral for loans. The sooner this is done the better, but this process has moved very slowly since 1994. In my opinion this aspect of privatization is more important than agricultural reform.

ERT: Can you delineate the responsibilities of the FSC and the Central Bank in regulating corporate transactions and capital markets? In what areas should they cooperate and in what areas should they have separate responsibilities?

Mr. Vasiliyev: I believe that each has its own functions—the main objective of the Central Bank, just like in any other country, is supporting the national currency. My task at the FSC is to protect investors and regulate the securities market.

ERT: In your view, what is the Russian public's perception of the local business community? If it is negative, how should businesses work to revamp this perception?

Mr. Vasiliyev: The attitude toward business people is not very good. I believe that the country's private sector should work on changing its tarnished image. It should be prestigious to be involved in business and society should appreciate that it has an important function. Changing the poor image of business will, of course, take a long time. The ideology of the old Soviet regime won't disappear overnight. In Russia it is the younger generation that is leaning toward capitalism.

The private sector, of course, will play a key role in the economy. It already plays an important role, but often in the form of speculation and the ''shadow'' economy. The Russian economy needs to move from the shadows to the daylight through simplification of regulation and licensing. We need to make it profitable to pay taxes. (See ERT No. 4, 1997 pp. 6–9 for a detailed discussion of how Russia's ''shadow'' economy operates.)

ERT: In Russia, much of the public perceives the privatization process as unfair. How would the changes in regulations that you have outlined in this interview improve this process?

Mr. Vasiliyev: We believe that the structure of ownership will gradually change. Many companies that were privatized as joint stock companies will probably leave the securities market. They are not interested in remaining publicly traded. We will probably have 500 to 1,000 publicly traded companies. Most small shops or factories employing less than 100 persons will gradually end up being privately owned or become closely held companies, which is fine. The number of publicly traded companies is declining in countries that went through mass privatization. We see this happening in the Czech Republic and it will eventually happen in Russia, too.

There were two components of Russia's privatization process. One was land privatization—the land ''under'' companies—and the other was securities markets development intended to rectify privatizations that were not done in a very efficient manner. We were forced to implement privatizations in the way we did. Other options then were not politically or psychologically acceptable in our country. I still believe this. But it is obvious that we encountered a lot of insider influence and very limited transparency because of the very fast pace of transition.

When we were first starting to privatize, I worked in the state property commission as a deputy to Mr. Anatoly Chubais, its chairman, and I drafted many documents on privatization. One of the main conditions we asked for was that companies become open joint stock corporations so that stock could be sold and bought. Now that there is a battle for control of these companies and the advent of outside shareholders is beginning to strengthen their positions, Russian companies are changing bit by bit. The securities markets are helping this transition.

The use of a central depository as a privatization mechanism has been adopted by many emerging market countries and is accepted by all securities commissions. If we could establish a central depository, we would be able to reduce the number of registrars and eventually move toward not using them at all. Later we could introduce centralized clearing settlements. These will lower investors' costs and significantly improve protection of their rights since they would then be protected from registrar-related risks. The attractiveness of the Russian market would benefit significantly from the results. So my position was and is that sooner or later this central depository will be created in Russia.

Right now our policy is that no single issuer can control more than 20% of a registrar, and that registrars handle a large number of issuers. They gradually are becoming more independent. Our largest registrars handle 200 to 300 issuers and millions of accounts so that they are no longer dependent on a particular issuer.

Of course, there are still registrars who are under the strong influence of a single issuer—Yukos, for example. But they are subject to strict control by the Commission. In the past year, we checked up on three-fourths of all registrars and have 125 of them left to check. Almost all of them are checked once a year.

ERT: More broadly, what lessons should policymakers in other developing countries learn from Russia's ongoing transition to a market-oriented economy?

Mr. Vasiliyev: The first lesson is that emerging markets cannot borrow the experience of Western countries. You cannot just transfer their legislation to other countries. We are at a different stage of development. The Russian economy and its financial instruments are nearly a century behind those of the US, for example, in terms of our legal base, the capitalization of our institutions,

and our familiarity with how a market economy works.

The Russian economy faces several key obstacles. First is a lack of expertise among Russian managers. A typical manager cannot write a reasonable plan for investors. A manager may have a project and an investor may have cash to invest, but without a decent plan, nothing will develop. Second, Russia must simplify its taxation rules and reduce the tax burden. Only then will we see real economic growth and more revenues. Third, we must greatly simplify procedures for the control and licensing of businesses. Starting up and/or liquidating a business should be easy. This would enable us to reduce crime and corruption and transfer part of the informal economy to the formal sector.

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Monday, July 12, 1999, the Federal debt stood at $5,621,471,104,821.73 (Five trillion, six hundred twenty-one billion, four hundred seventy-one million, one hundred four thousand, eight hundred twenty-one dollars and seventy-three cents).

Five years ago, July 12, 1994, the Federal debt stood at $4,621,828,000,000 (Four trillion, six hundred twenty-one billion, eight hundred twenty-eight million).

Ten years ago, July 12, 1989, the Federal debt stood at $2,800,467,000,000 (Two trillion, eight hundred billion, four hundred sixty-seven million).

Fifteen years ago, July 12, 1984, the Federal debt stood at $1,534,664,000,000 (One trillion, five hundred thirty-four billion, six hundred sixty-four million).

Twenty-five years ago, July 12, 1974, the Federal debt stood at $472,596,000,000 (Four hundred seventy-two billion, five hundred ninety-six million) which reflects a debt increase of more than $5 trillion—$5,148,875,104,821.73 (Five trillion, one hundred forty-eight billion, eight hundred seventy-five million, one hundred four thousand, eight hundred twenty-one dollars and seventy-three cents) during the past 25 years.

PRESERVING ACCESS TO CARE IN THE HOME ACT OF 1999

Mr. FEINGOLD. Mr. President, I rise today to commend my colleague Senator JAMES JEFFORDS of Vermont on legislation he introduced that makes several important first steps in addressing some serious access problems in the Medicare home health care program. Senator JEFFORDS' legislation, the Preserving Access to Care in the Home (PATCH) Act of 1999, contains several important provisions to ensure that all Medicare beneficiaries have access to home health services.

Mr. President, I have been working to promote the availability of home care and long-term care options for my entire public life. I believe it is vitally important that we in Congress work to enable people to stay in their own homes. Ensuring the availability of home health services is integral to preserving independence, dignity and hope for some of our frailest and most vulnerable fellow Americans. I feel strongly that where there is a choice, we should do our best to allow patients to choose home health care. I think Seniors need and deserve that choice. I applaud Senator JEFFORDS for his leadership on this issue, and I look forward to working with him to ensure that Seniors have access to the care that they need.

INDIVIDUAL DEVELOPMENT ACCOUNTS

Mr. ABRAHAM. Mr. President, within the next several weeks, the Senate will debate an issue of extreme importance to the future of our economy—whether and in what manner to return nearly $800 billion in tax relief to the American people over the next ten years.

I strongly support this tax cut. I believe we owe it to the American people, who after all provided the hard work that produced our current surpluses. I also believe that these surpluses provide us with a unique opportunity to reduce and simplify our current onerous, Byzantine tax code. Finally, and most important for my purposes here today, we now have an important opportunity to target and encourage further saving and investment.

To keep our economy growing and our budget balanced, we must do more to encourage saving and investment. Therefore, it is my view that part of the tax cut should be crafted following an innovative concept called Individual Development Accounts or IDAs. IDAs are emerging as one of the most promising tools to help low income working families save money, build wealth, and achieve economic independence. This pro-asset building idea is designed to reward the monthly savings of working-poor families who are trying to buy their first home, pay for post-secondary education, or start a small business. The reward or incentive can be provided through the use of tax credits to financial institutions that provide matching contributions to savings deposited by low income people. In this way those savings will accumulate more quickly, building assets and further incentives to save.

I believe so strongly in the many benefits that IDAs can provide to low income families that I have cosponsored S. 895, the Savings for Working Families Act written by my colleagues, Senators LIEBERMAN and SANTORUM. Similar to 401(k) plans, IDAs will make it easier for low income families to build the financial assets they need to achieve their economic goals. But availability is not enough. We also must empower the working poor in America to make use of this important economic tool. That is why a second key component of the IDA concept consists of financial education and counseling services to IDA account-holders. These services will allow IDA users to further improve their ability to save and improve their quality of life.

Let me briefly outline the four key reasons why I believe the IDA concept is so crucial to a well-crafted tax cut.

First, asset building is crucial to the long-term health and well being of low income families. Assets not only provide an economic cushion and enable people to make investments in their futures, they also provide a psychological orientation—toward the future, about one's children, about having a stake in the community—that income alone cannot provide. Put simply, families that fail to save fail to move up the ladder of economic success and well-being. Unfortunately, saving strategies have been ignored in the poverty assistance programs established over the past 35 years. IDAs will fill this critical gap in our social policy.

Second, our great Nation needs to address the wealth gap, and bring more people into the financial mainstream. While there has been considerable attention given to the income cap among our citizens, I wonder how many Americans realize that ten percent of the families control two-thirds of our Nation's wealth or that one-half of all American households have less that $1,000 in net financial assets, or that 20 percent of all American households do not have a checking or a savings account?

Current Federal tax policy provides more than $300 billion per year in incentives for middle-class and wealthy families to purchase housing, prepare for retirement, and invest in businesses and job creation. Yet, public policies have largely penalized low income people who try to save and build assets and savings incentives in the tax code are beyond their reach. It is time for us to find ways to expand these tax incentives so that they can reach low income families who want to work and save.

Third, IDAs are a good national investment, yielding over $5 for every $1 invested. According to the Corporation for Enterprise Development or CFED, the initial investment in IDAs would be multiplied more than five times in the form of new businesses, new jobs, increased earnings, higher tax receipts, and reduced welfare expenditures. And these increases will come from genuinely new asset development. Savings will be produced that could not have been produced by other, more general means, and in areas where there were no savings before.

Finally, IDAs have a successful track record we should not ignore. IDAs are working now in our communities and they are having a tremendous effect on families who choose to save for the future. There are already 150 active IDA programs around the country, with at least another 100 in development. Approximately 3,000 people are regularly saving in their IDAs. The CFED has compiled encouraging evidence from their IDA pilot programs showing that poor people, with proper incentives and

support will save regularly and acquire productive assets. There are almost 1,000 families participating in CFEDs privately funded IDA demonstration and as of December 31, 1998 these families saved over $165,000, an amount which leveraged another $343,000 in matching funds.

IDAs are already a tremendous success. But, unless additional resources can be found to provide the matching contributions so essential for IDAs to succeed, most low income families will never have the opportunity to save and build assets for the future. The major factor in delaying the creation of IDAs in the 100 communities mentioned above is the lack of a funding source that can provide the needed matching contributions. Our tax cut bill will and should provide nearly $800 billion in tax cuts over the next ten years. I believe that, within this bill, we should make a small investment of only $5–$10 billion in IDAs. This would ensure that millions of working, low income families who want to work and save for their first home, provide a post-secondary education for a child, or start a small business could establish their own IDA accounts.

I strongly encourage the Senate Finance Committee to look closely at IDAs as a means of helping low income families build the financial assets they need to achieve the American Dream.

FAIRNESS FOR FEDERAL WORKERS IN RHODE ISLAND

Mr. REED. Mr. President, I rise today to address an issue of critical importance to nearly 6,000 federal workers in the state of Rhode Island and to the agencies that employ them.

The absence of federal locality pay for workers in Rhode Island has created serious recruitment and retention problems for federal offices due to the substantial federal pay differential between Rhode Island and the neighboring states of Massachusetts and Connecticut.

Let me briefly give the background on this complex issue. Nine years ago, Congress enacted the Federal Employees Pay Comparability Act of 1990 to correct disparities between Federal and private salaries. The Act authorized the President to grant interim geographic pay adjustments of up to 8% in certain areas with significant pay disparities during 1991–1993. Beginning in 1994, the Act provided for a nationwide system of locality pay intended to close the gap between Federal and private salaries over a nine-year period.

Unfortunately, implementation of the Act has created significant pay disparities among Federal employees in southern New England, in particular between Federal employees in Rhode Island and those in Massachusetts and Connecticut.

Rhode Island is literally surrounded by locality pay areas. On its western border, Rhode Island is adjacent to the Hartford locality pay area, which includes all of New London County, Connecticut. Rhode Island's entire northern border is adjacent to the Boston-Worcester-Lawrence locality pay area, which includes the towns of Douglas, Uxbridge, Millville, and Blackstone in Worcester County, Massachusetts; and all of Norfolk County, Massachusetts. The Boston pay locality even reaches around the state of Rhode Island to encompass the adjacent town of Thompson, Connecticut, which lies directly west of Woonsocket, Rhode Island, on the opposite side of our state from Boston. Finally, Rhode Island's eastern border is separated from the Boston locality pay area by as little as four miles.

One facility within a few miles of the Boston locality pay area, the Naval Undersea Warfare Center in Newport—a premier Navy R&D laboratory with world class facilities and progressive employee benefits—has seen its starting salaries continue to fall below the industry average. As a result, the Center's acceptance rate has dropped to approximately 40% and the average GPA of new employees is down.

The Federal Salary Council's eligibility criteria have created what I frequently refer to as a ''donut hole'' in locality pay in our region that leaves thousands of federal employees in Rhode Island with a minus 3.45% pay differential in 1999 when compared to federal employees just a few miles to the north, east, and west.

Mr. CHAFEE. Will the Senator yield?

Mr. REED. I will be happy to yield to the senior Senator from Rhode Island.

Mr. CHAFEE. It is no wonder that Federal agencies in Rhode Island have trouble recruiting and retaining qualified employees given the very short travel time to the higher-paying Boston or Hartford locality pay areas. Most Americans know that Rhode Island is the smallest state in the nation, but I think it is worth emphasizing just how small the dimensions are, and the impact that has on commuting patterns in our region.

It is only 35 miles from the eastern edge of the Hartford locality pay area in Connecticut to the Boston locality pay area in Dartmouth, Massachusetts. In between, a little more than 30 miles across, is the state of Rhode Island and 3,700 federal employees without locality pay in Newport County. Where is the incentive for a federal employee living in central Rhode Island to continue working for a federal agency in our state when he or she could drive less than 20 miles in any direction and receive a nearly 4% raise?

Mr. REED. The Senator is correct. This situation makes no sense given the similar cost of labor across southern New England and the unusually heavy commuting patterns between Rhode Island and the Boston and Hartford pay localities, especially with the Boston area. It is only 45 miles from Providence to downtown Boston.

The question before us now is, how did we get into this situation, and how can we correct it? The main obstacle to federal locality pay in Rhode Island is the federal government's use of county data to determine the eligibility of ''Areas of Application'' to existing pay localities. First of all, I would note that Rhode Island has no county governments, and the Federal Salary Council's use of county data is, therefore, impractical and arbitrary. Secondly, the criteria for application are structured in such a way that our state cannot become eligible. To be considered, a county must be contiguous to a pay locality; contain at least 2,000 General Schedule employees; have a significant level of urbanization; and demonstrate some economic linkage with the pay locality, defined as commuting at a level of 5% or more into or from the areas in question.

Mr. CHAFEE. If the Senator will yield, I would point out that in our state, Newport County surpasses the employee requirement but is not contiguous to a pay locality because the President's Pay Agent excluded the towns of Westport and Fall River, Massachusetts from the Boston-Worcester-Lawrence pay locality. As a result, less than four miles separate the 3,700 Federal employees in Newport County from the locality pay provided to employees in the Boston pay locality.

Given our State's extremely small size and, as the Senator mentioned, the fact that Rhode Island has no county governments, the Salary Council's use of county data is inappropriate. The total land area of Rhode Island is only about two-thirds the size of Worcester County, Massachusetts, nearly all of which falls inside the Boston pay locality. As long as the Pay Agent applies its criteria on a county-by-county basis, no part of Rhode Island will be eligible for a higher level of locality pay, and existing Federal pay disparities between Rhode Island and its neighbors will continue to degrade Federal services in our state.

Simply put, the FEPCA law was intended to resolve a public-private pay disparity. In southern New England, however, it has created a public-public pay disparity.

Mr. REED. The Senator is absolutely right. And to remedy this situation, the bill we have introduced, S. 1313, the Rhode Island Federal Worker Fairness Act, will require the President's Pay Agent to consider the State of Rhode Island as one county strictly for the purposes of locality pay. We believe this bill will enable Rhode Island, the smallest state in the nation and about the same size as the average county in the United States, to apply for locality pay on an equal footing with county governments in other parts of the country.

We look forward to working with the distinguished Chairman of the Governmental Affairs Committee, Senator THOMPSON, and the Committee's ranking member, Senator LIEBERMAN, in our effort to reduce the inequities among Federal employees in our region

and enable federal offices in Rhode Island to attract and retain qualified employees.

I yield the floor.

MESSAGE FROM THE PRESIDENT

A message from the President of the United States was communicated to the Senate by Mr. Williams, one of his secretaries.

EXECUTIVE MESSAGE REFERRED

As in executive session the Presiding Officer laid before the Senate a message from the President of the United States submitting a treaty which was referred to the Committee on Foreign Relations.

REPORT ON THE NATIONAL EMERGENCY CONCERNING WEAPONS OF MASS DESTRUCTION—MESSAGE FROM THE PRESIDENT—PM 47

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Banking, Housing, and Urban Affairs.

To the Congress of the United States:

As required by section 204 of the International Emergency Economics Powers Act (50 U.S.C. 1703(c)) and section 401(c) of the National Emergencies Act (50 U.S.C. 1641(c)), I transmit herewith a 6-month report on the national emergency declared by Executive Order 12938 of November 14, 1994, in response to the threat posed by the proliferation of nuclear, biological, and chemical weapons (''weapons of mass destruction'') and of the means of delivering such weapons.

WILLIAM J. CLINTON.

THE WHITE HOUSE, *July 13, 1999.*

MESSAGE FROM THE HOUSE

At 2 p.m., a message from the House of Representatives, delivered by Mr. Hanrahan, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 2035. An act to correct errors in the authorizations of certain programs administered by the National Highway Traffic Administration.

The message also announced that the House has agreed to the following concurrent resolutions, in which it requests the concurrence of the Senate:

H. Con. Res. 107. Concurrent resolution expressing the sense of Congress rejecting the conclusions of a recent article published by the American Psychological Association that suggests that sexual relationships between adults and children might be positive for children.

H. Con. Res. 117. Concurrent resolution concerning United Nations General Assembly Resolution ES–10/6.

MEASURES REFERRED

The following bill, previously received from the House of Representative for the concurrence of the Senate, was read the first and second times by unanimous consent and referred as indicated:

H.R. 592. An act to designate a portion of Gateway National Recreation Area as ''World War Veterans Park at Miller Field''; to the Committee on Energy and Natural Resources.

The following concurrent resolution was read and referred as indicated:

H. Con. Res. 107. Concurrent resolution expressing the sense of Congress rejecting the conclusions of a recent article published by the American Psychological Association that suggests that sexual relationships between adults and children might be positive for children.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC–4144. A communication from the Secretary of Defense, transmitting, the report of a retirement; to the Committee on Armed Services.

EC–4145. A communication from the Secretary of Defense, transmitting, the report of a retirement; to the Committee on Armed Services.

EC–4146. A communication from the Chairman and Chief Executive Officer, Farm Credit Administration, transmitting, pursuant to law, the annual report of the Farm Credit System for calendar year 1998; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4147. A communication from the Director, Retirement and Insurance Services, Office of Personnel Management, transmitting, pursuant to law, the report of a rule entitled ''Federal Employees Health Benefits Program and Department of Defense Demonstration Project-Amendments to 48 CFR, Chapter 16'' (RIN3206–AI67), received July 12, 1999; to the Committee on Governmental Affairs.

EC–4148. A communication from the Director, Retirement and Insurance Services, Office of Personnel Management, transmitting, pursuant to law, the report of a rule entitled ''Federal Employees Health Benefits Program and Department of Defense Demonstration Project-Amendments to 5 CFR, Part 890 (RIN3206–AI67), received July 12, 1999; to the Committee on Governmental Affairs.

EC–4149. A communication from the Executive Director, Committee for the Purchase from People who are Blind or Severely Disabled, transmitting, pursuant to law, the report of a rule entitled ''Additions to and Deletions from the Procurement List'', received July 12, 1999; to the Committee on Governmental Affairs.

EC–4150. A communication from the Acting Deputy Director for Management, Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, a report entitled ''Electronic Purchasing and Payment in the Federal Government''; to the Committee on Governmental Affairs.

EC–4151. A communication from the Public Printer, Government Printing Office, transmitting, pursuant to law, the report of the Office of Inspector General for the period October 1, 1998, through March 31, 1999; to the Committee on Governmental Affairs.

EC–4152. A communication from the Executive Director, Committee for the Purchase from People who are Blind or Severely Disabled, transmitting, pursuant to law, the report of a rule entitled ''Additions to the Procurement List'', received July 6, 1999; to the Committee on Governmental Affairs.

EC–4153. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to law, a report relative to the elimination of the danger pay allowance for the Central African Republic; to the Committee on Foreign Relations.

EC–4154. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, a report of the International Labor Organization relative to general conditions to stimulate job creation in small and medium-sized enterprises; to the Committee on Foreign Relations.

EC–4155. A communication from the President of the United States, transmitting, pursuant to law, a report of a safeguard action on imports of lamb meat; to the Committee on Finance.

EC–4156. A communication from the Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Regulations under Section 1502 of the Internal Revenue Code of 1986; Limitations on Net Operating Loss Carryforwards and Certain Built-in Losses and Credits Following an Ownership Change of a Consolidated Group'' (RIN1545–AU32) (TD8824), received June 29, 1999; to the Committee on Finance.

EC–4157. A communication from the Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Regulations under Section 382 of the Internal Revenue Code of 1986; Application of Section 382 in Short Taxable Years and with Respect to Controlled Groups'' (RIN1545–AU33) (TD8825), received June 29, 1999; to the Committee on Finance.

EC–4158. A communication from the Chief, Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Removal of Regulations Providing Guidance under Subpart F Relating to Partnerships and Branches'' (TD8827), received July 9, 1999; to the Committee on Finance.

EC–4159. A communication from the Chief Counsel, Fiscal Service, Bureau of the Public Debt, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Final Rule to Amend 31 CFR Parts 315, 353, 357, and 370 to Consolidate Provisions Relating to Electronic Transactions and Funds Relating to United States Securities,'' received July 6, 1999; to the Committee on Finance.

EC–4160. A communication from the Director, Policy Directives and Instructions Branch, Immigration and Naturalization Service, Department of Justice, transmitting, pursuant to law, the report of a rule entitled ''Canadian Border Boat Landing Program'' (RIN1115–AE53) (INS No. 1796–96), received July 8, 1999; to the Committee on the Judiciary.

EC–4161. A communication from the Principal Deputy Director, Office of Community Oriented Policing Services, Department of Justice, transmitting, pursuant to law, the report of a rule entitled ''Police Recruitment Program Guidelines'' (RIN11015–AAE58), received July 6, 1999; to the Committee on the Judiciary.

EC–4162. A communication from the Chairman, Federal Energy Regulatory Commission, transmitting, pursuant to law, the annual report for fiscal year 1998; to the Committee on Energy and Natural Resources.

EC–4163. A communication from the Acting Assistant Secretary, Land and Minerals Management, Department of the Interior, transmitting, pursuant to law, the report of

a rule entitled ''Electronic Reporting'' (RIN1010–AC40), received June 30, 1999; to the Committee on the Budget.

EC–4164. A communication from the Assistant General Counsel for Regulatory Law. Office of Procurement and Assistance Management, Department of Energy, transmitting, pursuant to law, the report of a rule entitled ''Consortium Buying'' (AL 99–04), received July 12, 1999; to the Committee on Energy and Natural Resources.

EC–4165. A communication from the Director, Office of Regulatory Management, Office of Acquisition and Materiel Management, Department of Veterans Affairs, transmitting, pursuant to law, the report of a rule entitled ''VA Acquisition Regulation: Taxes'' (RIN2900–AJ32); to the Committee on Veterans' Affairs.

EC–4166. A communication from the Regulations Officer, Federal Highway Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''National Standards for Traffic Control Devices; Metric Conversion and Correction of Effective Date'' (RIN2125–AD63), received July 8, 1999; to the Committee on Environment and Public Works.

EC–4167. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plan; Illinois'' (FRL #6374–1), received July 8, 1999; to the Committee on Environment and Public Works.

EC–4168. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of State Plans for Designated Facilities and Pollutants: Massachusetts; Plan for Controlling MWC Emissions from Existing MWC Plants'' (FRL #6377–1), received July 8, 1999; to the Committee on Environment and Public Works.

EC–4169. A communication from the Director, Office of Regulatory Management and Information, Office of Policy, Planning and Evaluation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''National Emission Standards for Hazardous Air Pollutants for Source Categories: Off-Site Waste and Recovery'' (FRL #6377–5), received July 9, 1999; to the Committee on Environment and Public Works.

EC–4170. A communication from the Director, Office of Congressional Affairs, Office of State Programs, Nuclear Regulatory Commission, transmitting, pursuant to law, the report of a rule entitled ''NRC Management Directive 5.6, 'Integrated Materials Performance Evaluation Program' '', received July 12, 1999; to the Committee on Environment and Public Works.

EC–4171. A communication from the Secretary of Health and Human Services, transmitting, a draft of proposed legislation entitled ''Medicaid and Children's Health Insurance Program Amendments of 1999''; to the Committee on Finance.

EC–4172. A communication from the Administrator, Small Business Administration, transmitting, a draft of proposed legislation entitled ''The Small Business Programs Enhancement Act of 1999''; to the Committee on Small Business.

EC–4173. A communication from the Secretary of Housing and Urban Development, transmitting, a draft of proposed legislation relative to the President's fiscal year 2000 budget; to the Committee on Banking, Housing, and Urban Affairs.

EC–4174. A communication from the Secretary of Transportation, transmitting, pursuant to law, the annual report entitled ''Importing Noncomplying Motor Vehicles'' for calendar year 1998; to the Committee on Commerce, Science, and Transportation.

EC–4175. A communication from the Special Assistant to the Chief, Mass Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.202(b), Table of Allotments; FM Broadcast Stations; Shelby and Dutton Montana'' (MM Docket No. 99–63) (RM–9398), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4176. A communication from the Special Assistant to the Chief, Mass Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.202(b), Table of Allotments; FM Broadcast Stations; Lordsburg and Hurley, NM'' (MM Docket No. 98–222) (RM–9407), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4177. A communication from the Special Assistant to the Chief, Mass Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.202(b), Table of Allotments; FM Broadcast Stations; Madison, Indiana'' (MM Docket No. 98–105) (RM–9295), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4178. A communication from the Special Assistant to the Chief, Mass Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.202(b), Table of Allotments; FM Broadcast Stations; Belfield, ND; Medina, ND; Burlington, ND; Hazelton, ND; Gacke, ND; New England, ND'' (MM Docket Nos. 98–224; 98–225; 98–226; 98–230; 98–231; 98–232), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4179. A communication from the Special Assistant to the Chief, Mass Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.202(b), Table Allotments; FM Broadcast Stations; Buda and Giddings, Texas'' (MM Docket No. 99–69), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4180. A communication from the Special Assistant to the Chief, Mass Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.606(b), Table of Allotments; TV Broadcast Stations; El Dorado and Camden, Arkansas'' (MM Docket No. 99–4569) (RM 9401), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4181. A communication from the Chief, Office of Regulations and Administrative Law, US Coast Guard, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Revise Fees to Number Undocumented Vessels in Alaska (USCG–1998–3386)'' (RIN2115–AF62) (1999–0001), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4182. A communication from the Chief, Office of Regulations and Administrative Law, US Coast Guard, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Safety/Security Zone Regulations; Fenwick Fireworks Display, Long Island Sound (CGD01–99–095)'' (RIN2115–AA97) (1999–0043), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4183. A communication from the Chief, Office of Regulations and Administrative Law, US Coast Guard, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Safety/Security Zone Regulations; Koechlin Wedding Fireworks, Western Long Island Sound, Rye, New York (CGD01–99–030)'' (RIN2115–AA97) (1999–0040), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4184. A communication from the Chief, Office of Regulations and Administrative Law, US Coast Guard, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Safety/Security Zone Regulations; Royal Handel Fireworks, Boston, MA (CGD01–99–102)'' (RIN2115–AA97) (1999–0041), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4185. A communication from the Chief, Office of Regulations and Administrative Law, US Coast Guard, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Safety/Security Zone Regulations; Madison 4th of July Celebration, Long Island Sound (CGD01–99–092)'' (RIN2115–AA97) (1999–0042), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4186. A communication from the Chief, Office of Regulations and Administrative Law, US Coast Guard, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Safety/Security Zone Regulations; T E L Enterprises Fireworks Display, Great South Bay Off Davis Park, NY (CGD01–99–115)'' (RIN2115–AA97) (1999–0044), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4187. A communication from the Chief, Office of Regulations and Administrative Law, US Coast Guard, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Rules of Practice, Procedure, and Evidence for Administrative Proceedings of the Coast Guard (USCG–1998–3472)'' (RIN2115–AF59) (1999–0002), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4188. A communication from the Chief, Office of Regulations and Administrative Law, US Coast Guard, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Safety/Security Zone Regulations; Technical Amendments to USCG Regulations to Update RIN Numbers; Correction'' (RIN2115–AA97) (1999–0046), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4189. A communication from the Chief, Office of Regulations and Administrative Law, US Coast Guard, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Drawbridge Regulations; Harbour Town Fireworks Display, Calibogue Sound, Hilton Head, SC (CGD13–99–007)'' (RIN2115–AE47) (1999–0026), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

EC–4190. A communication from the Chief, Office of Regulations and Administrative Law, US Coast Guard, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Safety/Security Zone Regulations; Staten Island Fireworks, Raritan Bay and Lower New York Bay (CGD01–99–083)'' (RIN2115–AA97) (1999–0045), received July 8, 1999; to the Committee on Commerce, Science, and Transportation.

PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated:

POM–248. A resolution adopted by the Municipal Assembly of Isabela, Puerto Rico relative to U.S. Navy activity around the Island

of Vieques, Puerto Rico; to the Committee on Energy and Natural Resources.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. HELMS:

S. 1352. A bill to impose conditions on assistance authorized for North Korea, to impose restrictions on nuclear cooperation and other transactions with North Korea, and for other purposes; to the Committee on Foreign Relations.

By Mr. TORRICELLI:

S. 1353. A bill to combat criminal misuse of explosives; to the Committee on the Judiciary.

By Mr. KOHL (for himself and Mr. FEINGOLD):

S. 1354. A bill to provide for the eventual termination of milk marketing orders; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. DODD (for himself, Mr. KENNEDY, Mr. LEAHY, and Mrs. MURRAY):

S. 1355. A bill to establish demonstration projects to provide family income to respond to significant transitions, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. MOYNIHAN (for himself and Mr. SCHUMER):

S. 1356. A bill to amend the Marine Protection, Research, and Sanctuaries Act of 1972 to clarify the limitation on the dumping of dredged material in Long Island Sound; to the Committee on Environment and Public Works.

By Mr. JEFFORDS:

S. 1357. A bill to amend the Internal Revenue Code of 1986 to enhance the portability of retirement benefits, and for other purposes; to the Committee on Finance.

By Mr. JEFFORDS (for himself, Mr. REED, Mr. ENZI, and Mr. LEAHY):

S. 1358. A bill to amend title XVIII of the Social Security Act to provide more equitable payments to home health agencies under the medicare program; to the Committee on Finance.

By Mr. HOLLINGS:

S. 1359. A bill to amend chapter 51 of title 49, United States Code, to extend the coverage of the rules governing the transportation of hazardous materials, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. LEAHY:

S. 1360. A bill to preserve the effectiveness of Secret Service protection by establishing a protective function privilege, and for other purposes; to the Committee on the Judiciary.

By Mr. STEVENS (for himself, Mr. INOUYE, Mr. LOTT, Mrs. FEINSTEIN, Mr. AKAKA, and Mr. GRAHAM):

S. 1361. A bill to amend the Earthquake Hazards Reduction Act of 1977 to provide for an expanded Federal program of hazard mitigation, relief, and insurance against the risk of catastrophic natural disasters, such as hurricanes, earthquakes, and volcanic eruptions, and for other purposes; to the Committee on Commerce, Science, and Transportation.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. TORRICELLI:

S. 1353. A bill to combat criminal misuse of explosives; to the Committee on the Judiciary.

DANGEROUS EXPLOSIVES BACKGROUND CHECKS REQUIREMENT ACT

Mr. TORRICELLI. Mr. President, every year, thousands of people are killed or maimed because of the use or misuse of illegal explosive devices, and millions of dollars in property is lost. Between 1991 and 1995, there were more than 14,000 actual and attempted criminal bombings. Three hundred and twenty-six people were killed in those incidents and another 2,970 injured. More than $6 million in property damage resulted.

One bombing in particular, is carved into the national memory. On the morning of April 19, 1995, in one horrible moment, an explosion devastated the Alfred P. Murrah Federal Building in Oklahoma City, OK, and took the lives of 168 Americans. This tragedy, together with the bombing of the World Trade Center in New York, took the lives of many innocent men, women, and children, left others permanently scarred, and caused great suffering for the families of the victims—as well as all of America. These crimes were intended to tear the very fabric of our society; instead, their tragic consequences served to strengthen our resolve to stand firm against the insanity of terrorism and the criminal use of explosives.

In the wake of the Oklahoma City bombing, I was stunned—as were many—to learn how few restrictions on the use and sale of explosives really exist. I soon after introduced legislation to take a first step towards protecting the American people from those who would use explosives to do them harm. That bill, the Explosives Protection Act, would bring explosives law into line with gun laws. Specifically, it would take the list of categories of people who cannot obtain firearms and would add any of those categories not currently covered under the explosives law.

Today, I am taking the next step by introducing the Dangerous Explosives Background Check Requirement Act requiring background checks before the sale of explosives material identical to those already mandated for firearms sales. Current law prohibits felons and others from possessing explosives, but does little to actually stop these materials from getting into the wrong hands. This failure defies logic when we already have a system in place to facilitate background checks and assure that persons who are legally prohibited from purchasing explosives are not able to do so.

In November, 1998, the National Instant Criminal Background Check System (NICS) became operational. NICS is a new national database accessible to licensed firearms dealers that allows them to perform over-the-counter background checks on potential firearms purchasers. NICS, which checks national criminal history databases as well as information on other prohibited categories, such as illegal aliens and persons under domestic violence restraining orders, has already processed more than 3.7 million background checks and has stopped more than 39,000 felons and other prohibited persons from getting guns. In so doing, it has undoubtedly saved lives and prevented crimes from occurring.

Once again, it is time to bring the explosives law into line with gun laws by taking advantage of the success of the NICS system and expanding its use to include explosives purchases. In so doing, we will make it harder for many of the most dangerous or least accountable members of society to obtain materials which can result in a great loss of life. My hope is that this bill will, in some small way, prevent future bombings—whether by terrorists of symbolic targets, malcontents of random ones, or even spouses involved in marital disputes.

I hope we can quickly move to get this passed and protect Americans from future acts of explosive destruction. I ask unanimous consent that a copy of the legislation appear in the RECORD.

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

S. 1353

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Dangerous Explosives Background Checks Requirement Act''.

SEC. 2. PERMITS AND BACKGROUND CHECKS FOR PURCHASES OF EXPLOSIVES.

(a) PERMITS FOR PURCHASE OF EXPLOSIVES IN GENERAL.—

(1) IN GENERAL.—Section 842 of title 18, United States Code, is amended—

(A) in subsection (a)(3), by striking subparagraphs (A) and (B) and inserting the following:

''(A) to transport, ship, cause to be transported, or receive any explosive materials; or

''(B) to distribute explosive materials to any person other than a licensee or permittee.''; and

(B) in subsection (b)—

(i) by adding ''or'' at the end of paragraph (1);

(ii) by striking ''; or'' at the end of paragraph (2) and inserting a period; and

(iii) by striking paragraph (3).

(2) REGULATIONS.—

(A) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of the Treasury shall promulgate final regulations with respect to the amendments made by paragraph (1).

(B) NOTICE TO STATES.—On the promulgation of final regulations under subparagraph (A), the Secretary of the Treasury shall notify the States of the regulations in order that the States may consider legislation to amend relevant State laws relating to explosives.

(b) BACKGROUND CHECKS.—Section 842 of title 18, United States Code, is amended by adding at the end the following:

''(p) BACKGROUND CHECKS.—

''(1) DEFINITIONS.—In this subsection:

''(A) CHIEF LAW ENFORCEMENT OFFICER.—The term 'chief law enforcement officer' means the chief of police, the sheriff, or an equivalent officer or the designee of such an individual.

''(B) SYSTEM.—The term 'system' means the national instant criminal background

check system established under section 103 of the Brady Handgun Violence Prevention Act (18 U.S.C. 922 note).

''(2) PROHIBITION.—A licensed importer, licensed manufacturer, or licensed dealer shall not transfer explosive materials to a permitee unless—

''(A) before the completion of the transfer, the licensee contacts the system;

''(B)(i) the system provides the licensee with a unique identification number; or

''(ii) 5 days on which State offices are open have elapsed since the licensee contacted the system, and the system has not notified the licensee that the receipt of explosive materials by the transferee would violate subsection (i);

''(C) the transferor has verified the identity of the transferee by examining a valid identification document (as defined in section 1028) of the transferee containing a photograph of the transferee; and

''(D) the transferor has examined the permit issued to the transferee under section 843 and recorded the permit number on the record of the transfer.

''(3) IDENTIFICATION NUMBER.—If receipt of explosive materials would not violate section 842(i) or State law, the system shall—

''(A) assign a unique identification number to the transfer; and

''(B) provide the licensee with the number.

''(4) EXCEPTIONS.—Paragraph (2) shall not apply to a transfer of explosive materials between a licensee and another person if, on application of the transferor, the Secretary has certified that compliance with paragraph (2)(A) is impracticable because—

''(A) the ratio of the number of law enforcement officers of the State in which the transfer is to occur to the number of square miles of land area of the State does not exceed 0.0025;

''(B) the business premises of the licensee at which the transfer is to occur are extremely remote in relation to the chief law enforcement officer; and

''(C) there is an absence of telecommunications facilities in the geographical area in which the business premises are located.

''(5) INCLUSION OF IDENTIFICATION NUMBER.—If the system notifies the licensee that the information available to the system does not demonstrate that the receipt of explosive materials by the transferee would violate subsection (i) or State law, and the licensee transfers explosive materials to the transferee, the licensee shall include in the record of the transfer the unique identification number provided by the system with respect to the transfer.

''(6) PENALTIES.—If the licensee knowingly transfers explosive materials to another person and knowingly fails to comply with paragraph (2) with respect to the transfer, the Secretary may, after notice and opportunity for a hearing—

''(A) suspend for not more than 6 months or revoke any license issued to the licensee under section 843; and

''(B) impose on the licensee a civil penalty of not more than $5,000.

''(7) NO LIABILITY.—Neither a local government nor an employee of the Federal Government or of any State or local government, responsible for providing information to the system shall be liable in an action at law for damages—

''(A) for failure to prevent the transfer of explosive materials to a person whose receipt or possession of the explosive material is unlawful under this section; or

''(B) for preventing such a transfer to a person who may lawfully receive or possess explosive materials.

''(8) DETERMINATION OF INELIGIBILITY.—

''(A) WRITTEN REASONS PROVIDED ON REQUEST.—If the system determines that an individual is ineligible to receive explosive materials and the individual requests the system to provide the reasons for the determination, the system shall provide such reasons to the individual, in writing, not later than 5 business days after the date of the request.

''(B) CORRECTION OF ERRONEOUS SYSTEM INFORMATION.—

''(i) IN GENERAL.—If the system informs an individual contacting the system that receipt of explosive materials by a prospective transferee would violate subsection (i) or applicable State law, the prospective transferee may request the Attorney General to provide the prospective transferee with the reasons for the determination.

''(ii) TREATMENT OF REQUESTS.—On receipt a request under subparagraph (A), the Attorney General shall immediately comply with the request.

''(iii) SUBMISSION OF ADDITIONAL INFORMATION.—

''(I) IN GENERAL.—A prospective transferee may submit to the Attorney General information to correct, clarify, or supplement records of the system with respect to the prospective transferee.

''(II) ACTION BY THE ATTORNEY GENERAL.—After receipt of information under clause (i), the Attorney General shall—

''(aa) immediately consider the information;

''(bb) investigate the matter further; and

''(cc) correct all erroneous Federal records relating to the prospective transferee and give notice of the error to any Federal department or agency or any State that was the source of such erroneous records.''.

(c) REMEDY FOR ERRONEOUS DENIAL OF EXPLOSIVE MATERIALS.—

(1) IN GENERAL.—Chapter 40 of title 18, United States Code, is amended by inserting after section 843 the following:

''§ 843A. Remedy for erroneous denial of explosive materials

''(a) IN GENERAL.—Any person denied explosive materials under section 842(p)—

''(1) due to the provision of erroneous information relating to the person by any State or political subdivision of a State or by the national instant criminal background check system referred to in section 922(t); or

''(2) who was not prohibited from receiving explosive materials under section 842(i);

may bring an action against an entity described in subsection (b) for an order directing that the erroneous information be corrected or that the transfer be approved, as the case may be.

''(b) ENTITIES DESCRIBED.—An entity referred to in subsection (a) is the State or political subdivision responsible for providing the erroneous information referred to in subsection (a)(1) or denying the transfer of explosives or the United States, as the case may be.

''(c) ATTORNEY'S FEES.—In any action brought under this section, the court, in its discretion, may allow the prevailing party a reasonable attorney's fee as part of the costs.''.

(2) TECHNICAL AMENDMENT.—The analysis for chapter 40 of title 18, United States Code, is amended by inserting after the item relating to section 843 the following:

''843A. Remedy for erroneous denial of explosive materials.''.

(d) LICENSES AND USER PERMITS.—Section 843(a) of title 18, United States Code, is amended—

(1) by inserting '', including fingerprints and a photograph of the applicant'' before the period at the end of the first sentence; and

(2) by striking the second sentence and inserting the following: ''Each applicant for a license shall pay for each license a fee established by the Secretary in an amount not to exceed $300. Each applicant for a permit shall pay for each permit a fee established by the Secretary in an amount not to exceed $100.''.

(e) PENALTIES.—Section 844(a) of title 18, United States Code, is amended—

(1) by inserting ''(1) after ''(a)''; and

(2) by adding at the end the following:

''(2) BACKGROUND CHECKS.—A person who violates section 842(p) shall be fined under this title, imprisoned not more than 5 years, or both.''.

(f) EFFECTIVE DATE.—The amendments made by subsections (a), (b), (c), and (e) take effect 18 months after the date of enactment of this Act.

By Mr. KOHL (for himself and Mr. FEINGOLD):

S. 1354: A bill to provide for the eventual termination of milk marketing orders; to the Committee on Agriculture, Nutrition, and Forestry.

CONSUMER DAIRY RELIEF ACT

Mr. KOHL. Mr. President, today I am introducing the Consumers Dairy Relief Act, a bill that will save American consumers $500 million a year on their milk, cheese and dairy purchases. This legislation terminates the Federal Milk Marketing Orders by the year 2001.

Consumers are paying far more than necessary for their dairy purchases because our current system encourages milk production in high cost areas. Our nation's milk pricing laws, which were designed in the 1930's, are seriously outdated and long overdue to be reformed. Dairy farmers in Wisconsin have suffered under the present system for too long. Wisconsin loses, 1,500 dairy farmers a year, not because they are inefficient, but because a federal law discriminates against them by preventing them from competing on a level playing field.

Opponents of this legislation will tell you that we need to keep the present system in order to maintain a fresh milk supply in their states. While that may have been true in the 1930's, when we lacked the refrigeration technology necessary to store and transport milk, it is certainly not true today. We can now easily and safely transport perishable milk and cheese products between regions of the United States. In fact, the industry has actually perfected the system to such a degree that we now export cheese to countries around the world.

Mr. President, as the United States expands its role in the export dairy market and enters into more trade agreements, our domestic agricultural policy is coming under intense scrutiny. Another reason to eliminate our antiquated milk pricing system is that it will give us another negotiating tool to use during the next round of WTO discussions scheduled to take place in Seattle this fall.

Our trading partners are growing increasingly concerned about the intervention of the federal government in the pricing of milk. Earlier this month, The Dutch Ministry of Agriculture, Nature Management and Fisheries said

they want to put the issue of USDA's Federal Milk Marketing Orders and dairy compacts on the table for discussion at the next round of Agricultural discussions in Seattle this fall.

By passing this legislation and reforming our milk pricing laws, we can eliminate another hurdle currently in the way of negotiating agricultural trade agreements that would open up new markets for our farmers.

Mr. President, if the Senate decides to discuss reforming our milk pricing system, we must give serious consideration to eliminating the present system. Today I have touched on a few of the reasons we need to scrap our current milk pricing system. There are many others, but I will save those for another time.

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. 1354

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

SECTION 1. EVENTUAL TERMINATION OF MILK MARKETING ORDERS.

(a) TERMINATION.—Notwithstanding the implementation of the final decision for the consolidation and reform of Federal milk marketing orders, as required by section 143 of the Federal Agriculture Improvement and Reform Act of 1996 (7 U.S.C. 7253), effective January 1, 2001, section 8c of the Agricultural Adjustment Act (7 U.S.C. 608c), reenacted with amendments by the Agricultural Marketing Agreement Act of 1937, is amended by striking paragraphs (5) and (18).

(b) PROHIBITION ON SUBSEQUENT ORDERS REGARDING MILK.—Section 8c(2) of the Agricultural Adjustment Act (7 U.S.C. 608c(2)), reenacted with amendments by the Agricultural Marketing Agreement Act of 1937, is amended in the first sentence—

(1) in subparagraph (A), by striking ''Milk, fruits'' and inserting ''Fruits''; and

(2) in subparagraph (B), by inserting ''milk,'' after ''honey,''.

(c) CONFORMING AMENDMENTS.—

(1) Section 2(3) of the Agricultural Adjustment Act (7 U.S.C. 602(3), reenacted with amendments by the Agricultural Marketing Agreement Act of 1937, is amended by striking '', other than milk and its products,''.

(2) Section 8c of the Agricultural Adjustment Act (7 U.S.C. 608c), reenacted with amendments by the Agricultural Marketing Agreement Act of 1937, is amended—

(A) in paragraph (6), by striking '', other than milk and its products,'';

(B) in paragraph (7)(B), by striking ''(except for milk and cream to be sold for consumption in fluid form)'';

(C) in paragraph (11)(B), by striking ''Except in the case of milk and its products, orders'' and inserting ''Orders'';

(D) in paragraph (13)(A), by striking '', except to a retailer in his capacity as a retailer of milk and its products''; and

(E) in paragraph (17), by striking the second proviso.

(3) Section 8d(2) of the Agricultural Adjustment Act (7 U.S.C. 608d(2)), reenacted with amendments by the Agricultural Marketing Agreement Act of 1937, is amended by striking the second sentence.

(4) Section 10(b)(2) of the Agricultural Adjustment Act (7 U.S.C. 610(b)), reenacted with amendments by the Agricultural Marketing Agreement Act of 1937, is amended—

(A) by striking clause (i);

(B) by redesignating clauses (ii) and (iii) as clauses (i) and (ii), respectively; and

(C) in the first sentence of clause (i) (as so redesignated), by striking ''other commodity'' and inserting ''commodity''.

(5) Section 11 of the Agricultural Adjustment Act (7 U.S.C. 611), reenacted with amendments by the Agricultural Marketing Agreement Act of 1937, is amended in the first sentence by striking ''and milk, and its products,''.

(6) Section 715 of the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 1994 (7 U.S.C. 608d note; Public Law 103–111; 107 Stat. 1079), is amended by striking the third proviso.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2001.

By Mr. DODD (for himself, Mr. KENNEDY, Mr. LEAHY, and Mrs. MURRAY):

S. 1355. A bill to establish demonstration projects to provide family income to respond to significant transitions, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

THE FAMILY INCOME TO RESPOND TO SIGNIFICANT TRANSITIONS (FIRST) INSURANCE ACT

Ms. DODD. Mr. President. These last several weeks have been filled with profound questions about the strength of the American family and the priority we place on our children and on meeting the responsibilities of parenthood.

In my view, we must start at the very beginning. We know that some of the key moments of parenthood are in the first days and weeks of a child's life. These are the moments when parents fall in love with their children—when they learn the feel of their soft hair, the joy of their touch and the immense peacefulness of their sleeping faces.

These emotional bonds carry parents and children through all the challenging years that intervene between infancy and adulthood—from the terrible twos to adolescence.

Research tells us this bonding with parents is critical to a child's emotional, cognitive, and physical development. Scientists have produced vivid pictures of children's functioning brains—so not only do we know, we can also see that there is a difference between the way the brain of a neglected child and the brain of a nurtured child works.

Parents bonding with their children is not something one can mandate by law—but we must make sure that our policies support parents in these early days. And frankly, today as we sit on the cusp of the next millennium, we offer parents very limited support at this most critical time.

Today's working parents have less time to spend with their infants than past generations. Compared to 30 years ago, there has been an average decrease of 22 hours per week in time that parents spend with their children. That is nearly one day out of every week—or 52 days a year.

More parents work today than every before—fully 46 percent of workers are parents. Nearly one in five employed parents. Nearly one in five employed parents are single, and among these 27 percent are single fathers. The number of parents who were employed increased from 18.3 million in 1985 to 24.1 million in 1997.

One could argue whether these trends are going in the right direction. But no one can argue that they are the facts—the reality in which American families live everyday. And, my view, that reality is where public policy must operate.

Since 1986, I've worked, with many of my colleagues, to help working Americans meet these demands and care for new children and their close family members. In 1993, the Family and Medical Leave Act was finally signed into law, establishing a key safety net for America's families. I couldn't have done it without the support of my colleagues here in the Senate and the House, and without the support of the President.

But let's face it—the FMLA is like 911 for working Americans. It provides up to 12 weeks of unpaid leave to qualifying employees for the birth or adoption of a child, their own illness or the serious illness of a parent, child or spouse without fear of losing their jobs or health insurance. But the fact remains this leave is unpaid—and that is a high bar for most American families.

While millions of Americans—many estimate over twenty million families—have benefitted from the law and have taken the time they needed, for many it has been at major financial cost. In fact, taking an unpaid leave often drives employees earning low wages into poverty. Twenty-one percent of low-wage earners who take a leave without full wage replacement wind up on public assistance; 40 percent cut their leaves short because of financial concerns; 39 percent put off paying bills; and, 25 percent borrow money.

And there are many more families who do not take a needed leave because they can't afford it. Nearly two-thirds of employees who need to take a family or medical leave, but do not do so, report that the reason they did not take the leave was that they could not afford it. These are families with brand new children or where a spouse, parent or child is seriously ill.

Many employers do provide workers with some pay during these difficult times—but the benefit of these policies is not distributed equally. Employees with less education, lower income, female employees, employees from racial minority groups and younger employees are less likely to receive any income during leaves.

Our nation is a leader in so many areas. And yet not when it comes to helping families balance the responsibilities of work and home. Nearly every industrialized nation other than

the United States, as well as most developing nations, provide parents with paid leave for infant care.

I believe that we should learn from these nations, our own experiences, and the calls of American families and provide parents with the means to access desperately needed leave to care for new babies. This effort cannot be out of reach for a nation as rich and prosperous as our own.

The bi-partisan Commission on Leave, established as a part of the Family and Medical Leave Act and which I chaired, recommended further consideration and exploration of paid leave policies. Specifically, and I quote from the unanimous recommendations of the Commission, ''the Commission recommends that the development of a uniform system of wage replacement for periods of family and medical leave be given serious consideration by employers, employee representatives and others.'' The Commission went on to recommend that we should look to expanding employer-provided systems of paid leave, and expanding state systems like unemployment insurance or temporary disability insurance, in states with those systems.

Mr. President, this is not a pie in the sky idea. Many states have already recognized the need for such support for new parents. California, New Jersey, three other states and Puerto Rico have in place temporary disability insurance programs, that at a minimal cost to employees and employers, provide support to mothers who are temporarily disabled after pregnancy and childbirth as well as other workers temporarily disabled.

Other states are moving to provide income to families through different mechanisms. Massachusetts, Vermont, Washington and several other states are all considering legislation to expand their state unemployment compensation systems to provide partial wage replacement to workers taking family or medical leave. Just a few weeks ago, President Clinton announced his support of these bold initiatives and directed the Department of Labor to work with the states to allow for this expansion of these state unemployment insurance systems.

But I believe there is more for the federal government to do. We should be a partner in these state efforts and help spur the development of the unemployment insurance model as well as other financial mechanism that will, I hope, make paid leave a reality for all new parents in America.

I am proposing today legislation that would establish a federal demonstration program—which I am calling FIRST (Family Income to Respond to Significant Transitions) Insurance.

FIRST Insurance would support state demonstration projects that provide partial or full wage replacement to new parents who take time off from work for the birth or adoption of a child. States could also choose to expand these benefits to support other care giving needs, such as taking time to care for an ill parent, spouse or child, or to support parents who choose to stay home with an infant.

These would be state or community-based projects, entirely voluntary—in no way mandated by federal law. Clearly, there is already much going on in this area. Thousands of employers offer their employees and their families paid leave. There are private insurance systems that cover wages in various circumstances including the birth of a new child. There are state and local dollars that supplement the incomes of new families as well as protect families at other times of economic crisis. These federal dollars would leverage these state, private and other dollars to expand access to paid leave to more parents.

The demonstrations funded will form the basis of a large-scale investigation of the most effective way to provide support to families at these critical times in a family's life. Key questions to be answered include the costs of these projects, the reach and the impact on families and children. The demonstrations will also allow comparisons of different mechanisms to provide leave—including expansion of state unemployment insurance systems, temporary disability programs, and other viable mechanisms.

Mr. President, when a person is injured on the job, or when someone loses their job because of a plant closing or some other factor beyond their control, our nation rightly protects their families from the risk of catastrophic financial loss. That's the purpose of workman's compensation and unemployment insurance.

If we can protect families at times like this, shouldn't we protect them at another time of crucial family need as they struggle to meet the joyful challenge of raising a newborn?

Mr. President, this initiative is just one part of a better deal we owe to America's families. Just as the horrible tragedy in Littleton, Colorado was a wake up call to parents across the country, it must be a wake up call to us to re-examine our policies around children, families and parenthood.

There is much to be done—child care, education, expanding the basic protection of the Family and Medical Leave Act to more workers, intelligent gun control policies, and better alternatives for our youth out of school. But I believe a key piece is supporting parents in the very first days, weeks and months of a child's life—and hope that we can work together to make sure these all important days are possible for all parents.

Mr. President, I ask unanimous consent that this measure be printed in the RECORD.

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

S. 1355

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Family Income to Respond to Significant Transitions Insurance Act''.

SEC. 2. FINDINGS.

Congress finds that—

(1) nearly every industrialized nation other than the United States, and most developing nations, provide parents with paid leave for infant care;

(2)(A) parents' interactions with their infants have a major influence on the physical, cognitive, and social development of the infants; and

(B) optimal development of an infant depends on a strong attachment between an infant and the infant's parents;

(3) nearly ⅔ of employees, who need to take family or medical leave, but do not take the leave, report that they cannot afford to take the leave;

(4) although some employees in the United States receive wage replacement during periods of family or medical leave, the benefit of wage replacement is not shared equally in the workforce, as demonstrated by the fact that—

(A) employees with less education and lower income are less likely to receive wage replacement than employees with more education and higher salaries; and

(B) female employees, employees from racial minority groups, and younger employees are slightly less likely to receive wage replacement than male employees, white employees, and older employees, respectively;

(5) in order to cope financially with taking family or medical leave, of persons taking that leave without full wage replacement—

(A) 40 percent cut their leave short;

(B) 39 percent put off paying bills;

(C) 25 percent borrowed money; and

(D) 9 percent obtained public assistance;

(6) taking family or medical leave often drives employees earning low wages into poverty, and 21 percent of such low-wage employees who take family or medical leave without full wage replacement resort to public assistance;

(7) studies document shortages in the supply of infant care, and that the shortages are expected to worsen as welfare reform measures are implemented; and

(8) compared to 30 years ago, families have experienced an average decrease of 22 hours per week in time that parents spend with their children.

SEC. 3. PURPOSES.

The purposes of this Act are—

(1) to establish a demonstration program that supports the efforts of States and political subdivisions to provide partial or full wage replacement, often referred to as FIRST insurance, to new parents so that the new parents are able to spend time with a new infant or newly adopted child, and to other employees; and

(2) to learn about the most effective mechanisms for providing the wage replacement assistance.

SEC. 4. DEFINITIONS.

In this Act:

(1) SECRETARY.—The term ''Secretary'' means the Secretary of Labor, acting after consultation with the Secretary of Health and Human Services.

(2) SON OR DAUGHTER; STATE.—The terms ''son or daughter'' and ''State'' have the meanings given the terms in section 101 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2611).

SEC. 5. DEMONSTRATION PROJECTS.

(a) GRANTS.—The Secretary shall make grants to eligible entities to pay for the Federal share of the cost of carrying out projects that assist families by providing,

through various mechanisms, wage replacement for eligible individuals that are responding to caregiving needs resulting from the birth or adoption of a son or daughter or other family caregiving needs. The Secretary shall make the grants for periods of 5 years.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a State or political subdivision of a State.

(c) USE OF FUNDS.—

(1) IN GENERAL.—An entity that receives a grant under this section may use the funds made available through the grant to provide partial or full wage replacement as described in subsection (a) to eligible individuals—

(A) directly;

(B) through an insurance program, such as a State temporary disability insurance program or the State unemployment compensation benefit program;

(C) through a private disability or other insurance plan, or another mechanism provided by a private employer; or

(D) through another mechanism.

(2) ADMINISTRATIVE COSTS.—No entity may use more than 10 percent of the total funds made available through the grant during the 5-year period of the grant to pay for the administrative costs relating to a project described in subsection (a).

(d) ELIGIBLE INDIVIDUALS.—To be eligible to receive wage replacement under subsection (a), an individual shall—

(1) meet such eligibility criteria as the eligible entity providing the wage replacement may specify in an application described in subsection (e); and

(2) be—

(A) an individual who is taking leave, under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601 et seq.), other Federal, State, or local law, or a private plan, for a reason described in subparagraph (A) or (B) of section 102(a)(1) of the Family and Medical Leave Act of 1993 (29 U.S.C. 2612(a)(1));

(B) at the option of the eligible entity, an individual who—

(i) is taking leave, under that Act, other Federal, State, or local law, or a private plan, for a reason described in subparagraph (C) or (D) of section 102(a)(1) of the Family and Medical Leave Act of 1993 (29 U.S.C. 2612(a)(1)); or

(ii) leaves employment because the individual has elected to care for a son or daughter under age 1; or

(C) at the option of the eligible entity, an individual with other characteristics specified by the eligible entity in an application described in subsection (e).

(e) APPLICATION.—To be eligible to receive a grant under this section, an entity shall submit an application to the Secretary, at such time, in such manner, and containing such information as the Secretary may require, including, at a minimum—

(1) a plan for the project to be carried out with the grant;

(2) information demonstrating that the applicant consulted representatives of employers and employees, including labor organizations, in developing the plan;

(3) estimates of the costs and benefits of the project;

(4)(A) information on the number and type of families to be covered by the project, and the extent of such coverage in the area served under the grant; and

(B) information on any criteria or characteristics that the entity will use to determine whether an individual is eligible for wage replacement under subsection (a), as described in paragraphs (1) and (2)(C) of subsection (d);

(5) if the project will expand on State and private systems of wage replacement for eligible individuals, information on the manner in which the project will expand on the systems;

(6) information demonstrating the manner in which the wage replacement assistance provided through the project will assist families in which an individual takes leave as described in subsection (d)(1); and

(7) an assurance that the applicant will participate in efforts to evaluate the effectiveness of the project.

(f) SELECTION CRITERIA.—In selecting entities to receive grants for projects under this section, the Secretary shall—

(1) take into consideration—

(A) the scope of the proposed projects;

(B) the cost-effectiveness, feasibility, and financial soundness of the proposed projects;

(C) the extent to which the proposed projects would expand access to wage replacement in response to family caregiving needs, particularly for low-wage employees, in the area served by the grant; and

(D) the benefits that would be offered to families and children through the proposed projects; and

(2) to the extent feasible, select entities proposing projects that utilize diverse mechanisms, including expansion of State unemployment compensation benefit programs, and establishment or expansion of State temporary disability insurance programs, to provide the wage replacement.

(g) FEDERAL SHARE.—

(1) IN GENERAL.—The Federal share of the cost described in subsection (a) shall be—

(A) 50 percent for the first year of the grant period;

(B) 40 percent for the second year of that period;

(C) 30 percent for the third year of that period; and

(D) 20 percent for each subsequent year.

(2) NON-FEDERAL SHARE.—The non-Federal share of the cost may be in cash or in kind, fairly evaluated, including plant, equipment, and services and may be provided from State, local, or private sources, or Federal sources other than this Act.

(h) SUPPLEMENT NOT SUPPLANT.—Funds appropriated pursuant to the authority of this Act shall be used to supplement and not supplant other Federal, State, and local public funds and private funds expended to provide wage replacement.

(i) EFFECT ON EXISTING RIGHTS.—Nothing in this Act shall be construed to supersede, preempt, or otherwise infringe on the provisions of any collective bargaining agreement or any employment benefit program or plan that provides greater rights to employees than the rights established under this Act.

SEC. 6. EVALUATIONS AND REPORTS.

(a) AVAILABLE FUNDS.—The Secretary shall use not more than 2 percent of the funds made available under section 5 to carry out this section.

(b) EVALUATIONS.—The Secretary shall, directly or by contract, evaluate the effectiveness of projects carried out with grants made under section 5, including conducting—

(1) research relating to the projects, including research comparing—

(A) the scope of the projects, including the type of insurance or other wage replacement mechanism used, the method of financing used, the eligibility requirements, the level of the wage replacement benefit provided (such as the percentage of salary replaced), and the length of the benefit provided, for the projects;

(B) the utilization of the projects, including the characteristics of individuals who benefit from the projects, particularly low-wage workers, and factors that determine the ability of eligible individuals to obtain wage replacement through the projects; and

(C) the costs of and savings achieved by the projects, including the cost-effectiveness of the projects and their benefits for children and families;

(2) analysis of the overall need for wage replacement; and

(3) analysis of the impact of the projects on the overall availability of wage replacement.

(c) REPORTS.—

(1) INITIAL REPORT.—Not later than 3 years after the beginning of the grant period for the first grant made under section 5, the Secretary shall prepare and submit to Congress a report that contains information resulting from the evaluations conducted under subsection (b).

(2) SUBSEQUENT REPORTS.—Not later than 4 years after the beginning of that grant period, and annually thereafter, the Secretary shall prepare and submit to Congress a report that contains—

(A) information resulting from the evaluations conducted under subsection (b); and

(B) usage data for the demonstration projects, for the most recent year for which data are available.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this Act $400,000,000 for fiscal year 2000 and such sums as may be necessary for each subsequent fiscal year.

Mr. KENNEDY. Mr. President, I am honored to join as a cosponsor of Senator DODD's ''Family Income to Respond to Significant Transitions'' (FIRST) Insurance Demonstration Project Act. From his work on the Family and Medical Leave Act of 1993 to his countless efforts to improve the quality and accessibility of child care, Senator DODD has been a tireless advocate for families and children, and I commend his leadership on this important new initiation.

Millions of families have benefited from the Family and Medical Leave Act, but we must do more to support working families. Nearly two-thirds of employees cannot afford to take family or medical leave when a new child is born or a family member becomes ill. According to a survey by the National Partnership for Women and Families, 64 percent of Americans believe that the time pressures on working families are getting worse, not better. Two-thirds of women and men under the age of 45 believe that they will need to take a family or medical leave in the next 10 years. But, many of these families won't be able to afford it.

We should stop paying lip service to family values and find a way to help families afford family leave when they need it. This bill will provide grants to states and local communities to experiment with methods of wage replacement for workers who take family leave. States will use the grants for demonstration projects implementing wage replacement strategies to allow more employees to spend time with their families when family needs require it.

Under the Family and Medical Leave Act, businesses with 50 or more employees must provide up to 12 weeks of unpaid leave to employees to care for a newborn or newly-adopted child, or to care for a child, a spouse, or a parent who is ill. The Act has helped millions of workers care for their families, but too many obstacles prevent too many

workers from taking leave. Forty-one million people, nearly half the private workforce, are not protected by the law because their company is too small to be covered, or because they haven't worked there long enough to qualify for the leave.

Others are covered and entitled to a leave, but cannot benefit from the Act because they cannot afford to take an unpaid leave of absence. Although some workers are fortunate enough to receive wage replacement during periods of family or medical leave, most hard-working low-wage earners do not receive this benefit. Low-income employees are less likely to receive wage replacement than more highly educated, well-paid employees. Women, minorities, and younger employees are less likely than men, white Americans, and older workers to receive wage replacement benefits when taking family leave.

As a result, 40 percent employees without full wage replacement cut their leaves short, 39 percent put-off paying bills, 25 percent borrow money, and 9 percent turn to public assistance to cover their loss wages. Taking unpaid leave often drives low-wage earners into poverty. Workers who need to care for an ill family member, an elderly parent, or a new baby should not be plunged into poverty.

Our bill will help families take needed leave by allowing states to implement alternative funding programs. For example, states may choose to expand state or private Temporary Disability Insurance plans to provide partial or full replacement of wages for those taking time off form work to care for a new child. States may also expand their Unemployment Insurance Compensation to make leave from work economically feasible. The FIRST Act is an important step in the right direction. This bill will provide states with $400 million for fiscal year 2000 to fund demonstration programs, assisting states which are already working to establish wage replacement leave programs.

I am proud that Massachusetts is moving forward to address this problem. A bill to establish a Family and Employment Security Trust Fund has already been introduced, providing family leave replacement through the unemployment insurance system. Thousands of workers in Massachusetts will be able to care for their families without falling into poverty—including low-income employees living from paycheck to paycheck. Groups in Maryland, Vermont, and Washington are taking the lead with similar legislation.

We need to put families first and this bill does that. I urge my colleagues to support this needed initiative.

By Mr. MOYNIHAN (for himself and Mr. SCHUMER):

S. 1356. A bill to amend the Marine Protection, Research, and Sanctuaries Act of 1972 to clarify the limitation on the dumping of dredged material in Long Island Sound; to the Committee on Environment and Public Works.

THE LONG ISLAND SOUND PROTECTION ACT OF 1999

Mr. MOYNIHAN. Mr. President, I rise today to introduce a bill that will protect the natural beauty and resources of the Long Island Sound from current dredging policies that allow large amounts of material to be dumped into the estuary without stringent environmental review. The Long Island Sound Protection Act of 1999 would require all large dredging projects in the Sound to comply with sediment testing provisions of the Marine Protection Research and Sanctuaries Act, commonly known as the Ocean Dumping Act.

Under the Ocean Dumping Act, any Long Island Sound dredging project that disposes of more than 25,000 tons of dredged material must undergo toxicity and bioaccumulation tests before it is safe to dump. However, smaller nonfederal projects need only comply with the Clean Water Act, which does not require testing. In recent years, the Army Corps of Engineers has begun an unfortunate practice of avoiding the more rigorous requirements of the Ocean Dumping Act by individually permitting smaller projects that are clearly a part of larger dredging operations. Individually permitted, these projects need only comply with the Clean Water Act, even though they are dumped together in the Long Island Sound and have the same cumulative effect as one large project would to the local ecosystem. The Long Island Sound Protection Act would end this practice of stacking permits and would ensure that at least one environmentally acceptable disposal site is designated by the Environmental Protection Agency within a two-year period.

Dredging projects are critical to the people and businesses who rely extensively on the Sound to transport goods, services, and people every day. However, the health of the Long Island Sound ecosystem is also important to the 8 million people living within the boundaries of the Long Island Sound watershed, with more than $5 billion generated annually from boating, commercial and sport fishing, swimming, and beachgoing. The Long Island Sound is also an estuary of national significance that my State, in cooperation with the Environmental Protection Agency, has worked diligently to restore under the 1992 Long Island Sound Comprehensive Conservation and Management Plan. This bill would remove one of the barriers to achieving the laudable goals of this Plan.

A clean and safe Sound is important to us all. I urge my colleagues to join me in supporting this important legislation.

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

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

S. 1356

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Long Island Sound Protection Act''.

SEC. 2. LONG ISLAND SOUND PROTECTION.

Section 106 of the Marine Protection, Research, and Sanctuaries Act (33 U.S.C. 1416) is amended—

(1) by striking ''(f) In'' and inserting the following:

''(f) LONG ISLAND SOUND.—

''(1) IN GENERAL.—In''; and

(2) by adding at the end the following:

''(2) MULTIPLE PROJECTS.—

''(A) IN GENERAL.—Paragraph (1) shall apply to a project described in paragraph (1) if—

''(i) 1 or more projects of that type produce, in the aggregate, dredged material in excess of 25,000 cubic yards; and

''(ii)(I) the project or projects are carried out in a proximate geographical area; or

''(II) the aggregate quantity of dredged material produced by the project or projects is transported, for dumping purposes, by the same barge.

''(B) REGULATIONS.—As soon as practicable, but not later than 60 days after the date of enactment of this paragraph, the Administrator shall promulgate regulations that define the term 'proximate geographical area' for purposes of subparagraph (A)(i).

''(3) DESIGNATED SITE.—Not later than 2 years after the date of enactment of this paragraph, the Administrator shall designate under section 102(c) at least 1 site for the dumping of dredged material generated in the vicinity of Long Island Sound.

''(4) PROHIBITION ON DUMPING OF DREDGED MATERIAL.—Except at the site or sites designated under paragraph (3) (if the site or sites are located in Long Island Sound), no dredged material shall be dumped in Long Island Sound after the date on which the Administrator designates at least 1 site under paragraph (3).''.

By Mr. JEFFORDS:

s. 1357. A. bill to amend the Internal Revenue Code of 1986 to enhance the portability of retirement benefits, and for other purposes; to the Committee on Finance.

THE RETIREMENT ACCOUNT PORTABILITY ACT

Mr. JEFFORDS. Mr. President, today I am introducing S. 1357, the Retirement Account Portability (RAP) Act. This bill is a close companion to H.R. 738, the bill introduced by Congressman EARL POMEROY of North Dakota. It was also included as title III of the Pension Coverage and Portability Act, S. 741, introduced earlier this year by myself and Senators GRAHAM and GRASSLEY. Generally this bill is intended to be a further iteration of the concepts embodied in both of those bills.

The RAP Act standardizes the rules in the Internal Revenue Code (IRC) which regulate how portable a worker's retirement savings account is, and while it does not make portability of pension benefits perfect, it greatly improves the status quo. No employer will be ''required'' to accept rollovers from other plans, however. A rollover will occur when the employee offers, and the employer agrees to accept, a rollover from another plan.

Under current law, it is not possible for an individual to move an accumulated retirement savings account from a section 401(k) (for-profit) plan to a section 457 (state and local government) deferred compensation plan, to an Individual Retirement Account (IRA), then to a section 403(b) (non-profit organization or public school) deferred annuity plan and ultimately back into a section 401(k) plan, without violating various restrictions on the movement of their money. The RAP Act will make it possible for workers to take their retirement savings with them when they change jobs regardless of the type of employer for which they work.

This bill will also help make IRAs more portable and will improve the use of conduit IRAs. Conduit IRAs are individual retirement accounts to which certain distributions from a qualified retirement plan or from another individual retirement account have been transferred. RAP changes the rules regulating these IRAs so that workers leaving the for-profit, non-profit or governmental field can use a conduit IRA as a parking spot for a pre-retirement distribution. These special accounts are needed by many workers until they have another employer-sponsored plan in which to rollover their savings.

In many instances, this bill will allow an individual to rollover an IRA consisting exclusively of tax-deductible contributions into a retirement plan at his or her new place of employment, thus helping the individual consolidate retirement savings in a single account. Under certain circumstances, the RAP Act will also allow workers to rollover any after-tax contributions made at his or her previous workplace, into a new retirement plan. Under the provisions of the bill as drafted, after-tax contributions will be rollable from a plan to an IRA and from an IRA to an IRA, but not from a IRA to a plan, nor on a direct plan to plan basis. I am open to recommendations on how we can improve the treatment of after-tax rollovers and I look forward to hearing from my colleagues and the public on that topic.

Current law requires a worker who changes jobs to face a deadline of 60 days within which to roll over any retirement savings benefits either into an Individual Retirement Account, or into the retirement plan of his or her new employer. Failure to meet the deadline can result in both income and excise taxes being imposed on the account. We believe that this deadline should be waived under certain circumstances and we have outlined them in the bill. Consistent with the Pomeroy bill, in case of a Presidentially-declared natural disaster or military service in a combat zone, the Treasury Department will have the authority to disallow imposition of any tax penalty for the account holder. Consistent with the additional changes incorporated by Congressman POMEROY this year, however, we have included a waiver of tax penalties in the case of undue hardship, such as a serious personal injury or illness and we have given the Department of the Treasury the authority to waive the deadline.

The Retirement Account Portability Act will also change two complicated rules which harm both plan sponsors and plan participants; one dealing with certain business sales (the so-called ''same desk'' rule) and the other dealing with retirement plan distribution options. Each of these rules has impeded true portability of pensions and we believe they ought to be changed.

In addition, this bill will extend the Pension Benefit Guaranty Corporation's (PBGC) Missing Participant program to defined benefit multiemployer pension plans. Under current law, the PBGC has jurisdiction over both single-employer and multiemployer defined benefit pension plans. A few years ago, the agency initiated a program to locate missing participants from terminated, single-employer plans. The program attempts to locate individuals who are due a benefit, but who have not filed for benefits owed to them, or who have attempted to find their former employer but failed to receive their benefits. This bill expands the missing participant program to multiemployer pension plans.

I know of no reason why individuals covered by a multiemployer pension plans should not have the same protections as participants of single-employer pension plans and this change will help more former employees receive all the benefits to which they are entitled. This bill does not expand the missing participants program to defined contribution plans. Supervision of defined contribution plans is outside the statutory jurisdiction of the PBGC and I have not heard strong arguments for including those plans within the jurisdiction of the agency. I would be pleased to hear the recommendations of any of my colleagues on this matter.

In a particularly important provision, the Retirement Account Portability bill will allow public school teachers and other state and local employees who move between different states and localities to use their savings in their section 403(b) plan or section 457 deferred compensation arrangement to purchase ''service credit'' in the defined benefit plan in which they are currently participating, and thus obtain greater pension benefits in the plan in which they conclude their career.

As a final note, this bill, this bill does not reduce the vesting schedule from the current five year cliff vesting (or seven year graded) to a three year cliff or six year graded vesting schedule that has been contained in other bills. I support the shorter vesting schedules, but I feel that the abbreviated schedule makes a dramatic change to tax law without removing some of the disincentives to maintaining a pension plan that businesses—especially small businesses—desperately need. More discussion of this matter is needed.

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

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

S. 1357

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

SECTION 1. SHORT TITLE; AMENDMENT OF 1986 CODE.

(a) SHORT TITLE.—This Act may be cited as the ''Retirement Account Portability Act of 1999''.

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 2. ROLLOVERS ALLOWED AMONG VARIOUS TYPES OF PLANS.

(a) ROLLOVERS FROM AND TO SECTION 457 PLANS.—

(1) ROLLOVERS FROM SECTION 457 PLANS.—

(A) IN GENERAL.—Section 457(e) (relating to other definitions and special rules) is amended by adding at the end the following:

''(16) ROLLOVER AMOUNTS.—

''(A) GENERAL RULE.—In the case of an eligible deferred compensation plan, if—

''(i) any portion of the balance to the credit of an employee in such plan is paid to such employee in an eligible rollover distribution (within the meaning of section 402(c)(4) without regard to subparagraph (C) thereof),

''(ii) the employee transfers any portion of the property such employee receives in such distribution to an eligible retirement plan described in section 402(c)(8)(B), and

''(iii) in the case of a distribution of property other than money, the amount so transferred consists of the property distributed,

then such distribution (to the extent so transferred) shall not be includible in gross income for the taxable year in which paid.

''(B) CERTAIN RULES MADE APPLICABLE.—The rules of paragraphs (2) through (7) (other than paragraph (4)(C)) and (9) of section 402(c) and section 402(f) shall apply for purposes of subparagraph (A).

''(C) REPORTING.—Rollovers under this paragraph shall be reported to the Secretary in the same manner as rollovers from qualified retirement plans (as defined in section 4974(c)).''

(B) DEFERRAL LIMIT DETERMINED WITHOUT REGARD TO ROLLOVER AMOUNTS.—Section 457(b)(2) (defining eligible deferred compensation plan) is amended by inserting ''(other than rollover amounts)'' after ''taxable year''.

(C) DIRECT ROLLOVER.—Paragraph (1) of section 457(d) is amended by striking ''and'' at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting '', and'', and by inserting after subparagraph (B) the following:

''(C) the plan meets requirements similar to the requirements of section 401(a)(31).

Any amount transferred in a direct trustee-to-trustee transfer in accordance with section 401(a)(31) shall not be includible in gross income for the taxable year of transfer.''

(D) WITHHOLDING.—

(i) Paragraph (12) of section 3401(a) is amended by adding at the end the following:

''(E) under or to an eligible deferred compensation plan which, at the time of such payment, is a plan described in section 457(b); or''.

(ii) Paragraph (5) of section 3405(e) is amended by adding at the end the following: ''Such term shall include an eligible deferred compensation plan described in section 457(b).''

(iii) Paragraph (3) of section 3405(c) is amended to read as follows:

''(3) ELIGIBLE ROLLOVER DISTRIBUTION.—For purposes of this subsection, the term 'eligible rollover distribution' has the meaning given such term by section 402(f)(2)(A).''

(iv) LIABILITY FOR WITHHOLDING.—Subparagraph (B) of section 3405(d)(2) is amended by striking ''or'' at the end of clause (ii), by striking the period at the end of clause (iii) and inserting '', or'', and by adding at the end the following:

'(iv) section 457(b).''

(2) ROLLOVERS TO SECTION 457 PLANS.—

(A) Section 402(c)(8)(B) (defining eligible retirement plan) is amended by striking ''and'' at the end of clause (iii), by striking the period at the end of clause (iv) and inserting '', and'', and by adding at the end the following:

''(v) an eligible deferred compensation plan described in section 457(b) of an eligible employer described in section 457(e)(1)(A).''

(B) Paragraph (9) of section 402(c) is amended by striking ''except that'' and all that follows and inserting ''except that only an account or annuity described in clause (i) or (ii) of paragraph (8)(B) shall be treated as an eligible retirement plan with respect to such distribution.''

(C) Subsection (a) of section 457 (relating to year of inclusion in gross income) is amended by striking ''or otherwise made available''.

(3) MINIMUM DISTRIBUTIONS.—Paragraph (2) of section 457(d) is amended to read as follows:

''(2) MINIMUM DISTRIBUTION REQUIREMENTS.—A plan meets the distribution requirements of this paragraph if the plan meets the requirements of section 401(a)(9).''

(4) CONFORMING AMENDMENT.—Paragraph (9) of section 457(e) is amended to read as follows:

''(9) BENEFITS NOT TREATED AS FAILING TO MEET DISTRIBUTION REQUIREMENTS OF SUBSECTION (d).—A plan shall not be treated as failing to meet the distribution requirements of subsection (d) by reason of a distribution of the total amount payable to a participant under the plan if—

''(A) such amount does not exceed the dollar limit under section 411(a)(11)(A), and

''(B) such amount may be distributed only if—

''(i) no amount has been deferred under the plan with respect to such participant during the 2-year period ending on the date of the distribution, and

''(ii) there has been no prior distribution under the plan to such participant to which this paragraph applied.''

(b) ALLOWANCE OF ROLLOVERS FROM AND TO 403(b) PLANS.—

(1) ROLLOVERS FROM SECTION 403(b) PLANS.—Section 403(b)(8)(A)(ii) (relating to rollover amounts) is amended by striking ''such distribution'' and all that follows and inserting ''such distribution to an eligible retirement plan described in section 402(c)(8)(B), and''.

(2) ROLLOVERS TO SECTION 403(b) PLANS.—Section 402(c)(8)(B) (defining eligible retirement plan), as amended by subsection (a), is amended by striking ''and'' at the end of clause (iv), by striking the period at the end of clause (v) and inserting '', and'', and by adding at the end the following:

''(vi) an annuity contract described in section 403(b).''

(3) CONFORMING AMENDMENT.—Subparagraph (B) of section 403(b)(8) is amended by striking ''Rules similar to the'' and inserting ''The''.

(c) EXPANDED EXPLANATION TO RECIPIENTS OF ROLLOVER DISTRIBUTIONS.—Paragraph (1) of section 402(f) (relating to written explanation to recipients of distributions eligible for rollover treatment) is amended by striking ''and'' at the end of subparagraph (C), by striking the period at the end of subparagraph (D) and inserting '', and'', and by adding at the end the following new subparagraph:

''(E) of the provisions under which distributions from the eligible retirement plan receiving the distribution may be subject to restrictions and tax consequences which are different from those applicable to distributions from the plan making such distribution.''

(d) CONFORMING AMENDMENTS.—

(1) Section 72(o)(4) is amended by striking ''and 408(d)(3)'' and inserting ''403(b)(8), 408(d)(3), and 457(e)(16)''.

(2) Section 219(d)(2) is amended by striking ''or 408(d)(3)'' and inserting ''408(d)(3), or 457(e)(16)''.

(3) Section 401(a)(31)(B) is amended by striking ''and 403(a)(4)'' and inserting '', 403(a)(4), 403(b)(8), and 457(e)(16)''.

(4) Subparagraph (A) of section 402(f)(2) is amended by striking ''or paragraph (4) of section 403(a)'' and inserting '', paragraph (4) of section 403(a), subparagraph (A) of section 403(b)(8), or subparagraph (A) of section 457(e)(16)''.

(5) Paragraph (1) of section 402(f) is amended by striking ''from an eligible retirement plan''.

(6) Subparagraphs (A) and (B) of section 402(f)(1) are amended by striking ''another eligible retirement plan'' and inserting ''an eligible retirement plan''.

(7) Subparagraph (B) of section 403(b)(8) is amended by striking ''shall apply for purposes of subparagraph (A)'' and inserting ''and section 402(f) shall apply for purposes of subparagraph (A), except that section 402(f) shall be applied to the payor in lieu of the plan administrator''.

(8) Subparagraph (B) of section 403(b)(8) is amended by inserting ''and (9)'' after ''through (7)''.

(9) Section 408(a)(1) is amended by striking ''or 403(b)(8)'' and inserting '', 403(b)(8), or 457(e)(16)''.

(10) Subparagraphs (A) and (B) of section 415(b)(2) are each amended by striking ''and 408(d)(3)'' and inserting ''403(b)(8), 408(d)(3), and 457(e)(16)''.

(11) Section 415(c)(2) is amended by striking ''and 408(d)(3)'' and inserting ''408(d)(3), and 457(e)(16)''.

(12) Section 4973(b)(1)(A) is amended by striking ''or 408(d)(3)'' and inserting ''408(d)(3), or 457(e)(16)''.

(e) EFFECTIVE DATE; SPECIAL RULE.—

(1) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 1999.

(2) SPECIAL RULE.—Notwithstanding any other provision of law, subsections (h)(3) and (h)(5) of section 1122 of the Tax Reform Act of 1986 shall not apply to any distribution from an eligible retirement plan described in clause (iii) or (iv) of section 402(c)(8)(B) of the Internal Revenue Code of 1986 on behalf of an individual if there was a rollover to such plan on behalf of such individual which is permitted solely by reason of any amendment made by this section.

SEC. 3. ROLLOVERS OF IRAS INTO WORKPLACE RETIREMENT PLANS.

(a) IN GENERAL.—Subparagraph (A) of section 408(d)(3) (relating to rollover amounts) is amended by adding ''or'' at the end of clause (i), by striking clauses (ii) and (iii), and by adding at the end the following:

''(ii) the entire amount received (including money and any other property) is paid into an eligible retirement plan for the benefit of such individual not later than the 60th day after the date on which the individual receives the payment or distribution.

For purposes of clause (ii), the term 'eligible retirement plan' means an eligible retirement plan described in clause (iii), (iv), (v), or (vi) of section 402(c)(8)(B).''

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (1) of section 403(b) is amended by striking ''section 408(d)(3)(A)(iii)'' and inserting ''section 408(d)(3)(A)(ii)''.

(2) Clause (i) of section 408(d)(3)(D) is amended by striking ''(i), (ii), or (iii)'' and inserting ''(i) or (ii)''.

(3) Subparagraph (G) of section 408(d)(3) is amended to read as follows:

''(G) SIMPLE RETIREMENT ACCOUNTS.—In the case of any payment or distribution out of a simple retirement account (as defined in subsection (p)) to which section 72(t)(6) applies, this paragraph shall not apply unless such payment or distribution is paid into another simple retirement account.''

(c) EFFECTIVE DATE; SPECIAL RULE.—

(1) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 1999.

(2) SPECIAL RULE.—Notwithstanding any other provision of law, subsections (h)(3) and (h)(5) of section 1122 of the Tax Reform Act of 1986 shall not apply to any distribution from an eligible retirement plan described in clause (iii) or (iv) of section 402(c)(8)(B) of the Internal Revenue Code of 1986 on behalf of an individual if there was a rollover to such plan on behalf of such individual which is permitted solely by reason of the amendments made by this section.

SEC. 4. ROLLOVERS OF AFTER-TAX CONTRIBUTIONS; HARDSHIP EXCEPTION.

(a) AFTER-TAX CONTRIBUTIONS.—

(1) ROLLOVERS.—Subsection (c) of section 402 (relating to rules applicable to rollovers from exempt trusts) (as amended by section 2) is amended by striking paragraph (2) and redesignating paragraphs (3) through (10) as paragraphs (2) through (9), respectively.

(2) DIRECT TRANSFERS.—Paragraph (31) of section 401(a) (relating to optional direct transfer of eligible rollover distributions) is amended by striking subparagraph (B) and redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively.

(3) ANNUITIES.—Subparagraph (B) of section 408(d)(3) (relating to rollover contributions) is amended by striking ''which was not includible in his gross income because of the application of this paragraph'' and inserting ''to which this paragraph applied''.

(4) ELIGIBLE RETIREMENT PLAN.—Paragraph (7)(B) of section 402(c) (as redesignated by subsection (a)(1) and as amended by section 2) is amended—

(A) by striking ''The term'' and inserting ''Except as provided in this subparagraph, the term'', and

(B) by adding at the end the following:

''Arrangements described in clauses (iii), (iv) (v), and (vi) shall not be treated as eligible retirement plans for purposes of receiving a rollover contribution of an eligible rollover distribution to the extent that such eligible rollover distribution is not includible in gross income (determined without regard to paragraph (1)).''

(5) TAXATION OF DISTRIBUTIONS.—Paragraph (2) of section 408(d) is amended—

(A) by striking ''For purposes'' and inserting the following:

''(A) IN GENERAL.—Except as provided in this paragraph, for purposes'',

(B) by striking ''(A) all'' and inserting ''(i) all'';

(C) by striking ''(B) all'' and inserting ''(ii) all'';

(D) by striking ''(C) the'' and inserting ''(iii) the'',

(E) by striking ''subparagraph (C)'' and inserting ''clause (iii)'', and

(F) by inserting at the end the following:

''(B) APPLICATION OF SECTION 72.—For purposes of applying section 72, if—

''(i) a distribution is made from an individual retirement plan, and

''(ii) a rollover contribution described in paragraph (3) is made to an eligible retirement plan described in section 402(c)(7)(B)(iii), (iv), (v), or (vi) with respect to all or part of such distribution,

the includible amount in the individual's individual retirement plans shall be reduced by the amount described in subparagraph (C). As of the close of the calendar year in which the taxable year begins, the reduction of all amounts described in subparagraph (C)(i) shall be applied prior to the computations described in subparagraph (A)(iii). The amount of any distribution with respect to which there is a rollover contribution described in clause (ii) shall not be treated as a distribution for purposes of subparagraph (A).

''(C) AMOUNT DESCRIBED.—The amount described in this subparagraph is the sum of—

''(i) the amount of the rollover contribution described in subparagraph (B)(ii), and

''(ii) in the case of any portion of the distribution with respect to which there is not a rollover contribution described in paragraph (3), the amount of such portion that is included in gross income under section 72.

''(D) INCLUDIBLE AMOUNT.—For purposes of this paragraph, the term 'includible amount' shall mean the amount that is not investment in the contract (as defined in section 72).''

(6) TRANSFERS TO IRAS.—Subparagraph (C) of section 402(c)(5) (as redesignated by subsection (a)(1)) is amended by inserting after ''other than money'' the following: ''or where the amount of the distribution exceeds the amount of the rollover contribution''.

(b) HARDSHIP EXCEPTION TO 60-DAY RULE.—

(1) PLAN ROLLOVERS.—Paragraph (2) of section 402(c) (as so redesignated) is amended to read as follows:

''(2) TRANSFER MUST BE MADE WITHIN 60 DAYS OF RECEIPT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), paragraph (1) shall not apply to any transfer of a distribution made after the 60th day following the day on which the distributee received the property distributed.

''(B) HARDSHIP EXCEPTION.—The Secretary may waive the 60-day requirement under subparagraph (A) where the failure to waive such requirement would be against equity or good conscience, including casualty, disaster, or other events beyond the reasonable control of the individual subject to such requirement.''

(2) IRA ROLLOVERS.—Paragraph (3) of section 408(d) (relating to rollover contributions) is amended by adding at the end the following new subparagraph:

''(H) WAIVER OF 60-DAY REQUIREMENT.—The Secretary may waive the 60-day requirement under subparagraphs (A) and (D) where the failure to waive such requirement would be against equity or good conscience, including casualty, disaster, or other events beyond the reasonable control of the individual subject to such requirement.''

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (4) of section 402(c) (as redesignated by subsection (a)(1)) is amended by striking ''(8)(B)'' and inserting ''(7)(B)''.

(2) Subparagraph (B) of section 403(a)(4) is amended by striking ''(2) through (7)'' and inserting ''(2) through (6)''.

(3) Section 403(b)(8)(A)(ii) (as amended by section 2) is amended by striking ''section 402(c)(8)(B)'' and inserting ''section 402(c)(7)(B)''.

(4) Subparagraph (B) of section 403(b)(8) (as amended by section 2) is amended by striking ''(2) through (7) and (9) of section 402(c)'' and inserting ''(2) through (6) and (8) of section 402(c)''.

(5) Subparagraph (A) of section 408(d)(3) (as amended by section 3) is amended by striking ''402(c)(8)'' and inserting ''402(c)(7)''.

(6) Paragraph (16) of section 457(e) (as added by section 2) is amended—

(A) in subparagraph (A)(i) by striking ''402(c)(4)'' and inserting ''402(c)(3)'',

(B) in subparagraph (A)(ii) by striking ''402(c)(8)(B)'' and inserting ''402(c)(7)(B)'', and

(C) in subparagraph (B) by striking ''paragraphs (2) through (7) (other than paragraph (4)(C)) and (9) of section 402(c)'' and inserting ''paragraphs (2) through (6) (other than paragraph (3)(C)) and (8) of section 402(c)''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided by paragraph (2), the amendments made by this section shall apply to distributions made after December 31, 1999.

(2) HARDSHIP EXCEPTION.—The amendments made by subsection (b) shall apply to 60-day periods ending after the date of the enactment of this Act.

SEC. 5. EXTENSION OF MISSING PARTICIPANTS PROGRAM TO MULTIEMPLOYER PLANS.

(a) IN GENERAL.—Section 4050 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1350) is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

''(c) MULTIEMPLOYER PLANS.—The corporation shall prescribe rules similar to the rules in subsection (a) for multiemployer plans covered by this title that terminate under section 4041A.''

(b) CONFORMING AMENDMENT.—Section 206(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1056(f)) is amended by striking ''the plan shall provide that,''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after final regulations implementing subsection (c) of section 4050 of the Employee Retirement Income Security Act of 1974 (as added by subsection (a)) are prescribed.

SEC. 6. RATIONALIZATION OF RESTRICTIONS ON DISTRIBUTIONS FROM DEFINED CONTRIBUTION PLANS.

(a) DISTRIBUTIONS PERMITTED ON SEVERANCE FROM EMPLOYMENT.—

(1) 401(k) PLANS.—Section 401(k)(2)(B)(i)(I) (relating to qualified cash or deferred arrangements) is amended by striking ''separation from service'' and inserting ''severance from employment''.

(2) 403(b) CONTRACTS.—

(A) Clause (ii) of section 403(b)(7)(A) is amended by striking ''separates from service'' and inserting ''severs from employment''.

(B) Paragraph (11) of section 403(b) is amended—

(i) by striking ''SEPARATION FROM SERVICE'' in the heading and inserting ''SEVERANCE FROM EMPLOYMENT'', and

(ii) by striking ''separates from service'' and inserting ''severs from employment''.

(3) 457 PLANS.—Clause (ii) of section 457(d)(1)(A) is amended by striking ''is separated from service'' and inserting ''has a severance from employment''.

(b) BUSINESS SALE REQUIREMENTS DELETED.—

(1) IN GENERAL.—Section 401(k)(2)(B)(i)(II) (relating to qualified cash or deferred arrangements) is amended by striking ''an event'' and inserting ''a plan termination''.

(2) CONFORMING AMENDMENTS.—Section 401(k)(10) is amended—

(A) by striking subparagraph (A) and inserting the following:

''(A) IN GENERAL.—A plan termination is described in this paragraph if the termination of the plan does not involve the establishment or maintenance of another defined contribution plan (other than an employee stock ownership plan as defined in section 4975(e)(7)).'',

(B) in subparagraph (B)—

(i) by striking ''An event'' and inserting ''A termination'', and

(ii) by striking ''the event'' and inserting ''the termination'',

(C) by striking subparagraph (C), and

(D) by striking ''OR DISPOSITION OF ASSETS OR SUBSIDIARY'' in the heading.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 1999.

SEC. 7. TRANSFEREE DEFINED CONTRIBUTION PLAN NEED NOT HAVE SAME DISTRIBUTION OPTIONS AS TRANSFEROR DEFINED CONTRIBUTION PLAN.

(a) IN GENERAL.—Section 411(d)(6) (relating to accrued benefit not to be decreased by amendment) is amended by adding at the end the following new subparagraph:

''(D) PLAN TRANSFERS.—A defined contribution plan (in this subparagraph referred to as the 'transferee plan') shall not be treated as failing to meet the requirements of this paragraph merely because the transferee plan does not provide some or all of the forms of distribution previously available under another defined contribution plan (in this subparagraph referred to as the 'transferor plan') to the extent that—

''(i) the forms of distribution previously available under the transferor plan applied to the account of a participant or beneficiary under the transferor plan that was transferred from the transferor plan to the transferee plan pursuant to a direct transfer rather than pursuant to a distribution from the transferor plan,

''(ii) the terms of both the transferor plan and the transferee plan authorize the transfer described in clause (i),

''(iii) the transfer described in clause (i) was made pursuant to a voluntary election by the participant or beneficiary whose account was transferred to the transferee plan,

''(iv) the election described in clause (iii) was made after the participant or beneficiary received a notice describing the consequences of making the election,

''(v) if the transferor plan provides for an annuity as the normal form of distribution under the plan in accordance with section 417, the transfer is made with the consent of the participant's spouse (if any), and such consent meets requirements similar to the requirements imposed by section 417(a)(2), and

''(vi) the transferee plan allows the participant or beneficiary described in clause (iii) to receive any distribution to which the participant or beneficiary is entitled under transferee plan in the form of a single sum distribution.''

(b) AMENDMENT TO ERISA.—Section 204(g) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1054(g)) is amended by adding at the end the following new paragraph:

''(4) A defined contribution plan (in this paragraph referred to as the 'transferee plan') shall not be treated as failing to meet the requirements of this subsection merely because the transferee plan does not provide some or all of the forms of distribution previously available under another defined contribution plan (in this paragraph referred to as the 'transferor plan') to the extent that—

''(A) the forms of distribution previously available under the transferor plan applied

to the account of a participant or beneficiary under the transferor plan that was transferred from the transferor plan to the transferee plan pursuant to a direct transfer rather than pursuant to a distribution from the transferor plan,

''(B) the terms of both the transferor plan and the transferee plan authorize the transfer described in subparagraph (A),

''(C) the transfer described in subparagraph (A) was made pursuant to a voluntary election by the participant or beneficiary whose account was transferred to the transferee plan,

''(D) the election described in subparagraph (C) was made after the participant or beneficiary received a notice describing the consequences of making the election,

''(E) if the transferor plan provides for an annuity as the normal form of distribution under the plan in accordance with section 205, the transfer is made with the consent of the participant's spouse (if any), and such consent meets requirements similar to the requirements imposed by section 205(c)(2), and

''(F) the transferee plan allows the participant or beneficiary described in subparagraph (C) to receive any distribution to which the participant or beneficiary is entitled under transferee plan in the form of a single sum distribution.''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers after December 31, 1999.

SEC. 8. EMPLOYERS MAY DISREGARD ROLLOVERS FOR PURPOSES OF CASH-OUT AMOUNTS.

(a) AMENDMENTS TO 1986 CODE.—

(1) Section 411(a)(11) (relating to restrictions on certain mandatory distributions) is amended by adding at the end the following:

''(D) SPECIAL RULE FOR ROLLOVER CONTRIBUTIONS.—A plan shall not fail to meet the requirements of this paragraph if, under the terms of the plan, the present value of the nonforfeitable accrued benefit is determined without regard to that portion of such benefit which is attributable to rollover contributions (and earnings allocable thereto). For purposes of this subparagraph, the term 'rollover contributions' means any rollover contribution under sections 402(c), 403(a)(4), 403(b)(8), 408(d)(3)(A)(ii), and 457(e)(16).''

(2) Clause (i) of section 457(e)(9)(A) is amended by striking ''such amount'' and inserting ''the portion of such amount which is not attributable to rollover contributions (as defined in section 411(a)(11)(D))''.

(b) AMENDMENT TO ERISA.—Section 203(e) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1053(e)) is amended by adding at the end the following:

''(4) A plan shall not fail to meet the requirements of this subsection if, under the terms of the plan, the present value of the nonforfeitable accrued benefit is determined without regard to that portion of such benefit which is attributable to rollover contributions (and earnings allocable thereto). For purposes of this paragraph, the term 'rollover contributions' means any rollover contribution under sections 402(c), 403(a)(4), 403(b)(8), 408(d)(3)(A)(ii), and 457(e)(16) of the Internal Revenue Code of 1986.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 1999.

SEC. 9. PURCHASE OF SERVICE CREDIT IN GOVERNMENTAL DEFINED BENEFIT PLANS.

(a) 403(b) PLANS.—Subsection (b) of section 403 is amended by adding at the end the following new paragraph:

''(13) TRUSTEE-TO-TRUSTEE TRANSFERS TO PURCHASE PERMISSIVE SERVICE CREDIT.—No amount shall be includible in gross income by reason of a direct trustee-to-trustee transfer to a defined benefit governmental plan (as defined in section 414(d)) if such transfer is—

''(A) for the purchase of permissive service credit (as defined in section 415(n)(3)(A)) under such plan, or

''(B) a repayment to which section 415 does not apply by reason of subsection (k)(3) thereof.''

(b) 457 PLANS.—

(1) Subsection (e) of section 457 is amended by adding at the end the following new paragraph:

''(17) TRUSTEE-TO-TRUSTEE TRANSFERS TO PURCHASE PERMISSIVE SERVICE CREDIT.—No amount shall be includible in gross income by reason of a direct trustee-to-trustee transfer to a defined benefit governmental plan (as defined in section 414(d)) if such transfer is—

''(A) for the purchase of permissive service credit (as defined in section 415(n)(3)(A)) under such plan, or

''(B) a repayment to which section 415 does not apply by reason of subsection (k)(3) thereof.''

(2) Section 457(b)(2), as amended by section 2, is amended by striking ''(other than rollover amounts)'' and inserting ''(other than rollover amounts and amounts received in a transfer referred to in subsection (e)(17))''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to trustee-to-trustee transfers after December 31, 1999.

SEC. 10. PROVISIONS RELATING TO PLAN AMENDMENTS.

(a) IN GENERAL.—If this section applies to any plan or contract amendment—

(1) such plan or contract shall be treated as being operated in accordance with the terms of the plan during the period described in subsection (b)(2)(A), and

(2) such plan shall not fail to meet the requirements of section 411(d)(6) of the Internal Revenue Code of 1986 or section 204(g) of the Employee Retirement Income Security Act of 1974 by reason of such amendment.

(b) AMENDMENTS TO WHICH SECTION APPLIES.—

(1) IN GENERAL.—This section shall apply to any amendment to any plan or annuity contract which is made—

(A) pursuant to any amendment made by this Act or pursuant to any guidance issued by the Secretary of the Treasury (or the Secretary's delegate) under any such amendment, and

(B) on or before the last day of the first plan year beginning on or after January 1, 2002.

In the case of a governmental plan (as defined in section 414(d) of the Internal Revenue Code of 1986), this paragraph shall be applied by substituting ''2004'' for ''2002''.

(2) CONDITIONS.—This section shall not apply to any amendment unless—

(A) during the period—

(i) beginning on the date the legislative amendment or guidance described in paragraph (1)(A) takes effect (or in the case of a plan or contract amendment not required by such legislative amendment or guidance, the effective date specified by the plan), and

(ii) ending on the date described in paragraph (1)(B) (or, if earlier, the date the plan or contract amendment is adopted),

the plan or contract is operated as if such plan or contract amendment were in effect, and

(B) such plan or contract amendment applies retroactively for such period.

By Mr. JEFFORDS (for himself, Mr. REED, Mr. ENZI, and Mr. LEAHY):

S. 1358. A bill to amend title XVIII of the Social Security Act to provide more equitable payments to home health agencies under the Medicare Program; to the Committee on Finance.

THE PRESERVING ACCESS TO CARE IN THE HOME ACT OF 1999

Mr. JEFFORDS. Mr. President, I rise today to introduce the Preserving Access to Care in the Home Act of 1999, also known as the PATCH Act. This important bill has been crafted to protect access to care for those most in need, relieve the cash flow problems faced by agencies, and improve the interaction between home health agencies and HCFA. I want to recognize Senator REED, Senator ENZI, and Senator LEAHY. These cosponsors have shown tremendous effort and dedication in dealing with the crisis in home health care.

Abraham Lincoln said ''The legitimate object of government is to do for a community of people, whatever they need to have done, but cannot do at all, or cannot so well do for themselves, in their separate and individual capacities.'' This is the essence of home health care.

Home health care means so much to so many people: it means that people recovering from surgery can go home sooner—it means that someone recovering from an accident can get physical therapy in their home, it means our seniors can stay at home, and out of nursing homes. It is smart policy from human and financial standpoints.

My own State of Vermont is a model for providing high-quality, comprehensive care with a low price tag. For the past eight years, the average Medicare expenditure for home health care in Vermont has been the lowest in the nation. Vermont's home care system was designed to efficiently meet the needs of frail and elderly citizens in our largely rural State, but the Health Care Financing Administration's (HCFA) reimbursement system was not. HCFA's interim payment system (IPS) has been implemented in a manner that inadequately reimburses agencies for the care that they provide.

The Balanced Budget Act (BBA) did a lot of good, providing health care coverage for millions of low income children, providing targeted tax relief for families and students, tax incentives to encourage pensions savings, and extending the life of Medicare. However, as with most things in life, it was not perfect.

The BBA failed to recognize how the new home health reimbursement would affect small rural home health care providers. The IPS has caused such significant cash flow problems, that many agencies are struggling to meet their payroll needs. Home health care agencies are now facing the prospect of 15 percent budget cut next year. This budget cut, on top of already stretched budgets, would be disastrous for providers and patients alike.

The PATCH Act will rectify these problems.

First, the PATCH Act eliminates the 15-percent cut scheduled for next year. The actual savings under IPS have exceeded initial expectations, so the 15-percent cut is unnecessary to achieve the savings originally projected as needed.

Second, the PATCH Act clarifies the definition of ''homebound'' so that coverage decisions are based on the condition of the individual and not on an arbitrary number of absences from the home. Many seniors have found themselves virtual prisoners in their homes, threatened with loss of coverage if they attend adult day care, weekly religious services, or even visit family members in the hospital. This makes no sense because all of these activities are steps on the road to successful and healthy recovery. Often, home care professionals want patients to get outside a little bit, as part of their care plan. This helps fight off depression. Eligibility for home care should depend on the health of the patient.

Third, the PATCH Act creates an ''outlier'' provision so that medically complex patients suffering from multiple ailments are not excluded by the Medicare program. Agencies will receive reimbursements for reasonable costs so that they can continue to provide care for these complex patients without going bankrupt. Home health agencies can provide care to long-term chronic care patients at a lower cost than nursing homes, or hospitals.

Next, the PATCH Act also matches the rate of review to the rate of denial and provides a reward to agencies for ''good behavior'' and incentive to submit ''good claims.'' Conducting high cost, intense audits on all agencies, regardless of the past efficiency of the agency, is expensive and unproductive. Many agencies are finding themselves swamped by pre-payment reviews for claims that they submit. These reviews require that health professionals spend a substantial amount of their time filling out forms instead of providing urgently needed care to the elderly. Matching the rate of review to the rate of denial adds to the efficiency of home health agencies, and the efficiency of the regulatory. If the finalized denial rate of claims for a home health agency is less than 5 percent then (a) there will be no prepayment reviews, and (b) the post-payment review shall not exceed 10 percent of the claims.

Finally, the bill restores the periodic interim payment system (PIP) and provides guidelines to HCFA on the development of a prospective payment system (PPS) that will be fair to Vermont's low-cost, rural providers.

The sooner you can return patients to their homes, the sooner they can recover. The familiar environment of the home, family, and friends is more nurturing to recovering patients than the often stressful and unfamiliar surroundings of a hospital. Home health allows them to receive treatment for their medical conditions while being integrated back into independence. Home health is also a great avenue for education. It empowers families to assist in the care of their loved ones. This, too, results in lower costs because family members, in addition to health professionals, provide some of the care. Access to care in the home must be saved.

I look forward to turning this legislation into law. The women and men who provide home care are on the front line every day and deserve nothing but our best efforts.

By Mr. HOLLINGS:

S. 1359. A bill to amend chapter 51 of title 49, United States Code, to extend the coverage of the rules governing the transportation of hazardous materials, and for other purposes; to the Committee on Commerce, Science, and Transportation.

POSTAL HAZARDOUS MATERIALS SAFETY ENHANCEMENT ACT OF 1999

Mr. HOLLINGS. Mr. President, I rise to introduce a bill to insure the safe transportation of hazardous materials (hazmat) via the United States Postal Service and its contract carriers.

The Hazardous Materials Transportation Safety Improvement Act of 1990, P.L. 103–311, specifically exempted the U.S. Postal Service from Department of Transportation (DOT) hazmat enforcement. Although they are exempt from DOT hazmat enforcement, the U.S. Postal Service self-governs hazardous materials transportation through internal regulations and inspections.

The National Transportation Safety Board has made numerous recommendations over the years to subject the U.S. Postal Service to DOT inspections and increased enforcement efforts. In addition, they have also recommended that the Postal Service be subject to enforcement obligations similar to those observed by other package and express mail operations. Due to the fact that only a small percentage of mail is transported exclusively by the U.S. Postal Service and most of it is contracted out to other carriers, it makes sense that all mail and package transporters be subject to the same DOT regulations and inspections.

We all remember the horrifying crash of ValuJet Airlines, flight 592, into the Everglades in May of 1996. Although the cause of the ValuJet accident was not attributed to the U.S. Postal Service, the situation in which it occurred demonstrated the importance of accurate labeling in the transportation of hazardous materials. Following the ValuJet accident, the NTSB made multiple recommendations to the U.S. Postal Service about increased safety in the transport of hazmat. However, in the year following the ValuJet incident there were thirteen additional hazardous materials incidents that occurred when U.S. mail was transported via air. There should be a better safety net for the public and the employees who are charged with the safe transport of the packages, mail and express items.

Similarly, the frightening success of the Unabomber throughout the 1980's and 1990's underscores the need for tougher controls over hazardous materials sent via the U.S. Postal Service. Ted Kaczynski repeatedly sent explosive devices in packages through the mail system resulting in three deaths and 29 injuries. These packages, which weighed on average between five and ten pounds, were never inspected for hazardous contents. Largely in response to the Unabomber, the U.S. Postal Service implemented new requirements addressing package mail, however if a hazmat package is not identified at the source, it is important that the Department of Transportation hazmat inspectors have the authority to inspect packages carried by surface and air carriers.

These accidents clearly demonstrate that the shipment of undeclared hazardous materials is a serious problem that needs more attention. While the U.S. Postal Service has worked hard to train its employees to recognize hazmat shipments, much of the transportation of postal material is done via contract carriers who are not U.S. Postal Service employees. Efforts to address this issue have been hindered by the exclusion of DOT inspectors from regulating hazardous materials shipped via the U.S. Postal Service.

Mr. President, I believe that the U.S. Postal Service and the DOT hazmat inspectors are faced with an enormous task—keeping our mail and our transportation systems safe. My bill would provide for increased authority in hazmat inspections by authorizing DOT inspectors to work in tandem with U.S. Postal Inspectors. The safety of our transportation system is dependent on the safety of the cargo it is carrying—all hazmat packages should be adequately inspected and if found unsafe, they should be treated appropriately, expeditiously and equally.

I ask unanimous consent that the full 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. 1359

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Postal Hazardous Materials Safety Enhancement Act''.

SEC. 2. APPLICATION OF HAZMAT REQUIREMENTS.

(a) IN GENERAL.—Section 5102(9)(B) of title 49, United States Code, is amended to read as follows:

''(B) for purposes of sections 5123 and 5124 of this title, does not include a department, agency, or instrumentality of the Government.''

(b) COORDINATION.—In carrying out the provisions of chapter 51 of title 49, United States Code, the Secretary of Transportation shall consult with the Postmaster General in order to coordinate, to the greatest extent feasible, the enforcement of that chapter.

SEC. 3 TRANSPORTATION OF HAZARDOUS MATERIALS VIA THE UNITED STATES MAIL.

(a) IN GENERAL.—Section 5102 of title 49, United States Code, is amended by—

(1) redesignating paragraph (13) as paragraph (14); and

(2) inserting after paragraph (12) the following:

''(13) 'transportation of hazardous material in commerce' and 'transporting hazardous material in commerce' include the transportation of hazardous material in the United States mail.''.

(b) REPEAL OF EXCEPTION.—Section 5126(b) of such title is amended to read as follows:

''(b) NONAPPLICATION.—This chapter does not apply to a pipeline subject to regulation under chapter 601 of this title.''.

By Mr. LEAHY:

S. 1360. A bill to preserve the effectiveness of Secret Service protection by establishing a protective function privilege, and for other purposes; to the Committee on the Judiciary.

SECRET SERVICE PROTECTION PRIVILEGE ACT OF 1999

Mr. LEAHY. Mr. President, I rise today to introduce the Secret Service Protective Privilege Act of 1999. This legislation is intended to ensure the ability of the United States Secret Service to fulfill its vital mission of protecting the life and safety of the President and other important persons.

Almost five months have passed since the impeachment proceedings against President Clinton were concluded, and the time has come for Congress to repair some of the damage that was done during that divisive episode. I refer to the misguided efforts of Independent Counsel Kenneth Starr to compel Secret Service agents to answer questions about what may have observed or overheard while protecting the life of the President.

Few national interests are more compelling than protecting the life of the President of the United States. The Supreme Court has said that the nation has ''an overwhelming interest in protecting the safety of its Chief Executive and in allowing him to perform his duties without interference from threats of physical violence.'' [Watts v. United States, 394 U.S. 705, 707 (1969).] What's at stake is not merely the safety of one person. What's at stake is the ability of the Executive Branch to function in an effective and orderly fashion, and the capacity of the United States to respond to threats and crises. Think of the shock waves that rocked the world in November 1963 when President Kennedy was assassinated. The assassination of a President has international repercussions and threatens the security and future of the entire nation.

The threat to our national security and to our democracy extends beyond the life of the President to those in direct line of the Office of the President—the Vice President, the President-elect, and the Vice President elect. By Act of Congress, these officials are required to accept the protection of the Secret Service—they may not turn it down. This statutory mandate reflects the critical importance that Congress has attached to the physical safety of these officials.

Congress has also charged the Secret Service with responsibility for protecting visiting heads of foreign states and foreign governments. The assassination of a foreign head of state on American soil could be catastrophic from a foreign relations standpoint and could seriously threaten national security.

The Secret Service Protective Privilege Act of 1999 would enhance the Secret Service's ability to protect these officials, and the nation, from the risk of assassination. It would do this by facilitating the relationship of trust between these officials and their Secret Service protectors that is essential to the Service's protective strategy.

The Service uses a ''protective envelope'' method of protection. Agents and officers surround the protectee with an all-encompassing zone of protection on a 24-hour-a-day basis. In the face of danger, they will shield the protectee's body with their own bodies and move him to a secure location.

That is how the Secret Service averted a national tragedy on March 30, 1981, when John Hinckley attempted to assassinate President Reagan. Within seconds of the first shot being fired, Secret Service personnel had shielded the President's body and maneuvered him into the waiting limousine. One agent in particular, Agent Tim McCarthy, positioned his body to intercept a bullet intended for the President. If Agent McCarthy had been even a few feet farther from the President, history might have gone very differently.

For the Secret Service to maintain this sort of close, unremitting proximity to the President and other protectees, it must have their complete, unhesitating trust and confidence. Secret Service personnel must be able to remain at the President's side even during confidential and sensitive conversations, when they may overhear military secrets, diplomatic exchanges, and family and private matters. If our Presidents do not have complete trust in the Secret Service personnel who protect them, they could try to push away the Service's ''protective envelope'' or undermine it to the point where it could no longer be fully effective.

This is more than a theoretical possibility. Consider what former President Bush wrote last April, after hearing of the independent counsel's efforts to compel Secret Service testimony:

> The bottom line is I hope that [Secret Service] agents will be exempted from testifying before the Grand Jury. What's at stake here it the protection of the life of the President and his family and the confidence and trust that a President must have in the [Secret Service].
>
> If a President feels that Secret Service agents can be called to testify about what they might have seen or heard then it is likely that the President will be uncomfortable having the agents near by.
>
> I allowed the agents to have proximity first because they had my full confidence and secondly because I knew them to be totally discreet and honorable. . . .
>
> . . . I can assure you that had I felt they would be compelled to testify as to what they had seen or heard, no matter what the subject, I would not have felt comfortable having them close in
>
> . . . I feel very strongly that the [Secret Service] agents should not be made to appear in court to discuss that which they might or might not have seen or heard.
>
> What's at stake here is the confidence of the President in the discretion of the [Secret Service]. If that confidence evaporates the agents, denied proximity, cannot properly protect the President.

As President Bush's letter makes plain, requiring Secret Service agents to betray the confidence of the people whose lives they protect could seriously jeopardize the ability of the Service to perform its crucial national security function.

The possibility that Secret Service personnel might be compelled to testify about their protectees could have a particularly devastating affect on the Service's ability to protect foreign dignitaries. The mere fact that this issue has surfaced is likely to make foreign governments less willing to accommodate Secret Service both with respect to the protection of the President and Vice President on foreign trips, and the protection of foreign heads of state traveling in the United States.

The recent court decisions, which refused to recognize a protective function privilege, could have a devastating impact upon the Secret Service's ability to provide effective protection. The courts ignored the voices of experience—former Presidents, Secret Service Directors, and others—who warned of the potentially deadly consequences. The courts disregarded the lessons of history. We cannot afford to be so cavalier; the stakes are just too high.

The security of our chief executive officers and visiting foreign heads of state is a matter that transcends all partisan politics. I urge my colleagues to support this legislation and ask unanimous consent that the bill and a summary of the bill be printed in the RECORD.

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

S. 1360

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Secret Service Protective Privilege Act of 1999''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress makes the following findings:

(1) The physical safety of the Nation's top elected officials is a public good of transcendent importance.

(2) By virtue of the critical importance of the Office of the President, the President and those in direct line of the Presidency are subject to unique and mortal jeopardy—jeopardy that in turn threatens profound disruption to our system of representative government and to the security and future of the Nation.

(3) The physical safety of visiting heads of foreign states and foreign governments is also a matter of paramount importance. The assassination of such a person while on American soil could have calamitous consequences for our foreign relations and national security.

(4) Given these grave concerns, Congress has provided for the Secret Service to protect the President and those in direct line of the Presidency, and has directed that these officials may not waive such protection. Congress has also provided for the Secret Service to protect visiting heads of foreign states and foreign governments.

(5) The protective strategy of the Secret Service depends critically on the ability of its personnel to maintain close and unremitting physical proximity to the protectee.

(6) Secret Service personnel must remain at the side of the protectee on occasions of confidential conversations and, as a result, may overhear top secret discussions, diplomatic exchanges, sensitive conversations, and matters of personal privacy.

(7) The necessary level of proximity can be maintained only in an atmosphere of complete trust and confidence between the protectee and his or her protectors.

(8) If a protectee has reason to doubt the confidentiality of actions or conversations taken in sight or hearing of Secret Service personnel, the protectee may seek to push the protective envelope away or undermine it to the point at which it could no longer be fully effective.

(9) The possibility that Secret Service personnel might be compelled to testify against their protectees could induce foreign nations to refuse Secret Service protection in future state visits, making it impossible for the Secret Service to fulfill its important statutory mission of protecting the life and safety of foreign dignitaries.

(10) A privilege protecting information acquired by Secret Service personnel while performing their protective function in physical proximity to a protectee will preserve the security of the protectee by lessening the incentive of the protectee to distance Secret Service personnel in situations in which there is some risk to the safety of the protectee.

(11) Recognition of a protective function privilege for the President and those in direct line of the Presidency, and for visiting heads of foreign states and foreign governments, will promote sufficiently important interests to outweigh the need for probative evidence.

(12) Because Secret Service personnel retain law enforcement responsibility even while engaged in their protective function, the privilege must be subject to a crime/treason exception.

(b) PURPOSES.—The purposes of this Act are—

(1) to facilitate the relationship of trust and confidence between Secret Service personnel and certain protected officials that is essential to the ability of the Secret Service to protect these officials, and the Nation, from the risk of assassination; and

(2) to ensure that Secret Service personnel are not precluded from testifying in a criminal investigation or prosecution about unlawful activity committed within their view or hearing.

SEC. 3. ESTABLISHMENT OF PROTECTIVE FUNCTION PRIVILEGE.

(a) ADMISSIBILITY OF INFORMATION ACQUIRED BY SECRET SERVICE PERSONNEL WHILE PERFORMING THEIR PROTECTIVE FUNCTION.—Chapter 203 of title 18, United States Code, is amended by inserting after section 3056 the following:

''§ 3056A. Testimony by Secret Service personnel; protective function privilege

''(a) DEFINITIONS.—In this section:

''(1) PROTECTEE.—The term 'protectee' means—

''(A) the President;

''(B) the Vice President (or other officer next in the order of succession to the Office of President);

''(C) the President-elect;

''(D) the Vice President-elect; and

''(E) visiting heads of foreign states or foreign governments who, at the time and place concerned, are being provided protection by the United States Secret Service.

''(2) SECRET SERVICE PERSONNEL.—The term 'Secret Service personnel' means any officer or agent of the United States Secret Service.

''(b) GENERAL RULE OF PRIVILEGE.—Subject to subsection (c), testimony by Secret Service personnel or former Secret Service personnel regarding information affecting a protectee that was acquired during the performance of a protective function in physical proximity to the protectee shall not be received in evidence or otherwise disclosed in any trial, hearing, or other proceeding in or before any court, grand jury, department, officer, agency, regulatory body, or other authority of the United States, a State, or a political subdivision thereof.

''(c) EXCEPTIONS.—There is no privilege under this section—

''(1) with respect to information that, at the time the information was acquired by Secret Service personnel, was sufficient to provide reasonable grounds to believe that a crime had been, was being, or would be committed; or

''(2) if the privilege is waived by the protectee or the legal representative of a protectee or deceased protectee.

''(d) CONCURRENT PRIVILEGES.—The proximity of Secret Service personnel to a protectee engaged in a privileged communication with another shall not, by itself, defeat an otherwise valid claim of privilege.''.

(b) TECHNICAL AND CONFORMING AMENDMENT.—The analysis for chapter 203 of title 18, United States Code, is amended by inserting after the item relating to section 3056 the following:

''3056A. Testimony by Secret Service personnel; protective function privilege.''.

SEC. 4. APPLICATION.

This Act and the amendments made by this Act shall apply to any proceeding commenced on or after the date of enactment of this Act.

SUMMARY OF THE SECRET SERVICE PROTECTIVE PRIVILEGE ACT OF 1999

The proposed legislation would add a new section 2056A to title 18, United States Code, establishing a protective function privilege. There are four subsections.

Subsection (a) establishes the definitions used in the section.

Subsection (b) states the general rule that testimony by Secret Service personnel or former Secret Service personnel regarding information affecting a protectee that was acquired during the performance of a protective function in physical proximity to the protectee shall not be received in evidence or otherwise disclosed. The privilege operates only with respect to the President, the Vice President (or other officer next in the order of succession to the Office of President), the President-elect, the Vice President-elect, and visiting heads of foreign states or foreign governments.

Subsection (c) creates a crime-fraud exception to the privilege, which applies with respect to information that, at the time it was acquired by Secret Service personnel, was sufficient to provide reasonable grounds to believe that a crime had been, was being, or would be committed. This subsection also provides that the privilege may be waived by a protectee or by his or her legal representative.

Subsection (d) provides that the proximity of Secret Service personnel to a protectee shall not, by itself, defeat an otherwise valid claim of privilege. This addresses the situation in which Secret Service personnel overhear confidential communications between the protectee and, say, the protectee's spouse or attorney.

By Mr. STEVENS (for himself, (Mr. INOUYE, Mr. LOTT, Mrs. FEINSTEIN, Mr. AKAKA, and Mr. GRAHAM):

S. 1361. A bill to amend the Earthquake Hazards Reduction Act of 1977 to provide for an expanded Federal program of hazard mitigation, relief, and insurance against the risk of catastrophic natural disasters, such as hurricanes, earthquakes, and volcanic eruptions, and for other purposes; to the Committee on Commerce, Science, and Transportation.

NATURAL DISASTER PROTECTION AND INSURANCE ACT OF 1999

Mr. STEVENS. Mr. President, today I am introducing the Natural Disaster Protection and Insurance Act of 1999. This bill will provide the Nation with a way of dealing with major national disasters. As many of my colleagues are aware I have maintained an interest in this area for some time. Over the last decade we have witnessed natural disasters and the devastating effect that they can have on our property, economy and quality of life.

Damages from Hurricane Andrew resulted in the insolvency of insurance companies and a lack of confidence within the industry to deal with similar catastrophes in the future. Major hurricane risk is increasing. Some scientists predict that the next decade will bring more favorable conditions for a major hurricane hitting the U.S. than existed in the period leading up the Hurricane Andrew.

Over half of the population of the United States resides within the coastal zone (approximately 300 km centered at the coastline). Infrastructure and population along our coast is growing rapidly and so our vulnerability to hurricanes is increasing dramatically.

My Home State of Alaska has had at least nine major earthquakes of 7.4 magnitude or more on the Richter scale. Alaska's 1964 Good Friday Earthquake was one of the world's most powerful, registering, a magnitude of 9.2 on the Richter scale.

The Alaska quake of 1964 destroyed the economic basis of entire communities. Whole fishing fleets, harbors,

and canneries were lost. The shaking caused tidal waves. Petroleum storage tanks ruptured and the contents caught fire. Burning oil ran into the bay and was carried to the waterfront by large waves. These waves of fire destroyed docks, piers, and small-boat harbors. Total property damage was $311 million in 1964 dollars. Experts predict that a quake this size in the lower 48 would kill thousands and cost up to $200 billion.

According to Michael J. Armstrong, associate director, mitigation directorate of the Federal Emergency Management Agency:

Earthquakes represent the largest single potential for casualties and damage from a natural hazard facing this country. They represent a national threat, as all but seven States in the U.S. are at some level of risk.

In our most recent earthquake disaster, Northridge, (CA), a moderate earthquake centered on the fringe of a major metropolitan area caused an estimated $40 billion in damage. A large magnitude earthquake located under one of several urban regions in the United States could cause thousands of casualties and losses approaching $200 billion.

Accordingly, reducing earthquake losses is a matter of national concern—recent findings show a significantly increased potential for damaging earthquake in southern California, and in northern California on the Hayward Fault. Studies also show higher potential earthquakes for the Pacific Northwest and Coastal South Carolina. This is in addition to areas of earthquake risk that have already been identified, such as the New Madrid Fault Zone in the Central U.S. and Wasatch Front in Utah.

Before 1989, the United States had never experienced a disaster costing more than $1 billion in insured losses. Since then, we have had nine disasters that have cost more than $1 billion.

Today, Senators INOUYE, LOTT, BOB GRAHAM, FEINSTEIN, AKAKA, and I introduce this bill to reduce the cost to the Federal Government of earthquakes, hurricanes, and other natural disasters.

First, the bill will reduce Federal costs by expanding the use and availability of private insurance.

Second, the bill will provide incentives to improve State disaster strategic planning.

And, third, the bill will create a national, privately funded catastrophic insurance pool to shoulder the risk of very large disasters.

Mr. President, the more private insurance individuals buy, the less disaster relief Federal taxpayers must pay. For instance, if this bill had been in place before Hurricane Andrew and California's Northridge Earthquake, I am advised that it could have reduced Federal costs by at least $5 billion.

I ask my colleagues to join me and the cosponsors in supporting this bill. Because major natural catastrophes are increasingly common and costly for U.S. citizens, we must be willing to make a commitment now to prepare for these future events in advance.

Mr. GRAHAM. Mr. President, I rise to join the distinguished chairman and Ranking Member of the Senate Appropriations Committee in introducing legislation that creates a federal complement to efforts of state governments, local communities, and the private sector to make future disasters cost less.

Mr. President, I am a life-long Floridian. When children grow up in Florida they learn, usually from first hand experience, to expect devastating storm activity in their communities. Hurricane Season is an annual event. Florida suffers from often violent summer storms, tornadoes, and wildfires. With all of this natural disaster activity in my state alone, you can image that the costs of paying for the damages incurred by these events is quite staggering. These costs require the immediate action of Congress.

In August of 1992, Hurricane Andrew roared ashore in the middle of the night and devastated much of South Florida. The total costs of cleanup and rebuilding from Hurricane Andrew was $36 billion. This includes nearly $16 billion in total insured loses, of which $12 billion were homeowner policies. After Andrew 10 private insurance companies in the State of Florida were rendered insolvent and had to leave the state. Nearly 960,000 insurance policies were canceled or not renewed.

There may be more Hurricane Andrew's in our future. The National Weather Service has predicted 1999 will be an extremely active hurricane season. They have estimated that up to 14 named storms will develop in the Atlantic Ocean, 10 of those are expected to become hurricanes.

The rising costs associated with events such as Hurricane Andrew have also demonstrated that insurers face the risk of insolvency if they are overly concentrated in vulnerable regions of our country. Since 1992, insurers have widely avoided writing policies in disaster prone areas of Florida. A congressional report on this subject revealed that the total supply of available reinsurance is approximately $7 billion. This is only 10 percent of the potential loss which might occur from a worst case natural disaster scenario.

Companies that provide insurance of last resort have entered disaster-vulnerable insurance markets and filled this vacuum. Generally, these products of last resort provide less coverage than a commercial property insurance policy, but at much greater price. In Florida, such a policy averages in excess of 500 percent as compared to a commercial policy.

State Insurance Commissions and state legislatures have literally created rainy day funds in an attempt to prevent an insurance availability crisis. This includes: Florida Catastrophe Reinsurance Fund, the California Earthquake Authority, and the Hawaii Hurricane Relief Fund. In my State of Florida, we have also created programs to provide insurance for those who cannot purchase insurance from any private source because of the risk involved including the Florida Joint Underwriters Associations, and the expansion of the Florida Windstorm Underwriters Association.

Our recent experience tells us that it is time for Congress to help reverse the rising costs of natural disasters. The Natural Disaster Protection and Insurance Act of 1999 is a step in the right direction. This legislation directs the Secretary of the Treasury to carry out a program to make reinsurance available for purchase by eligible state programs, private insurers and reinsurers by way of auctions. It provides a backstop for state-operated insurance programs, and complements existing insurance industry efforts without encroaching upon the private sector.

This initiative appropriately allows state and industry leaders to assist in addressing local needs. Specifically,

Contractural coverage would include residential property losses resulting from disasters.

The Treasury Department would be prohibited from offering any coverage that competes with or replaces private insurers.

A portion of the premiums would go to a mitigation fund to support state level emergency preparedness.

This initiative is a bipartisan and bicameral effort. My Florida colleague, Congressman BILL MCCOLLUM, has joined Representative LAZIO to lead this effort in the House of Representatives. We have been working closely with the Administration, affected state and local level organizations, and private realtors and insurers. We all agree that the insurance industry cannot endure the ravage of large scale natural disasters alone. Action at the federal level is needed to continue insuring individual homeowners and business in areas vulnerable to catastrophe.

Mr. President, we have an opportunity today to continue the working partnership between the federal government, states, local communities and the private sector. The consequences of insurance shortages and exposure to known hazards must be addressed immediately. I encourage my colleagues to support this initiative.

ADDITIONAL COSPONSORS

S. 57

At the request of Ms. MIKULSKI, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 57, a bill to amend title 5, United States Code, to provide for the establishment of a program under which long-term care insurance is made available to Federal employees and annuitants, and for other purposes.

S. 211

At the request of Mr. MOYNIHAN, the names of the Senator from New Mexico (Mr. BINGAMAN) and the Senator from Arkansas (Mrs. LINCOLN) were added as cosponsors of S. 211, a bill to amend the Internal Revenue Code of 1986 to make permanent the exclusion for employer-

provided educational assistance programs, and for other purposes.

S. 253

At the request of Mr. MURKOWSKI, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 253, a bill to provide for the reorganization of the Ninth Circuit Court of Appeals, and for other purposes.

S. 335

At the request of Ms. COLLINS, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 335, a bill to amend chapter 30 of title 39, United States Code, to provide for the nonmailability of certain deceptive matter relating to games of chance, administrative procedures, orders, and civil penalties relating to such matter, and for other purposes.

S. 345

At the request of Mr. ALLARD, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 345, a bill to amend the Animal Welfare Act to remove the limitation that permits interstate movement of live birds, for the purpose of fighting, to States in which animal fighting is lawful.

At the request of Ms. COLLINS, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 345, supra.

S. 429

At the request of Mr. DURBIN, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 429, a bill to designate the legal public holiday of ''Washington's Birthday'' as ''Presidents' Day'' in honor of George Washington, Abraham Lincoln, and Franklin Roosevelt and in recognition of the importance of the institution of the Presidency and the contributions that Presidents have made to the development of our Nation and the principles of freedom and democracy.

S. 459

At the request of Mr. BREAUX, the names of the Senator from Connecticut (Mr. LIEBERMAN), the Senator from Alaska (Mr. MURKOWSKI), and the Senator from Hawaii (Mr. AKAKA) were added as cosponsors of S. 459, a bill to amend the Internal Revenue Code of 1986 to increase the State ceiling on private activity bonds.

S. 472

At the request of Mr. GRASSLEY, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 472, a bill to amend title XVIII of the Social Security Act to provide certain medicare beneficiaries with an exemption to the financial limitations imposed on physical, speech-language pathology, and occupational therapy services under part B of the medicare program, and for other purposes.

S. 632

At the request of Mr. DEWINE, the name of the Senator from Arkansas (Mr. HUTCHINSON) was added as a cosponsor of S. 632, a bill to provide assistance for poison prevention and to stabilize the funding of regional poison control centers.

S. 717

At the request of Ms. MIKULSKI, the names of the Senator from Massachusetts (Mr. KERRY) and the Senator from South Dakota (Mr. JOHNSON) were added as cosponsors of S. 717, a bill to amend title II of the Social Security Act to provide that the reductions in social security benefits which are required in the case of spouses and surviving spouses who are also receiving certain Government pensions shall be equal to the amount by which two-thirds of the total amount of the combined monthly benefit (before reduction) and monthly pension exceeds $1,200, adjusted for inflation.

S. 821

At the request of Mr. LAUTENBERG, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 821, a bill to provide for the collection of data on traffic stops.

S. 836

At the request of Mr. GRAHAM, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 836, a bill to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that group health plans and health insurance issuers provide women with adequate access to providers of obstetric and gynecological services.

S. 861

At the request of Mr. DURBIN, the name of the Senator from Illinois (Mr. FITZGERALD) was added as a cosponsor of S. 861, a bill to designate certain Federal land in the State of Utah as wilderness, and for other purposes.

S. 875

At the request of Mr. ALLARD, the name of the Senator from Kansas (Mr. BROWNBACK) was added as a cosponsor of S. 875, a bill to amend the Internal Revenue Code of 1986 to expand S corporation eligibility for banks, and for other purposes.

S. 877

At the request of Mr. BROWNBACK, the names of the Senator from Montana (Mr. BURNS) and the Senator from Michigan (Mr. ABRAHAM) were added as cosponsors of S. 877, a bill to encourage the provision of advanced service, and for other purposes.

S. 879

At the request of Mr. CONRAD, the name of the Senator from Alaska (Mr. MURKOWSKI) was added as a cosponsor of S. 879, a bill to amend the Internal Revenue Code of 1986 to provide a shorter recovery period for the depreciation of certain leasehold improvements.

S. 892

At the request of Mr. HATCH, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 892, a bill to amend the Internal Revenue Code of 1986 to permanently extend the subpart F exemption for active financing income.

S. 926

At the request of Mr. DODD, the names of the Senator from Maryland (Ms. MIKULSKI) and the Senator from Pennsylvania (Mr. SANTORUM) were added as cosponsors of S. 926, a bill to provide the people of Cuba with access to food and medicines from the United States, and for other purposes.

S. 984

At the request of Ms. COLLINS, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 984, a bill to amend the Internal Revenue Code of 1986 to modify the tax credit for electricity produced from certain renewable resources.

S. 1006

At the request of Mr. TORRICELLI, the names of the Senator from Illinois (Mr. DURBIN) and the Senator from Massachusetts (Mr. KENNEDY) were added as cosponsors of S. 1006, a bill to end the use of conventional steel-jawed leghold traps on animals in the United States.

S. 1016

At the request of Mr. DEWINE, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 1016, a bill to provide collective bargaining for rights for public safety officers employed by States or their political subdivisions.

S. 1025

At the request of Mr. MOYNIHAN, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 1025, a bill to amend title XVIII of the Social Security Act to ensure the proper payment of approved nursing and allied health education programs under the medicare program.

S. 1038

At the request of Mr. GRASSLEY, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1038, a bill to amend the Internal Revenue Code of 1986 to exempt small issue bonds for agriculture from the State volume cap.

S. 1053

At the request of Mr. BOND, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. 1053, a bill to amend the Clean Air Act to incorporate certain provisions of the transportation conformity regulations, as in effect on March 1, 1999.

S. 1087

At the request of Mr. HUTCHINSON, the name of the Senator from Minnesota (Mr. WELLSTONE) was added as a cosponsor of S. 1087, a bill to amend title 38, United States Code, to add bronchioloalveolar carcinoma to the list of diseases presumed to be service-connected for certain radiation-exposed veterans.

S. 1091

At the request of Mr. DEWINE, the name of the Senator from Minnesota (Mr. WELLSTONE) was added as a cosponsor of S. 1091, a bill to amend the

Public Health Service Act to provide for the establishment of a pediatric research initiative.

S. 1144

At the request of Mr. VOINOVICH, the names of the Senator from Illinois (Mr. DURBIN) and the Senator from Maine (Ms. SNOWE) were added as cosponsors of S. 1144, a bill to provide increased flexibility in use of highway funding, and for other purposes.

At the request of Mr. VOINOVICH, the name of the Senator from New York (Mr. SCHUMER) was withdrawn as a cosponsor of S. 1144, supra.

S. 1166

At the request of Mr. NICKLES, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of S. 1166, a bill to amend the Internal Revenue Code of 1986 to clarify that natural gas gathering lines are 7-year property for purposes of depreciation.

S. 1216

At the request of Mr. TORRICELLI, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 1216, a bill to amend the Marine Mammal Protection Act of 1972 to establish a Marine Mammal Rescue Grant Program, and for other purposes.

S. 1232

At the request of Mr. COCHRAN, the names of the Senator from Tennessee (Mr. THOMPSON), the Senator from Connecticut (Mr. LIEBERMAN), the Senator from Virginia (Mr. WARNER), the Senator from Maryland (Mr. SARBANES), and the Senator from Vermont (Mr. LEAHY) were added as cosponsors of S. 1232, a bill to provide for the correction of retirement coverage errors under chapters 83 and 84 of title 5, United States Code.

S. 1266

At the request of Mr. GORTON, the name of the Senator from New Mexico (Mr. DOMENICI) was added as a cosponsor of S. 1266, a bill to allow a State to combine certain funds to improve the academic achievement of all its students.

S. 1274

At the request of Mr. GRAMS, the names of the Senator from Colorado (Mr. ALLARD) and the Senator from North Carolina (Mr. HELMS) were added as cosponsors of S. 1274, a bill to amend the Internal Revenue Code of 1986 to increase the accessibility to and affordability of health care, and for other purposes.

S. 1277

At the request of Mr. GRASSLEY, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of S. 1277, a bill to amend title XIX of the Social Security Act to establish a new prospective payment system for Federally-qualified health centers and rural health clinics.

S. 1293

At the request of Mr. COCHRAN, the name of the Senator from New York (Mr. MOYNIHAN) was added as a cosponsor of S. 1293, a bill to establish a Congressional Recognition for Excellence in Arts Education Board.

S. 1296

At the request of Mr. MCCONNELL, the name of the Senator from North Carolina (Mr. HELMS) was added as a cosponsor of S. 1296, a bill to designate portions of the lower Delaware River and associated tributaries as a component of the National Wild and Scenic Rivers System.

S. 1317

At the request of Mr. AKAKA, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 1317, a bill to reauthorize the Welfare-To-Work program to provide additional resources and flexibility to improve the administration of the program.

S. 1332

At the request of Mr. BAYH, the names of the Senator from Oregon (Mr. SMITH), and the Senator from Maine (Ms. COLLINS) were added as cosponsors of S. 1332, a bill to authorize the President to award a gold medal on behalf of Congress to Father Theodore M. Hesburg, in recognition of his outstanding and enduring contributions to civil rights, higher education, the Catholic Church, the Nation, and the global community.

SENATE RESOLUTION 99

At the request of Mr. REID, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of Senate Resolution 99, a resolution designating November 20, 1999, as ''National Survivors for Prevention of Suicide Day.''

AMENDMENTS SUBMITTED

PATIENTS' BILL OF RIGHTS ACT

NICKLES (AND OTHERS) AMENDMENT NO. 1236

Mr. NICKLES (for himself, Mr. GRAMM, and Ms. COLLINS) proposed an amendment to the bill (S. 1344) to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage; as follows:

At the appropriate place, insert the following:

SEC. ___. EXEMPTIONS.

(a) IN GENERAL.—Notwithstanding any other provision of this Act, the provisions of this Act shall not apply with respect to a group health plan (or health insurance coverage offered in connection with the group health plan) if the provisions of this Act for a plan year during which this Act is fully implemented result in—

(1) a greater than 1 percent increase in the cost of the group health plan's premiums for the plan year, as determined under subsection (b); or

(2) a decrease, in the plan year, of 100,000 or more in the number of individuals in the United States with private health insurance, as determined under subsection (c).

(b) EXEMPTION FOR INCREASED COST.—For purposes of subsection (a)(1), if an actuary certified in accordance with generally recognized standards of actuarial practice by a member of the American Academy of Actuaries or by another individual whom the Secretary has determined to have an equivalent level of training and expertise certifies that the application of this Act to a group health plan (or health insurance coverage offered in connection with the group health plan) will result in the increase described in subsection (a)(1) for a plan year during which this Act is fully implemented, the provisions of this Act shall not apply with respect to the group health plan (or the coverage).

(c) EXEMPTION FOR DECREASED NUMBER OF INSURED PERSONS.—For purposes of subsection (a)(2), unless the Administrator of the Health Care Financing Administration certifies, on the basis of projections by the National Association of Insurance Commissioners, that the provisions of this Act will not result in the decrease described in subsection (a)(2) for a plan year during which this Act is fully implemented, the provisions of this Act shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan).

ROBB (AND OTHERS) AMENDMENT NO. 1237

Mr. KENNEDY (for Mr. ROBB (for himself, Mrs. MURRAY, Mrs. BOXER, Ms. MIKULSKI, Mr. KENNEDY, Mr. REID, Mr. DURBIN, Mr. FEINGOLD, Mrs. LINCOLN, Mr. DASCHLE, Mr. BYRD, Mr. LIEBERMAN, Mr. BINGAMAN, Mr. BRYAN, and Mr. HARKIN)) proposed an amendment to amendment No. 1236 proposed by Mr. NICKLES to the bill, S. 1344, supra; as follows:

In the amendment, strike all after the first word and insert the following:

STANDARDS RELATING TO BENEFITS FOR CERTAIN BREAST CANCER TREATMENT AND ACCESS TO APPROPRIATE OBSTETRICAL AND GYNECOLOGICAL CARE

(a) BREAST CANCER TREATMENT.—

(1) INPATIENT CARE.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in his or her professional judgment consistent with generally accepted medical standards, and the patient, to be medically appropriate following—

(A) a mastectomy;

(B) a lumpectomy; or

(C) a lymph node dissection for the treatment of breast cancer.

(2) PROHIBITIONS.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, may not—

(A) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage, solely for the purpose of avoiding the requirements of this subsection;

(B) provide monetary payments or rebates to patients to encourage such patients to accept less than the minimum protections available under this subsection;

(C) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant, beneficiary or enrollee in accordance with this subsection;

(D) provide incentives (monetary or otherwise) to an attending provider to induce such

provider to provide care to an individual participant, beneficiary or enrollee in a manner inconsistent with this subsection; or

(E) subject to paragraph (3)(B), restrict benefits for any portion of a period within a hospital length of stay required under paragraph (1) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(3) RULES OF CONSTRUCTION.—

(A) Nothing in this subsection shall be construed to require a patient who is a participant, beneficiary or enrollee—

(i) to undergo a mastectomy, lumpectomy or lymph node dissection in a hospital; or

(ii) to stay in the hospital for a fixed period of time following a mastectomy, lumpectomy or lymph node dissection.

(B) Nothing in this subsection shall be construed as preventing a group health plan or a health insurance issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with a mastectomy, lumpectomy or lymph node dissection for the treatment of breast cancer under the plan except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under paragraph (1) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(4) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this subsection shall be construed to prevent a group health plan or a health insurance issuer from negotiating the level and type of reimbursement with a provider for care provided in accordance with this subsection.

(5) DEFINITION.—In this subsection, the term ''mastectomy'' means the surgical removal of all or part of a breast.

(b) OBSTETRICAL AND GYNECOLOGICAL CARE.—

(1) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of group health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care provider—

(A) the plan or issuer shall permit such an individual who is a female to designate a participating physician who specializes in obstetrics and gynecology as the individual's primary care provider; and

(B) if such an individual has not designated such a provider as a primary care provider, the plan or issuer—

(i) shall not require authorization or a referral by the individual's primary care provider or otherwise for coverage of covered gynecological care and pregnancy-related services provided by a participating health care professional who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and

(ii) shall treat the ordering of other obstetrical and gynecological care by such a participating health professional as the authorization of the primary care provider with respect to such care under the plan or coverage.

(2) CONSTRUCTION.—Nothing in paragraph (1)(B)(ii) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of obstetrical and gynecological care so ordered.

(c) SPECIAL RULE.—Nothing in subsection (b) shall be construed as preventing a plan or issuer from offering (but not requiring a participant or beneficiary to accept) a health care professional trained, credentialed, and operating within the scope of their licensure to perform gynecological and obstetric care.

(d) APPLICATION OF SECTION.—This section shall supersede the provisions of sections 104(a) and 152.

(e) REVIEW.—Failure to meet the requirements of this section shall constitute an appealable decision under section 132(a)(2).

(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any provision of this subchapter, the group health plan shall not be liable for such violation unless the plan caused such violation.

(g) NONAPPLICATION OF CERTAIN PROVISION.—Only for purposes of applying the requirements of this section under section 714 of the Employee Retirement Income Security Act of 1974 (as added by section 301 of this Act), sections 2707 and 2753 of the Public Health Service Act (as added by sections 201 and 202 of this Act), and section 9813 of the Internal Revenue Code of 1986 (as added by section 401 of this Act)—

(1) section 2721(b)(2) of the Public Health Service Act and section 9831(a)(1) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section; and

(2) with respect to limited scope dental benefits, subparagraph (A) of section 733(c)(2) of the Employee Retirement Income Security Act of 1974, subparagraph (A) of section 2791(c)(2) of the Public Health Service Act, and subparagraph (A) of section 9832(c)(2) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section.

(h) NO IMPACT ON SOCIAL SECURITY TRUST FUND.—

(1) IN GENERAL.—Nothing in this section shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(2) TRANSFERS.—

(A) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this section has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(B) TRANSFER OF FUNDS.—If, under subparagraph (A), the Secretary of the Treasury estimates that the enactment of this section has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such section.

(i) LIMITATION ON ACTIONS.—

(1) IN GENERAL.—Except as provided for in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 by a participant or beneficiary seeking relief based on the application of any provision in this section.

(2) PERMISSIBLE ACTIONS.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 by a participant or beneficiary seeking relief based on the application of this section to the individual circumstances of that participant or beneficiary; except that—

(A) such an action may not be brought or maintained as a class action; and

(B) in such an action relief may only provide for the provision of (or payment for) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.

(j) EFFECTIVE DATE.—The provisions of this section shall apply to group health plans for plan years beginning after, and to health insurance issuers for coverage offered or sold after, October 1, 2000.''.

(k) INFORMATION REQUIREMENTS.—

(1) INFORMATION FROM GROUP HEALTH PLANS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following:

''(7) INFORMATION FROM GROUP HEALTH PLANS.—

''(A) PROVISION OF INFORMATION BY GROUP HEALTH PLANS.—The administrator of a group health plan subject to the requirements of paragraph (1) shall provide to the Secretary such of the information elements described in subparagraph (C) as the Secretary specifies, and in such manner and at such times as the Secretary may specify (but not more frequently than 4 times per year), with respect to each individual covered under the plan who is entitled to any benefits under this title.

''(B) PROVISION OF INFORMATION BY EMPLOYERS AND EMPLOYEE ORGANIZATIONS.—An employer (or employee organization) that maintains or participates in a group health plan subject to the requirements of paragraph (1) shall provide to the administrator of the plan such of the information elements required to be provided under subparagraph (A), and in such manner and at such times as the Secretary may specify, at a frequency consistent with that required under subparagraph (A) with respect to each individual described in subparagraph (A) who is covered under the plan by reason of employment with that employer or membership in the organization.

''(C) INFORMATION ELEMENTS.—The information elements described in this subparagraph are the following:

''(i) ELEMENTS CONCERNING THE INDIVIDUAL.—

''(I) The individual's name.

''(II) The individual's date of birth.

''(III) The individual's sex.

''(IV) The individual's social security insurance number.

''(V) The number assigned by the Secretary to the individual for claims under this title.

''(VI) The family relationship of the individual to the person who has or had current or employment status with the employer.

''(ii) ELEMENTS CONCERNING THE FAMILY MEMBER WITH CURRENT OR FORMER EMPLOYMENT STATUS.—

''(I) The name of the person in the individual's family who has current or former employment status with the employer.

''(II) That person's social security insurance number.

''(III) The number or other identifier assigned by the plan to that person.

''(IV) The periods of coverage for that person under the plan.

''(V) The employment status of that person (current or former) during those periods of coverage.

''(VI) The classes (of that person's family members) covered under the plan.

''(iii) PLAN ELEMENTS.—

''(I) The items and services covered under the plan.

''(II) The name and address to which claims under the plan are to be sent.

''(iv) ELEMENTS CONCERNING THE EMPLOYER.—

''(I) The employer's name.

''(II) The employer's address.

''(III) The employer identification number of the employer.

''(D) USE OF IDENTIFIERS.—The administrator of a group health plan shall utilize a unique identifier for the plan in providing information under subparagraph (A) and in other transactions, as may be specified by

the Secretary, related to the provisions of this subsection. The Secretary may provide to the administrator the unique identifier described in the preceding sentence.

''(E) PENALTY FOR NONCOMPLIANCE.—Any entity that knowingly and willfully fails to comply with a requirement imposed by the previous subparagraphs shall be subject to a civil money penalty not to exceed $1,000 for each incident of such failure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as those provisions apply to a penalty or proceeding under section 1128A(a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect 180 days after the date of the enactment of this Act.

(l) LIMITATIONS ON WELFARE BENEFIT FUNDS OF 10 OR MORE EMPLOYER PLANS.—

(1) BENEFITS TO WHICH EXCEPTION APPLIES.—Section 419A(f)(6)(A) of the Internal Revenue Code of 1986 (relating to exception for 10 or more employer plans) is amended to read as follows:

''(A) IN GENERAL.—This subpart shall not apply to a welfare benefit fund which is part of a 10 or more employer plan if the only benefits provided through the fund are 1 or more of the following:

''(i) Medical benefits.

''(ii) Disability benefits.

''(iii) Group term life insurance benefits which do not provide for any cash surrender value or other money that can be paid, assigned, borrowed, or pledged for collateral for a loan.

The preceding sentence shall not apply to any plan which maintains experience-rating arrangements with respect to individual employers.''

(2) LIMITATION ON USE OF AMOUNTS FOR OTHER PURPOSES.—Section 4976(b) of such Act (defining disqualified benefit) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR 10 OR MORE EMPLOYER PLANS EXEMPTED FROM PREFUNDING LIMITS.—For purposes of paragraph (1)(C), if—

''(A) subpart D of part I of subchapter D of chapter 1 does not apply by reason of section 419A(f)(6) to contributions to provide 1 or more welfare benefits through a welfare benefit fund under a 10 or more employer plan, and

''(B) any portion of the welfare benefit fund attributable to such contributions is used for a purpose other than that for which the contributions were made,

then such portion shall be treated as reverting to the benefit of the employers maintaining the fund.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

(d) DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS INCREASED.—

(1) IN GENERAL.—Section 162(l)(1) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended to read as follows:

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

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

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

(e) EXTENSION OF TAXES.—

(1) ENVIRONMENTAL TAX.—Section 59A(e) of the Internal Revenue Code of 1986 is amended to read as follows:

''(e) APPLICATION OF TAX.—The tax imposed by this section shall apply to taxable years beginning after December 31, 1986, and before January 1, 1996, and to taxable years beginning after December 31, 1999, and before January 1, 2009.''

(2) EFFECTIVE DATES.—The amendment made by subsection (e)(1) shall apply to taxable years beginning after December 31, 1999.

FRIST (AND JEFFORDS) AMENDMENT NO. 1238

Mr. NICKLES (for Mr. FRIST (for himself and Mr. JEFFORDS)) proposed an amendment to amendment No. 1236 proposed by Mr. NICKLES to the bill, S. 1344, supra; as follows:

At the end add the following:

Notwithstanding any other provision of this Act, subtitle D of title I and all that follows through section 151 is null, void, and shall have no effect.

Subtitle E—Protecting the Doctor-Patient Relationship

SEC. 141. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) PROHIBITION.—

(1) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or restrict the provider from engaging in medical communications with the provider's patient.

(2) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of paragraph (1) shall be null and void.

(b) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

(1) to prohibit the enforcement, as part of a contract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by a group health plan or health insurance issuer to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider) but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers and their patients; or

(2) to permit a health care provider to misrepresent the scope of benefits covered under the group health plan or health insurance coverage or to otherwise require a group health plan health insurance issuer to reimburse providers for benefits not covered under the plan or coverage.

(c) MEDICAL COMMUNICATION DEFINED.—In this section:

(1) IN GENERAL.—The term ''medical communication'' means any communication made by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) with respect to—

(A) the patient's health status, medical care, or treatment options;

(B) any utilization review requirements that may affect treatment options for the patient; or

(C) any financial incentives that may affect the treatment of the patient.

(2) MISREPRESENTATION.—The term ''medical communication'' does not include a communication by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) if the communication involves a knowing or willful misrepresentation by such provider.

SEC. 142. PROHIBITION AGAINST TRANSFER OF INDEMNIFICATION OR IMPROPER INCENTIVE ARRANGEMENTS.

(a) PROHIBITION OF TRANSFER OF INDEMNIFICATION.—

(1) IN GENERAL.—No contract or agreement between a group health plan or health insurance issuer (or any agent acting on behalf of such a plan or issuer) and a health care provider shall contain any provision purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions, or omissions of the plan, issuer, or agent (as opposed to the provider).

(2) NULLIFICATION.—Any contract or agreement provision described in paragraph (1) shall be null and void.

(b) PROHIBITION OF IMPROPER PHYSICIAN INCENTIVE PLANS.—

(1) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in subparagraph (A) of such section are met with respect to such a plan.

(2) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

SEC. 143. ADDITIONAL RULES REGARDING PARTICIPATION OF HEALTH CARE PROFESSIONALS.

(a) PROCEDURES.—Insofar as a group health plan, or health insurance issuer that offers health insurance coverage, provides benefits through participating health care professionals, the plan or issuer shall establish reasonable procedures relating to the participation (under an agreement between a professional and the plan or issuer) of such professionals under the plan or coverage. Such procedures shall include—

(1) providing notice of the rules regarding participation;

(2) providing written notice of participation decisions that are adverse to professionals; and

(3) providing a process within the plan or issuer for appealing such adverse decisions, including the presentation of information and views of the professional regarding such decision.

(b) CONSULTATION IN MEDICAL POLICIES.—A group health plan, and health insurance issuer that offers health insurance coverage, shall consult with participating physicians

(if any) regarding the plan's or issuer's medical policy, quality, and medical management procedures.

SEC. 144. PROTECTION FOR PATIENT ADVOCACY.

(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—In accordance with section 510 of the Employee Retirement Income Security Act, a group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title.

(b) PROTECTION FOR QUALITY ADVOCACY BY HEALTH CARE PROFESSIONALS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may not retaliate or discriminate against a protected health care professional because the professional in good faith—

(A) discloses information relating to the care, services, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries, or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

(2) GOOD FAITH ACTION.—For purposes of paragraph (1), a protected health care professional is considered to be acting in good faith with respect to disclosure of information or participation if, with respect to the information disclosed as part of the action—

(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with the same licensure or certification and the same experience;

(B) the professional reasonably believes the information to be true;

(C) the information evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider established for the purpose of addressing quality concerns before making the disclosure.

(3) EXCEPTION AND SPECIAL RULE.—

(A) GENERAL EXCEPTION.—Paragraph (1) does not protect disclosures that would violate Federal or State law or diminish or impair the rights of any person to the continued protection of confidentiality of communications provided by such law.

(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

(C) INTERNAL PROCEDURE EXCEPTION.—Subparagraph (D) of paragraph (2) also shall not apply if—

(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

(5) NOTICE.—A group health plan, health insurance issuer, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

(6) CONSTRUCTIONS.—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and protected health care professionals under other applicable Federal or State laws.

(7) PROTECTED HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term ''protected health care professional'' means an individual who is a licensed or certified health care professional and who—

(A) with respect to a group health plan or health insurance issuer, is an employee of the plan or issuer or has a contract with the plan or issuer for provision of services for which benefits are available under the plan or issuer; or

(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the provider respecting the provision of health care services.

SEC. 145. AMENDMENT TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Notwithstanding section 301(b), section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended to read as follows:

''SEC. 503. CLAIMS PROCEDURE, COVERAGE DETERMINATION, GRIEVANCES AND APPEALS.

''(a) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every employee benefit plan shall—

''(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant; and

''(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

''(b) COVERAGE DETERMINATIONS UNDER GROUP HEALTH PLANS.—

''(1) PROCEDURES.—

''(A) IN GENERAL.—A group health plan or health insurance issuer conducting utilization review shall ensure that procedures are in place for—

''(i) making determinations regarding whether a participant or beneficiary is eligible to receive a payment or coverage for health services under the plan or coverage involved and any cost-sharing amount that the participant or beneficiary is required to pay with respect to such service;

''(ii) notifying a covered participant or beneficiary (or the authorized representative of such participant or beneficiary) and the treating health care professionals involved regarding determinations made under the plan or issuer and any additional payments that the participant or beneficiary may be required to make with respect to such service; and

''(iii) responding to requests, either written or oral, for coverage determinations or for internal appeals from a participant or beneficiary (or the authorized representative of such participant or beneficiary) or the treating health care professional with the consent of the participant or beneficiary.

''(B) ORAL REQUESTS.—With respect to an oral request described in subparagraph (A)(iii), a group health plan or health insurance issuer may require that the requesting individual provide written evidence of such request.

''(2) TIMELINE FOR MAKING DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—A group health plan or a health insurance issuer shall maintain procedures to ensure that prior authorization determinations concerning the provision of non-emergency items or services are made within 30 days from the date on which the request for a determination is submitted, except that such period may be extended where certain circumstances exist that are determined by the Secretary to be beyond control of the plan or issuer.

''(B) EXPEDITED DETERMINATION.—

''(i) IN GENERAL.—A prior authorization determination under this subsection shall be made within 72 hours, in accordance with the medical exigencies of the case, after a request is received by the plan or issuer under clause (ii) or (iii).

''(ii) REQUEST BY PARTICIPANT OR BENEFICIARY.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of a participant or beneficiary if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the participant or beneficiary.

''(iii) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if

the request involved indicates that the treating health care professional has reasonably documented, based on the medical exigencies, that a determination under the procedures described in subparagraph (A) could seriously jeopardize the life or health of the participant or beneficiary.

''(C) CONCURRENT DETERMINATIONS.—A plan or issuer shall maintain procedures to certify or deny coverage of an extended stay or additional services.

''(D) RETROSPECTIVE DETERMINATION.—A plan or issuer shall maintain procedures to ensure that, with respect to the retrospective review of a determination made under paragraph (1), the determination shall be made within 30 working days of the date on which the plan or issuer receives necessary information.

''(3) NOTICE OF DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(A), the plan or issuer shall issue notice of such determination to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and, consistent with the medical exigencies of the case, to the treating health care professional involved not later than 2 working days after the date on which the determination is made.

''(B) EXPEDITED DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(B), the plan or issuer shall issue notice of such determination to the participant or beneficiary (or the authorized representative of the participant or beneficiary), and consistent with the medical exigencies of the case, to the treating health care professional involved within the 72 hour period described in paragraph (2)(B).

''(C) CONCURRENT REVIEWS.—With respect to the determination under a plan or issuer under paragraph (2)(C) to certify or deny coverage of an extended stay or additional services, the plan or issuer shall issue notice of such determination to the treating health care professional and to the participant or beneficiary involved (or the authorized representative of the participant or beneficiary) within 1 working day of the determination.

''(D) RETROSPECTIVE REVIEWS.—With respect to the retrospective review under a plan or issuer of a determination made under paragraph (2)(D), the plan or issuer shall issue written notice of an approval or disapproval of a determination under this subparagraph to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and health care provider involved within 5 working days of the date on which such determination is made.

''(E) REQUIREMENTS OF NOTICE OF ADVERSE COVERAGE DETERMINATIONS.—A written notice of an adverse coverage determination under this subsection, or of an expedited adverse coverage determination under paragraph (2)(B), shall be provided to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and treating health care professional (if any) involved and shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average participant or beneficiary;

''(ii) the procedures for obtaining additional information concerning the determination; and

''(iii) notification of the right to appeal the determination and instructions on how to initiate an appeal in accordance with subsection (d).

''(c) GRIEVANCES.—A group health plan or a health insurance issuer shall have written procedures for addressing grievances between the plan or issuer offering health insurance coverage in connection with a group health plan and a participant or beneficiary. Determinations under such procedures shall be non-appealable.

''(d) INTERNAL APPEAL OF COVERAGE DETERMINATIONS.—

''(1) RIGHT TO APPEAL.—

''(A) IN GENERAL.—A participant or beneficiary (or the authorized representative of the participant or beneficiary) or the treating health care professional with the consent of the participant or beneficiary (or the authorized representative of the participant or beneficiary), may appeal any adverse coverage determination under subsection (b) under the procedures described in this subsection.

''(B) TIME FOR APPEAL.—A plan or issuer shall ensure that a participant or beneficiary has a period of not less than 180 days beginning on the date of an adverse coverage determination under subsection (b) in which to appeal such determination under this subsection.

''(C) FAILURE TO ACT.—The failure of a plan or issuer to issue a determination under subsection (b) within the applicable timeline established for such a determination under such subsection shall be treated as an adverse coverage determination for purposes of proceeding to internal review under this subsection.

''(2) RECORDS.—A group health plan and a health insurance issuer shall maintain written records, for at least 6 years, with respect to any appeal under this subsection for purposes of internal quality assurance and improvement. Nothing in the preceding sentence shall be construed as preventing a plan and issuer from entering into an agreement under which the issuer agrees to assume responsibility for compliance with the requirements of this section and the plan is released from liability for such compliance.

''(3) ROUTINE DETERMINATIONS.—A group health plan or a health insurance issuer shall complete the consideration of an appeal of an adverse routine determination under this subsection not later than 30 working days after the date on which a request for such appeal is received.

''(4) EXPEDITED DETERMINATION.—

''(A) IN GENERAL.—An expedited determination with respect to an appeal under this subsection shall be made in accordance with the medical exigencies of the case, but in no case more than 72 hours after the request for such appeal is received by the plan or issuer under subparagraph (B) or (C).

''(B) REQUEST BY PARTICIPANT OR BENEFICIARY.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of a participant or beneficiary if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the participant or beneficiary.

''(C) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if the request involved indicates that the treating health care professional has reasonably documented, based on the medical exigencies of the case that a determination under the procedures described in paragraph (2) could seriously jeopardize the life or health of the participant or beneficiary.

''(5) CONDUCT OF REVIEW.—A review of an adverse coverage determination under this subsection shall be conducted by an individual with appropriate expertise who was not directly involved in the initial determination.

''(6) LACK OF MEDICAL NECESSITY.—A review of an appeal under this subsection relating to a determination to deny coverage based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, shall be made only by a physician with appropriate expertise, including age-appropriate expertise, who was not involved in the initial determination.

''(7) NOTICE.—

''(A) IN GENERAL.—Written notice of a determination made under an internal review process shall be issued to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and the treating health care professional not later than 2 working days after the completion of the review (or within the 72-hour period referred to in paragraph (4) if applicable).

''(B) ADVERSE COVERAGE DETERMINATIONS.—With respect to an adverse coverage determination made under this subsection, the notice described in subparagraph (A) shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average participant or beneficiary;

''(ii) the procedures for obtaining additional information concerning the determination; and

''(iii) notification of the right to an independent external review under subsection (e) and instructions on how to initiate such a review.

''(e) INDEPENDENT EXTERNAL REVIEW.—

''(1) ACCESS TO REVIEW.—

''(A) IN GENERAL.—A group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan shall have written procedures to permit a participant or beneficiary (or the authorized representative of the participant or beneficiary) access to an independent external review with respect to an adverse coverage determination concerning a particular item or service (including a circumstance treated as an adverse coverage determination under subparagraph (B)) where—

''(i) the particular item or service involved—

''(I)(aa) would be a covered benefit, when medically necessary and appropriate under the terms and conditions of the plan, and the item or service has been determined not to be medically necessary and appropriate under the internal appeals process required under subsection (d) or there has been a failure to issue a coverage determination as described in subparagraph (B); and

''(bb)(AA) the amount of such item or service involved exceeds a significant financial threshold; or

''(BB) there is a significant risk of placing the life or health of the participant or beneficiary in jeopardy; or

''(II) would be a covered benefit, when not considered experimental or investigational under the terms and conditions of the plan, and the item or service has been determined to be experimental or investigational under the internal appeals process required under subsection (d) or there has been a failure to issue a coverage determination as described in subparagraph (B); and

''(ii) the participant or beneficiary has completed the internal appeals process under subsection (d) with respect to such determination.

''(B) FAILURE TO ACT.—The failure of a plan or issuer to issue a coverage determination under subsection (d)(6) within the applicable timeline established for such a determination under such subsection shall be treated as an adverse coverage determination for

purposes of proceeding to independent external review under this subsection.

''(2) INITIATION OF THE INDEPENDENT EXTERNAL REVIEW PROCESS.—

''(A) FILING OF REQUEST.—A participant or beneficiary (or the authorized representative of the participant or beneficiary) who desires to have an independent external review conducted under this subsection shall file a written request for such a review with the plan or issuer involved not later than 30 working days after the receipt of a final denial of a claim under subsection (d). Any such request shall include the consent of the participant or beneficiary (or the authorized representative of the participant or beneficiary) for the release of medical information and records to independent external reviewers regarding the participant or beneficiary.

''(B) INFORMATION AND NOTICE.—Not later than 5 working days after the receipt of a request under subparagraph (A), or earlier in accordance with the medical exigencies of the case, the plan or issuer involved shall select an external appeals entity under paragraph (3)(A) that shall be responsible for designating an independent external reviewer under paragraph (3)(B).

''(C) PROVISION OF INFORMATION.—The plan or issuer involved shall forward necessary information (including medical records, any relevant review criteria, the clinical rationale consistent with the terms and conditions of the contract between the plan or issuer and the participant or beneficiary for the coverage denial, and evidence of the coverage of the participant or beneficiary) to the independent external reviewer selected under paragraph (3)(B).

''(D) NOTIFICATION.—The plan or issuer involved shall send a written notification to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and the plan administrator, indicating that an independent external review has been initiated.

''(3) CONDUCT OF INDEPENDENT EXTERNAL REVIEW.—

''(A) DESIGNATION OF EXTERNAL APPEALS ENTITY BY PLAN OR ISSUER.—

''(i) IN GENERAL.—A plan or issuer that receives a request for an independent external review under paragraph (2)(A) shall designate a qualified entity described in clause (ii), in a manner designed to ensure that the entity so designated will make a decision in an unbiased manner, to serve as the external appeals entity.

''(ii) QUALIFIED ENTITIES.—A qualified entity shall be—

''(I) an independent external review entity licensed or credentialed by a State;

''(II) a State agency established for the purpose of conducting independent external reviews;

''(III) any entity under contract with the Federal Government to provide independent external review services;

''(IV) any entity accredited as an independent external review entity by an accrediting body recognized by the Secretary for such purpose; or

''(V) any other entity meeting criteria established by the Secretary for purposes of this subparagraph.

''(B) DESIGNATION OF INDEPENDENT EXTERNAL REVIEWER BY EXTERNAL APPEALS ENTITY.—The external appeals entity designated under subparagraph (A) shall, not later than 30 days after the date on which such entity is designated under subparagraph (A), or earlier in accordance with the medical exigencies of the case, designate one or more individuals to serve as independent external reviewers with respect to a request received under paragraph (2)(A). Such reviewers shall be independent medical experts who shall—

''(i) be appropriately credentialed or licensed in any State to deliver health care services;

''(ii) not have any material, professional, familial, or financial affiliation with the case under review, the participant or beneficiary involved, the treating health care professional, the institution where the treatment would take place, or the manufacturer of any drug, device, procedure, or other therapy proposed for the participant or beneficiary whose treatment is under review;

''(iii) have expertise (including age-appropriate expertise) in the diagnosis or treatment under review and, when reasonably available, be of the same specialty as the physician treating the participant or beneficiary or recommending or prescribing the treatment in question;

''(iv) receive only reasonable and customary compensation from the group health plan or health insurance issuer in connection with the independent external review that is not contingent on the decision rendered by the reviewer; and

''(v) not be held liable for decisions regarding medical determinations (but may be held liable for actions that are arbitrary and capricious).

''(4) STANDARD OF REVIEW.—

''(A) IN GENERAL.—An independent external reviewer shall—

''(i) make an independent determination based on the valid, relevant, scientific and clinical evidence to determine the medical necessity, appropriateness, experimental or investigational nature of the proposed treatment; and

''(ii) take into consideration appropriate and available information, including any evidence-based decision making or clinical practice guidelines used by the group health plan or health insurance issuer; timely evidence or information submitted by the plan, issuer, patient or patient's physician; the patient's medical record; expert consensus; and medical literature as defined in section 556(5) of the Federal Food, Drug, and Cosmetic Act.

''(B) NOTICE.—The plan or issuer involved shall ensure that the participant or beneficiary receives notice, within 30 days after the determination of the independent medical expert, regarding the actions of the plan or issuer with respect to the determination of such expert under the independent external review.

''(5) TIMEFRAME FOR REVIEW.—

''(A) IN GENERAL.—The independent external reviewer shall complete a review of an adverse coverage determination in accordance with the medical exigencies of the case.

''(B) LIMITATION.—Notwithstanding subparagraph (A), a review described in such subparagraph shall be completed not later than 30 working days after the later of—

''(i) the date on which such reviewer is designated; or

''(ii) the date on which all information necessary to completing such review is received.

''(6) BINDING DETERMINATION.—The determination of an independent external reviewer under this subsection shall be binding upon the plan or issuer if the provisions of this subsection or the procedures implemented under such provisions were complied with by the independent external reviewer.

''(7) STUDY.—Not later than 2 years after the date of enactment of this section, the General Accounting Office shall conduct a study of a statistically appropriate sample of completed independent external reviews. Such study shall include an assessment of the process involved during an independent external review and the basis of decision-making by the independent external reviewer. The results of such study shall be submitted to the appropriate committees of Congress.

''(8) EFFECT ON CERTAIN PROVISIONS.—Nothing in this section shall be construed as affecting or modifying section 514 of this Act with respect to a group health plan.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a plan administrator or plan fiduciary or health plan medical director from requesting an independent external review by an independent external reviewer without first completing the internal review process.

''(g) DEFINITIONS.—In this section:

''(1) ADVERSE COVERAGE DETERMINATION.—The term 'adverse coverage determination' means a coverage determination under the plan which results in a denial of coverage or reimbursement.

''(2) COVERAGE DETERMINATION.—The term 'coverage determination' means with respect to items and services for which coverage may be provided under a health plan, a determination of whether or not such items and services are covered or reimbursable under the coverage and terms of the contract.

''(3) GRIEVANCE.—The term 'grievance' means any complaint made by a participant or beneficiary that does not involve a coverage determination.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' shall have the meaning given such term in section 733(a). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 733(b)(1). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 733(b)(2).

''(7) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means a coverage determination prior to the provision of the items and services as a condition of coverage of the items and services under the coverage.

''(8) TREATING HEALTH CARE PROFESSIONAL.—The term 'treating health care professional' with respect to a group health plan, health insurance issuer or provider sponsored organization means a physician (medical doctor or doctor of osteopathy) or other health care practitioner who is acting within the scope of his or her State licensure or certification for the delivery of health care services and who is primarily responsible for delivering those services to the participant or beneficiary.

''(9) UTILIZATION REVIEW.—The term 'utilization review' with respect to a group health plan or health insurance coverage means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.''

(b) ENFORCEMENT.—Section 502(c)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)(1)) is amended by inserting after ''or section 101(e)(1)'' the following: '', or fails to comply with a coverage determination as required under section 503(e)(6),''.

(c) CONFORMING AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the item relating to section 503

and inserting the following new item:

''Sec. 503. Claims procedures, coverage determination, grievances and appeals.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after October 1, 2000. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

DODD (AND OTHERS) AMENDMENT NO. 1239

Mr. DODD (for himself, Mrs. BOXER, Mr. HARKIN, Mr. KENNEDY, Mr. REID, Mrs. MURRAY, Mr. DURBIN, Mr. ROCKEFELLER, Mr. FEINGOLD, Mrs. FEINSTEIN, and Mr. DASCHLE) proposed an amendment to amendment No. 1232 proposed by Mr. DASCHLE to the bill, S. 1344, supra; as follows:

At the appropriate place in subtitle A of title I, insert the following:

SEC. ___. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS AND ACCESS TO APPROVED DRUGS AND DEVICES.

(a) ERISA.—Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as added by section 101(a)(2) of this Act, is amended by adding at the end the following:

''SEC. 730A. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS AND ACCESS TO APPROVED DRUGS AND DEVICES.

''(a) COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.—

''(1) COVERAGE.—

''(A) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with group health insurance coverage, provides coverage to a qualified individual (as defined in paragraph (2)), the plan or issuer—

''(i) may not deny the individual participation in the clinical trial referred to in paragraph (2)(B);

''(ii) subject to paragraph (3), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(iii) may not discriminate against the individual on the basis of the participant's, beneficiaries or enrollee's participation in such trial.

''(B) EXCLUSION OF CERTAIN COSTS.—For purposes of subparagraph (A)(ii), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(C) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in subparagraph (A) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(2) QUALIFIED INDIVIDUAL DEFINED.—For purposes of paragraph (1), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan or enrollee under health insurance coverage and who meets the following conditions:

''(A)(i) The individual has a life-threatening or serious illness for which no standard treatment is effective.

''(ii) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

''(iii) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(B) Either—

''(i) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in subparagraph (A); or

''(ii) the participant, beneficiary or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in subparagraph (A).

''(3) PAYMENT.—

''(A) IN GENERAL.—Under this subsection a group health plan, or a health insurance issuer in connection with group health insurance coverage, shall provide for payment for routine patient costs described in paragraph (1)(B) but is not required to pay for costs of items and services that are reasonably expected (as determined by the Secretary) to be paid for by the sponsors of an approved clinical trial.

''(B) PAYMENT RATE.—In the case of covered items and services provided by—

''(i) a participating provider, the payment rate shall be at the agreed upon rate, or

''(ii) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under clause (i).

''(4) APPROVED CLINICAL TRIAL DEFINED.—

''(A) IN GENERAL.—In this subsection, the term 'approved clinical trial' means a clinical research study or clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

''(i) The National Institutes of Health.

''(ii) A cooperative group or center of the National Institutes of Health.

''(iii) Either of the following if the conditions described in subparagraph (B) are met:

''(I) The Department of Veterans Affairs.

''(II) The Department of Defense.

''(B) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

''(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(5) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

''(b) ACCESS TO NEEDED PRESCRIPTION DRUGS.—If a group health plan, or health insurance issuer that offers group health insurance coverage, provides benefits with respect to prescription drugs but the coverage limits such benefits to drugs included in a formulary, the plan or issuer shall—

''(1) ensure participation of participating physicians and pharmacists in the development of the formulary;

''(2) disclose to providers and, disclose upon request to participants, beneficiaries, and enrollees, the nature of the formulary restrictions; and

''(3) consistent with the standards for a utilization review program, provide for exceptions from the formulary limitation when a non-formulary alternative is medically indicated, except that—

''(A) an exception provided under this paragraph shall be provided in accordance with cost-sharing rules in effect for drugs included in the formulary; and

''(B) nothing in this paragraph shall be construed to prevent the plan or issuer from implementing a program of differential cost-sharing for drugs included in the formulary and drugs not included in the formulary, if the drugs that are not included in the formulary do not meet the conditions described in this section.

''(c) ACCESS TO APPROVED DRUGS AND DEVICES.—

''(1) IN GENERAL.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, that provides any coverage of prescription drugs or medical devices shall not deny coverage of such a drug or device on the basis that the use is investigational, if the use—

''(A) in the case of a prescription drug—

''(i) is included in the labeling authorized by the application in effect for the drug pursuant to subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act, without regard to any postmarketing requirements that may apply under such Act; or

''(ii) is included in the labeling authorized by the application in effect for the drug under section 351 of the Public Health Service Act, without regard to any postmarketing requirements that may apply pursuant to such section; or

''(B) in the case of a medical device, is included in the labeling authorized by a regulation under subsection (d) or (3) of section 513 of the Federal Food, Drug, and Cosmetic Act, an order under subsection (f) of such section, or an application approved under section 515 of such Act, without regard to any postmarketing requirements that may apply under such Act.

''(2) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a group health plan or health insurance issuer to provide any coverage of prescription drugs or medical devices.

''(d) APPLICATION OF SECTION.—This section shall supersede the provisions of section 728.

''(e) REVIEW.—Failure to meet the requirements of this section shall constitute an appealable decision under this Act.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any provision of this subchapter, the group health plan shall not be liable for such violation unless the plan caused such violation.

''(g) APPLICABILITY.—The provisions of this section shall apply to group health plans and health insurance issuers as if included in—

''(1) subpart 2 of part A of title XXVII of the Public Health Service Act;

''(2) the first subpart 3 of part B of title XXVII of the Public Health Service Act (relating to other requirements); and

''(3) subchapter B of chapter 100 of the Internal Revenue Code of 1986.

''(h) NONAPPLICATION OF CERTAIN PROVISION.—Only for purposes of applying the requirements of this section under section 714 of the Employee Retirement Income Security Act of 1974 (as added by section 301 of this Act), sections 2707 and 2753 of the Public Health Service Act (as added by sections 201 and 202 of this Act), and section 9813 of the Internal Revenue Code of 1986 (as added by section 401 of this Act)—

''(1) section 2721(b)(2) of the Public Health Service Act and section 9831(a)(1) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section; and

''(2) with respect to limited scope dental benefits, subparagraph (A) of section 733(c)(2) of the Employee Retirement Income Security Act of 1974, subparagraph (A) of section

2791(c)(2) of the Public Health Service Act, and subparagraph (A) of section 9832(c)(2) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section.

''(i) NO IMPACT ON SOCIAL SECURITY TRUST FUND.—

''(1) IN GENERAL.—Nothing in this section shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

''(2) TRANSFERS.—

''(A) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this section has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

''(B) TRANSFER OF FUNDS.—If, under subparagraph (A), the Secretary of the Treasury estimates that the enactment of this section has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such section.

''(j) LIMITATION ON ACTIONS.—

''(1) IN GENERAL.—Except as provided for in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 by a participant or beneficiary seeking relief based on the application of any provision in this section.

''(2) PERMISSIBLE ACTIONS.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 by a participant or beneficiary seeking relief based on the application of this section to the individual circumstances of that participant or beneficiary; except that—

''(A) such an action may not be brought or maintained as a class action; and

''(B) in such an action relief may only provide for the provision of (or payment for) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.

''(k) EFFECTIVE DATE.—The provisions of this section shall apply to group health plans for plan years beginning after, and to health insurance issuers for coverage offered or sold after, October 1, 2000.''.

(b) INFORMATION REQUIREMENTS.—

(1) INFORMATION FROM GROUP HEALTH PLANS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following:

''(7) INFORMATION FROM GROUP HEALTH PLANS.—

''(A) PROVISION OF INFORMATION BY GROUP HEALTH PLANS.—The administrator of a group health plan subject to the requirements of paragraph (1) shall provide to the Secretary such of the information elements described in subparagraph (C) as the Secretary specifies, and in such manner and at such times as the Secretary may specify (but not more frequently than 4 times per year), with respect to each individual covered under the plan who is entitled to any benefits under this title.

''(B) PROVISION OF INFORMATION BY EMPLOYERS AND EMPLOYEE ORGANIZATIONS.—An employer (or employee organization) that maintains or participates in a group health plan subject to the requirements of paragraph (1) shall provide to the administrator of the plan such of the information elements required to be provided under subparagraph (A), and in such manner and at such times as the Secretary may specify, at a frequency consistent with that required under subparagraph (A) with respect to each individual described in subparagraph (A) who is covered under the plan by reason of employment with that employer or membership in the organization.

''(C) INFORMATION ELEMENTS.—The information elements described in this subparagraph are the following:

''(i) ELEMENTS CONCERNING THE INDIVIDUAL.—

''(I) The individual's name.

''(II) The individual's date of birth.

''(III) The individual's sex.

''(IV) The individual's social security insurance number.

''(V) The number assigned by the Secretary to the individual for claims under this title.

''(VI) The family relationship of the individual to the person who has or had current or employment status with the employer.

''(ii) ELEMENTS CONCERNING THE FAMILY MEMBER WITH CURRENT OR FORMER EMPLOYMENT STATUS.—

''(I) The name of the person in the individual's family who has current or former employment status with the employer.

''(II) That person's social security insurance number.

''(III) The number or other identifier assigned by the plan to that person.

''(IV) The periods of coverage for that person under the plan.

''(V) The employment status of that person (current or former) during those periods of coverage.

''(VI) The classes (of that person's family members) covered under the plan.

''(iii) PLAN ELEMENTS.—

''(I) The items and services covered under the plan.

''(II) The name and address to which claims under the plan are to be sent.

''(iv) ELEMENTS CONCERNING THE EMPLOYER.—

''(I) The employer's name.

''(II) The employer's address.

''(III) The employer identification number of the employer.

''(D) USE OF IDENTIFIERS.—The administrator of a group health plan shall utilize a unique identifier for the plan in providing information under subparagraph (A) and in other transactions, as may be specified by the Secretary, related to the provisions of this subsection. The Secretary may provide to the administrator the unique identifier described in the preceding sentence.

''(E) PENALTY FOR NONCOMPLIANCE.—Any entity that knowingly and willfully fails to comply with a requirement imposed by the previous subparagraphs shall be subject to a civil money penalty not to exceed $1,000 for each incident of such failure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as those provisions apply to a penalty or proceeding under section 1128A(a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect 180 days after the date of the enactment of this Act.

(c) MODIFICATION TO FOREIGN TAX CREDIT CARRYBACK AND CARRYOVER PERIODS.—

(1) IN GENERAL.—Section 904(c) of the Internal Revenue Code of 1986 (relating to limitation on credit) is amended—

(A) by striking ''in the second preceding taxable year,'', and

(B) by striking ''or fifth'' and inserting ''fifth, sixth, or seventh''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to credits arising in taxable years beginning after December 31, 2001.

(d) LIMITATIONS ON WELFARE BENEFIT FUNDS OF 10 OR MORE EMPLOYER PLANS.—

(1) BENEFITS TO WHICH EXCEPTION APPLIES.—Section 419A(f)(6)(A) of the Internal Revenue Code of 1986 (relating to exception for 10 or more employer plans) is amended to read as follows:

''(A) IN GENERAL.—This subpart shall not apply to a welfare benefit fund which is part of a 10 or more employer plan if the only benefits provided through the fund are 1 or more of the following:

''(i) Medical benefits.

''(ii) Disability benefits.

''(iii) Group term life insurance benefits which do not provide for any cash surrender value or other money that can be paid, assigned, borrowed, or pledged for collateral for a loan.

The preceding sentence shall not apply to any plan which maintains experience-rating arrangements with respect to individual employers.''

(2) LIMITATION ON USE OF AMOUNTS FOR OTHER PURPOSES.—Section 4976(b) of such Act (defining disqualified benefit) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR 10 OR MORE EMPLOYER PLANS EXEMPTED FROM PREFUNDING LIMITS.—For purposes of paragraph (1)(C), if—

''(A) subpart D of part I of subchapter D of chapter 1 does not apply by reason of section 419A(f)(6) to contributions to provide 1 or more welfare benefits through a welfare benefit fund under a 10 or more employer plan, and

''(B) any portion of the welfare benefit fund attributable to such contributions is used for a purpose other than that for which the contributions were made,

then such portion shall be treated as reverting to the benefit of the employers maintaining the fund.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

TREASURY-POSTAL SERVICE APPROPRIATIONS

CAMPBELL AMENDMENT NO. 1240

Mr. JEFFORDS (for Mr. CAMPBELL) proposed an amendment to the bill (S. 1282) making appropriations for the Treasury Department, the United States Postal Service, the Executive Office of the President, and certain Independence Agencies, for the fiscal year ending September 30, 2000, and for other purposes; as follows:

Amend page 57, line 14 by reducing the dollar figure by $17,000,000.

On page 11, line 16 strike ''$569,225,000'' and insert in lieu thereof ''$570,345,000''.

NOTICES OF HEARINGS

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. MURKOWSKI. Mr. President, I would like to announce that on Friday, July 16, 1999, the Committee on Energy and Natural Resources will hold an oversight hearing on Damage to the National Security from Chinese Espionage at DOE Nuclear Weapons Laboratories. The hearing will be held at 9:00

a.m. in room 366 of the Dirksen Senate Office Building in Washington, D.C.

Those who wish further information may wright to the Committee on Energy and Natural Resources, U.S. Senate, Washington, D.C. 20510.

COMMITTEE ON INDIAN AFFAIRS

Mr. CAMPBELL. Mr. President, I would like to announce that the Senate Committee on Indian Affairs will meet during the session of the Senate on Wednesday, July 21, 1999, at 9:30 a.m. to conduct a hearing on S. 985, *the Intergovernmental Gaming Agreement Act of 1999*. The hearing will be held in room 485, Russell Senate Building.

Please direct any inquiries to committee staff at 202/224–2251.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON THE JUDICIARY

Mr. NICKLES. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet for a hearing re judicial nominations, during the session of the Senate on Tuesday, July 13, 1999, at 2:00 p.m., in SD226.

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

SUBCOMMITTEE ON FORESTS AND PUBLIC LAND MANAGEMENT

Mr. NICKLES. Mr. President, I ask unanimous consent that the Subcommittee on Forests and Public Land Management of the Committee on Energy and Natural Resources be granted permission to meet during the session of the Senate on Tuesday, July 13, for purposes of conducting a subcommittee hearing which is schedules to begin at 2:30 p.m. The purpose of this hearing is to receive testimony on issues relating to. S. 1330, a bill to give the city of Mesquite, Nevada, the right to purchase at fair market value certain parcels of public land in the city, and S. 1329, a bill to direct the Secretary of the Interior to convey certain land to Nye County, Nevada, and for other purposes.

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

SUBCOMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Mr. NICKLES. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet for a hearing on ''ESEA: Drug Free Schools'' during the session of the Senate on Tuesday, July 13, 1999, at 9:30.

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

ADDITIONAL STATEMENTS

SEIZING THE MILE

• Mr. SCHUMER. Mr. President, I rise to commend John Sexton, Dean of New York University Law School, for his many years of hard work and dedication to the Law School, the residents of New York State, and to the improvement of legal education for all Americans. Since 1988, when Sexton became Dean, NYU Law School has become one of America's finest law schools. Dean Sexton should be recognized for his efforts. I ask that the text of ''John Sexton Seizing the Mile'' by Stephen Englund be printed in the CONGRESSIONAL RECORD.

The text follows:

[From Lifestyles, Pre-Spring 1999]

JOHN SEXTON SEIZING THE MILE

(By Stephen Englund)

In the late spring of 1997, veteran reporter James Traub asked, in a headline to a New York Times Magazine feature article, ''Is NYU's law school challenging Harvard's as the nation's best?'' It was a fair question. NYU Law had come a long way in a short time. A law school that had been little more than a commuter school at the end of World War II was, by 1997, considered by anyone familiar with current developments in legal education to be, as one professor said, ''one of the five or six law schools that could plausibly claim to be among the top three in the country.'' Distinguished academics like Harvard's Laurence Tribe and Arthur Miller had placed NYU (with their own school and with Yale, Stanford and Chicago) in that group. As Tribe put it: ''The array of faculty that has moved to NYU over the last decade or so has created a level of scholarship and intellectual distinction and range that is extremely impressive.''

In 1997, the notion that NYU's School of Law might be the best was certainly provocative. But 18 months later, after an astonishing (indeed unprecedented) day-long forum at the school titled ''Strengthening Democracy in the Global Economy''—a meeting that brought to Washington Square President Clinton, Britain's Prime Minister Tony Blair, Italy's President Romano Prodi and Bulgaria's President Peter Stoyanov, as well as First Lady Hillary Rodham Clinton and a supporting cast of respected intellectuals and other leaders—many people are answering Traub's question with a resounding ''Yes!''

Indeed, the rise of NYU over the past few years has been one of the most noted advances on the academic scene—with a growing number of those both in the academy and at the bar offering the view that NYU has become the nation's premier site for legal education. For instance, Michael Ryan, senior partner at New York's oldest law firm, Cadwalader, Wickersham, and Taft—himself a Harvard Law School graduate—told me: ''NYU is a more exciting and innovative place that any other law school. The place combines the energy, vitality and diversity like that of the Lexington Avenue subway with the cohesiveness and spirit. The school's innovative global initiative is alone worth the price of admission. If I were a student, I'd choose it over any other school.'' Chief Judge Harry Edwards of the United States Court of Appeals for the District of Columbia Circuit, viewed by many as the nation's second most important court, said virtually the same thing: NYU is absolutely the place to be these days. I hear more comments about the quality, excitement, and originality of what's going on there than I do about any other law school.'' As did Pasquale Pasquino, one of Europe's foremost political theorists, who is teaching at the law school this year'' ''NYU surely has the most prominent, the most productive and the most interesting faculty. Its programs raise some of the most interesting questions raised in any law school.'' And when I spoke with Dwight Opperman, who for decades was the leader of West Publishing, the world's largest publisher of law books, he volunteered: ''NYU surpasses Harvard in many areas.''

Frankly, when I first read Traub's article, and even more when I began to hear views like those of Ryan, Edwards, Pasquino and Opperman, I was more than a little bit surprised. How was it that NYU had come to be seen as seriously challenging—or even surpassing—''name brand'' schools like Harvard, Yale, Chicago and Stanford? And how had it happened so quickly? As a former academic, I know that the academy is one of the least variable theaters on the world stage. Far more than in other realms, reputations of colleges, universities and professional schools are improved, if at all at a glacial creep, though they may decline precipitously. Little wonder, then, that NYU's rise to the top of legal education continues to be the topic of so much discussion.

What does explain NYU's ascendancy? Well, one key element is surely the astonishing migration of academic stars from other leading law schools to Washington Square. In academe, it is big news when an established professor at a leading school makes a ''lateral move'' to a peer institution—even more so when the professor leaves a distinguished chaired professorship in making the move. In legal education, such moves have been relatively rare, in part because law faculties are small (the largest in the country has only 70 to 80 members). Yet over the last 10 years, there has been an unprecedented migration to NYU from schools like Chicago, Harvard, Michigan Pennsylvania, Stanford, Virginia, and Yale, and NYU can now boast the most distinguished set or ''laterals'' of any law school.

Another element is its student body. For decades, NYU has drawn strong students, but today the school attracts many of the very best in the country. Today, by any objective criteria-grade point averages, LSAT scores, the number of graduate academic degrees earned, the languages spoken-NYU's student body is among the three of four most selective in the nation.

And then, too, there is NYU's remarkable record in providing those students, as they graduate, with the most coveted legal jobs. NYU's graduates long have dominated the public service bar, but the dramatic development of the past decade is that NYU has edged ahead of Harvard in providing the greatest number of hires by the American Lawyer's 50 leading law firms.

The school's arrival at the top has been ratified in perhaps the most brutal arena of them all: fund-raising. In December 1998, NYU Law completed an extraordinary successful five-year fund-raising campaign. Under the leadership of Martin Payson ('61), the campaign's chairman; Board Chair Martin Lipton ('55); and Vice-Chair Lester Pollack ('57), the campaign has generated 45 gifts in excess of $1 million. Eight have been in excess of $5 million, including gifts from Alfred ('65) and Gail Engelberg, Jay ('71) and Gail Furman, Rita ('59) and Gustave Hauser, LL.M. ('57), Jerome Kern ('60) Dwight Opperman, Ingeborg and Ira Rennert, and the Wachtell, Lipton, Rosen & Katz law firm. It took NYU just three years to reach its original five-year goal of $125 million, and it easily surpassed its revised goal of $175 million. Only Yale and Harvard law schools join NYU at this level.

Once I discovered these facts, the startling idea that NYU Law School may be the best in the country—perhaps in the world—began to grow on me. And I also realized that this transformation was a riveting tale of ''from there to here''—one of the most remarkable in education history. Here it is in a nutshell.

A HISTORICAL PERSPECTIVE

Fade in. Scene One. It is 1942. Arthur T. Vanderbilt becomes dean of NYU Law School. Though already more than a century old (it was founded in 1835) and boasting graduates like Samuel J. Tilden, Elihu Root and Jacob Javits, NYU is not an impressive place. Its facilities are limited to two floor of an antiquated factory building in Greenwich Village. It is a ''commuter school,'' drawing its students from the New York metropolitan area. Justice Felix Frankfurter, in his biography, described it as one of the worst schools in the country.

But the visionary Vanderbilt sees the potential oak lurking within the acorn. He sees NYU as a national and international ''center of the law.'' Many in the upper reaches of the university see his dream as ''Vanderbilt's folly,'' but the determined Vanderbilt, dedicated to the dream, presses on.

First, he begins to exploit the school's unique asset: its Greenwich Village location in the legal, financial, cultural and intellectual hub of the world, New York City. Methodically, he plans for an expansion of the school's physical plant. Soon he opens an attractive new classroom building that the law school can call its own, and he follows three years later, in 1955, with the school's first residence hall.

Along the way, seeking to raise much-needed cash, the dean's natural financial savvy intersects with luck, when he purchases the C.F. Mueller Macaroni Company for the law school. The company generates profits each year and gives the school lasting security, for when the Mueller Company is sold in 1977, it is worth more than 20 times the school's original investment. Even after providing $40 million to the then-financially pressed university, the law school realizes a gain of nearly $80 million. And, in return for having shared its profits with the university, the law school is granted a degree of autonomy unprecedented in education. It will henceforth do its own planning, and its decisions will be a product of its dean, its faculty and its own independent Board of Trustees.

Vanderbilt officially resigns in 1947 to become Chief Justice of the New Jersey Supreme Court, but he continues to play Pygmalion with the school until his death in 1957. He adds significant new programs designed to give the school a national reputation, he deploys a merit scholarship program to attract the best students and he begins the process of building a strong faculty. Still, though NYU Law School now is a very good school, Vanderbilt's dream is not nearly realized. Fade out.

Fade in Scene Two. It is the opening of the 1990 academic year. We are seated in a hall at the law school, listening to a distinguished leader of the faculty explain ''How NYU became a Major Law School.'' The words spoken by Prof. Norman Dorsen are appealing—for their modesty as well as for their insight and depth. Dorsen, an eminent scholar and defender of civil rights, has just retired as president of the American Civil Liberties Union. Reading between the lines of his talk, it is clear he is also a painfully honest man. It's not difficult to sense that he is not entirely convinced that his law school is altogether as eminent a place as some have claimed it to be. Indeed, he tells his audience that recent years have been a time of ''deceleration'' in NYU's ''steady drive to the summit of American legal education, which seemed inexorable a few years before.''

What does Dorsen mean? After all, in the quarter century since Vanderbilt, the law school has added eight new buildings, including two splendid residence halls and a magnificent underground library—all state of the art. Its student body has become more selective and much more diverse, boasting students from a dozen countries. Its faculty now has a core of highly regarded scholars and clinicians. Still, in the previous five years, NYU has made only one addition to its tenure track faculty, and two junior leading lights have defected to Columbia (one of whom, David Leebron, would later become Columbia's dean). There was the discomfiting prospect that Columbia— and other schools would persuade more faculty members to move. This is not good, Dorsen says. It should be NYU that is doing the luring and hiring. In his view, the mood of contentment reigning at the law school, though understandable, is potentially destructive.

On the positive side, Dorsen says, the school does have a dynamic new dean, John Sexton. However, Sexton has been dean only two years now, and it is too soon to assay his potential. If Sexton succeeds in reigniting the law school's ''steady drive'' to the top, says Dorsen, it will be because he has managed to replenish the school's slipping endowment, to stanch the incipient hemorrhage of top scholars to other law schools and galvanize NYU Law with a sense of mission. Dorsen allows as how ''there is ample ground to hope'' this all might happen, so that ''within a few years NYU will be firmly established in fact and in the consciousness of the profession and the public as being among the best in the nation.'' Fade out.

Fade in. Scene Three. It is 1994. Richard Stewart, formerly a chaired professor and associate dean at Harvard Law School and recently assistant attorney general for the environment, is sitting in John Sexton's office at NYU. Stewart is a towering figure in law, widely recognized as the nation's leading scholar in environmental and administrative law. Harvard wants him back. Columbia, where Stewart's former Harvard colleague and co-author is dean, has launched a major effort to attract him. But Sexton thinks Stewart should come to Washington Square—that he should become part of what he calls ''the Enterprise,'' the group of NYU faculty who are devoted to making the school the world's leading center of the study of law.

The Enterprise is committed to several principles, Sexton tells Stewart. It rejects the notion, prevalent in elite schools, that faculty members are ''independent contractors'' teaching what they want to teach when they want to teach it, and available to colleagues and students as much or as little as they please. Instead, faculty in the Enterprise undertake a reciprocal obligation to each other and to their students—they pledge to be engaged with each other in a learning community, reading drafts and being present for one another in an ongoing conversation about law.

Sexton continues: ''The Enterprise rejects contentment in favor of constant improvement and aspiration. The school always should be asking: How can we become better? Members of the Enterprise are willing, occasionally at least, to subordinate personal interests to those of the collective. They delight in having colleagues who challenge their ideas; they are not afraid to be around people who are smarter than they are.''

In making his case to Stewart, Sexton reaches back to a phrase he first heard from the Jesuits: ''Most of all, the Enterprise is committed to thinking constantly about the ratio studiorum of the school: why do we do things the way we do?'' The Enterprise, Sexton tells Stewart, is open to everyone who wishes to join. It is the center of gravity of NYU's faculty, and NYU's unique attraction.

''Count me in, Stewart says. Fade out.

Fade in. Scene four. It is 1998. We are seated in another auditorium on the Washington Square campus of NYU, this time listening to Dr. L. Jay Oliva expatiate to NYU alumni and friends about his aspirations for the university he has presided over since he succeeded John Brademas in 1992. Some college presidents, he observes, especially those in the Midwest, strive to make their institutions as good as their football team. Others want it to be as fine as the music conservatory or the medical school. Here at NYU, Oliva says with a smile, ''I will be satisfied when I leave office if the university matches the quality and the renown of its law school.'' Fade out.

THE NEW DEAN

NYU Law's ascent unquestionably has been the product of many factors. No. 1, just as Vanderbilt foresaw, is its unique location. By the dawn of the '90's, as Professor Richard Revesz notes, New York City itself was ''no longer a minus'' in hiring faculty. The city had solved many of its worst problems and was becoming attractive again, especially to academics in two-career families (Revesz's wife, Vicki Been, for instance is also professor at the law school). And Greenwich Village is a particularly attractive part of the city. However, to invoke ''other factors'' in accounting for NYU's rise to the top of legal education while downplaying the role of Dean John Sexton would be like trying to discuss the right of judicial review without highlighting John Marshall; it's talking ''Scopes'' while soft-pedaling Darrow. It's To Kill A Mockingbird without Atticus Finch. When Norman Redlich retired in 1988 and John Sexton, a member of the Enterprise, was selected as his successor, the law school got more than it expected. The dean calls himself ''a catalyst, not the cause'' of the law school's arrival at the top, but any measure and by all accounts, he is a catalyst nonpareil.

We owe to the ancient Greek poet Archilochus the familiar observation that ''the fox knows many things, but the hedgehog knows one great thing.'' John Sexton, with his round cheeks, his bright eyes, and bushy hair, resembles as well as personifies the hedgehog. There is about Sexton a deep intelligence and a grand sense of humor, but the one ''great thing'' that he knows, and knows well, is single-minded devotion to a team or institution.

Sexton came to teach at NYU in 1981, immediately following a clerkship with Chief Justice Warren Burger, and was granted tenure a mere three years later. He has run NYU Law School for a decade now, and recently, happily signed on for another term of five years. This alone is rare. Law schools these days are desperate for deans because deans are desperate to leave their posts. The average tenure of an American law dean is fewer than four years. In the words of Chief Judge Harry Edwards: ''John is a truly visionary dean, and if that statement sounds like an oxymoron, it's because no one these days thinks of law deans as visionary. They aren't thought to hold a job that allows them to be visionary. Even if some deans might want to do something special, the drudgery of running a law school, especially of holding its factions together, doesn't permit it. That's why deans turn over so quickly.''

Sexton's personality is haimish-warm and embracing, your quintessential ''good guy.'' John (as he urges everyone, including his students, to call him) is disarmingly self-effacing, gracious, ready and eager to brag about others, to share credit even for things he has largely accomplished on his own. He is above all eager to elicit people's counsel and ideas, to involve them in his grand project of building up the law school. Despite his Harvard J.D. and his Fordham Ph.D. (in religion), he is profoundly non-elitist. A

Brooklynite who has kept (indeed cultivated) the accent, he is absolutely comfortable with himself. Being around the super-wealthy, the super-powerful, or the super-brilliant neither fazes nor inhibits him in the least. And he's no clothes-horse, either. There's often a slightly rumpled or professorial air about him.

In short, this man is, in style and appearance, closer to a New York ward heeler than, say, the cosmopolitan director of the Metropolitan Museum. From his nasal Brooklynese to the show-and-tell hands, from the wide-open, explosive laugh and the rapid-fire banter to the sharing of jokes and stories, Sexton is more like a New York mayor in the Ed Koch mold than he is a white-shoe lawyer or John Houseman's Professor Kingsfield in The Paper Chase. He can out—Rudin the Rudin Brothers at boostering New York—he follows and knows the Yankees, Knicks, Jets and Giants as few who aren't sports journalists do, and he can (and will) tell you where to find the best bagel in the five boroughs.

Among his skills is the ability to take the edge off irritability or anger, to foster a sense of camaraderie among the disparate group of people. And if he is no expert on culture (and doesn't pretend to be), Sexton is yet reminiscent of that mesmerizing czar of New York's not-for-profit theater, the late Joseph Papp. For, like the founder of the New York Shakespeare Festival, Sexton is a salesman, par excellence, of his ''idea'' and institution. He knows he's got the greatest thing in the world, and he's gonna buttonhole, assault, cajole, and wear you down until you know it too. And if at first you don't agree with him, that's okay, he just hasn't done a good enough job of persuading you—yet.

With his students and faculty, Sexton can be—everyone says so—like a parish priest. As confidant and counselor, he is peerless, inclined, as he himself puts it, to ''hear confessions'' and impart advice, including no small amount of moral exhortation, with a helpfulness and zeal that are both legendary and unusual in the secular academy. ''John gets this quizzical, almost surprised, look on his face while he's listening to you,'' a student in his civil procedure course said recently ''as if he's not sure he grasps all of what you are saying—only he does. He seems bemused, but he isn't. When he speaks, he talks quickly and a lot, but he's helpful.'' A faculty colleague of Sexton's notes, ''John is more expansive and discursive than articulate and concise, but he can also be dead-on cogent when he needs to be. He'll present all aspects of a subject, he'll summarize his opponents' viewpoints with a fairness they cannot reproach, but then, after all the praise and prefatory remarks and analysis, he'll bear in for the kill. When he gets to his point, watch out. It's not for nothing he was a national debating champ and coach when he was younger.''

Though it is unusual for a law school dean to have a heavy teaching load (many do no teaching), Sexton teaches—and teaches. Indeed, he teaches more than many faculty who have no administrative responsibilities. This fall he is teaching three courses. ''I draw energy from the students,'' Sexton says. ''Being with them reminds me why we do everything else. They keep my eye on the ultimate goal. The students incarnate our possibilities.'' Even outside of class, Sexton spends a huge amount of time with students. His students congregate for casual hours in his office on Monday evenings—and the sessions often run past midnight. Students may raise any topic they like, except the day's lecture. Asked how he can spare so many hours for students and the classroom, Sexton replies, ''I don't do the usual flag carrying, the external things. If you go back over my eleven years as dean, you could count on the fingers of one hand the number of black-tie dinners and dais-sittings I've done. I avoid events where I am introduced as a 'comma person' __ you know, John Sexton, comma, dean of __.' '' In short, if it isn't students, or meetings, or intellectual events, Dean Sexton is at home with his family.

Sexton at home differs little from Sexton in public. He is a paterfamilias who readily assumes tasks and responsibilities, from helping his daughter, Katie, 10, with her homework, to working out a solution to his aging mother-in-law's care needs. You wouldn't describe John as ''uxorious'' where his wife, Lisa Goldberg, is concerned (she, like her husband, is a Harvard-trained lawyer, and the executive vice president of the Charles H. Revson Foundation), but his devotion to her is such that the word passes through your mind. Home and hearth mean a great deal to John, and if ''family'' certainly starts with Lisa, Katie and grown son Jed, an actor, and Jed's wife, Danielle, it also includes others, for John and Lisa readily invite additions to the mishpocha. He enjoys contributing—he almost needs to contribute—to the sense of fulfillment and well-being of those around him.

A hedgehog in his devotion to one great idea, Sexton also is a hedgehog in the way he pursues it. The NYU Law dean hasn't the chameleon's morphing talent, and only some of the fox's canniness, but he is the exemplar of the persistent sell. Unlike any other leading law dean, Sexton, in service to his ideal, is not afraid to give himself away, to look ridiculous, to give everyone he talks to his or her full due—and maybe a little (actually, a lot) more—often at his own expense. Sexton readily refers to himself as ''the P.T. Barnum of legal education,'' and if the listener actually goes away thinking ''that is truly what this guy is,'' that's okay, as long as he or she has come to understand Sexton's ''great idea'' and agreed to serve it in some fashion.

In short, Sexton's is a personality that couldn't work for a standard academic mandarin, someone with a brittle ego or ticklish vanity. ''Being John Sexton'' requires too much self-confidence and idealism—above all too much ease with himself—for that. For only a man who knows who he is and who believes in his ideal will so willingly run the risk of being labeled ''Crusader Babbitt,'' as a critic of Sexton recently described him.

Nowhere is Sexton's personality more, let's-say-it, profitable to NYU than in his job as fund-raiser. Like it or not—and no dean likes to admit it—fund-raising is the basis of the top job. It is necessary, if not sufficient; in legal terminology, it's dispositive—and it has been for decades.

Deans of professional schools hold a major trump card in raising money: they represent the school that graduated (read that, credentialed) the people to whom they are appealing. The appeal to alumni turns first and last on self-interest: helping us is helping yourself. This often works, but its success speaks less to the talents of the fund-seeker than it does to the motives of the potential donor.

John Sexton has raised a huge amount of money from NYU Law School's graduates, but he has raised still more from other sources. And he has done both less by appealing to self-interest than by stimulating interest in and commitment to ideas, and evoking collaboration in common causes and projects.

Chief Judge Edwards, a graduate of Harvard says, ''John adds value to his appeal because he is able to convince people that they are an integral part of NYU's educational enterprise. He shows them how the law school will be a better place, better able to do its job, if they are a part of it, in this or that specific way or program. He's the first dean most people have met who has made a thought-out overture to them for their personalities, their ideas, their ongoing involvement, not just their money.''

West Publishing's Dwight Opperman is a graduate of Drake University Law School, yet he has given millions of dollars to NYU. As he puts it: '' I am approached all the time by people with their hands out. There are so many worthy causes and bright people to choose from. What John Sexton does better than anybody else I've ever met is to show me how I can be part of something original and interesting.'' Recently, for example, Opperman gave several hundred thousand dollars so that NYU could host the forum with President Clinton, Tony Blair and the other leaders.

Then, too, Sexton knows how to give even when he's not getting. A few months ago, the Las Vegas entrepreneur James Rogers was profiled in the New York Times for his record-setting gift of $115 million to his alma mater, the University of Arizona Law School. In the quest to make the best use of this generosity, Rogers and Arizona's law school dean, Joel Seligman, toured the country seeking advice from leaders at the nation's top law schools. In the end, Rogers asked Sexton to help them shape their plans. Why Sexton? Rogers says that he was impressed by NYU Law's ''incredibly swift'' rise in prominence: ''It already has bested Harvard in some areas. It has great potential to get out in front and stay in front.'' And he was no less emphatic about ''the spirit of the place.'' ''The NYU people have high IQs and strong opinions, but they're united in their focus on being the best. They're a team.''

On short notice, Sexton recently flew to Tucson for a weekend. In a series of intense discussions with Rogers, Seligman and the Arizona faculty, they discussed options for the University of Arizona Law School Foundation. (Sexton will be one of the seven members of the board.) He asked nothing for NYU, nor did he press Arizona to use NYU as a model. When asked, ''What's in it for NYU?'' Sexton responded: ''That's an irrelevant consideration. Generosity like Jim's commands the sweat equity of everyone who cares about legal education and the law.''

Rogers hasn't given a nickel to NYU Law school, but he's impressed with its dean. ''John is generous and unself-seeking. He's genuine in his feelings. You know he means what he says. He isn't hidebound like a lot of academics can be. Some of the deans are caught up in their traditions and styles. But John is unfettered, in his imagination as much as his personality. They're all smart, of course, but John's inspiring, a true visionary. In his persuasiveness and energy level, he's above everyone else. You're ready to go out and conquer the world after a meeting with him.''

When pressed, Sexton had little to say about his role as consigliere for Arizona, stressing only the generosity of Rogers' gift and the care that has gone into allocating it. As Judge Edwards puts it: ''One of John's best traits is how self-effacing he is. He has no desire to come between someone else and the credit they deserve, or don't deserve. But he himself has big ideas that benefit people, and people know it. He has galvanized them in their self-interest and made them care.''

MAKING NYU LAW SCHOOL THE BEST IT CAN BE

When Sexton took over as dean in the fall of 1988, the NYU law faculty already boasted more than a handful of men and women of great talent and considerable achievement. A few, such as Anthony Amsterdam, the criminal law scholar and renowned death

penalty opponent, had national reputations. NYU's strengths as a law school were quadripolar: traditional meat and potatoes (''booklarnin'') curricula, clinical (practical) education, a developing cadre devoted to an interdisciplinary approach and a tradition of supplying legal talent to the public sector. In all these areas, the past decade has seen the law school advance both quantitatively and qualitatively.

The biggest advance has been the growth of its faculty. From the beginning of his tenure, Sexton told all who would listen that the key to making NYU the finest law school it could be would be using the faculty already at the school and the special notion of professional education articulated by the Enterprise to attract ever more outstanding scholar-teachers.

Since then, NYU's ability to attract brilliant lateral appointments has become legendary. In the last decade, the school snapped up nearly a score of celebrated scholars—names like Barry Adler (formerly of Virginia); Stephen Holmes (formerly of Chicago); Benedict Kingsbury (formerly of Duke); Larry Kramer (formerly of Michigan); Geoffrey Miller (formerly of Chicago); Daniel Shaviro (formerly of Chicago) Michael Schill (formerly of Pennsylvania); and Richard Stewart (formerly of Harvard). Moreover, NYU has made a conscious decision not to use outsized salaries to attract these top scholars—in other words, not to enter into the academic equivalent of what the sports world calls free agency. Instead, as Sexton puts it: ''We seek to make ourselves irresistibly attractive to the people for whom we are right. If you want the benefits of the kind of reciprocal community the Enterprise has created, and if you are willing to undertake the obligations associated with that community, we want you, and we can offer you exactly what you want.''

And let there be no doubt that the degree and kind of intellectual heat and light generated at NYU is doubtless a draw to faculty and students alike. A weekly bulletin informs the reader of an astonishing number of events, lectures, and meetings, usually animated by a vast array of eminent guests. Supreme Court Justices are regular visitors to NYU, as are their equivalents from foreign lands. So are leading corporate, labor, political and cultural leaders from the United States and abroad. As one faculty member put it: ''Each week, there are two or three events here, any one of which would be the major intellectual event at most other schools.''

A visiting professor summarized his recent year at NYU this way: ''I've spent time at most of the leading law schools; simply put, none has the level of intellectual activity I found here.'' Another said, ''Before I spent a semester here, I knew that NYU's faculty was among the very best in the country. What I didn't know was how much interaction there was among the faculty and students. I certainly didn't anticipate the steady flow of the leading thinkers and players in the law. It seems that everybody who is anybody in law either is at NYU, is about to be at NYU, or has just been at NYU.''

Part of the extraordinary intellectual vitality of NYU can be captured in a word unfamiliar to an outsider—''colloquia.'' A colloquium is a specific and rigorous ''meta-seminar'' designed to engage faculty and students in demanding discourse at the most advanced level. Typically, a student's formal classroom time in one of the ten colloquia is divided between a session of several hours devoted to grilling a leader in the field (the ''guest'' participant) and an independent seminar session devoted to student work related to the week's topic. The distinction between teacher and student often dissolves in the colloquia, replaced by a joint pursuit of advanced study not only of the law but—more usually—of other disciplines as well. There are ten colloquia ranging from traditional topics such as ''Legal History,'' ''Constitutional Theory,'' and ''Tax Policy,'' to the less expected ''Law and Society'' and Law, Philosophy and Political Theory.'' In short, interdisciplinary work is not only a priority, it is central—in no small part because the law school has an unusual number of world-class scholars from disciplines other than law—in fields ranging from economics, to politics, to philosophy, to psychology, to sociology. In fact, NYU Law School boasts one of the finest philosophy ''departments'' in the world, with Ronald Dworkin, Jurgen Habermas, Liam Murphy, Thomas Nagel, David Richards and Lawrence Sager all in residence. And Jerome Bruner, viewed by many as the father of cognitive psychology, is also at the law school.

The fact that Bruner is at NYU is itself a testament to creative thinking. Over the psychologist's protests that he ''knew no law,'' the faculty brought him to NYU in 1992 to help the faculty and students analyze and understand legal cognition more profoundly. The a priori questions he studies, and which now valuably inform the general awareness of faculty and students not only at NYU but at other schools as well, include: ''What does law presuppose about the function of the mind? How does the human penchant for categorization affect legal thinking? How do lawyers listen? Does stare decisis (the strength of precedent) apply to all human decision-making, not just legal?'' This type of ''meta'' question is routine at NYU Law.

THE GLOBAL LAW SCHOOL INITIATIVE

There is another factor in the remarkable story of NYU's growth—a factor that has both helped to attract faculty and generated an unparalleled intellectual activity: the willingness to take risks. A common, if often rued, characteristic of most elite schools is that they tend to be conservative, risk-averse. As one dean candidly put it, ''We change as slowly as an aircraft carrier turns.'' Such an approach is not the approach of NYU Law School. As Sexton puts it: ''We embrace the positive doctrine of original sin. If we are not to be perfect in this life, we should seize our imperfection as an opportunity always to improve—to follow Martin Luther's advice to 'sin boldly.'" This led the National Law Journal to say about NYU in 1995: ''NYU, already a powerhouse, has become the leader in innovation among elite law schools.''

The best example of all is NYU's boldest gamble to date—what will turn out, incontrovertibly, to be the most extraordinary innovation of Sexton's tenure at the law school—NYU's Global Law School Initiative.

In proposing the initiative six years ago, Sexton and Norman Dorsen, the faculty member he calls the ''father'' of this venture, precipitated a revolution in legal education. Hailed today by many as the most significant step since Langdell developed the case method, the initiative is predicated on an inevitability of the next century, that the world will become smaller and increasingly interdependent. The importance of the rule of law as the basis of economic interdependence and the foundation of national and international human rights will become self-evident. As governments adopt legal systems based on the rule of law, more and more people will experience political and economic justice for the first time.

Taking globalization seriously means understanding that there are no significant legal or social problems today that are purely domestic—from labor standards and NAFTA to intellectual property and trade, to the impact of foreign creditors on domestic monetary policy.

NYU's faculty has long been interested in international issues, and its curriculum has reflected this. Its student body, composed of a high proportion of foreign students, have always been able to choose from array of traditional, clinical, and interdisciplinary courses offered by scholars in public and private international law, comparative law, international taxation and jurisprudence. But the Global Law School initiative is something different—subtler, grander, more challenging. It is not a program for the study of international or comparative law, it is about bringing a global perspective to every aspect of the study of law, leading to a new way of seeing and understanding not only law, but the world. Its central premise is that there is value in viewing and reviewing law and society from new vantage points; the more you widen the cultural-conceptual circle of discussants, the more the discussion widens, and the more likely it is that the overall fund of good ideas will grow.

Of the four major components of the Global Law School, the most important is the Global Law Faculty, a score of leading legal scholars and practitioners from around the world, who, though they retain their ''day jobs,'' agree to come to Washington Square for a minimum of two months a year. The Global Faculty, which supplements and complements NYU's extraordinary American Faculty, represents six continents and eighteen nations and boasts the names of many of the planet's leading scholars: Sir John Baker, the eminent Cambridge University law historian and dean of Cambridge's law faculty; Uprendra Baxi, vice chancellor of New Delhi University; Menachem Elon, retired deputy president of the Supreme Court of Israel; and Hisashi Owada, permanent representative of Japan to the United Nations, are just a few. These men and women are not ''visiting professors'' in the usual sense. They come in far greater numbers, are in residence longer, and they maintain a continuing relationship with NYU after they have returned to their home countries. Most return for second and third teaching and research stints at NYU. In Dorsen's words, ''They are part of us, and we of them.''

Fifty years ago, Arthur T. Vanderbilt saw the value of attracting students from abroad to the school, and he instituted a special program to bring experienced foreign lawyers to the school for a year of study. The Global Law School initiative takes Vanderbilt's notion to a new level. Stimulated in part by a $5 million gift from Rita and Gustave Hauser, NYU established what is now the world's premier legal scholarship program for foreign students, the Hauser Scholars Program. (Sir Robert Jennings, immediate past president of the World Court, has called it ''the Rhodes Scholarship of Law.'') Each year, a committee chaired by the president of the World Court chooses the finest young lawyers in the world and brings them to NYU. This has led others to come as well, and the result has been the creation of the most diverse student body anywhere: This academic year, there are more than 300 full-time students studying at the law school who are citizens of foreign countries; they come from almost three dozen countries and six continents.

Not surprisingly, the curriculum that flows from the Global Law School initiative goes well beyond supplementing a traditional American legal education with doses of comparative and international law. Mere supplementation would only reinforce the notion that foreign law is something peripheral, lurking on the outskirts of what a ''good American lawyer'' needs to know to

ply his trade. Instead, NYU has forged a pedagogy and curriculum that give every student a deeper understanding of the global dimension of the life of a modern lawyer. Members of the Global Faculty teach a wide array of courses, including ''basic'' courses like dispute resolution, property or tax law, bringing new and critical thinking to fields that have long needed them.

The foreign students, too, bring different and important perspectives. As one American professor told me: ''I was teaching Roe v. Wade (the abortion case) as usual when a female Chinese student asked me to use Justice Blackmun's decision to assess her government's policy which had required her to have an abortion. An American student never would have asked that wonderful question.''

The Global School initiative has led NYU to create a broad range of inter-university agreements, institutes and centers designed to advance the global perspective. And the school's success with the program has generated conferences, forums and special events that have brought the world to NYU—and NYU to the world's attention. So, for example, a conference on the enforcement ability in domestic courts of judgments rendered by the array of new international tribunals brought three U.S. Supreme Court justices to NYU, where they spent three days in conversation with counterparts from around the world—using a set of papers prepared and presented by students as springboards for discussion. A conference on constitutional adjudication attracted U.S. Supreme Court Justices to Washington Square for four days of talks with twelve justices from the Constitutional Courts of Germany, Italy, and Russia.

And then there was last fall's day-long forum, ''Strengthening Democracy in the Global Economy: An Opening Dialogue.'' There never had been an event like it at any university. The cast of participants was overwhelming. In a room packed with NYU's faculty and students, and before a world wide television and media audience (Ten networks were present and 350 journalists were credentialed), leaders grappled in genuine conversation with the need for new political and economic answers in a globalized world. When the capstone panel of the day (a two-hour reflection on the earlier discussions moderated by Dean Sexton and featuring the four heads of state) concluded with a look forward to the continuation of the dialogue under the auspices of the law school, it was clear that NYU Law had become the venue for a global conversation about law.

Successfully incorporating what Dorsen calls ''the inevitable but only faintly understood globalization of law'' is obviously a long-term proposition. So also is effecting the transformation of perspective that will change legal education. And everyone at NYU acknowledges that the Global Law School initiative faces challenges that will not be met easily—for instance, the difficulty of truly integrating foreign and American law students and faculty, day to day. Still, as First Lady Hillary Rodham Clinton put it, it is now clear that ''NYU Law School has arrived at a place where the rest of legal education will strive to be five or ten years from now.''

A COMMUNITY WITH HEART . . .

When you ask Dorsen what he believes ''excellence'' in legal education is all about, the Stokes professor is quick to explain that, for him, it goes well beyond intellectual quality and attainment. The two additional factors Dorsen deems necessary—''and which have epitomized NYU Law School for me''—are ''variety and heart.'' ''Variety'' of course refers to NYU's diversity, not only in gender and the social, ethnic, racial, and national backgrounds of its students and teachers, but also in the teaching styles and scholarly traditions, educational activities, programs, institutes, and opportunities; and, far from least, the array of legal and public vocations elected by graduates, far from all of whom go into corporate law.

As to ''heart,'' this is ''not a simple concept,'' Dorsen concedes, for all that it is absolutely pivotal. ''Heart'' is what it all rests on and serves—reputation, quality, prestige, success. It refers to judgement, morality, higher goals, and to the sense of community that comes with being united in a common pursuit. ''Heart'' is a fragile thing, ''constantly at risk'' in a world where ''intense preoccupation'' with individual pursuits easily drives out concern for public welfare and community values.

If you press members of the NYU Law School on this topic, ''heart'' (or some similar word or phrase) is what they answer to the questions of why they love the place and why it has fared so well. The challenge, beyond attracting faculty stars, the best students and terrific administrators, is to create an environment that is not only intellectually fulfilling but also socially congenial and inspiring to everyone. This is perhaps Sexton's most important contribution to NYU. With him as its catalytic stimulus, the law school has moved from the ''independent contractor'' model of an academic institution—with its competition and factionalism—to being what the dean, with his Jesuit education, loves to call ''a communitas'' of mutual collaboration and commitment.

As I looked at NYU Law 18 months after the publication of his profile of its dean, I again asked James Traub the question the New York Times had asked in the headline to his piece: ''Is NYU's law school challenging Harvard's as the nation's best?'' He replied: ''Where NYU might beat even Harvard or Yale is as a place to be. NYU is ahead of everybody as a happy place. Law professors are notoriously critical and skeptical. They have trouble feeling part of any institution. You can feel the unease and the disarray at many of the best law schools in the country, but not at NYU.''

As Richard Revesz, one of NYU's brightest young stars, says: ''The possibilities in this place come together remarkably, combining individual freedom with the dean's sense of community. We have a pluralistic, not a homogeneous, community at NYU.'' His colleague, Stephen Holmes, a leading political theorist, formerly of the University of Chicago, puts it a little differently: ''There is a poisonousness in academic life, and a degree of backbiting and professorial whining that are absent here. John's genius is creating opportunities for the faculty that take the edge of this tendency. He can take energies that can easily turn into mutual recrimination, energies that have done so in other places, and manage to make them productive. NYU is the least bitter institution I've worked at. There's a mutuality and purposiveness here. The administration makes it possible for each of us to do his or her best work without obsessing over our neighbor's advantage. No one seems to get a stomachache here because someone else is doing well.''

When asked if that is due to a sense of community, Holmes says he doesn't especially like that word, but he affirms that ''discussion at the law school mainly goes on, as in the colloquia, in a public setting. This is a very public-minded institution. It isn't dominated by the corridor setting and the gossip that that setting usually creates.''

. . . and a dean with soul

At the drop of a very small pin, Sexton will expand warmly upon his current plans for the law school: to bring the global initiative to full fruition, to develop a curriculum for the 21st century that ''addresses a broader range of the cognitive talents we in the law use in working with the law,'' to build the finest center in the world for research and teaching about law in order to ensure that law and lawyers are used to make our world better.

And—another bold idea—to make NYU tuition free. This last dream, especially close to his heart these days, would be funded partly by building the law school's endowment so that it generates more income and partly by a structured plan that will see NYU graduates who go into corporate law contributing back to the law school the tuition they never had to pay when they were law students. As president of the Association of American Law Schools—legal education's oldest and most distinguished collectivity—Sexton was remorseless in advocating his idea that practicing lawyers should contribute 1% of their income over $50,000 to the law school from which they graduated. ''It is imperative,'' Sexton says, ''to reduce the enormous debt our graduates incur to pay for their education.'' (It is not unusual for a student to graduate with $120,000 in law-school-related debt.) He continues: ''If we do not reduce their debt, they will be forced to choose income over service.''

Where did all these ideas come from? When asked, Sexton will remind you of Arthur Vanderbilt's hopes, of the dreams of ''the Enterprise,'' and of Dorsen's expansive notion of ''heart.'' But, too, he speaks of ''the Tocquevillian ideal of the law,'' infusing that ideal with his own insights, as he did in a recent ''President's column'' in the newsletter of the Association of American Law Schools:

''From the beginning America has been a society based on law and forged by lawyers; for us, the law has been the great arbiter and the principal means by which we have been able to knit one nation out of a people whose dominant characteristic always has been our diversity. Just as the law has been the means for founding, defining, preserving, reforming and democratizing a united America, America's lawyers have been charged with setting the nation's values. Unlike other countries, America has no unifying religion or ethnicity; our principle of unification is law.''

Lest this be heard as after-dinner boiler plate, or, worse, an attempt to promote self-satisfaction in his audience, Sexton is quick to point to the historical irony that the American Constitution is becoming a model for nations that have never known the rule of law, precisely at a time ''when we in America are becoming more humble about how much we don't know, how much we haven't managed to get right.''

Sexton's high-minded idealism, some have noted, is suffused and informed by an Irish-Catholic religiousness lurking just below the surface of his energy, as between the words of all his speeches. It often leads him to enunciate strange definitions in the tin ears of a secular age. ''Legal research,'' in the Sextonian reading, becomes ''serious thinking about the 'ought' of the law, not the parody evoked by the phrase 'yet another law review article.'" Where most are content to speak of law as a profession, Sexton lovingly dubs it ''a vocation, a deep calling, that governs or ought to govern our professional lives.''

It is in this elucidation of ideals and the moral exhortation with which they are pressed home that Sexton is most himself. The single-mindedness of his dedication to his cause permits him more leeway than others allow themselves. As Chief Judge Harry Edwards puts it, ''People with true values and beliefs have a big head start in any conversation.'' The school's former Board chair,

Martin Lipton, who recently became chair of the university's Board, adds, ''Anyone who knows or works with John soon realizes that he is a man not only of vision but of complexity, a man whose drive toward meaning is not encompassed or summed up by the standard references of the academic marketplace: prestige, rankings, or VIPs.''

A friend of the Sexton family, the writer and literary scholar Peter Pitzele, recalling John's original vocation as a professor of religion, puts it another way: ''I would set John in the historic context of Americans who have worked to create an institution—a corporate body—that in some strange way is, or seeks to be, sanctified. I think it is this drive to sacralize that really animates what John is doing.'' He adds, ''Though genius and genial are etymologically related, in life they rarely are. It seems to me that—rare though the combination is—John is both.''

Another friend of Sexton's, and his colleague to boot, Richard Revesz recalls one of the biggest bestsellers of the early 1980s, a novel written by a professor of his at Princeton. In The Vicar of Christ, Walter Murphy tells the story of an American law school dean who ends up as Pope. Notes Revesz, with a smile, ''Every time John starts out a conversation saying to me, 'Let me be your pastor, Ricky, tell me what's on your mind,' I think to myself of Murphy's novel and I wonder . . .''●

TRIBUTE TO LILLIAN A. HART

● Mr. MCCONNELL. Mr. President, I rise today to pay tribute to the late Lillian A. Hart, a committed public servant and devoted wife, mother and grandmother, who bravely battled cancer in the last several months of her life.

Lillian has made it easy for us to remember her—she has left behind an impressive list of accomplishments that most people only hope to achieve in their lifetime. Lillian was a leader in the community and a role model for many women. She was a pioneer, exploring occupations and civic positions women had never held before.

Lillian was the first woman to be the state executive director of the Agricultural Stabilization and Conservation Service in Kentucky, her most recent public position. Lillian served Kentucky in this capacity from 1981 to 1989, and received a national award in 1987, for her work on behalf of farmers and all Kentuckians.

Before Lillian became state executive director, she was also the first woman to be appointed a district director of the Agricultural Stabilization and Conservation Service. She served 19 Northern Kentucky counties as district director for 12 years, including in her home county of Pendleton.

Lillian was active in her community, once serving as president of the Pendleton County Republican Women's Club and being chosen as a delegate to the Republican National Convention. She also founded a chapter of Habitat for Humanity in Pendleton County, and was a member of the Kincaid Regional Theatre board of directors.

I am certain that the legacy of excellence that Lillian Hart has left will continue on, and will encourage and inspire others. Hopefully it will be a comfort to the family and friends she leaves behind to know that her efforts to better the community will be felt for years to come. On behalf of myself and my colleagues, we offer our deepest condolences to Lillian's loved ones, and express our gratitude for all she contributed to Pendleton County, the State of Kentucky, and to our great Nation.●

TRIBUTE TO MEG GREENFIELD

● Ms. MIKULSKI. Mr. President, I rise today to reflect on the passing of a truly remarkable woman: Washington Post Editorial Page Editor Meg Greenfield. A tough, tenacious and trailblazing woman, Ms. Greenfield had a sharp intellect, a vibrant sense of humor, and a keen political instinct.

Meg Greenfield was at the center of many of Washington's intellectual, cultural and political developments in the past three decades. Her fiercely independent eye for news gave her the ability to cultivate relationships with individuals from every political, cultural and economic background. Her insightful portraits of life in our nation's capital were profound and memorable.

Ms. Greenfield forever changed the access and acceptance women have in the field of journalism. She astutely examined tough issues such as global disarmament and international affairs which were traditionally seen as ''male'' issues. She commanded respect and demanded fairness and impartiality from her staff.

In 1978, Ms. Greenfield moved the world with her commentary on issues of international affairs, civil rights and the press. For her efforts she claimed the much coveted Pulitzer Prize for editorial writing. One year later, she moved into the post of Editor for the Washington Post editorial page. A responsibility she undertook with dignity, grace, a keen wit and what she would call ''the sensibility of 1950s liberals—conservative on foreign policy and national defense, but liberal on social issues'' for over 20 years.

For these and many other reasons I admired Meg Greenfield and her vastly important work. She also played a critical role in my own career. When I ran for the United States Senate, I met with the Washington Post editorial board, and I had heard about the tough, no-nonsense Meg Greenfield. I was very impressed with her, and she believed in me and my ideas for Maryland.

The endorsement I received from the Washington Post in the 1986 Democratic primary was a turning point in the campaign. I was running against two very good friends of mine: the terrific Congressman from Montgomery County, Mike Barnes, and Maryland's Governor Harry Hughes. The confidence and support I received from Meg Greenfield and the Post editorial board gave me pride and momentum, and helped lead me to victory.

Meg Greenfield's colleagues at the editorial page wrote the day after her death, ''The anonymity typical of editorial pages could not disguise the hand of Meg Greenfield. As a writer her work was often instantly recognizable . . . for its felicity and stateliness and not least for its wry and mischievous humor. As an editor she imprinted her special blend of a wise skepticism and a reach for the public good on a long generation of Post editorials.'' In this tribute, they describe not only her as the consummate professional, but as the wonderful and caring woman that she was.

Meg Greenfield will be dearly missed in the many circles of Washington life. Her spirit and legacy will inspire us for years to come.●

FREEMEN PROSECUTION AWARD

● Mr. BURNS. Mr. President, I am pleased to come to the floor to honor a Department of Justice team that is receiving the top prosecution award today at Constitution Hall. This team of 12 prosecutors and investigators was faced with the challenging task of bringing LeRoy Schweitzer, Richard Clark, Daniel Petersen, Rodney Skurdal, Dale Jacobi, Russell Landers, and others, known as the ''Freemen,'' to justice.

As you may remember, the Montana Freemen were a group of individuals who refused to recognize any authority by U.S. officials. Instead, they created their own ''republic'' and court system. After warrants were prepared for multiple counts of fraud, armed robbery, and firearms violations, they holed up on their ranch for 81 days in a tense standoff. The team recognized today were critical in preparing the warrants, negotiating the peaceful resolution of the standoff, and convicting twenty-one members of the group. In addition, this team worked with many other prosecution teams to prepare and present related cases in over thirty federal districts.

It makes me especially proud that there were seven Montanans among the group being recognized. They are Assistant U.S. Attorney James Seykora, Paralegal Specialist Deborah Boyle, IRS Special Agents Michael Mayott and Loretta Rodriquez, FBI Senior Resident Agent Daniel Vierthaler, FBI Special Agent Randall Jackson, and Montana Department of Justice Agent Bryan Costigan. I also appreciate the contribution of Robertson Park, George Toscas, David Kris, Tommie Canady, and Timothy Healy as award winners contributing from agencies outside of the state. I also think it's only appropriate to recognize the investigation and prosecution leader, Montana U.S. Attorney Sherry Matteucci. Although this entire prosecution effort fell under her responsibility, as a political appointee, she is not eligible for this award.

The Attorney General's Award for Exceptional Service is given once each year, with the decision based upon the following: performance of a special

service in the public interest that is over and above the normal requirements and of an outstanding and distinctive character in terms of improved operations, public understanding of the department's mission, or accomplishment of one of the major goals of the department, exceptionally outstanding contributions to the Department of Justice or exceptionally outstanding leadership in the administration of major programs that resulted in highly successful accomplishments to meet unique or emergency situations, or extraordinary courage and voluntary risk of life in performing an act resulting in direct benefits to the department or nation. From where I sit, this team has met or exceeded all of these high standards during the course of the investigation. Few other prosecutions have received the external scrutiny in the press, Justice management, and the public eye as did the Freemen prosecution. A terrific amount of juggling priorities and concerns was necessary to pull off a peaceful resolution of this crisis. Their conviction record on this case was solid, and will likely be the model from any similar situations in the future.

So, it gives me great pleasure to bring our attention to this team's success, and I add my thanks for a job well done. We wish them nothing but continued success as they move on to other jobs within their home agencies. Again, congratulations on this great, well-deserved honor.●

BEATRIZ RIVAS ROGALSKI

● Mrs. BOXER. Mr. President, I rise to salute my Deputy Chief of Staff, Beatriz (Bea) Rivas Rogalski, on the occasion of her upcoming retirement after 25 years of distinguished service to the people of the United States. As director of casework in my House and Senate offices for more than 16 years, she has helped literally thousands of Californians get the timely assistance they need from their federal government. As Deputy Chief of Staff, she is beloved by staff members and constituents alike.

Bea began her public service as I did, in the office of then-Congressman John Burton. In 1974, Bea Rivas was a recent immigrant from El Salvador. While working at Macy's department store in San Francisco, she took a second part-time job to help support her mother.

Bea went to work in John Burton's campaign office on a temporary basis as a key-punch operator. Given a six-month project, Bea completed it in two months. Following the election, she went to work as a staff assistant in Congressman Burton's district office, answering phones and tracking bills. Her diligence and demeanor quickly impressed her supervisors, who promoted her to case worker.

It was a perfect fit. She quickly learned the most arcane workings of government and did her utmost to help constituents negotiate the shoals of bureaucracy.

Bea has what it takes to help people get their due from their government. She is kind, considerate, generous, and above all patient. I cannot overstate how she always listens carefully, always acts diligently, always goes the extra mile to take care of constituents' needs. She is incomparable and irrepressible. She will also be irreplaceable.

Mr. President, by serving the people of California so well, Beatriz Rogalski has brought honor on this institution and the United States Government. I hope you will join me in thanking her and sending best wishes to her, her husband Hans Rogalski, and their son Hans, Jr.●

TRIBUTE TO HITCHINER MANUFACTURING COMPANY

● Mr. SMITH of New Hampshire. Mr. President I rise today to pay tribute to Hitchiner Manufacturing Co., Inc. for receiving Business NH Magazine's 1999 Business of the Year Award.

Since the company moved to Milford, New Hampshire in 1951, Hitchiner has been extremely active within the community. Hitchiner supports the community through contributions to the arts, education, and community welfare. Specifically, they offer much-needed dollars to local and state non-profits and they make time available for their employees to participate in community affairs. Hitchiner President/CEO, John Morison III, believes when employees work in the community their experiences will translate into a positive experience for the company as a whole.

In addition to being involved in community affairs, Hitchiner Manufacturing is a leader in technology. The company is an international player for investment castings for customers such as General Motors, BMW and General Electric. Hitchiner will soon acquire their tenth patent, thereby establishing themselves as the leader in metallurgical advances.

Hitchiner's profit sharing philosophy has helped create a spirit of team work among its employees. President Morison believes that by sharing the profits and risks, of working as a team, the company will be better equipped to stay on the cutting edge of technology—this is the key to future success.

Mr. President, I salute Hitchiner Manufacturing Company, Inc. and commend their president, John Morison, for his innovative ideas and spirit of community. It is an honor to represent them in the United States Senate.●

SOUTH CAROLINA PEACHES

● Mr. HOLLINGS. Mr. President, I rise today to recognize South Carolina's peach farmers for their hard work and their delicious peaches.

My staff has been delivering South Carolina peaches to offices throughout the Senate and the U.S. Capitol all day. Thanks to South Carolina peach farmers, those of us here in Washington will be able to cool off from the summer heat with delicious South Carolina peaches.

For a relatively small state, South Carolina is second in the nation in peach production. In fact, this year farmers across South Carolina planted more than 16,000 acres of peaches. As my colleagues can attest, these are some of the finest peaches produced anywhere in the United States.

As we savor the taste of these South Carolina peaches, we should remember the work and labor that goes into producing such a delicious fruit. While Americans enjoy peaches for appetizers, entrees, and desserts, most do not stop to consider where they come from. Farmers will be laboring all summer in the heat and humidity to bring us what we call the ''perfect candy.'' What else curbs a sweet tooth—is delicious, nutritious, and satisfying, but not fattening? The truth is, Mr. President, that our farmers are too often the forgotten workers in our country. Through their dedication and commitment, our nation is able to enjoy a wonderful selection of fresh fruit, vegetables, and other foods. In fact, our agricultural system, at times, is the envy of the world.

Mr. President, as Senators and their staff feast on these delicious peaches, I hope they will remember the people in South Carolina who made this endeavor possible: David Winkles and the entire South Carolina Farm Bureau; and the South Carolina Peach Council. They have all worked extremely hard to ensure that the Senate gets a taste of South Carolina.

I hope everyone in our Nation's Capitol will be smiling as they enjoy the pleasure of South Carolina peaches.●

TRIBUTE TO TOM RECHTIN, SR.

● Mr. MCCONNELL. Mr. President, I rise today to honor a fine Kentucky businessman, Tom Rechtin, Sr., President of Tom Rechtin Heating, Air Conditioning and Electric Company.

Tom was recently named ''1999 Outstanding Business Person'' by the Northern Kentucky Chamber of Commerce for his community leadership and 35 years of education advocacy. The honor was given as part of the A.D. Albright awards program, which is named for Northern Kentucky University's president emeritus, who was known for encouraging educational excellence in the region.

The Albright Award recognizes Tom's commitment to supporting and encouraging educational activities in the workplace and in the community. His own company serves as a model for his philosophy, as his employees attend and participate in numerous classes and seminars he facilitates. Tom Rechtin's company also employs student interns who are seeking certification.

Tom was also recently named the ''1998 National Contractor of the Year''

by the National Association of Plumbing, Heating and Cooling Contractors, and ''Kentucky Contractor of the Year'' by the Kentucky Association of Plumbing, Heating and Cooling Contractors.

Tom began working in the industry after high school and, over the years, moved through the ranks from an entry-level position to eventually owning his own company. Today, Tom is one of the most well-known and well-respected businessmen in the state, with over 12,000 customers in Northern Kentucky, Eastern Indiana, and Southern Ohio.

Tom is a three-time appointee by the Governor to the Kentucky HVAC Licensing Board, which oversees the licensing and continuing education programs for the state's HVAC journeymen and Master License holders. He has been an example to board members and the entire industry by implementing his own rigorous employee training programs. His leadership and success in the field is one of the reasons Tom has been named Vice President of the Kentucky HVAC Licensing Board.

My colleagues and I congratulate you, Tom, on your recent accomplishments and commend your many years of service to Northern Kentucky's business community. Best wishes for many years of continued success.

Mr. President, I ask that the following Campbell County Recorder article from June 17, 1999, be printed in the RECORD.

The article follows:

[From the Campbell County Recorder, June 17, 1999]

CHAMBER ANNOUNCES ALBRIGHT WINNERS

TOM RECHTIN

This year's Outstanding Business Person recipient, Tom Rechtin, has been a community leader, role model and an advocate for education for more than 35 years. Rechtin has used his personal and professional experience, knowledge and ability to include others to advance the educational system and consequently the economy in Northern Kentucky.

This recipient of the Albright Award encourages employees to attend certification classes, participate in seminars and get involved in company educational programs. He provides tuition assistance for employees and currently employs four student interns who are seeking certification.

He supports education within his company and is an educational advocate in the community. Coupled with Cincinnati Public Schools, he helped found the first apprenticeship and continuing education program in the Tristate. Along with the Northern Kentucky Home Builders Association, he helped develop the first heating and cooling apprenticeship program in Northern Kentucky, and as chairman of the apprenticeship committee, he continues to develop new programs and lead efforts to fund the program.

Further, Rechtin is a member of the Kentucky State Licensing Board, serves on a Citizens Task Force aimed at evaluating and improving Bellevue Schools, and founded SMART TECH—a class that is offered at NKU annually to journeymen to meet state licensing requirements. Most recently, he sought to carry out a federal School-To-Work federal initiative promoting schools and businesses to share knowledge and develop practical curriculums for students entering the workforce.

Outside of his work with education and his company, he is a member of the Chamber of Commerce's Workforce Readiness Council, a Master with the Boy Scouts of America, an athletic sponsor with the Bellevue Vets, a member of the Bellevue Renewal Committee and a council member of Sacred Heart Catholic Church.

The Chamber of Commerce is the largest volunteer business organization in Northern Kentucky. It works to encourage and promote economic well being, quality growth and community development for both Northern Kentucky and the region.●

TRI-CITIES, TN–VA: 1999 RECIPIENT OF THE ALL-AMERICA CITY AWARD

● Mr. FRIST. Mr. President, when our Founding Fathers began their fight for our Nation's independence, they had a vision of what America would be like. They saw a free and self-reliant people, ruled by State and local governments, who took responsibility for their own welfare and progress, and cared for themselves and for others in their own communities.

When Alexis de Tocqueville came to America almost a century later, that is what he saw. He later wrote that, In America, when a citizen saw a problem that needed solving, he would cross the street and discuss it with a neighbor, together the neighbors would form a committee, and before long the problem would be solved. ''You may not believe this,'' he said, ''but not a single bureaucrat would ever have been involved.''

While today our citizens are increasingly ruled, not by local governments, but by Washington, the essence of what it means to be an American has not changed: We are a people willing to lend a hand, lift a spirit, and work together to make our land a better place.

For 50 years, the All-America City Awards have designated—from among all the cities in America—10 communities that have carried on this time-honored tradition and kept the spirit of America alive. And I'm proud to say that among this year's winners is Tri-Cities, TN–VA, a place our founding fathers would recognize as a fulfillment of their vision of what a free people, living and working together, can accomplish.

Among the criteria by which all participants were judged were citizen involvement, effective government performance, philanthropic and volunteer resources, a strong capacity for cooperation, and community vision and pride. And, Tri-Cities—the first-ever region to be so honored by this award—possesses those qualities in spades.

Included in the presentation which tipped the judges' decision in their favor were their efforts to involve youth in the decision-making process; improve health care in isolated communities and create an interest in rural medicine among future physicians; and celebrate and preserve the Appalachian region's oral and musical traditions. And they did it all without government handouts or mandates from Washington. Their message, set to the sound of bluegrass music: we are willing to work; we are willing to lead.

I think the song, written by a local storyteller and sung by all the Tri-Cities delegates, says it all:

If you call, we will answer;
If you need us, we will come.
We'll lend a hand—there's strength in numbers;
If we work together, we can get it done.

Mr. President, on behalf of all the people of Tennessee, and all Americans everywhere, I congratulate the citizens of Tri-Cities, Tennessee-Virginia for their accomplishment. Not only they, but all of us, are winners because of their efforts.●

CLEVELAND SCHOLARSHIP AND TUTORING PROGRAM

● Mr. VOINOVICH. Mr. President, today I rise to recognize the achievements of the Cleveland Scholarship and Tutoring Program. Now in its third school year, this program, which is one of only two school choice experiments in the country, continues to offer hope and promise to nearly 3,700 inner city children and their parents by making private schools, including religious schools, affordable. I have been a longtime supporter of the Scholarship Program, as well as the school choice concept in general. Believing that competition fosters improvement, I made the implementation of this pilot school scholarship plan one of my education reform priorities by signing a 2-year budget package that included $5 million for the introduction of the program in 1995.

The Cleveland Scholarship Program is the first of its kind in the country that offers state-funded scholarships for use at both secular and religious private schools, giving low-income students access to an otherwise unattainable private school education in Cleveland, where schools graduate a mere 36 percent of its high school seniors. In September of 1996, during it's first school year, the program provided scholarships to approximately 1,855 students for the public, private, or religious school of their choice. Recent growth of the program's budget enabled the parents of nearly 3,700 students to use vouchers to enroll in 59 participating area schools during the 1998–1999 school year.

Two separate studies by Harvard University on the Cleveland Scholarship Program found parents of voucher recipients were more satisfied with many aspects of their school than were parents of students in Cleveland public schools. That satisfaction included the school's academic program, school safety, school discipline, teacher skills, the teaching of moral values, and class size. A separate study found that test

score results in mathematics and reading show substantial gains for Cleveland Scholarship Program students attending the Hope schools, two non-sectarian schools which were created in response to the establishment of the program. Additionally, parents of voucher recipients reported lower levels of disruption in their child's school—including fighting, racial conflict, and vandalism.

The results of these studies further underscore the success of this program. Time and again, data and surveys from the state have confirmed the Cleveland Scholarship Program meets the one true test of any taxpayer-supported program—it works. Although the program is not without its critics, I believe the best way to put these criticisms to rest is to continue demonstrating the program's effectiveness in Cleveland as we continue to look beyond the conventional and pursue creative and imaginative approaches to education.

I applaud the achievements of the Cleveland Scholarship Program and its contributions to the education of our children, and am proud to say that my hometown serves as a model for the rest of the Nation.●

TRIBUTE TO CHRISTOPHER R. ROVZAR ON BEING NAMED PRESIDENTIAL SCHOLAR

● Mr. SMITH of New Hampshire. Mr. President, I rise today to honor Christopher R. Rovzar, of Exeter, New Hampshire, for being selected as a 1999 Presidential Scholar by the U.S. Secretary of Education.

Of the over 2.5 million graduating seniors nationwide, Christopher is one of only 141 seniors to receive this distinction for academics. This impressive young man is well-deserving of the title of Presidential Scholar. I wish to commend Christopher for his outstanding achievement.

As a student at Phillips Exeter Academy in New Hampshire, Christopher has served as a role model for his peers through his commitment to excellence. Christopher's determination promises to guide him in the future.

It is certain that Christopher will continue to excel in his future endeavors. I wish to offer my most sincere congratulations and best wishes to Christopher. His achievements are truly remarkable. It is an honor to represent him in the United States Senate.●

IN RECOGNITION OF REAR ADMIRAL LEONARD VINCENT, SUPPLY CORPS, U.S. NAVY

● Mr. INHOFE. Mr. President, I recognize and honor Rear Admiral Leonard Vincent, U.S. Navy as he retires upon completion of 32 years of service to the Navy, The Department of Defense and the Nation.

Born in Tulsa, Oklahoma, a graduate of McAlester High School, Oklahoma he enlisted in the Navy Reserve in 1961. He graduated from Southeastern State College, Durant, Oklahoma, in 1965 and received his commission as a Ensign in the Navy Supply Corps that same year. In 1976 he receive his Masters in Business Administration from George Washington University.

A distinguished professional, Admiral Vincent currently commands the Defense Systems Management College (DSMC). As the Commandant of DSMC, he has been a leader of change agents for acquisition reform. And he has brought a wealth of acquisition, logistics, and contract management experience to the vital task of training our nation's Department of Defense Acquisition Workforce.

Afloat he has served as the Supply Officer of an amphibious ship, the USS *Pensacola* (LSD 38) and the Supply Officer of a submarine tender, the USS *Dixon* (AS 37).

Ashore his assignments have included duty as Supply Officer with Naval Special Warfare Group and with Naval Inshore Warfare Command, Atlantic, both in Little Creek, Virginia.

His varied acquisition assignments include Director of Contracts, Naval Supply Center, Puget Sound; Contracting Officer for the Supervisor, Shipbuilding and Repair, Bath, Maine; Director of the Combat Systems department and Director of the Contracts department at the Navy's inventory control point, Mechanicsburg, Pennsylvania; Assistant Commander for Contracts, Naval Air Systems Command; Deputy Director for Acquisition for the Defense Logistics Agency; and prior to his current assignment, RADM Vincent was the Deputy Chief of Staff for Logistics, Fleet Supply and Ordnance, Pacific Fleet.

In addition to his current assignment, his command tours have included Commander, Defense Contract Administration Services Region, Los Angeles, California; Commander, Defense Contract Management Command International, Dayton, Ohio; and Commander, Contract Management Command, Washington, D.C.

Throughout his career Admiral Vincent has displayed exemplary performance of duty, extraordinary initiative and leadership, keen judgment, and dedication to the highest principles of devotion to his country. He leaves the military and the acquisition community better by having served them. His contributions will have lasting consequence.

Mr. President, Leonard Vincent, his wife Shirley and their three children, Lori, Tiffany and Stephen have made many sacrifices during his 32 year Navy career. A man of his leadership, enthusiasm and integrity is rare and while his honorable service will be genuinely missed, it gives me great pleasure today to recognize him before my colleagues and wish to him ''Fair Winds and Following Seas'' as he brings to a close a long and distinguished career in the United States Naval Service.

I ask that an article and narrative on Rear Admiral Vincent be printed in the RECORD.

The article and narrative follows:

REAR ADMIRAL LEONARD VINCENT—COMMANDANT, DEFENSE SYSTEMS MANAGEMENT COLLEGE

Rear Admiral Leonard ''Lenn'' Vincent became the Commandant Defense Systems Management College (DSMC), Fort Belvoir, Virginia, in January 1998. The College is a graduate-level institution that promotes sound systems-management principles by the acquisition workforce through education, research, consulting, and information dissemination.

Admiral Vincent entered the Naval Reserve program as a sea-man recruit in October 1961. Upon graduation from Southeastern State Teachers College in Oklahoma, he received a commission in July 1965 from the Officers Candidate School, Newport, Rhode Island, as an ensign in the Supply Corps, U.S. Navy.

Since returning to the Navy in 1970, RADM Vincent's wide variety of afloat and shore-based assignments have provided him extensive contracting, contract management, and logistics experience.

Afloat he has served as the Supply Officer of an amphibious ship, the USS PENSACOLA (LSD 38) and the Supply Officer of a submarine tender, the USS DIXON (AS 37).

Ashore his assignments have included duty as Supply Officer with Naval Special Warfare Group and with Naval Inshore Warfare Command, Atlantic, both in Little Creek, Virginia. He attended the Armed Forces Staff College, Norfolk, Virginia; and then in Washington, D.C., he earned a Masters in Business Administration from George Washington University.

His varied acquisition assignments include Director of Contracts, Naval Supply Center, Puget Sound; Contracting Officer for the Supervisor, Shipbuilding and Repair, Bath, Maine; Director of the Combat Systems department and Director of the Contracts department at the Navy's inventory control point, Mechanicsburg, Pennsylvania; Assistant Commander for Contracts, Naval Air Systems Command; Deputy Director for Acquisition for the Defense Logistics Agency; and prior to his current assignment, RADM Vincent was the Deputy Chief of Staff for Logistics, Fleet Supply and Ordnance, Pacific Fleet.

In addition to his current assignment as Commandant, DSMC, his command tours have included Commander, Defense Contract Administration Services Region, Los Angeles, Contract Administration Services Region, Los Angeles, California; Commander, Defense Contract Management Command International, Dayton, Ohio; and Commander, Contract Management Command, Washington, D.C.

His military decorations include the Defense Superior Service Medal with gold star, Legion of Merit with gold star, Defense Meritorious Service Medal, Meritorious Service Medal with three gold stars, Navy Commendation Medal, and Navy Achievement Medal.

NARRATIVE

Rear Admiral Vincent distinguished himself by exceptionally outstanding achievement throughout thirty two years of service culminating in his distinguished performance as Commandant of the Defense Systems Management College (DSMC) from 30 December 1997 to 31 July 1999.

Admiral Vincent exhibited extensive knowledge, technical competence, tireless energy, imagination, and superb leadership.

As Commandant, he focused the College on improvements essential for the entire Department of Defense Acquisition Workforce (AWF), and dramatically improved the quality and greatly expanded the scope of their education and training. During his tenure, student throughput increased by nearly five percent, greatly helping the military departments to meet the formal acquisition education requirements that public law imposed on all major system program managers. These achievements are all the more remarkable because they were accomplished during a period when DSMC funding decreased by over seven percent, and personnel by over 11 percent.

Admiral Vincent also successfully focused the exceptional capabilities of the College's staff and faculty on meeting the rapidly changing needs of the acquisition workforce. Upon assuming command of DSMC, he led the College's senior leadership through the development of a corporate plan that set the course into the new millennium for the education and training of acquisition professionals. This dynamic plan provided the foundation for DSMC operations and outlined a series of strategic goals, objectives, and metrics that guided the College through the efficient accomplishment of its four-pronged mission of providing education and training, research, consulting, and information dissemination. He successfully challenged the College to achieve these improvements, while maintaining the highest quality of support available to the acquisition workforce.

Anticipating the need to achieve a cultural transformation within the acquisition community, Admiral Vincent encouraged the students, staff, and faculty at DSMC to become change agents and instilled in them a sense of urgency to keep up the momentum of Acquisition Reform. He directed the assessment and revision of over thirty DSMC-sponsored courses to reflect the latest changes, ensuring that Acquisition Reform initiatives are seamlessly threaded throughout the 12 functional areas. To further enrich the learning environment, he spearheaded the effort to recruit students from industry, bringing a commercial business perspective into every classroom—he served as the catalyst to stimulate partnering with industry and effective teaming within program offices. Beginning with the students, staff, and faculty at DSMC, he successfully developed a cultural mindset that would revolutionize the way DoD approaches its business affairs—embracing best practices, empowering the workforce, and achieving optimal solutions at the lowest costs.

In a push to constantly improve the quality of integrated courses, Admiral Vincent created the Acquisition Management Curriculum Enhancement Program (AMCEP) to seamlessly integrate the Acquisition Management Functional Board requirements with the Defense Acquisition University (DAU) course development and delivery processes. The result was a continuous evolutionary process that facilitated and improved the current integrated acquisition management curriculum. The enhancement effort created a learning environment characterized by a problem-based learning curriculum which replicated to the highest possible fidelity actual problems the graduates would likely encounter in their subsequent assignments.

Additionally, to further improve the efficiency at DSMC, Admiral Vincent consolidated all information/automation systems enhancement efforts at the College under the Chief Information/Knowledge Officer. By concentrating the information technology activities under one person, Admiral Vincent effectively orchestrated the consolidation of automated systems requirements, significantly reducing costs and making educational information widely available to internal and external customers. Under Admiral Vincent's guidance, the College underwent the process of standardizing the automation equipment in each classroom and upgrading the server infrastructure, along with video tele-conference capability, to better support distance learning conversion efforts of DSMC courses. This initiative, while minimizing costs to infuse information technology capability, not only improved the students' learning environment, but also made acquisition education and training more accessible to the workforce.

Admiral Vincent also provided the thrust behind the development of the Integrated Curriculum Environment (ICE) database, an automated, centralized management system for DSMC courseware and supporting documentation. This standardized curriculum management tool will significantly simplify the course revision process, and eventually, will make course materials available electronically to all students and accessible by all graduates. Through his active leadership and visionary foresight of the information revolution, Admiral Vincent launched DSMC—and acquisition education and training—into the 21st Century, guiding the College through the transformation process of becoming the acquisition workforce's Center for Continuous Learning.

Admiral Vincent further improved the stature of DSMC as the Department of Defense world-class center for international acquisition education excellence. Under his leadership, DSMC co-sponsored the 10th Annual International Defense Educational Arrangement (IDEA) seminar with France and hosted the 11th IDEA seminar in the United States—a fifteen-nation symposium on Intra-European and Transatlantic armaments cooperation. Additionally, Admiral Vincent initiated the first IDEA Pacific seminar with the Australian Defense Force Academy, providing eight nations of the Pacific Rim with a forum for exchange of acquisition best practices. With the growing emphasis on international cooperation, the College also hosted biannual international acquisition forums for DUSD (International Programs) and the Services international program offices. As the principal U.S. representative to IDEA, Admiral Vincent provided the leadership and facilitated international cooperation, significantly advancing the understanding and effectiveness of international cooperative acquisition issues among participating nations.

His distinguished career included additional command tours as Commander, Defense Contract Administration Services Region, Los Angeles; Commander, Defense Contract Management Command International; Deputy Director for Acquisition Management and Commander, Defense Contract Management Command, Defense Logistics Agency.

Throughout the period of his assignment as Commandant, DSMC, and his thirty-two-year career, Admiral Vincent displayed exemplary performance of duty, extraordinary initiative and leadership, keen judgment, and dedication to the highest principles of devotion to his country. He leaves the Defense Systems Management College and the acquisition community better by having served them. His personal dedication has been solely responsible for numerous contributions of lasting consequence, which will enhance the ability of each Service to accomplish its mission better, now and in the future. His exceptional performance in extremely important and challenging positions has been in keeping with the highest traditions of the Service and reflects great credit upon himself, the United States Navy, and the Department of Defense.●

TREASURY AND GENERAL GOVERNMENT APPROPRIATIONS ACT, 2000

The text of S. 1282, passed by the Senate on July 1, 1999, follows:

S. 1282

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the Treasury Department, the United States Postal Service, the Executive Office of the President, and certain Independent Agencies, for the fiscal year ending September 30, 2000, and for other purposes, namely:

TITLE I—DEPARTMENT OF THE TREASURY

DEPARTMENTAL OFFICES

SALARIES AND EXPENSES

For necessary expenses of the Departmental Offices including operation and maintenance of the Treasury Building and Annex; hire of passenger motor vehicles; maintenance, repairs, and improvements of, and purchase of commercial insurance policies for, real properties leased or owned overseas, when necessary for the performance of official business; not to exceed $2,900,000 for official travel expenses; not to exceed $150,000 for official reception and representation expenses; not to exceed $258,000 for unforeseen emergencies of a confidential nature, to be allocated and expended under the direction of the Secretary of the Treasury and to be accounted for solely on his certificate, $133,168,000.

DEPARTMENT-WIDE SYSTEMS AND CAPITAL INVESTMENTS PROGRAMS

(INCLUDING TRANSFER OF FUNDS)

For development and acquisition of automatic data processing equipment, software, and services for the Department of the Treasury, $35,561,000, to remain available until expended: *Provided,* That these funds shall be transferred to accounts and in amounts as necessary to satisfy the requirements of the Department's offices, bureaus, and other organizations: *Provided further,* That this transfer authority shall be in addition to any other transfer authority provided in this Act: *Provided further,* That none of the funds appropriated shall be used to support or supplement the Internal Revenue Service appropriations for Information Systems.

OFFICE OF INSPECTOR GENERAL

SALARIES AND EXPENSES

For necessary expenses of the Office of Inspector General in carrying out the provisions of the Inspector General Act of 1978, as amended, not to exceed $2,000,000 for official travel expenses; including hire of passenger motor vehicles; and not to exceed $100,000 for unforeseen emergencies of a confidential nature, to be allocated and expended under the direction of the Inspector General of the Treasury, $30,483,000.

INSPECTOR GENERAL FOR TAX ADMINISTRATION

SALARIES AND EXPENSES

For necessary expenses of the Treasury Inspector General for Tax Administration in carrying out the Inspector General Act of 1978, as amended, including purchase (not to exceed 150 for replacement only for police-type use) and hire of passenger motor vehicles (31 U.S.C. 1343(b)); and services authorized by 5 U.S.C. 3109, at such rates as may be determined by the Inspector General for Tax Administration; not to exceed $6,000,000 for official travel expenses; not to exceed $500,000 for unforeseen emergencies of a confidential nature, to be allocated and expended under the direction of the Inspector General for Tax Administration, $111,340,000.

TREASURY BUILDING AND ANNEX REPAIR AND RESTORATION

For the repair, alteration, and improvement of the Treasury Building and Annex, $15,000,000, to remain available until expended.

FINANCIAL CRIMES ENFORCEMENT NETWORK

SALARIES AND EXPENSES

For necessary expenses of the Financial Crimes Enforcement Network, including hire of passenger motor vehicles; travel expenses of non-Federal law enforcement personnel to attend meetings concerned with financial intelligence activities, law enforcement, and financial regulation; not to exceed $14,000 for official reception and representation expenses; and for assistance to Federal law enforcement agencies, with or without reimbursement, $27,681,000: *Provided,* That funds appropriated in this account may be used to procure personal services contracts.

VIOLENT CRIME REDUCTION PROGRAMS

(INCLUDING TRANSFER OF FUNDS)

For activities authorized by Public Law 103–322, to remain available until expended, which shall be derived from the Violent Crime Reduction Trust Fund, as follows:

(1) As authorized by section 190001(e), $181,000,000; of which $17,847,000 shall be available to the Bureau of Alcohol, Tobacco and Firearms, including $3,000,000 for administering the Gang Resistance Education and Training program, $1,608,000 for an explosives repository clearinghouse, $12,600,000 for the integrated violence reduction strategy, and $639,000 for building security; of which $21,950,000 shall be available to the United States Secret Service, including $5,854,000 for the protective program, $2,014,000 for the protective research program, $5,886,000 for the workspace program, $5,000,000 for counterfeiting investigations, and $3,196,000 for forensic and related support of investigations of missing and exploited children, of which $1,196,000 shall be available as a grant for activities related to the investigations of exploited children and shall remain available until expended; of which $52,774,000 shall be available for the United States Customs Service, including $4,300,000 for conducting pre-hiring polygraph examinations, $2,000,000 for technology for the detection of undeclared outbound currency, $9,000,000 for non-intrusive mobile personal inspection technology, $4,952,000 for land border automation equipment, $8,000,000 for agent and inspector relocation: *Provided,* That $3,000,000 shall not be available for obligation until September 30, 2000, $5,735,000 for laboratory modernization, $2,400,000 for cybersmuggling, $5,430,000 for Hardline/Gateway equipment, $2,500,000 for the training program, $3,640,000 to maintain fiscal year 1998 equipment, and $4,817,000 for investigative counter-narcotics and money laundering operations; of which $28,366,000 shall be available for Interagency Crime and Drug Enforcement; of which $1,863,000 shall be available for the Financial Crimes Enforcement Network, including $600,000 for GATEWAY, $300,000 to expand data mining technology, $500,000 to continue the magnitude of money laundering study, $200,000 to enhance electronic filing of SARS and other BSA databases, and $263,000 for technical advances for GATEWAY; of which $9,200,000 shall be available to the Federal Law Enforcement Training Center for construction of two firearms ranges at the Artesia Center: *Provided,* That these funds shall not be available for obligation until September 30, 2000; and of which $49,000,000 shall be available to the Office of National Drug Control Policy Special Forfeiture Fund to support a national media campaign, as authorized in the Drug-Free Media Campaign Act of 1998: *Provided further,* That these funds shall not be available for obligation until September 30, 2000;

(2) As authorized by section 32401, $13,000,000 to the Bureau of Alcohol, Tobacco and Firearms for disbursement through grants, cooperative agreements, or contracts to local governments for Gang Resistance Education and Training: *Provided,* That notwithstanding sections 32401 and 310001, such funds shall be allocated to State and local law enforcement and prevention organizations.

FEDERAL LAW ENFORCEMENT TRAINING CENTER

SALARIES AND EXPENSES

For necessary expenses of the Federal Law Enforcement Training Center, as a bureau of the Department of the Treasury, including materials and support costs of Federal law enforcement basic training; purchase (not to exceed 52 for police-type use, without regard to the general purchase price limitation) and hire of passenger motor vehicles; for expenses for student athletic and related activities; uniforms without regard to the general purchase price limitation for the current fiscal year; the conducting of and participating in firearms matches and presentation of awards; for public awareness and enhancing community support of law enforcement training; not to exceed $9,500 for official reception and representation expenses; room and board for student interns; and services as authorized by 5 U.S.C. 3109, $80,114,000, of which up to $16,511,000 for materials and support costs of Federal law enforcement basic training shall remain available until September 30, 2002: *Provided,* That the Center is authorized to accept and use gifts of property, both real and personal, and to accept services, for authorized purposes, including funding of a gift of intrinsic value which shall be awarded annually by the Director of the Center to the outstanding student who graduated from a basic training program at the Center during the previous fiscal year, which shall be funded only by gifts received through the Center's gift authority: *Provided further,* That notwithstanding any other provision of law, students attending training at any Federal Law Enforcement Training Center site shall reside in on-Center or Center-provided housing, insofar as available and in accordance with Center policy: *Provided further,* That funds appropriated in this account shall be available, at the discretion of the Director, for the following: training United States Postal Service law enforcement personnel and Postal police officers; State and local government law enforcement training on a space-available basis; training of foreign law enforcement officials on a space-available basis with reimbursement of actual costs to this appropriation, except that reimbursement may be waived by the Secretary for law enforcement training activities in foreign countries undertaken pursuant to section 801 of the Antiterrorism and Effective Death Penalty Act of 1996, Public Law 104–32; training of private sector security officials on a space-available basis with reimbursement of actual costs to this appropriation; and travel expenses of non-Federal personnel to attend course development meetings and training sponsored by the Center: *Provided further,* That the Center is authorized to obligate funds in anticipation of reimbursements from agencies receiving training sponsored by the Federal Law Enforcement Training Center, except that total obligations at the end of the fiscal year shall not exceed total budgetary resources available at the end of the fiscal year: *Provided further,* That the Federal Law Enforcement Training Center is authorized to provide training for the Gang Resistance Education and Training program to Federal and non-Federal personnel at any facility in partnership with the Bureau of Alcohol, Tobacco and Firearms: *Provided further,* That the Federal Law Enforcement Training Center is authorized to provide short-term medical services for students undergoing training at the Center.

ACQUISITION, CONSTRUCTION, IMPROVEMENTS, AND RELATED EXPENSES

For expansion of the Federal Law Enforcement Training Center, for acquisition of necessary additional real property and facilities, and for ongoing maintenance, facility improvements, and related expenses, $21,611,000, to remain available until expended.

FINANCIAL MANAGEMENT SERVICE

SALARIES AND EXPENSES

For necessary expenses of the Financial Management Service, $200,054,000, of which not to exceed $10,635,000 shall remain available until September 30, 2002, for information systems modernization initiatives; and of which not to exceed $2,500 shall be available for official reception and representation expenses.

BUREAU OF ALCOHOL, TOBACCO AND FIREARMS

SALARIES AND EXPENSES

For necessary expenses of the Bureau of Alcohol, Tobacco and Firearms, including purchase of not to exceed 812 vehicles for police-type use, of which 650 shall be for replacement only, and hire of passenger motor vehicles; hire of aircraft; services of expert witnesses at such rates as may be determined by the Director; for payment of per diem and/or subsistence allowances to employees where an assignment to the National Response Team during the investigation of a bombing or arson incident requires an employee to work 16 hours or more per day or to remain overnight at his or her post of duty; not to exceed $15,000 for official reception and representation expenses; for training of State and local law enforcement agencies with or without reimbursement, including training in connection with the training and acquisition of canines for explosives and fire accelerants detection; and provision of laboratory assistance to State and local agencies, with or without reimbursement, $570,345,000, of which $39,320,000 may be used for the Youth Crime Gun Interdiction Initiative, of which $1,120,000 shall be provided for the purpose of expanding the program to include Las Vegas, Nevada; of which not to exceed $1,000,000 shall be available for the payment of attorneys' fees as provided by 18 U.S.C. 924(d)(2); and of which $1,000,000 shall be available for the equipping of any vessel, vehicle, equipment, or aircraft available for official use by a State or local law enforcement agency if the conveyance will be used in joint law enforcement operations with the Bureau of Alcohol, Tobacco and Firearms and for the payment of overtime salaries, travel, fuel, training, equipment, supplies, and other similar costs of State and local law enforcement personnel, including sworn officers and support personnel, that are incurred in joint operations with the Bureau of Alcohol, Tobacco and Firearms: *Provided,* That no funds made available by this or any other Act may be used to transfer the functions, missions, or activities of the Bureau of Alcohol, Tobacco and Firearms to other agencies or Departments in fiscal year 2000: *Provided further,* That no funds appropriated herein shall be available for salaries or administrative expenses in connection with consolidating or centralizing, within the Department of the Treasury, the records, or any portion thereof, of acquisition and disposition of firearms maintained by Federal firearms licensees: *Provided further,* That no funds appropriated herein shall be used to

pay administrative expenses or the compensation of any officer or employee of the United States to implement an amendment or amendments to 27 CFR 178.118 or to change the definition of ''Curios or relics'' in 27 CFR 178.11 or remove any item from ATF Publication 5300.11 as it existed on January 1, 1994: *Provided further,* That none of the funds appropriated herein shall be available to investigate or act upon applications for relief from Federal firearms disabilities under 18 U.S.C. 925(c): *Provided further,* That such funds shall be available to investigate and act upon applications filed by corporations for relief from Federal firearms disabilities under 18 U.S.C. 925(c): *Provided further,* That no funds in this Act may be used to provide ballistics imaging equipment to any State or local authority who has obtained similar equipment through a Federal grant or subsidy unless the State or local authority agrees to return that equipment or to repay that grant or subsidy to the Federal Government: *Provided further,* That no funds under this Act may be used to electronically retrieve information gathered pursuant to 18 U.S.C. 923(g)(4) by name or any personal identification code.

UNITED STATES CUSTOMS SERVICE

SALARIES AND EXPENSES

For necessary expenses of the United States Customs Service, including purchase and lease of up to 1,050 motor vehicles of which 550 are for replacement only and of which 1,030 are for police-type use and commercial operations; hire of motor vehicles; contracting with individuals for personal services abroad; not to exceed $40,000 for official reception and representation expenses; and awards of compensation to informers, as authorized by any Act enforced by the United States Customs Service, $1,670,747,000, of which such sums as become available in the Customs User Fee Account, except sums subject to section 13031(f)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (19 U.S.C. 58c(f)(3)), shall be derived from that Account; of the total, not to exceed $150,000 shall be available for payment for rental space in connection with preclearance operations; not to exceed $4,000,000 shall be available until expended for research, of which $900,000 shall be provided to a land grant university in North and/or South Dakota to conduct a research program on the bilateral United States/Canadian bilateral trade of agricultural commodities and products; of which $100,000 shall be provided for the child pornography tipline; of which $200,000 shall be for Project Alert; not to exceed $5,000,000 shall be available until expended for conducting special operations pursuant to 19 U.S.C. 2081, and; up to $8,000,000 shall be available until expended for the procurement of automation infrastructure items, including hardware, software, and installation; up to $5,400,000, to be available until expended, may be transferred to the Treasury-wide Systems and Capital Investments Programs account for an international trade data system; and up to $5,000,000, to remain available until expended, for repairs to Customs facilities: *Provided,* That uniforms may be purchased without regard to the general purchase price limitation for the current fiscal year: *Provided further,* That the Hector International Airport in Fargo, North Dakota shall be designated an International Port of Entry: *Provided further,* That notwithstanding any other provision of law, the fiscal year aggregate overtime limitation prescribed in subsection 5(c)(1) of the Act of February 13, 1911 (19 U.S.C. 261 and 267) shall be $30,000.

HARBOR MAINTENANCE FEE COLLECTION

(INCLUDING TRANSFER AUTHORITY)

For Administrative expenses related to the collection of the Harbor Maintenance Fee, pursuant to Public Law 103–182, $3,000,000, to be derived from the Harbor Maintenance Trust Fund and to be transferred to and merged with the Customs ''Salaries and Expenses'' account for such purposes.

OPERATION, MAINTENANCE AND PROCUREMENT, AIR AND MARINE INTERDICTION PROGRAMS

For expenses, not otherwise provided for, necessary for the operation and maintenance of marine vessels, aircraft, and other related equipment of the Air and Marine Programs, including operational training and mission-related travel, and rental payments for facilities occupied by the air or marine interdiction and demand reduction programs, the operations of which include the following: the interdiction of narcotics and other goods; the provision of support to Customs and other Federal, State, and local agencies in the enforcement or administration of laws enforced by the Customs Service; and, at the discretion of the Commissioner of Customs, the provision of assistance to Federal, State, and local agencies in other law enforcement and emergency humanitarian efforts, $108,688,000, which shall remain available until expended: *Provided,* That no aircraft or other related equipment, with the exception of aircraft which is one of a kind and has been identified as excess to Customs requirements and aircraft which has been damaged beyond repair, shall be transferred to any other Federal agency, department, or office outside of the Department of the Treasury, during fiscal year 2000 without the prior approval of the Committees on Appropriations.

BUREAU OF THE PUBLIC DEBT

ADMINISTERING THE PUBLIC DEBT

For necessary expenses connected with any public-debt issues of the United States, $181,383,000, of which not to exceed $2,500 shall be available for official reception and representation expenses, and of which not to exceed $2,000,000 shall remain available until expended for systems modernization: *Provided,* That the sum appropriated herein from the General Fund for fiscal year 2000 shall be reduced by not more than $4,400,000 as definitive security issue fees and Treasury Direct Investor Account Maintenance fees are collected, so as to result in a final fiscal year 2000 appropriation from the General Fund estimated at $176,983,000, and in addition, $20,000, to be derived from the Oil Spill Liability Trust Fund to reimburse the Bureau for administrative and personnel expenses for financial management of the Fund, as authorized by section 1012 of Public Law 101–380.

INTERNAL REVENUE SERVICE

PROCESSING, ASSISTANCE, AND MANAGEMENT

For necessary expenses of the Internal Revenue Service for tax returns processing; revenue accounting; tax law and account assistance to taxpayers by telephone and correspondence; programs to match information returns and tax returns; management services; rent and utilities; and services as authorized by 5 U.S.C. 3109, at such rates as may be determined by the Commissioner, $3,291,945,000, of which up to $3,950,000 shall be for the Tax Counseling for the Elderly Program, and of which not to exceed $25,000 shall be for official reception and representation expenses.

TAX LAW ENFORCEMENT

For necessary expenses of the Internal Revenue Service for determining and establishing tax liabilities; providing litigation support; issuing technical rulings; examining employee plans and exempt organizations; conducting criminal investigation and enforcement activities; securing unfiled tax returns; collecting unpaid accounts; compiling statistics of income and conducting compliance research; purchase (for police-type use, not to exceed 850) and hire of passenger motor vehicles (31 U.S.C. 1343(b)); and services as authorized by 5 U.S.C. 3109, at such rates as may be determined by the Commissioner, $3,305,090,000, of which not to exceed $1,000,000 shall remain available until September 30, 2002, for research and, of which not to exceed $150,000 shall be for official reception and representation expenses associated with hosting the Inter-American Center of Tax Administration (CIAT) 2000 Conference.

EARNED INCOME TAX CREDIT COMPLIANCE INITIATIVE

For funding essential earned income tax credit compliance and error reduction initiatives pursuant to section 5702 of the Balanced Budget Act of 1997 (Public Law 105–33), $144,000,000, of which not to exceed $10,000,000 may be used to reimburse the Social Security Administration for the costs of implementing section 1090 of the Taxpayer Relief Act of 1997.

INFORMATION SYSTEMS

For necessary expenses of the Internal Revenue Service for information systems and telecommunications support, including developmental information systems and operational information systems; the hire of passenger motor vehicles (31 U.S.C. 1343(b)); and services as authorized by 5 U.S.C. 3109, at such rates as may be determined by the Commissioner, $1,450,100,000.

ADMINISTRATIVE PROVISIONS—INTERNAL REVENUE SERVICE

SEC. 101. Not to exceed 5 percent of any appropriation made available in this Act to the Internal Revenue Service may be transferred to any other Internal Revenue Service appropriation upon the advance approval of the Committees on Appropriations.

SEC. 102. The Internal Revenue Service shall maintain a training program to ensure that Internal Revenue Service employees are trained in taxpayers' rights, in dealing courteously with the taxpayers, and in cross-cultural relations.

SEC. 103. The Internal Revenue Service shall institute and enforce policies and procedures which will safeguard the confidentiality of taxpayer information.

SEC. 104. Funds made available by this or any other Act to the Internal Revenue Service shall be available for improved facilities and increased manpower to provide sufficient and effective 1–800 help line service for taxpayers. The Commissioner shall continue to make the improvement of the Internal Revenue Service 1–800 help line service a priority and allocate resources necessary to increase phone lines and staff to improve the Internal Revenue Service 1–800 help line service.

SEC. 105. Notwithstanding any other provision of law, no reorganization of the field office structure of the Internal Revenue Service Criminal Investigation Division will result in a reduction of criminal investigators in Wisconsin and South Dakota from the 1996 level.

UNITED STATES SECRET SERVICE

SALARIES AND EXPENSES

For necessary expenses of the United States Secret Service, including purchase of not to exceed 739 vehicles for police-type use, of which 675 shall be for replacement only, and hire of passenger motor vehicles; hire of aircraft; training and assistance requested by State and local governments, which may be provided without reimbursement; services of expert witnesses at such rates as may be determined by the Director; rental of buildings in the District of Columbia, and fencing, lighting, guard booths, and other facilities

on private or other property not in Government ownership or control, as may be necessary to perform protective functions; for payment of per diem and/or subsistence allowances to employees where a protective assignment during the actual day or days of the visit of a protectee require an employee to work 16 hours per day or to remain overnight at his or her post of duty; the conducting of and participating in firearms matches; presentation of awards; for travel of Secret Service employees on protective missions without regard to the limitations on such expenditures in this or any other Act if approval is obtained in advance from the Committees on Appropriations; for research and development; for making grants to conduct behavioral research in support of protective research and operations; not to exceed $20,000 for official reception and representation expenses; not to exceed $50,000 to provide technical assistance and equipment to foreign law enforcement organizations in counterfeit investigations; for payment in advance for commercial accommodations as may be necessary to perform protective functions; and for uniforms without regard to the general purchase price limitation for the current fiscal year, $638,816,000.

ACQUISITION, CONSTRUCTION, IMPROVEMENTS, AND RELATED EXPENSES

For necessary expenses of construction, repair, alteration, and improvement of facilities, $4,923,000, to remain available until expended.

GENERAL PROVISIONS—DEPARTMENT OF THE TREASURY

SEC. 110. Any obligation or expenditure by the Secretary of the Treasury in connection with law enforcement activities of a Federal agency or a Department of the Treasury law enforcement organization in accordance with 31 U.S.C. 9703(g)(4)(B) from unobligated balances remaining in the Fund on September 30, 2000, shall be made in compliance with reprogramming guidelines.

SEC. 111. Appropriations to the Department of the Treasury in this Act shall be available for uniforms or allowances therefor, as authorized by law (5 U.S.C. 5901), including maintenance, repairs, and cleaning; purchase of insurance for official motor vehicles operated in foreign countries; purchase of motor vehicles without regard to the general purchase price limitations for vehicles purchased and used overseas for the current fiscal year; entering into contracts with the Department of State for the furnishing of health and medical services to employees and their dependents serving in foreign countries; and services authorized by 5 U.S.C. 3109.

SEC. 112. The funds provided to the Bureau of Alcohol, Tobacco and Firearms for fiscal year 2000 in this Act for the enforcement of the Federal Alcohol Administration Act shall be expended in a manner so as not to diminish enforcement efforts with respect to section 105 of the Federal Alcohol Administration Act.

SEC. 113. Not to exceed 2 percent of any appropriations in this Act made available to the Federal Law Enforcement Training Center, Financial Crimes Enforcement Network, Bureau of Alcohol, Tobacco and Firearms, United States Customs Service, and United States Secret Service may be transferred between such appropriations upon the advance approval of the Committees on Appropriations. No transfer may increase or decrease any such appropriation by more than 2 percent.

SEC. 114. Not to exceed 2 percent of any appropriations in this Act made available to the Departmental Offices, Office of Inspector General, Treasury Inspector General for Tax Administration, Financial Management Service, and Bureau of the Public Debt, may be transferred between such appropriations upon the advance approval of the Committees on Appropriations. No transfer may increase or decrease any such appropriation by more than 2 percent.

SEC. 115. Of the funds available for the purchase of law enforcement vehicles, no funds may be obligated until the Secretary of the Treasury certifies that the purchase by the respective Treasury bureau is consistent with Departmental vehicle management principles: *Provided*, That the Secretary may delegate this authority to the Assistant Secretary for Management.

SEC. 116. VOLUNTARY SEPARATION INCENTIVE PAYMENTS FOR EMPLOYEES OF THE OFFICE OF THE TREASURY INSPECTOR GENERAL FOR TAX ADMINISTRATION. During the period from October 1, 1999 through January 1, 2003, the Treasury Inspector General for Tax Administration is authorized to offer voluntary separation incentives in order to provide the necessary flexibility to carry out the plan to establish and reorganize the Office of the Treasury Inspector General for Tax Administration (''the Office'' hereafter).

(a) DEFINITION.—In this section, the term ''employee'' means an employee (as defined by 5 U.S.C. 2105) who is employed by the Office serving under an appointment without time limitation, and has been currently employed by the Office or the Internal Revenue Service or the Office of Inspector General of the Department of the Treasury for a continuous period of at least 3 years, but does not include—

(1) a reemployed annuitant under subchapter III of chapter 83 or chapter 84 of title 5, United States Code, or another retirement system;

(2) an employee having a disability on the basis of which such employee is or would be eligible for disability retirement under the applicable retirement system referred to in paragraph (1);

(3) an employee who is in receipt of a specific notice of involuntary separation for misconduct or unacceptable performance;

(4) an employee who has previously received any voluntary separation incentive payment by the Federal Government under this section or any other authority and has not repaid such payment;

(5) an employee covered by statutory reemployment rights who is on transfer to another organization; or

(6) any employee who, during the 24-month period preceding the date of separation, has received a recruitment or relocation bonus under 5 U.S.C. 5753 or who, within the 12-month period preceding the date of separation, received a retention allowance under 5 U.S.C. 5754.

(b) AUTHORITY TO PROVIDE VOLUNTARY SEPARATION INCENTIVE PAYMENTS.—

(1) IN GENERAL.—The Treasury Inspector General for Tax Administration may pay voluntary separation incentive payments under this section to any employee to the extent necessary to organize the Office so as to perform the duties specified in the Internal Revenue Service Restructuring and Reform Act of 1998, Pub. L. 105–206.

(2) AMOUNT AND TREATMENT OF PAYMENTS.—A voluntary separation incentive payment—

(A) shall be paid in a lump sum after the employee's separation;

(B) shall be paid from appropriations available for the payment of the basic pay of the employees of the Office;

(C) shall be equal to the lesser of—

(i) an amount equal to the amount the employee would be entitled to receive under 5 U.S.C. 5595(c); or

(ii) an amount determined by the Treasury Inspector General for Tax Administration, not to exceed $25,000;

(D) may not be made except in the case of any qualifying employee who voluntarily separates (whether by retirement or resignation) before January 1, 2003;

(E) shall not be a basis for payment, and shall not be included in the computation, of any other type of Government benefit; and

(F) shall not be taken into account in determining the amount of any severance pay to which the employee may be entitled under 5 U.S.C. 5595 based on any other separation.

(c) ADDITIONAL OFFICE OF THE TREASURY INSPECTOR GENERAL FOR TAX ADMINISTRATION CONTRIBUTIONS TO THE RETIREMENT FUND.—

(1) IN GENERAL.—In addition to any other payments which it is required to make under subchapter III of chapter 83 or chapter 84 of title 5, United States Code, the Office shall remit to the Office of Personnel Management for deposit in the Treasury of the United States to the credit of the Civil Service Retirement and Disability Fund an amount equal to 15 percent of the final basic pay of each employee who is covered under subchapter III of chapter 83 or chapter 84 of title 5, United States Code, to whom a voluntary separation incentive has been paid under this section.

(2) DEFINITION.—In paragraph (1), the term ''final basic pay'', with respect to an employee, means the total amount of basic pay which would be payable for a year of service by such employee, computed using the employee's final rate of basic pay, and, if last serving on other than a full-time basis, with appropriate adjustment therefor.

(d) EFFECT OF SUBSEQUENT EMPLOYMENT WITH THE GOVERNMENT.—An individual who has received a voluntary separation incentive payment under this section and accepts any employment for compensation with the Government of the United States, or who works for any agency of the United States Government through a personal services contract, within 5 years after the date of the separation on which the payment is based, shall be required to pay, prior to the individual's first day of employment, the entire amount of the incentive payment to the Office.

(e) EFFECT ON OFFICE OF THE TREASURY INSPECTOR GENERAL FOR TAX ADMINISTRATION EMPLOYMENT LEVELS.—

(1) INTENDED EFFECT.—Voluntary separations under this section are not intended to necessarily reduce the total number of full-time equivalent positions in the Office.

(2) USE OF VOLUNTARY SEPARATIONS.—The Office may redeploy or use the full-time equivalent positions vacated by voluntary separations under this section to make other positions available to more critical locations or more critical occupations.

SEC. 117. VOLUNTARY SEPARATION INCENTIVE PAYMENTS FOR EMPLOYEES OF THE CHICAGO FINANCIAL CENTER OF THE FINANCIAL MANAGEMENT SERVICE. (a) AUTHORITY.—During the period from October 1, 1999 through January 31, 2000, the Commissioner of the Financial Management Service (FMS) of the Department of the Treasury is authorized to offer voluntary separation incentives in order to provide the necessary flexibility to carry out the closure of the Chicago Financial Center (CFC) in a manner which the Commissioner shall deem most efficient, equitable to employees, and cost effective to the Government.

(b) DEFINITION.—In this section, the term ''employee'' means an employee (as defined by 5 U.S.C. 2105) who is employed by FMS at CFC under an appointment without time limitation, and has been so employed continuously for a period of at least 3 years, but does not include—

(1) a reemployed annuitant under subchapter III of chapter 83 or chapter 84 of title 5, United States Code, or another retirement system;

(2) an employee with a disability on the basis of which such employee is or would be eligible for disability retirement under the retirement systems referred to in paragraph (1) or another retirement system for employees of the Government;

(3) an employee who is in receipt of a specific notice of involuntary separation for misconduct or unacceptable performance;

(4) an employee who has previously received any voluntary separation incentive payment from an agency or instrumentality of the Government of the United States under any authority and has not repaid such payment;

(5) an employee covered by statutory reemployment rights who is on transfer to another organization; or

(6) an employee who during the 24 month period preceding the date of separation has received and not repaid a recruitment or relocation bonus under section 5753 of Title 5, United States Code, or who, within the twelve month period preceding the date of separation, has received and not repaid a retention allowance under section 5754 of that Title.

(c) AGENCY PLAN; APPROVAL.—

(1) The Secretary, Department of the Treasury, prior to obligating any resources for voluntary separation incentive payments, shall submit to the Office of Management and Budget a strategic plan outlining the intended use of such incentive payments and a proposed organizational chart for the agency once such incentive payments have been completed.

(2) The agency's plan under subsection (1) shall include—

(A) the specific positions and functions to be reduced or eliminated;

(B) a proposed coverage for offers of incentives;

(C) the time period during which incentives may be paid;

(D) the number and amounts of voluntary separation incentive payments to be offered; and

(E) a description of how the agency will operate without the eliminated positions and functions.

(3) The Director of the Office of Management and Budget shall review the agency's plan and approve or disapprove such plan, and may make appropriate modifications in the plan including waivers of the reduction in agency employment levels required by this Act.

(d) AUTHORITY TO PROVIDE VOLUNTARY SEPARATION INCENTIVE PAYMENTS.—

(1) A voluntary separation incentive payment under this Act may be paid by the agency head to an employee only in accordance with the strategic plan under section (c).

(2) A voluntary incentive payment—

(A) shall be offered to agency employees on the basis of organizational unit, occupational series or level, geographic location, other nonpersonal factors, or an appropriate combination of such factors;

(B) shall be paid in a lump sum after the employee's separation;

(C) shall be equal to the lesser of—

(i) an amount equal to the amount the employee would be entitled to receive under section 5595(c) of title 5, United States Code, if the employee were entitled to payment under such section (without adjustment for any previous payment made); or

(ii) an amount determined by the agency head, not to exceed $25,000;

(D) may be made only in the case of an employee who voluntarily separates (whether by retirement or resignation) under the provisions of this Act;

(E) shall not be a basis for payment, and shall not be included in the computation of any other type of Government benefit;

(F) shall not be taken into account in determining the amount of any severance pay to which the employee may be entitled under section 5595 of title 5, United States Code, based on any other separation; and

(G) shall be paid from appropriations or funds available for the payment of the basic pay of the employee.

(e) ELIGIBILITY FOR PAYMENTS.—Payments under this section may be made to any qualifying employee who voluntarily separates, whether by retirement or resignation, between October 1, 1999 and January 31, 2000.

(f) EFFECT ON SUBSEQUENT EMPLOYMENT WITH THE GOVERNMENT.—An individual who has received a voluntary separation incentive payment under this section and accepts any employment for compensation with any agency or instrumentality of the Government of the United States within 5 years after the date of the separation on which the payment is based shall be required to pay, prior to the individual's first day of employment, the entire amount of the incentive payment to FMS.

(g) CONTRIBUTIONS TO THE RETIREMENT FUND.—

(1) In addition to any other payments which it is required to make under subchapter III of chapter 83 or chapter 84 of title 5, United States Code, FMS shall remit to the office of Personnel Management for deposit in the Treasury to the credit of Civil Service Retirement and Disability Fund an amount equal to 15 percent of the final annual basic pay for each employee covered under subchapter III of chapter 83 or chapter 84 of title 5 United States Code, to whom a voluntary separation incentive has been paid under this section.

(2) For the purpose of paragraph (1), the term ''final basic pay'' with respect to an employee, means the total amount of basic pay which would be payable for a year of service by such employee, computed using the employee's final rate of basic pay, and, if last serving on other than a full-time basis, with appropriate adjustment therefor.

(h) REDUCTION OF AGENCY EMPLOYMENT LEVELS.—

(1) The total number of funded employee positions in the agency shall be reduced by one position for each vacancy created by the separation of any employee who has received, or is due to receive, a voluntary separation incentive payment under this Act. For the purposes of this subsection, positions shall be counted on a full-time equivalent basis.

(2) The President, through the Office of Management and Budget, shall monitor the agency and take any action necessary to ensure that the requirement of this section are met.

(3) At the request of the Secretary, Department of the Treasury, the Office of Management and Budget may waive the reduction in total number of funded employee positions required by subsection (1) if it believes the agency plan required by section (c) satisfactorily demonstrates that the positions would better be used to reallocate occupations or reshape the workforce and to produce a more cost-effective result.

SEC. 118. ENFORCEMENT OF CERTAIN ANTI-TERRORISM JUDGMENTS. (a) DEFINITION.—

(1) IN GENERAL.—Section 1603(b) of title 28, United States Code, is amended—

(A) in paragraph (3) by striking the period and inserting a semicolon and ''and'';

(B) by redesignating paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C), respectively;

(C) by striking ''(b)'' through ''entity—'' and inserting the following:

''(b) An 'agency or instrumentality of a foreign state' means—

''(1) any entity—''; and

(D) by adding at the end the following:

''(2) for purposes of sections 1605(a)(7) and 1610 (a)(7) and (f), any entity as defined under subparagraphs (A) and (B) of paragraph (1), and subparagraph (C) of paragraph (1) shall not apply.''.

(2) TECHNICAL AND CONFORMING AMENDMENT.—Section 1391(f)(3) of title 28, United States Code, is amended by striking ''1603(b)'' and inserting ''1603(b)(1)''.

(b) ENFORCEMENT OF JUDGMENTS.—Section 1610(f) of title 28, United States Code, is amended—

(1) in paragraph (1)—

(A) in subparagraph (A) by striking ''(including any agency or instrumentality or such state)'' and inserting ''(including any agency or instrumentality of such state)''; and

(B) by adding at the end the following:

''(C) Notwithstanding any other provision of law, moneys due from or payable by the United States (including any agency, subdivision or instrumentality thereof) to any state against which a judgment is pending under section 1605(a)(7) shall be subject to attachment and execution, in like manner and to the same extent as if the United States were a private person.''; and

(2) by adding at the end the following:

''(3)(A) Subject to subparagraph (B), upon determining on an asset-by-asset basis that a waiver is necessary in the national security interest, the President may waive this subsection in connection with (and prior to the enforcement of) any judicial order directing attachment in aid of execution or execution against the principal office of a foreign mission to the United States used for diplomatic or related purposes, or any funds held by or in the name of such foreign mission determined by the President to be necessary to satisfy actual operating expenses of such principal office.

''(B) A waiver under this paragraph shall not apply to—

''(i) the principal office of a foreign mission if such office has been used for any nondiplomatic purpose (including as commercial rental property) by either the foreign state or by the United States, or to the proceeds of such nondiplomatic purpose; or

''(ii) if any asset of such principal office is sold or otherwise transferred for value to a third party, the proceeds of such sale or transfer.''.

(c) TECHNICAL AND CONFORMING AMENDMENT.—Section 117(d) of the Treasury Department Appropriations Act, 1999 (Public Law 105–277; 112 Stat. 2681–492) is repealed.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to any claim for which a foreign state is not immune under section 1605(a)(7) of title 28, United States Code, arising before, on, or after the date of enactment of this Act.

SEC. 119. *Provided further*, That the Customs Service Commissioner shall utilize $50,000,000 to hire 500 new Customs inspectors, agents, appropriate equipment and intelligence support within the funds available under the Customs Service headings in the bill, in addition to funds provided to the Customs Service under the Fiscal Year 1999 Emergency Drug Supplemental.

This title may be cited as the ''Treasury Department Appropriations Act, 2000''.

TITLE II—POSTAL SERVICE

PAYMENT TO THE POSTAL SERVICE FUND

For payment to the Postal Service Fund for revenue forgone on free and reduced rate mail, pursuant to subsections (c) and (d) of section 2401 of title 39, United States Code, $93,436,000, of which $64,436,000 shall not be

available for obligation until October 1, 2000: *Provided,* That mail for overseas voting and mail for the blind shall continue to be free: *Provided further,* That 6-day delivery and rural delivery of mail shall continue at not less than the 1983 level: *Provided further,* That none of the funds made available to the Postal Service by this Act shall be used to implement any rule, regulation, or policy of charging any officer or employee of any State or local child support enforcement agency, or any individual participating in a State or local program of child support enforcement, a fee for information requested or provided concerning an address of a postal customer: *Provided further,* That none of the funds provided in this Act shall be used to consolidate or close small rural and other small post offices in the fiscal year ending on September 30, 2000.

This title may be cited as the ''Postal Service Appropriations Act, 2000''.

TITLE III—EXECUTIVE OFFICE OF THE PRESIDENT AND FUNDS APPROPRIATED TO THE PRESIDENT

COMPENSATION OF THE PRESIDENT AND THE WHITE HOUSE OFFICE

COMPENSATION OF THE PRESIDENT

For compensation of the President, including an expense allowance at the rate of $50,000 per annum as authorized by 3 U.S.C. 102; $250,000: *Provided,* That none of the funds made available for official expenses shall be expended for any other purpose and any unused amount shall revert to the Treasury pursuant to section 1552 of title 31, United States Code: *Provided further,* That none of the funds made available for official expenses shall be considered as taxable to the President.

SALARIES AND EXPENSES

For necessary expenses for the White House as authorized by law, including not to exceed $3,850,000 for services as authorized by 5 U.S.C. 3109 and 3 U.S.C. 105; subsistence expenses as authorized by 3 U.S.C. 105, which shall be expended and accounted for as provided in that section; hire of passenger motor vehicles, newspapers, periodicals, teletype news service, and travel (not to exceed $100,000 to be expended and accounted for as provided by 3 U.S.C. 103); not to exceed $19,000 for official entertainment expenses, to be available for allocation within the Executive Office of the President, $52,444,000.

EXECUTIVE RESIDENCE AT THE WHITE HOUSE

OPERATING EXPENSES

For the care, maintenance, repair and alteration, refurnishing, improvement, heating, and lighting, including electric power and fixtures, of the Executive Residence at the White House and official entertainment expenses of the President, $9,260,000, to be expended and accounted for as provided by 3 U.S.C. 105, 109, 110, and 112–114.

REIMBURSABLE EXPENSES

For the reimbursable expenses of the Executive Residence at the White House, such sums as may be necessary: *Provided,* That all reimbursable operating expenses of the Executive Residence shall be made in accordance with the provisions of this paragraph: *Provided further,* That, notwithstanding any other provision of law, such amount for reimbursable operating expenses shall be the exclusive authority of the Executive Residence to incur obligations and to receive offsetting collections, for such expenses: *Provided further,* That the Executive Residence shall require each person sponsoring a reimbursable political event to pay in advance an amount equal to the estimated cost of the event, and all such advance payments shall be credited to this account and remain available until expended: *Provided further,* That the Executive Residence shall require the national committee of the political party of the President to maintain on deposit $25,000, to be separately accounted for and available for expenses relating to reimbursable political events sponsored by such committee during such fiscal year: *Provided further,* That the Executive Residence shall ensure that a written notice of any amount owed for a reimbursable operating expense under this paragraph is submitted to the person owing such amount within 60 days after such expense is incurred, and that such amount is collected within 30 days after the submission of such notice: *Provided further,* That the Executive Residence shall charge interest and assess penalties and other charges on any such amount that is not reimbursed within such 30 days, in accordance with the interest and penalty provisions applicable to an outstanding debt on a United States Government claim under section 3717 of title 31, United States Code: *Provided further,* That each such amount that is reimbursed, and any accompanying interest and charges, shall be deposited in the Treasury as miscellaneous receipts: *Provided further,* That the Executive Residence shall prepare and submit to the Committees on Appropriations, by not later than 90 days after the end of the fiscal year covered by this Act, a report setting forth the reimbursable operating expenses of the Executive Residence during the preceding fiscal year, including the total amount of such expenses, the amount of such total that consists of reimbursable official and ceremonial events, the amount of such total that consists of reimbursable political events, and the portion of each such amount that has been reimbursed as of the date of the report: *Provided further,* That the Executive Residence shall maintain a system for the tracking of expenses related to reimbursable events within the Executive Residence that includes a standard for the classification of any such expense as political or nonpolitical: *Provided further,* That no provision of this paragraph may be construed to exempt the Executive Residence from any other applicable requirement of subchapter I or II of chapter 37 of title 31, United States Code.

WHITE HOUSE REPAIR AND RESTORATION

For the repair, alteration, and improvement of the Executive Residence at the White House, $810,000, to remain available until expended for required maintenance, safety and health issues, and continued preventative maintenance.

SPECIAL ASSISTANCE TO THE PRESIDENT AND THE OFFICIAL RESIDENCE OF THE VICE PRESIDENT

SALARIES AND EXPENSES

For necessary expenses to enable the Vice President to provide assistance to the President in connection with specially assigned functions, services as authorized by 5 U.S.C. 3109 and 3 U.S.C. 106, including subsistence expenses as authorized by 3 U.S.C. 106, which shall be expended and accounted for as provided in that section; and hire of passenger motor vehicles; $3,617,000.

OPERATING EXPENSES

(INCLUDING TRANSFER OF FUNDS)

For the care, operation, refurnishing, improvement, heating and lighting, including electric power and fixtures, of the official residence of the Vice President, the hire of passenger motor vehicles, and not to exceed $90,000 for official entertainment expenses of the Vice President, to be accounted for solely on his certificate; $345,000: *Provided,* That advances or repayments or transfers from this appropriation may be made to any department or agency for expenses of carrying out such activities.

COUNCIL OF ECONOMIC ADVISERS

SALARIES AND EXPENSES

For necessary expenses of the Council in carrying out its functions under the Employment Act of 1946 (15 U.S.C. 1021), $3,840,000.

OFFICE OF POLICY DEVELOPMENT

SALARIES AND EXPENSES

For necessary expenses of the Office of Policy Development, including services as authorized by 5 U.S.C. 3109 and 3 U.S.C. 107; $4,032,000.

NATIONAL SECURITY COUNCIL

SALARIES AND EXPENSES

For necessary expenses of the National Security Council, including services as authorized by 5 U.S.C. 3109, $6,997,000.

OFFICE OF ADMINISTRATION

SALARIES AND EXPENSES

For necessary expenses of the Office of Administration, including services as authorized by 5 U.S.C. 3109 and 3 U.S.C. 107, and hire of passenger motor vehicles $39,198,000, of which $8,806,000 shall be available for a capital investment plan which provides for the continued modernization of the information technology infrastructure.

OFFICE OF MANAGEMENT AND BUDGET

SALARIES AND EXPENSES

For necessary expenses of the Office of Management and Budget (OMB), including hire of passenger motor vehicles and services as authorized by 5 U.S.C. 3109, $63,495,000, of which not to exceed $5,000,000 shall be available to carry out the provisions of chapter 35 of title 44, United States Code: *Provided,* That, as provided in 31 U.S.C. 1301(a), appropriations shall be applied only to the objects for which appropriations were made except as otherwise provided by law: *Provided further,* That none of the funds appropriated in this Act for the Office of Management and Budget may be used for the purpose of reviewing any agricultural marketing orders or any activities or regulations under the provisions of the Agricultural Marketing Agreement Act of 1937 (7 U.S.C. 601 et seq.): *Provided further,* That none of the funds made available for the Office of Management and Budget by this Act may be expended for the altering of the transcript of actual testimony of witnesses, except for testimony of officials of the Office of Management and Budget, before the Committees on Appropriations or the Committees on Veterans' Affairs or their subcommittees: *Provided further,* That the preceding shall not apply to printed hearings released by the Committees on Appropriations or the Committees on Veterans' Affairs: *Provided further,* That from within existing funds provided under this heading, the President may establish a National Intellectual Property Coordination Center.

OFFICE OF NATIONAL DRUG CONTROL POLICY

SALARIES AND EXPENSES

(INCLUDING TRANSFER OF FUNDS)

For necessary expenses of the Office of National Drug Control Policy; for research activities pursuant to Division C, title VII, of Public Law 105–277; not to exceed $8,000 for official reception and representation expenses; and for participation in joint projects or in the provision of services on matters of mutual interest with nonprofit, research, or public organizations or agencies, with or without reimbursement; $21,963,000, of which up to $600,000 shall be available for the evaluation of the Drug-Free Communities Act: *Provided,* That the Office is authorized to accept, hold, administer, and utilize gifts, both real and personal, public and private, without fiscal year limitation, for the purpose of aiding or facilitating the work of the Office.

COUNTERDRUG TECHNOLOGY ASSESSMENT CENTER

(INCLUDING TRANSFER OF FUNDS)

For necessary expenses for the Counterdrug Technology Assessment Center, $31,100,000, which shall remain available until expended, consisting of $2,100,000 for policy research and evaluation, $16,000,000 for counternarcotics research and development projects, and $13,000,000 for the continued operation of the technology transfer program: *Provided,* That the $16,000,000 for counternarcotics research and development projects shall be available for transfer to other Federal departments or agencies.

FEDERAL DRUG CONTROL PROGRAMS

HIGH INTENSITY DRUG TRAFFICKING AREAS PROGRAM

(INCLUDING TRANSFER OF FUNDS)

For necessary expenses of the Office of National Drug Control Policy's High Intensity Drug Trafficking Area Program, $205,277,000 for drug control activities consistent with the approved strategy for each of the designated High Intensity Drug Trafficking Areas, of which $7,000,000 shall be used for methamphetamine programs above the sums allocated in fiscal year 1999, $5,000,000 shall be used for High Intensity Drug Trafficking Areas that are designated after July 1, 1999 and $5,000,000 to be used at the discretion of the Office of National Drug Control Policy with no less than half of the $7,000,000 going to areas solely dedicated to fighting methamphetamine usage, of which no less than 51 percent shall be transferred to State and local entities for drug control activities, which shall be obligated within 120 days of the date of enactment of this Act: *Provided,* That up to 49 percent may be transferred to Federal agencies and departments at a rate to be determined by the Director: *Provided further,* That of this latter amount, $1,800,000 shall be used for auditing services: *Provided further,* That, hereafter, of the amount appropriated for fiscal year 2000 or any succeeding fiscal year for the High Intensity Drug Trafficking Area Program, the funds to be obligated or expended during such fiscal year for programs addressing the treatment or prevention of drug use as part of the approved strategy for a designated High Intensity Drug Trafficking Area (HIDTA) shall not be less than the funds obligated or expended for such programs during fiscal year 1999 for each designated HIDTA: *Provided further,* That Campbell County and Uinta County are hereby designated as part of the Rocky Mountain High Intensity Drug Trafficking Area for the State of Wyoming.

SPECIAL FORFEITURE FUND

(INCLUDING TRANSFER OF FUNDS)

For activities to support a national anti-drug campaign for youth, and other purposes, authorized by Public Law 105–277, $127,500,000, to remain available until expended: *Provided,* That such funds may be transferred to other Federal departments and agencies to carry out such activities: *Provided further,* That of the funds provided, $96,500,000 shall be to support a national media campaign, as authorized in the Drug-Free Media Campaign Act of 1998: *Provided further,* That none of the funds provided for the support of the national media campaign may be obligated until ONDCP has submitted for written approval to the Committee on Appropriations the evaluation and results of phase II of the campaign: *Provided further,* That of the funds provided, $30,000,000 shall be to continue a program of matching grants to drug-free communities, as authorized in the Drug-Free Communities Act of 1997: *Provided further,* That of the funds provided, $1,000,000 shall be available to the Director for transfer as grants to State and local agencies or non-profit organizations for the National Drug Court Institute.

This title may be cited as the ''Executive Office Appropriations Act, 2000''.

TITLE IV—INDEPENDENT AGENCIES

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

SALARIES AND EXPENSES

For necessary expenses of the Committee for Purchase From People Who Are Blind or Severely Disabled established by the Act of June 23, 1971, Public Law 92–28, $2,657,000.

FEDERAL ELECTION COMMISSION

SALARIES AND EXPENSES

For necessary expenses to carry out the provisions of the Federal Election Campaign Act of 1971, as amended, $38,175,000, of which no less than $4,866,500 shall be available for internal automated data processing systems, and of which not to exceed $5,000 shall be available for reception and representation expenses.

FEDERAL LABOR RELATIONS AUTHORITY

SALARIES AND EXPENSES

For necessary expenses to carry out functions of the Federal Labor Relations Authority, pursuant to Reorganization Plan Numbered 2 of 1978, and the Civil Service Reform Act of 1978, including services authorized by 5 U.S.C. 3109, including hire of experts and consultants, hire of passenger motor vehicles, and rental of conference rooms in the District of Columbia and elsewhere, $23,681,000: *Provided,* That public members of the Federal Service Impasses Panel may be paid travel expenses and per diem in lieu of subsistence as authorized by law (5 U.S.C. 5703) for persons employed intermittently in the Government service, and compensation as authorized by 5 U.S.C. 3109: *Provided further,* That notwithstanding 31 U.S.C. 3302, funds received from fees charged to non-Federal participants at labor-management relations conferences shall be credited to and merged with this account, to be available without further appropriation for the costs of carrying out these conferences.

GENERAL SERVICES ADMINISTRATION

FEDERAL BUILDINGS FUND

LIMITATIONS ON AVAILABILITY OF REVENUE

To carry out the purpose of the Fund established pursuant to section 210(f) of the Federal Property and Administrative Services Act of 1949, as amended (40 U.S.C. 490(f)), the revenues and collections deposited into the Fund shall be available for necessary expenses of real property management and related activities not otherwise provided for, including operation, maintenance, and protection of federally owned and leased buildings; rental of buildings in the District of Columbia; restoration of leased premises; moving governmental agencies (including space adjustments and telecommunications relocation expenses) in connection with the assignment, allocation and transfer of space; contractual services incident to cleaning or servicing buildings, and moving; repair and alteration of federally owned buildings including grounds, approaches and appurtenances; care and safeguarding of sites; maintenance, preservation, demolition, and equipment; acquisition of buildings and sites by purchase, condemnation, or as otherwise authorized by law; acquisition of options to purchase buildings and sites; conversion and extension of federally owned buildings; preliminary planning and design of projects by contract or otherwise; construction of new buildings (including equipment for such buildings); and payment of principal, interest, and any other obligations for public buildings acquired by installment purchase and purchase contract; in the aggregate amount of $5,244,478,000, of which: (1) $76,979,000 shall remain available until expended for construction of additional projects at locations and at maximum construction improvement costs (including funds for sites and expenses and associated design and construction services) as follows:

New construction:

Maryland:

Montgomery County, FDA Consolidation, $35,000,000

Michigan:

Sault Sainte Marie, Border Station, $8,263,000

Montana:

Roosville, Border Station, $753,000

Sweetgrass, Border Station, $11,480,000

Texas:

Fort Hancock, Border Station, $277,000

Washington:

Oroville, Border Station, $11,206,000

Nationwide:

Non-prospectus, $10,000,000:

Provided, That each of the immediately foregoing limits of costs on new construction projects may be exceeded to the extent that savings effected in other such projects, but not to exceed 10 percent unless advance approval is obtained from the Committees on Appropriations of a greater amount: *Provided further,* That all funds for direct construction projects shall expire on September 30, 2001, and remain in the Federal Buildings Fund except for funds for projects as to which funds for design or other funds have been obligated in whole or in part prior to such date: *Provided further,* That of the funds provided for non-prospectus construction, $1,974,000 shall be available until expended for acquisition, lease, construction, and equipping of flexiplace telecommuting centers: *Provided further,* That of the amount provided under this heading in Public Law 104–208, $20,782,000 are rescinded and shall remain in the Fund; (2) $607,869,000 shall remain available until expended, for repairs and alterations which includes associated design and construction services: *Provided,* That funds made available in this Act or any previous Act in the Federal Buildings Fund for Repairs and Alterations shall, for prospectus projects, be limited to the amount by project as follows, except each project may be increased by an amount not to exceed 10 percent unless advance approval is obtained from the Committees on Appropriations of a greater amount:

Repairs and alterations:

Alabama:

Montgomery, Frank M. Johnson, Jr., Federal Building—U.S. Courthouse, $11,606,000

Alaska:

Anchorage, Federal Building—U.S. Courthouse Annex, $21,098,000

California:

Menlo Park, USGS Building 1, $6,831,000

Menlo Park, USGS Building 2, $5,284,000

Sacramento, Moss Federal Building—U.S. Courthouse, $7,948,000

District of Columbia:

Interior Building (Phase 1) $1,100,000

Main Justice Building (Phase 2), $47,226,000

State Department Building (Phase 2), $10,511,000

Maryland:

Baltimore, Metro West Building, $36,705,000

Woodlawn, Social Security Administration Annex, $25,890,000

Minnesota:

Ft. Snelling, Bishop H. Whipple Federal Building, $10,989,000

New Mexico:

Albuquerque, Federal Building—500 Gold Avenue, $8,537,000

Ohio:

Cleveland, Celebrezze Federal Building, $7,234,000

Nationwide:

Chlorofluorocarbons Program, $16,000,000

Energy Program, $16,000,000

Design Program, $17,715,000

Elevators—Various Buildings, $24,195,000

Basic Repairs and Alterations, $333,000,000: *Provided further,* That additional projects for which prospectuses have been fully approved may be funded under this category only if advance approval is obtained from the Committees on Appropriations: *Provided further,* That the amounts provided in this or any prior Act for ''Repairs and Alterations'' may be used to fund costs associated with implementing security improvements to buildings necessary to meet the minimum standards for security in accordance with current law and in compliance with the reprogramming guidelines of the appropriate Committees of the House and Senate: *Provided further,* That the difference between the funds appropriated and expended on any projects in this or any prior Act, under the heading ''Repairs and Alterations'', may be transferred to Basic Repairs and Alterations or used to fund authorized increases in prospectus projects: *Provided further,* That all funds for repairs and alterations prospectus projects shall expire on September 30, 2001, and remain in the Federal Buildings Fund except funds for projects as to which funds for design or other funds have been obligated in whole or in part prior to such date: *Provided further,* That the amount provided in this or any prior Act for Basic Repairs and Alterations may be used to pay claims against the Government arising from any projects under the heading ''Repairs and Alterations'' or used to fund authorized increases in prospectus projects and $1,600,000 shall be available for the repairs and alterations of the Kansas City Federal Courthouse at 811 Grand Avenue, Kansas City, Missouri and $1,250,000 shall be available for the repairs and alteration of the Federal Courthouse at 40 Center Street, New York, New York; (3) $205,668,000 for installment acquisition payments including payments on purchase contracts which shall remain available until expended; (4) $2,782,186,000 for rental of space which shall remain available until expended; and (5) $1,590,183,000 for building operations which shall remain available until expended: *Provided further,* That funds available to the General Services Administration shall not be available for expenses of any construction, repair, alteration and acquisition project for which a prospectus, if required by the Public Buildings Act of 1959, as amended, has not been approved, except that necessary funds may be expended for each project for required expenses for the development of a proposed prospectus: *Provided further,* That funds available in the Federal Buildings Fund may be expended for emergency repairs when advance approval is obtained from the Committees on Appropriations: *Provided further,* That amounts necessary to provide reimbursable special services to other agencies under section 210(f)(6) of the Federal Property and Administrative Services Act of 1949, as amended (40 U.S.C. 490(f)(6)) and amounts to provide such reimbursable fencing, lighting, guard booths, and other facilities on private or other property not in Government ownership or control as may be appropriate to enable the United States Secret Service to perform its protective functions pursuant to 18 U.S.C. 3056, shall be available from such revenues and collections: *Provided further,* That of the amount provided, $475,000 shall be available for the Plains States De-population Symposium: *Provided further,* That revenues and collections and any other sums accruing to this Fund during fiscal year 2000, excluding reimbursements under section 210(f)(6) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 490(f)(6)) in excess of $5,244,478,000 shall remain in the Fund and shall not be available for expenditure except as authorized in appropriations Acts.

POLICY AND OPERATIONS

For expenses authorized by law, not otherwise provided for, for Government-wide policy and oversight activities associated with asset management activities; utilization and donation of surplus personal property; transportation; procurement and supply; Government-wide responsibilities relating to automated data management, telecommunications, information resources management, and related technology activities; utilization survey, deed compliance inspection, appraisal, environmental and cultural analysis, and land use planning functions pertaining to excess and surplus real property; agency-wide policy direction; Board of Contract Appeals; accounting, records management, and other support services incident to adjudication of Indian Tribal Claims by the United States Court of Federal Claims; services as authorized by 5 U.S.C. 3109; and not to exceed $5,000 for official reception and representation expenses, $120,198,000, of which $12,758,000 shall remain available until expended: *Provided,* That of the funds provided, $2,750,000 shall be available for GSA to enter into a memorandum of understanding with the North Dakota State University to establish a Virtual Archive Storage Terminal.

OFFICE OF INSPECTOR GENERAL

For necessary expenses of the Office of Inspector General and services authorized by 5 U.S.C. 3109, $33,858,000: *Provided,* That not to exceed $15,000 shall be available for payment for information and detection of fraud against the Government, including payment for recovery of stolen Government property: *Provided further,* That not to exceed $2,500 shall be available for awards to employees of other Federal agencies and private citizens in recognition of efforts and initiatives resulting in enhanced Office of Inspector General effectiveness.

ALLOWANCES AND OFFICE STAFF FOR FORMER PRESIDENTS

(INCLUDING TRANSFER OF FUNDS)

For carrying out the provisions of the Act of August 25, 1958, as amended (3 U.S.C. 102 note), and Public Law 95–138, $2,241,000: *Provided,* That the Administrator of General Services shall transfer to the Secretary of the Treasury such sums as may be necessary to carry out the provisions of such Acts.

GENERAL SERVICES ADMINISTRATION—GENERAL PROVISIONS

SEC. 401. The appropriate appropriation or fund available to the General Services Administration shall be credited with the cost of operation, protection, maintenance, upkeep, repair, and improvement, included as part of rentals received from Government corporations pursuant to law (40 U.S.C. 129).

SEC. 402. Funds available to the General Services Administration shall be available for the hire of passenger motor vehicles.

SEC. 403. Funds in the Federal Buildings Fund made available for fiscal year 2000 for Federal Buildings Fund activities may be transferred between such activities only to the extent necessary to meet program requirements: *Provided,* That any proposed transfers shall be approved in advance by the Committees on Appropriations.

SEC. 404. No funds made available by this Act shall be used to transmit a fiscal year 2001 request for United States Courthouse construction that: (1) does not meet the design guide standards for construction as established and approved by the General Services Administration, the Judicial Conference of the United States, and the Office of Management and Budget; and (2) does not reflect the priorities of the Judicial Conference of the United States as set out in its approved 5-year construction plan: *Provided,* That the fiscal year 2001 request must be accompanied by a standardized courtroom utilization study of each facility to be constructed, replaced, or expanded.

SEC. 405. None of the funds provided in this Act may be used to increase the amount of occupiable square feet, provide cleaning services, security enhancements, or any other service usually provided through the Federal Buildings Fund, to any agency which does not pay the rate per square foot assessment for space and services as determined by the General Services Administration in compliance with the Public Buildings Amendments Act of 1972 (Public Law 92–313).

SEC. 406. Funds provided to other Government agencies by the Information Technology Fund, General Services Administration, under 40 U.S.C. 757 and sections 5124(b) and 5128 of Public Law 104–106, Information Technology Management Reform Act of 1996, for performance of pilot information technology projects which have potential for Government-wide benefits and savings, may be repaid to this Fund from any savings actually incurred by these projects or other funding, to the extent feasible.

SEC. 407. From funds made available under the heading ''Federal Buildings Fund Limitations on Revenue'', claims against the Government of less than $250,000 arising from direct construction projects and acquisition of buildings may be liquidated from savings effected in other construction projects with prior notification to the Committees on Appropriations.

SEC. 408. Funds made available for new construction projects under the heading ''Federal Buildings Fund, Limitations on Availability of Revenue'' in Public Law 104–208 shall remain available until expended so long as funds for design or other funds have been obligated in whole or in part prior to September 30, 1999.

SEC. 409. The Federal building located at 220 East Rosser Avenue in Bismarck, North Dakota, is hereby designated as the ''William L. Guy Federal Building, Post Office and United States Courthouse''. Any reference in a law, map, regulation, document, paper or other record of the United States to the Federal building herein referred to shall be deemed to be a reference to the ''William L. Guy Federal Building, Post Office and United States Courthouse''.

SEC. 410. From the funds made available under the heading ''Federal Buildings Fund Limitations on Availability of Revenue'', $59,203,500 shall not be available for rental of space and $59,203,500 shall not be available for building operations: *Provided,* That the amounts provided under this heading for rental of space, building operations and in aggregate amount for the Federal Buildings Fund, are reduced accordingly.

SEC. 411. CONVEYANCE OF LAND TO THE COLUMBIA HOSPITAL FOR WOMEN. (a) ADMINISTRATOR OF GENERAL SERVICES.—Subject to subsection (f) and such terms and conditions as the Administrator of General Services (in this section referred to as the ''Administrator'') shall require in accordance with this section, the Administrator shall convey to the Columbia Hospital for Women (formerly Columbia Hospital for Women and Lying-In Asylum; in this section referred to as ''Columbia Hospital''), located in Washington, District of Columbia, for $14,000,000 plus accrued interest to be paid in accordance with the terms set forth in subsection (d), all right, title, and interest of the United States in and to those pieces or parcels of land in the District of Columbia, described in subsection (b), together with all improvements thereon and appurtenances thereto.

The purpose of this conveyance is to enable the expansion by Columbia Hospital of its Ambulatory Care Center, Betty Ford Breast Center, and the Columbia Hospital Center for Teen Health and Reproductive Toxicology Center.

(b) PROPERTY DESCRIPTION.—

(1) IN GENERAL.—The land referred to in subsection (a) was conveyed to the United States of America by deed dated May 2, 1888, from David Fergusson, widower, recorded in liber 1314, folio 102, of the land records of the District of Columbia, and is that portion of square numbered 25 in the city of Washington in the District of Columbia which was not previously conveyed to such hospital by the Act of June 28, 1952 (66 Stat. 287; chapter 486).

(2) PARTICULAR DESCRIPTION.—The property is more particularly described as square 25, lot 803, or as follows: all that piece or parcel of land situated and lying in the city of Washington in the District of Columbia and known as part of square numbered 25, as laid down and distinguished on the plat or plan of said city as follows: beginning for the same at the northeast corner of the square being the corner formed by the intersection of the west line of Twenty-fourth Street Northwest, with the south line of north M Street Northwest and running thence south with the line of said Twenty-fourth Street Northwest for the distance of two hundred and thirty-one feet ten inches, thence running west and parallel with said M Street Northwest for the distance of two hundred and thirty feet six inches and running thence north and parallel with the line of said Twenty-fourth Street Northwest for the distance of two hundred and thirty-one feet ten inches to the line of said M Street Northwest and running thence east with the line of said M Street Northwest to the place of beginning two hundred and thirty feet and six inches together with all the improvements, ways, easements, rights, privileges, and appurtenances to the same belonging or in anywise appertaining.

(c) DATE OF CONVEYANCE.—

(1) DATE.—The date of the conveyance of property required under subsection (a) shall be the date upon which the Administrator receives from Columbia Hospital written notice of its exercise of the purchase option granted by this section, which notice shall be accompanied by the first of 30 equal installment payments of $869,000 toward the total purchase price of $14,000,000, plus accrued interest.

(2) DEADLINE FOR CONVEYANCE OF PROPERTY.—Written notification and payment of the first installment payment from Columbia Hospital under paragraph (1) shall be ineffective, and the purchase option granted Columbia Hospital under this section shall lapse, if that written notification and installment payment are not received by the Administrator before the date which is 1 year after the date of enactment of this section.

(3) QUITCLAIM DEED.—Any conveyance of property to Columbia Hospital under this section shall be by quitclaim deed.

(d) CONVEYANCE TERMS.—

(1) IN GENERAL.—The conveyance of property required under subsection (a) shall be consistent with the terms and conditions set forth in this section and such other terms and conditions as the Administrator deems to be in the interest of the United States, including—

(A) the provision for the prepayment of the full purchase price if mutually acceptable to the parties;

(B) restrictions on the use of the described land for use of the purposes set out in subsection (a);

(C) the conditions under which the described land or interests therein may be sold, assigned, or otherwise conveyed in order to facilitate financing to fulfill its intended use; and

(D) the consequences in the event of default by Columbia Hospital for failing to pay all installments payments toward the total purchase price when due, including revision of the described property to the United States.

(2) PAYMENT OF PURCHASE PRICE.—Columbia Hospital shall pay the total purchase price of $14,000,000, plus accrued interest over the term at a rate of 4.5 percent annually, in equal installments of $869,000, for 29 years following the date of conveyance of the property and receipt of the initial installment of $869,000 by the Administrator under subsection (c)(1). Unless the full purchase price, plus accrued interest, is prepaid, the total amount paid for the property after 30 years will be $26,070,000.

(e) TREATMENT OF AMOUNTS RECEIVED.—Amounts received by the United States as payments under this section shall be paid into the fund established by section 210(f) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 490(f)), and may be expended by the Administrator for real property management and related activities not otherwise provided for, without further authorization.

(f) REVERSIONARY INTEREST.—

(1) IN GENERAL.—The property conveyed under subsection (a) shall revert to the United States, together with any improvements thereon—

(A) 1 year from the date on which Columbia Hospital defaults in paying to the United States an annual installment payment of $869,000, when due; or

(B) immediately upon any attempt by Columbia Hospital to assign, sell, or convey the described property before the United States has received full purchase price, plus accrued interest.

The Columbia Hospital shall execute and provide to the Administrator such written instruments and assurances as the Administrator may reasonably request to protect the interests of the United States under this subsection.

(2) RELEASE OF REVERSIONARY INTEREST.—The Administrator may release, upon request, any restriction imposed on the use of described property for the purposes of paragraph (1), and release any reversionary interest of the United States in the property conveyed under this subsection only upon receipt by the United States of full payment of the purchase price specified under subsection (d)(2).

(3) PROPERTY RETURNED TO THE GENERAL SERVICES ADMINISTRATION.—Any property that reverts to the United States under this subsection shall be under the jurisdiction, custody and control of the General Services Administration shall be available for use or disposition by the Administrator in accordance with applicable Federal law.

SEC. 412. Notwithstanding section 1346 of title 31, United States Code, funds made available for fiscal year 2000 by this or any other Act to any department or agency, which is a member of the Joint Financial Management Improvement Program (JFMIP) shall be available to finance an appropriate share of JFMIP salaries and administrative costs.

SEC. 413. The Administrator of General Services may provide from Government-wide credit card rebates, up to $3,000,000 in support of the Joint Financial Management Improvement Program as approved by the Chief Financial Officers Council.

MERIT SYSTEMS PROTECTION BOARD

SALARIES AND EXPENSES

(INCLUDING TRANSFER OF FUNDS)

For necessary expenses to carry out functions of the Merit Systems Protection Board pursuant to Reorganization Plan Numbered 2 of 1978 and the Civil Service Reform Act of 1978, including services as authorized by 5 U.S.C. 3109, rental of conference rooms in the District of Columbia and elsewhere, hire of passenger motor vehicles, and direct procurement of survey printing, $27,422,000 together with not to exceed $2,430,000 for administrative expenses to adjudicate retirement appeals to be transferred from the Civil Service Retirement and Disability Fund in amounts determined by the Merit Systems Protection Board.

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION

OPERATING EXPENSES

For necessary expenses in connection with the administration of the National Archives (including the Information Security Oversight Office) and archived Federal records and related activities, as provided by law, and for expenses necessary for the review and declassification of documents, and for the hire of passenger motor vehicles, $179,738,000: *Provided*, That the Archivist of the United States is authorized to use any excess funds available from the amount borrowed for construction of the National Archives facility, for expenses necessary to provide adequate storage for holdings.

ARCHIVES FACILITIES REPAIRS AND RESTORATION

For the repair, alteration, and improvement of archives facilities, and to provide adequate storage for holdings, $21,518,000, to remain available until expended.

RECORDS CENTER REVOLVING FUND

(a) There is hereby established in the Treasury a revolving fund to be available for expenses and equipment necessary to provide for storage and related services for all temporary and pre-archival Federal records, which are to be stored or stored at Federal National and Regional Records Centers by agencies and other instrumentalities of the Federal government. The Fund shall be available without fiscal year limitation for expenses necessary for operation of these activities.

(b) START-UP CAPITAL.—

(1) There is appropriated $22,000,000 as initial capitalization of the Fund.

(2) In addition, the initial capital of the Fund shall include the fair and reasonable value at the Fund's inception of the inventories, equipment, receivables, and other assets, less the liabilities, transferred to the Fund. The Archivist of the United States is authorized to accept inventories, equipment, receivables and other assets from other Federal entities that were used to provide for storage and related services for temporary and pre-archival Federal records.

(c) USER CHARGES.—The Fund shall be credited with user charges received from other Federal government accounts as payment for providing personnel, storage, materials, supplies, equipment, and services as authorized by subsection (a). Such payments may be made in advance or by way of reimbursement. The rates charged will return in full the expenses of operation, including reserves for accrued annual leave, worker's compensation, depreciation of capitalized equipment and shelving, and amortization of information technology software and systems.

(d) FUNDS RETURNED TO MISCELLANEOUS RECEIPTS OF THE DEPARTMENT OF THE TREASURY.—

(1) In addition to funds appropriated to and assets transferred to the Fund in subsection (b), an amount not to exceed 4 percent of the total annual income may be retained in the Fund as an operating reserve or for the replacement or acquisition of capital equipment, including shelving, and the improvement and implementation of NARA's financial management, information technology, and other support systems.

(2) Funds in excess of the 4 percent at the close of each fiscal year shall be returned to the Treasury of the United States as miscellaneous receipts.

(e) REPORTING REQUIREMENT.—The National Archives and Records Administration shall provide quarterly reports to the Committees on Appropriations and Governmental Affairs of the Senate, and the Committees on Appropriations and Government Reform of the House of Representatives on the operation of the Records Center Revolving Fund.

NATIONAL HISTORICAL PUBLICATIONS AND RECORDS COMMISSION

GRANTS PROGRAM

(INCLUDING RESCISSION OF FUNDS)

For necessary expenses for allocations and grants for historical publications and records as authorized by 44 U.S.C. 2504, as amended, $6,250,000, to remain available until expended: *Provided*, That of the funds appropriated under this heading in Public Law 105–277, $3,800,000 are rescinded: *Provided further*, That the Treasury and General Government Appropriations Act, 1999 (as contained in division A, section 101(h), of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105–277)) is amended in Title IV, under the heading ''National Historical Publications and Records Commission, Grants Program'' by striking the proviso.

OFFICE OF GOVERNMENT ETHICS

SALARIES AND EXPENSES

For necessary expenses to carry out functions of the Office of Government Ethics pursuant to the Ethics in Government Act of 1978, as amended and the Ethics Reform Act of 1989, including services as authorized by 5 U.S.C. 3109, rental of conference rooms in the District of Columbia and elsewhere, hire of passenger motor vehicles, and not to exceed $1,500 for official reception and representation expenses, $9,071,000.

OFFICE OF PERSONNEL MANAGEMENT

SALARIES AND EXPENSES

(INCLUDING TRANSFER OF TRUST FUNDS)

For necessary expenses to carry out functions of the Office of Personnel Management pursuant to Reorganization Plan Numbered 2 of 1978 and the Civil Service Reform Act of 1978, including services as authorized by 5 U.S.C. 3109; medical examinations performed for veterans by private physicians on a fee basis; rental of conference rooms in the District of Columbia and elsewhere; hire of passenger motor vehicles; not to exceed $2,500 for official reception and representation expenses; advances for reimbursements to applicable funds of the Office of Personnel Management and the Federal Bureau of Investigation for expenses incurred under Executive Order No. 10422 of January 9, 1953, as amended; and payment of per diem and/or subsistence allowances to employees where Voting Rights Act activities require an employee to remain overnight at his or her post of duty, $91,584,000; and in addition $95,486,000 for administrative expenses, to be transferred from the appropriate trust funds of the Office of Personnel Management without regard to other statutes, including direct procurement of printed materials, for the retirement and insurance programs, of which $4,000,000 shall remain available until expended for the cost of automating the retirement recordkeeping systems: *Provided*, That the provisions of this appropriation shall not affect the authority to use applicable trust funds as provided by sections 8348(a)(1)(B) and 8909(g) of title 5, United States Code: *Provided further*, That no part of this appropriation shall be available for salaries and expenses of the Legal Examining Unit of the Office of Personnel Management established pursuant to Executive Order No. 9358 of July 1, 1943, or any successor unit of like purpose: *Provided further*, That the President's Commission on White House Fellows, established by Executive Order No. 11183 of October 3, 1964, may, during the fiscal year ending September 30, 2000, accept donations of money, property, and personal services in connection with the development of a publicity brochure to provide information about the White House Fellows, except that no such donations shall be accepted for travel or reimbursement of travel expenses, or for the salaries of employees of such Commission.

OFFICE OF INSPECTOR GENERAL

SALARIES AND EXPENSES

(INCLUDING TRANSFER OF TRUST FUNDS)

For necessary expenses of the Office of Inspector General in carrying out the provisions of the Inspector General Act, as amended, including services as authorized by 5 U.S.C. 3109, hire of passenger motor vehicles, $960,000; and in addition, not to exceed $9,645,000 for administrative expenses to audit, investigate, and provide other oversight of the Office of Personnel Management's retirement and insurance programs, to be transferred from the appropriate trust funds of the Office of Personnel Management, as determined by the Inspector General: *Provided*, That the Inspector General is authorized to rent conference rooms in the District of Columbia and elsewhere.

GOVERNMENT PAYMENT FOR ANNUITANTS, EMPLOYEES HEALTH BENEFITS

For payment of Government contributions with respect to retired employees, as authorized by chapter 89 of title 5, United States Code, and the Retired Federal Employees Health Benefits Act (74 Stat. 849), as amended, such sums as may be necessary.

GOVERNMENT PAYMENT FOR ANNUITANTS, EMPLOYEE LIFE INSURANCE

For payment of Government contributions with respect to employees retiring after December 31, 1989, as required by chapter 87 of title 5, United States Code, such sums as may be necessary.

PAYMENT TO CIVIL SERVICE RETIREMENT AND DISABILITY FUND

For financing the unfunded liability of new and increased annuity benefits becoming effective on or after October 20, 1969, as authorized by 5 U.S.C. 8348, and annuities under special Acts to be credited to the Civil Service Retirement and Disability Fund, such sums as may be necessary: *Provided*, That annuities authorized by the Act of May 29, 1944, as amended, and the Act of August 19, 1950, as amended (33 U.S.C. 771–775), may hereafter be paid out of the Civil Service Retirement and Disability Fund.

OFFICE OF SPECIAL COUNSEL

SALARIES AND EXPENSES

For necessary expenses to carry out functions of the Office of Special Counsel pursuant to Reorganization Plan Numbered 2 of 1978, the Civil Service Reform Act of 1978 (Public Law 95–454), the Whistleblower Protection Act of 1989 (Public Law 101–12), Public Law 103–424, and the Uniformed Services Employment and Reemployment Act of 1994 (Public Law 103–353), including services as authorized by 5 U.S.C. 3109, payment of fees and expenses for witnesses, rental of conference rooms in the District of Columbia and elsewhere, and hire of passenger motor vehicles; $9,689,000.

UNITED STATES TAX COURT

SALARIES AND EXPENSES

For necessary expenses, including contract reporting and other services as authorized by 5 U.S.C. 3109, $34,179,000: *Provided*, That travel expenses of the judges shall be paid upon the written certificate of the judge.

This title may be cited as the ''Independent Agencies Appropriations Act, 2000''.

TITLE V—GENERAL PROVISIONS

THIS ACT

SEC. 501. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein.

SEC. 502. The expenditure of any appropriation under this Act for any consulting service through procurement contract, pursuant to 5 U.S.C. 3109, shall be limited to those contracts where such expenditures are a matter of public record and available for public inspection, except where otherwise provided under existing law, or under existing Executive order issued pursuant to existing law.

SEC. 503. None of the funds made available by this Act shall be available for any activity or for paying the salary of any Government employee where funding an activity or paying a salary to a Government employee would result in a decision, determination, rule, regulation, or policy that would prohibit the enforcement of section 307 of the Tariff Act of 1930.

SEC. 504. None of the funds made available by this Act shall be available in fiscal year 2000 for the purpose of transferring control over the Federal Law Enforcement Training Center located at Glynco, Georgia, and Artesia, New Mexico, out of the Department of the Treasury.

SEC. 505. No part of any appropriation contained in this Act shall be available to pay the salary for any person filling a position, other than a temporary position, formerly held by an employee who has left to enter the Armed Forces of the United States and has satisfactorily completed his period of active military or naval service, and has within 90 days after his release from such service or from hospitalization continuing after discharge for a period of not more than 1 year, made application for restoration to his former position and has been certified by the Office of Personnel Management as still qualified to perform the duties of his former position and has not been restored thereto.

SEC. 506. No funds appropriated pursuant to this Act may be expended by an entity unless the entity agrees that in expending the assistance the entity will comply with sections 2 through 4 of the Act of March 3, 1933 (41 U.S.C. 10a–10c, popularly known as the ''Buy American Act'').

SEC. 507. (a) PURCHASE OF AMERICAN-MADE EQUIPMENT AND PRODUCTS.—In the case of any equipment or products that may be authorized to be purchased with financial assistance provided under this Act, it is the sense of the Congress that entities receiving such assistance should, in expending the assistance, purchase only American-made equipment and products.

(b) NOTICE TO RECIPIENTS OF ASSISTANCE.—In providing financial assistance under this Act, the Secretary of the Treasury shall provide to each recipient of the assistance a notice describing the statement made in subsection (a) by the Congress.

SEC. 508. If it has been finally determined by a court or Federal agency that any person

intentionally affixed a label bearing a ''Made in America'' inscription, or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to this Act, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

SEC. 509. Except as otherwise specifically provided by law, not to exceed 50 percent of unobligated balances remaining available at the end of fiscal year 2000 from appropriations made available for salaries and expenses for fiscal year 2000 in this Act, shall remain available through September 30, 2001, for each such account for the purposes authorized: *Provided*, That a request shall be submitted to the Committees on Appropriations for approval prior to the expenditure of such funds: *Provided further*, That these requests shall be made in compliance with reprogramming guidelines.

SEC. 510. None of the funds made available in this Act may be used by the Executive Office of the President to request from the Federal Bureau of Investigation any official background investigation report on any individual, except when it is made known to the Federal official having authority to obligate or expend such funds that—

(1) such individual has given his or her express written consent for such request not more than 6 months prior to the date of such request and during the same presidential administration; or

(2) such request is required due to extraordinary circumstances involving national security.

SEC. 511. INVENTORY OF FEDERAL GRANT PROGRAMS. The Director of the Office of Management and Budget shall prepare an inventory of existing Federal grant programs after consulting each agency that administers Federal grant programs including formula funds, competitive grant funds, block grant funds, and direct payments. The inventory shall include the name of the program, a copy of relevant statutory and regulatory guidelines, the funding level in fiscal year 1999, a list of the eligibility criteria both statutory and regulatory, and a copy of the application form. The Director shall submit the inventory no later than six months after enactment to the Committees on Appropriations and relevant authorizing committees.

TITLE VI—GENERAL PROVISIONS

DEPARTMENTS, AGENCIES, AND CORPORATIONS

SEC. 601. Funds appropriated in this or any other Act may be used to pay travel to the United States for the immediate family of employees serving abroad in cases of death or life threatening illness of said employee.

SEC. 602. No department, agency, or instrumentality of the United States receiving appropriated funds under this or any other Act for fiscal year 2000 shall obligate or expend any such funds, unless such department, agency, or instrumentality has in place, and will continue to administer in good faith, a written policy designed to ensure that all of its workplaces are free from the illegal use, possession, or distribution of controlled substances (as defined in the Controlled Substances Act) by the officers and employees of such department, agency, or instrumentality.

SEC. 603. Unless otherwise specifically provided, the maximum amount allowable during the current fiscal year in accordance with section 16 of the Act of August 2, 1946 (60 Stat. 810), for the purchase of any passenger motor vehicle (exclusive of buses, ambulances, law enforcement, and undercover surveillance vehicles), is hereby fixed at $8,100 except station wagons for which the maximum shall be $9,100: *Provided*, That these limits may be exceeded by not to exceed $3,700 for police-type vehicles, and by not to exceed $4,000 for special heavy-duty vehicles: *Provided further*, That the limits set forth in this section may not be exceeded by more than 5 percent for electric or hybrid vehicles purchased for demonstration under the provisions of the Electric and Hybrid Vehicle Research, Development, and Demonstration Act of 1976: *Provided further*, That the limits set forth in this section may be exceeded by the incremental cost of clean alternative fuels vehicles acquired pursuant to Public Law 101–549 over the cost of comparable conventionally fueled vehicles.

SEC. 604. Appropriations of the executive departments and independent establishments for the current fiscal year available for expenses of travel, or for the expenses of the activity concerned, are hereby made available for quarters allowances and cost-of-living allowances, in accordance with 5 U.S.C. 5922–5924.

SEC. 605. Unless otherwise specified during the current fiscal year, no part of any appropriation contained in this or any other Act shall be used to pay the compensation of any officer or employee of the Government of the United States (including any agency the majority of the stock of which is owned by the Government of the United States) whose post of duty is in the continental United States unless such person: (1) is a citizen of the United States; (2) is a person in the service of the United States on the date of enactment of this Act who, being eligible for citizenship, has filed a declaration of intention to become a citizen of the United States prior to such date and is actually residing in the United States; (3) is a person who owes allegiance to the United States; (4) is an alien from Cuba, Poland, South Vietnam, the countries of the former Soviet Union, or the Baltic countries lawfully admitted to the United States for permanent residence; (5) is a South Vietnamese, Cambodian, or Laotian refugee paroled in the United States after January 1, 1975; or (6) is a national of the People's Republic of China who qualifies for adjustment of status pursuant to the Chinese Student Protection Act of 1992: *Provided*, That for the purpose of this section, an affidavit signed by any such person shall be considered prima facie evidence that the requirements of this section with respect to his or her status have been complied with: *Provided further*, That any person making a false affidavit shall be guilty of a felony, and, upon conviction, shall be fined no more than $4,000 or imprisoned for not more than 1 year, or both: *Provided further*, That the above penal clause shall be in addition to, and not in substitution for, any other provisions of existing law: *Provided further*, That any payment made to any officer or employee contrary to the provisions of this section shall be recoverable in action by the Federal Government. This section shall not apply to citizens of Ireland, Israel, or the Republic of the Philippines, or to nationals of those countries allied with the United States in a current defense effort, or to international broadcasters employed by the United States Information Agency, or to temporary employment of translators, or to temporary employment in the field service (not to exceed 60 days) as a result of emergencies.

SEC. 606. Appropriations available to any department or agency during the current fiscal year for necessary expenses, including maintenance or operating expenses, shall also be available for payment to the General Services Administration for charges for space and services and those expenses of renovation and alteration of buildings and facilities which constitute public improvements performed in accordance with the Public Buildings Act of 1959 (73 Stat. 749), the Public Buildings Amendments of 1972 (87 Stat. 216), or other applicable law.

SEC. 607. In addition to funds provided in this or any other Act, all Federal agencies are authorized to receive and use funds resulting from the sale of materials, including Federal records disposed of pursuant to a records schedule recovered through recycling or waste prevention programs. Such funds shall be available until expended for the following purposes:

(1) Acquisition, waste reduction and prevention, and recycling programs as described in Executive Order No. 13101 (September 14, 1998), including any such programs adopted prior to the effective date of the Executive order.

(2) Other Federal agency environmental management programs, including, but not limited to, the development and implementation of hazardous waste management and pollution prevention programs.

(3) Other employee programs as authorized by law or as deemed appropriate by the head of the Federal agency.

SEC. 608. Funds made available by this or any other Act for administrative expenses in the current fiscal year of the corporations and agencies subject to chapter 91 of title 31, United States Code, shall be available, in addition to objects for which such funds are otherwise available, for rent in the District of Columbia; services in accordance with 5 U.S.C. 3109; and the objects specified under this head, all the provisions of which shall be applicable to the expenditure of such funds unless otherwise specified in the Act by which they are made available: *Provided*, That in the event any functions budgeted as administrative expenses are subsequently transferred to or paid from other funds, the limitations on administrative expenses shall be correspondingly reduced.

SEC. 609. No part of any appropriation for the current fiscal year contained in this or any other Act shall be paid to any person for the filling of any position for which he or she has been nominated after the Senate has voted not to approve the nomination of said person.

SEC. 610. No part of any appropriation contained in this or any other Act shall be available for interagency financing of boards (except Federal Executive Boards), commissions, councils, committees, or similar groups (whether or not they are interagency entities) which do not have a prior and specific statutory approval to receive financial support from more than one agency or instrumentality.

SEC. 611. Funds made available by this or any other Act to the Postal Service Fund (39 U.S.C. 2003) shall be available for employment of guards for all buildings and areas owned or occupied by the Postal Service and under the charge and control of the Postal Service, and such guards shall have, with respect to such property, the powers of special policemen provided by the first section of the Act of June 1, 1948, as amended (62 Stat. 281; 40 U.S.C. 318), and, as to property owned or occupied by the Postal Service, the Postmaster General may take the same actions as the Administrator of General Services may take under the provisions of sections 2 and 3 of the Act of June 1, 1948, as amended (62 Stat. 281; 40 U.S.C. 318a and 318b), attaching thereto penal consequences under the authority and within the limits provided in section 4 of the Act of June 1, 1948, as amended (62 Stat. 281; 40 U.S.C. 318c).

SEC. 612. None of the funds made available pursuant to the provisions of this Act shall be used to implement, administer, or enforce any regulation which has been disapproved

pursuant to a resolution of disapproval duly adopted in accordance with the applicable law of the United States.

SEC. 613. (a) Notwithstanding any other provision of law, and except as otherwise provided in this section, no part of any of the funds appropriated for fiscal year 2000, by this or any other Act, may be used to pay any prevailing rate employee described in section 5342(a)(2)(A) of title 5, United States Code—

(1) during the period from the date of expiration of the limitation imposed by section 614 of the Treasury and General Government Appropriations Act, 1999, until the normal effective date of the applicable wage survey adjustment that is to take effect in fiscal year 2000, in an amount that exceeds the rate payable for the applicable grade and step of the applicable wage schedule in accordance with such section 614; and

(2) during the period consisting of the remainder of fiscal year 2000, in an amount that exceeds, as a result of a wage survey adjustment, the rate payable under paragraph (1) by more than the sum of—

(A) the percentage adjustment taking effect in fiscal year 2000 under section 5303 of title 5, United States Code, in the rates of pay under the General Schedule; and

(B) the difference between the overall average percentage of the locality-based comparability payments taking effect in fiscal year 2000 under section 5304 of such title (whether by adjustment or otherwise), and the overall average percentage of such payments which was effective in fiscal year 1999 under such section.

(b) Notwithstanding any other provision of law, no prevailing rate employee described in subparagraph (B) or (C) of section 5342(a)(2) of title 5, United States Code, and no employee covered by section 5348 of such title, may be paid during the periods for which subsection (a) is in effect at a rate that exceeds the rates that would be payable under subsection (a) were subsection (a) applicable to such employee.

(c) For the purposes of this section, the rates payable to an employee who is covered by this section and who is paid from a schedule not in existence on September 30, 1999, shall be determined under regulations prescribed by the Office of Personnel Management.

(d) Notwithstanding any other provision of law, rates of premium pay for employees subject to this section may not be changed from the rates in effect on September 30, 1999, except to the extent determined by the Office of Personnel Management to be consistent with the purpose of this section.

(e) This section shall apply with respect to pay for service performed after September 30, 1999.

(f) For the purpose of administering any provision of law (including any rule or regulation that provides premium pay, retirement, life insurance, or any other employee benefit) that requires any deduction or contribution, or that imposes any requirement or limitation on the basis of a rate of salary or basic pay, the rate of salary or basic pay payable after the application of this section shall be treated as the rate of salary or basic pay.

(g) Nothing in this section shall be considered to permit or require the payment to any employee covered by this section at a rate in excess of the rate that would be payable were this section not in effect.

(h) The Office of Personnel Management may provide for exceptions to the limitations imposed by this section if the Office determines that such exceptions are necessary to ensure the recruitment or retention of qualified employees.

SEC. 614. During the period in which the head of any department or agency, or any other officer or civilian employee of the Government appointed by the President of the United States, holds office, no funds may be obligated or expended in excess of $5,000 to furnish or redecorate the office of such department head, agency head, officer, or employee, or to purchase furniture or make improvements for any such office, unless advance notice of such furnishing or redecoration is expressly approved by the Committees on Appropriations. For the purposes of this section, the word ''office'' shall include the entire suite of offices assigned to the individual, as well as any other space used primarily by the individual or the use of which is directly controlled by the individual.

SEC. 615. Notwithstanding any other provision of law, no executive branch agency shall purchase, construct, and/or lease any additional facilities, except within or contiguous to existing locations, to be used for the purpose of conducting Federal law enforcement training without the advance approval of the Committees on Appropriations, except that the Federal Law Enforcement Training Center is authorized to obtain the temporary use of additional facilities by lease, contract, or other agreement for training which cannot be accommodated in existing Center facilities.

SEC. 616. Notwithstanding section 1346 of title 31, United States Code, or section 610 of this Act, funds made available for fiscal year 2000 by this or any other Act shall be available for the interagency funding of national security and emergency preparedness telecommunications initiatives which benefit multiple Federal departments, agencies, or entities, as provided by Executive Order No. 12472 (April 3, 1984).

SEC. 617. (a) None of the funds appropriated by this or any other Act may be obligated or expended by any Federal department, agency, or other instrumentality for the salaries or expenses of any employee appointed to a position of a confidential or policy-determining character excepted from the competitive service pursuant to section 3302 of title 5, United States Code, without a certification to the Office of Personnel Management from the head of the Federal department, agency, or other instrumentality employing the Schedule C appointee that the Schedule C position was not created solely or primarily in order to detail the employee to the White House.

(b) The provisions of this section shall not apply to Federal employees or members of the armed services detailed to or from—

(1) the Central Intelligence Agency;

(2) the National Security Agency;

(3) the Defense Intelligence Agency;

(4) the offices within the Department of Defense for the collection of specialized national foreign intelligence through reconnaissance programs;

(5) the Bureau of Intelligence and Research of the Department of State;

(6) any agency, office, or unit of the Army, Navy, Air Force, and Marine Corps, the Federal Bureau of Investigation and the Drug Enforcement Administration of the Department of Justice, the Department of Transportation, the Department of the Treasury, and the Department of Energy performing intelligence functions; and

(7) the Director of Central Intelligence.

SEC. 618. No department, agency, or instrumentality of the United States receiving appropriated funds under this or any other Act for fiscal year 2000 shall obligate or expend any such funds, unless such department, agency, or instrumentality has in place, and will continue to administer in good faith, a written policy designed to ensure that all of its workplaces are free from discrimination and sexual harassment and that all of its workplaces are not in violation of title VII of the Civil Rights Act of 1964, as amended, the Age Discrimination in Employment Act of 1967, and the Rehabilitation Act of 1973.

SEC. 619. No part of any appropriation contained in this Act may be used to pay for the expenses of travel of employees, including employees of the Executive Office of the President, not directly responsible for the discharge of official governmental tasks and duties: *Provided*, That this restriction shall not apply to the family of the President, Members of Congress or their spouses, Heads of State of a foreign country or their designees, persons providing assistance to the President for official purposes, or other individuals so designated by the President.

SEC. 620. None of the funds appropriated in this or any other Act shall be used to acquire information technologies which do not comply with part 39.106 (Year 2000 compliance) of the Federal Acquisition Regulation, unless an agency's Chief Information Officer determines that noncompliance with part 39.106 is necessary to the function and operation of the requesting agency or the acquisition is required by a signed contract with the agency in effect before the date of enactment of this Act. Any waiver granted by the Chief Information Officer shall be reported to the Office of Management and Budget, and copies shall be provided to Congress.

SEC. 621. None of the funds made available in this Act for the United States Customs Service may be used to allow the importation into the United States of any good, ware, article, or merchandise mined, produced, or manufactured by forced or indentured child labor, as determined pursuant to section 307 of the Tariff Act of 1930 (19 U.S.C. 1307).

SEC. 622. No part of any appropriation contained in this or any other Act shall be available for the payment of the salary of any officer or employee of the Federal Government, who—

(1) prohibits or prevents, or attempts or threatens to prohibit or prevent, any other officer or employee of the Federal Government from having any direct oral or written communication or contact with any Member, committee, or subcommittee of the Congress in connection with any matter pertaining to the employment of such other officer or employee or pertaining to the department or agency of such other officer or employee in any way, irrespective of whether such communication or contact is at the initiative of such other officer or employee or in response to the request or inquiry of such Member, committee, or subcommittee; or

(2) removes, suspends from duty without pay, demotes, reduces in rank, seniority, status, pay, or performance of efficiency rating, denies promotion to, relocates, reassigns, transfers, disciplines, or discriminates in regard to any employment right, entitlement, or benefit, or any term or condition of employment of, any other officer or employee of the Federal Government, or attempts or threatens to commit any of the foregoing actions with respect to such other officer or employee, by reason of any communication or contact of such other officer or employee with any Member, committee, or subcommittee of the Congress as described in paragraph (1).

SEC. 623. Section 627(b) of the Treasury and General Government Appropriations Act, 1999 (as contained in section 101(h) of division A of Public Law 105–277) is amended by striking ''Notwithstanding'' and inserting the following: ''Effective on the date of the enactment of this Act and thereafter, and notwithstanding''.

SEC. 624. Notwithstanding any provision of law, the President, or his designee, must certify to Congress, annually, that no person or persons with direct or indirect responsibility

for administering the Executive Office of the President's Drug-Free Workplace Plan are themselves subject to a program of individual random drug testing.

SEC. 625. (a) None of the funds made available in this or any other Act may be obligated or expended for any employee training that—

(1) does not meet identified needs for knowledge, skills, and abilities bearing directly upon the performance of official duties;

(2) contains elements likely to induce high levels of emotional response or psychological stress in some participants;

(3) does not require prior employee notification of the content and methods to be used in the training and written end of course evaluation;

(4) contains any methods or content associated with religious or quasi-religious belief systems or ''new age'' belief systems as defined in Equal Employment Opportunity Commission Notice N–915.022, dated September 2, 1988; or

(5) is offensive to, or designed to change, participants' personal values or lifestyle outside the workplace.

(b) Nothing in this section shall prohibit, restrict, or otherwise preclude an agency from conducting training bearing directly upon the performance of official duties.

SEC. 626. No funds appropriated in this or any other Act for fiscal year 2000 may be used to implement or enforce the agreements in Standard Forms 312 and 4355 of the Government or any other nondisclosure policy, form, or agreement if such policy, form, or agreement does not contain the following provisions: ''These restrictions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities created by Executive Order No. 12958; section 7211 of title 5, United States Code (governing disclosures to Congress); section 1034 of title 10, United States Code, as amended by the Military Whistleblower Protection Act (governing disclosure to Congress by members of the military); section 2302(b)(8) of title 5, United States Code, as amended by the Whistleblower Protection Act (governing disclosures of illegality, waste, fraud, abuse or public health or safety threats); the Intelligence Identities Protection Act of 1982 (50 U.S.C. 421 et seq.) (governing disclosures that could expose confidential Government agents); and the statutes which protect against disclosure that may compromise the national security, including sections 641, 793, 794, 798, and 952 of title 18, United States Code, and section 4(b) of the Subversive Activities Act of 1950 (50 U.S.C. 783(b)). The definitions, requirements, obligations, rights, sanctions, and liabilities created by said Executive order and listed statutes are incorporated into this agreement and are controlling.'': *Provided*, That notwithstanding the preceding paragraph, a nondisclosure policy form or agreement that is to be executed by a person connected with the conduct of an intelligence or intelligence-related activity, other than an employee or officer of the United States Government, may contain provisions appropriate to the particular activity for which such document is to be used. Such form or agreement shall, at a minimum, require that the person will not disclose any classified information received in the course of such activity unless specifically authorized to do so by the United States Government. Such nondisclosure forms shall also make it clear that they do not bar disclosures to Congress or to an authorized official of an executive agency or the Department of Justice that are essential to reporting a substantial violation of law.

SEC. 627. No part of any funds appropriated in this or any other Act shall be used by an agency of the executive branch, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, and for the preparation, distribution or use of any kit, pamphlet, booklet, publication, radio, television or film presentation designed to support or defeat legislation pending before the Congress, except in presentation to the Congress itself.

SEC. 628. (a) IN GENERAL.—For calendar year 2001, the Director of the Office of Management and Budget shall prepare and submit to Congress, with the budget submitted under section 1105 of title 31, United States Code, an accounting statement and associated report containing—

(1) an estimate of the total annual costs and benefits (including quantifiable and nonquantifiable effects) of Federal rules and paperwork, to the extent feasible—

(A) in the aggregate;

(B) by agency and agency program; and

(C) by major rule;

(2) an analysis of impacts of Federal regulation on State, local, and tribal government, small business, wages, and economic growth; and

(3) recommendations for reform.

(b) NOTICE.—The Director of the Office of Management and Budget shall provide public notice and an opportunity to comment on the statement and report under subsection (a) before the statement and report are submitted to Congress.

(c) GUIDELINES.—To implement this section, the Director of the Office of Management and Budget shall issue guidelines to agencies to standardize—

(1) measures of costs and benefits; and

(2) the format of accounting statements.

(d) PEER REVIEW.—The Director of the Office of Management and Budget shall provide for independent and external peer review of the guidelines and each accounting statement and associated report under this section. Such peer review shall not be subject to the Federal Advisory Committee Act (5 U.S.C. App.).

SEC. 629. None of the funds appropriated by this Act or any other Act, may be used by an agency to provide a Federal employee's home address to any labor organization except when it is made known to the Federal official having authority to obligate or expend such funds that the employee has authorized such disclosure or when such disclosure has been ordered by a court of competent jurisdiction.

SEC. 630. The Secretary of the Treasury is authorized to establish scientific certification standards for explosives detection canines, and shall provide, on a reimbursable basis, for the certification of explosives detection canines employed by Federal agencies, or other agencies providing explosives detection services at airports in the United States.

SEC. 631. None of the funds made available in this Act or any other Act may be used to provide any non-public information such as mailing or telephone lists to any person or any organization outside of the Federal Government without the approval of the Committees on Appropriations.

SEC. 632. No part of any appropriation contained in this or any other Act shall be used for publicity or propaganda purposes within the United States not heretofore authorized by the Congress.

SEC. 633. (a) In this section the term ''agency''—

(1) means an Executive agency as defined under section 105 of title 5, United States Code;

(2) includes a military department as defined under section 102 of such title, the Postal Service, and the Postal Rate Commission; and

(3) shall not include the General Accounting Office.

(b) Unless authorized in accordance with law or regulations to use such time for other purposes, an employee of an agency shall use official time in an honest effort to perform official duties. An employee not under a leave system, including a Presidential appointee exempted under section 6301(2) of title 5, United States Code, has an obligation to expend an honest effort and a reasonable proportion of such employee's time in the performance of official duties.

SEC. 634. (a) None of the funds appropriated by this Act may be used to enter into or renew a contract which includes a provision providing prescription drug coverage, except where the contract also includes a provision for contraceptive coverage.

(b) Nothing in this section shall apply to a contract with—

(1) any of the following religious plans:

(A) Providence Health Plan;

(B) Personal Care's HMO;

(C) Care Choices;

(D) OSF Health Plans, Inc.;

(E) Yellowstone Community Health Plan; and

(2) any existing or future plan, if the plan objects to such coverage on the basis of religious beliefs.

(c) In implementing this section, any plan that enters into or renews a contract under this section may not subject any individual to discrimination on the basis that the individual refuses to prescribe contraceptives because such activities would be contrary to the individual's religious beliefs or moral convictions.

(d) Nothing in this section shall be construed to require coverage of abortion or abortion-related services.

SEC. 635. FEDERAL FUNDS IDENTIFIED. Any request for proposals, solicitation, grant application, form, notification, press release, or other publications involving the distribution of Federal funds shall indicate the agency providing the funds and the amount provided. This provision shall apply to direct payments, formula funds, and grants received by a State receiving Federal funds.

SEC. 636. (a) Congress finds that—

(1) the Veterans of Foreign Wars of the United States (in this section referred to as the ''VFW''), which was formed by veterans of the Spanish-American War and the Philippine Insurrection to help secure rights and benefits for their service, will be celebrating its 100th anniversary in 1999;

(2) members of the VFW have fought, bled, and died in every war, conflict, police action, and military intervention in which the United States has engaged during this century;

(3) over its history, the VFW has ably represented the interests of veterans in Congress and State Legislatures across the Nation and established a network of trained service officers who, at no charge, have helped millions of veterans and their dependents to secure the education, disability compensation, pension, and health care benefits they are rightfully entitled to receive as a result of the military service performed by those veterans:

(4) the VFW has also been deeply involved in national education projects, awarding nearly $2,700,000 in scholarships annually, as well as countless community projects initiated by its 10,000 posts; and

(5) the United States Postal Service has issued commemorative postage stamps honoring the VFW's 50th and 75th anniversaries, respectively.

(b) Therefore, it is the sense of the Senate that the United States Postal Service is encouraged to issue a commemorative postage stamp in honor of the 100th anniversary of

the founding of the Veterans of Foreign Wars of the United States.

SEC. 637. No funds appropriated by this Act shall be available to pay for an abortion, or the administrative expenses in connection with any health plan under the Federal employees health benefit program which provides any benefits or coverage for abortions.

SEC. 638. The provision of section 637 shall not apply where the life of the mother would be endangered if the fetus were carried to term, or the pregnancy is the result of an act of rape or incest.

SEC. 639. EVALUATION OF OUTCOME OF WELFARE REFORM AND FORMULA FOR BONUSES TO HIGH PERFORMANCE STATES. (a) ADDITIONAL MEASURES OF STATE PERFORMANCE.—Section 403(a)(4)(C) of the Social Security Act (42 U.S.C. 603(a)(4)(C)) is amended—

(1) by striking ''Not later'' and inserting the following:

''(i) IN GENERAL.—Not later'';

(2) by inserting ''The formula shall provide for the awarding of grants under this paragraph based on criteria contained in clause (ii) and in accordance with clauses (iii), (iv), and (v).'' after the period; and

(3) by adding at the end the following:

''(ii) FORMULA CRITERIA.—The grants awarded under this paragraph shall be based on—

''(I) employment-related measures, including work force entries, job retention, and increases in household income of current recipients of assistance under the State program funded under this title;

''(II) the percentage of former recipients of such assistance (who have ceased to receive such assistance for not more than 6 months) who receive subsidized child care;

''(III) the improvement since 1995 in the proportion of children in working poor families eligible for food stamps that receive food stamps to the total number of children in the State; and

''(IV) the percentage of members of families which are former recipients of assistance under the State program funded under this title (which have ceased to receive such assistance for not more than 6 months) who currently receive medical assistance under the State plan approved under title XIX or the child health assistance under title XXI.

For purposes of subclause (III), the term 'working poor families' means families which receives earnings equal to at least the comparable amount which would be received by an individual working a half-time position for minimum wage.

''(iii) EMPLOYMENT RELATED MEASURES.—Not less than $100,000,000 of the amount appropriated for a fiscal year under subparagraph (F) shall be used to award grants to States under this paragraph for that fiscal year based on scores for the criteria described in clause (ii)(I) and the criteria described in clause (ii)(II) with respect employed former recipients.

''(iv) FOOD STAMP MEASURES.—Not less than $50,000,000 of the amount appropriated for a fiscal year under subparagraph (F) shall be used to award grants to States under this paragraph for that fiscal year based on scores for the criteria described in clause (ii)(III).

''(v) MEDICAID AND SCHIP CRITERIA.—Not less than $50,000,000 of the amount appropriated for a fiscal year under subparagraph (F) shall be used to award grants to States under this paragraph for that fiscal year based on scores for the criteria described in clause (ii)(IV).''.

(b) DATA COLLECTION AND REPORTING.—Section 411(a) of the Social Security Act (42 U.S.C. 611(a)) is amended by adding at the end the following:

''(8) REPORT ON OUTCOME OF WELFARE REFORM FOR STATES NOT PARTICIPATING IN BONUS GRANTS UNDER SECTION 403(a)(4).—

''(A) IN GENERAL.—In the case of a State which does not participate in the procedure for awarding grants under section 403(a)(4) pursuant to regulations prescribed by the Secretary, the report required by paragraph (1) for a fiscal quarter shall include data regarding the characteristics and well-being of former recipients of assistance under the State program funded under this title for an appropriate period of time after such recipient has ceased receiving such assistance.

''(B) CONTENTS.—The data required under subparagraph (A) shall consist of information regarding former recipients, including—

''(i) employment status;

''(ii) job retention;

''(iii) poverty status;

''(iv) receipt of food stamps, medical assistance under the State plan approved under title XIX or child health assistance under title XXI, or subsidized child care;

''(v) accessibility of child care and child care cost; and

''(vi) measures of hardship, including lack of medical insurance and difficulty purchasing food.

''(C) SAMPLING.—A State may comply with this paragraph by using a scientifically acceptable sampling method approved by the Secretary.

''(D) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to ensure that—

''(i) data reported under this paragraph is in such a form as to promote comparison of data among States; and

''(ii) a State reports, for each measure, changes in data over time and comparisons in data between such former recipients and comparable groups of current recipients.''.

(c) REPORT OF CURRENTLY COLLECTED DATA.—Not later than July 1, 2000, the Secretary of Health and Human Services shall transmit to Congress a report regarding earnings and employment characteristics of former recipients of assistance under the State program funded under this part, based on information currently being received from States. Such report shall consist of a longitudinal record for a sample of States, which represents at least 80 percent of the population of each State, including a separate record for each of fiscal years 1997 through 2000 for—

(1) earnings of a sample of former recipients using unemployment insurance data;

(2) earnings of a sample of food stamp recipients using unemployment insurance data; and

(3) earnings of a sample of current recipients of assistance using unemployment insurance data.

(d) EFFECTIVE DATES.—

(1) The amendment made by subsection (a) applies to each of fiscal years 2000 through 2003.

(2) The amendment made by subsection (b) applies to reports in fiscal years beginning in fiscal year 2000.

SEC. 640. ITEMIZED INCOME TAX RECEIPT. (a) IN GENERAL.—Not later than April 15, 2000, the Secretary of the Treasury shall establish an interactive program on an Internet website where any taxpayer may generate an itemized receipt showing a proportionate allocation (in money terms) of the taxpayer's total tax payments among the major expenditure categories.

(b) INFORMATION NECESSARY TO GENERATE RECEIPT.—For purposes of generating an itemized receipt under subsection (a), the interactive program—

(1) shall only require the input of the taxpayer's total tax payments, and

(2) shall not require any identifying information relating to the taxpayer.

(c) TOTAL TAX PAYMENTS.—For purposes of this section, total tax payments of an individual for any taxable year are—

(1) the tax imposed by subtitle A of the Internal Revenue Code of 1986 for such taxable year (as shown on his return), and

(2) the tax imposed by section 3101 of such Code on wages received during such taxable year.

(d) CONTENT OF TAX RECEIPT.—

(1) MAJOR EXPENDITURE CATEGORIES.—For purposes of subsection (a), the major expenditure categories are:

(A) National defense.

(B) International affairs.

(C) Medicaid.

(D) Medicare.

(E) Means-tested entitlements.

(F) Domestic discretionary.

(G) Social Security.

(H) Interest payments.

(I) All other.

(2) OTHER ITEMS ON RECEIPT.—

(A) IN GENERAL.—In addition, the tax receipt shall include selected examples of more specific expenditure items, including the items listed in subparagraph (B), either at the budget function, subfunction, or program, project, or activity levels, along with any other information deemed appropriate by the Secretary of the Treasury and the Director of the Office of Management and Budget to enhance taxpayer understanding of the Federal budget.

(B) LISTED ITEMS.—The expenditure items listed in this subparagraph are as follows:

(i) Public schools funding programs.

(ii) Student loans and college aid.

(iii) Low-income housing programs.

(iv) Food stamp and welfare programs.

(v) Law enforcement, including the Federal Bureau of Investigation, law enforcement grants to the States, and other Federal law enforcement personnel.

(vi) Infrastructure, including roads, bridges, and mass transit.

(vii) Farm subsidies.

(viii) Congressional Member and staff salaries.

(ix) Health research programs.

(x) Aid to the disabled.

(xi) Veterans health care and pension programs.

(xii) Space programs.

(xiii) Environmental cleanup programs.

(xiv) United States embassies.

(xv) Military salaries.

(xvi) Foreign aid.

(xvii) Contributions to the North Atlantic Treaty Organization.

(xviii) Amtrak.

(xix) United States Postal Service.

(e) COST.—No charge shall be imposed to cover any cost associated with the production or distribution of the tax receipt.

(f) REGULATIONS.—The Secretary of the Treasury may prescribe such regulations as may be necessary to carry out this section.

TITLE VII—CHILD CARE CENTERS IN FEDERAL FACILITIES

SEC. 701. SHORT TITLE. This title may be cited as the ''Federal Employees Child Care Act''.

SEC. 702. DEFINITIONS. In this title (except as otherwise provided in section 705):

(1) ADMINISTRATOR.—The term ''Administrator'' means the Administrator of General Services.

(2) CHILD CARE ACCREDITATION ENTITY.—The term ''child care accreditation entity'' means a nonprofit private organization or public agency that—

(A) is recognized by a State agency or by a national organization that serves as a peer review panel on the standards and procedures of public and private child care or school accrediting bodies; and

(B) accredits a facility to provide child care on the basis of—

(i) an accreditation or credentialing instrument based on peer-validated research;

(ii) compliance with applicable State or local licensing requirements, as appropriate, for the facility;

(iii) outside monitoring of the facility; and

(iv) criteria that provide assurances of—

(I) use of developmentally appropriate health and safety standards at the facility;

(II) use of developmentally appropriate educational activities, as an integral part of the child care program carried out at the facility; and

(III) use of ongoing staff development or training activities for the staff of the facility, including related skills-based testing.

(3) ENTITY SPONSORING A CHILD CARE FACILITY.—The term ''entity sponsoring a child care facility'' means a Federal agency that operates, or an entity that enters into a contract or licensing agreement with a Federal agency to operate, a child care facility primarily for the use of Federal employees.

(4) EXECUTIVE AGENCY.—The term ''Executive agency'' has the meaning given the term in section 105 of title 5, United States Code, except that the term—

(A) does not include the Department of Defense and the Coast Guard; and

(B) includes the General Services Administration, with respect to the administration of a facility described in paragraph (5)(B).

(5) EXECUTIVE FACILITY.—The term ''executive facility''—

(A) means a facility that is owned or leased by an Executive agency; and

(B) includes a facility that is owned or leased by the General Services Administration on behalf of a judicial office.

(6) FEDERAL AGENCY.—The term ''Federal agency'' means an Executive agency, a legislative office, or a judicial office.

(7) JUDICIAL FACILITY.—The term ''judicial facility'' means a facility that is owned or leased by a judicial office (other than a facility that is also a facility described in paragraph (5)(B)).

(8) JUDICIAL OFFICE.—The term ''judicial office'' means an entity of the judicial branch of the Federal Government.

(9) LEGISLATIVE FACILITY.—The term ''legislative facility'' means a facility that is owned or leased by a legislative office.

(10) LEGISLATIVE OFFICE.—The term ''legislative office'' means an entity of the legislative branch of the Federal Government.

(11) STATE.—The term ''State'' has the meaning given the term in section 658P of the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858n).

SEC. 703. PROVIDING QUALITY CHILD CARE IN FEDERAL FACILITIES. (a) EXECUTIVE FACILITIES.—

(1) STATE AND LOCAL LICENSING REQUIREMENTS.—

(A) IN GENERAL.—Any entity sponsoring a child care facility in an executive facility shall—

(i) comply with child care standards described in paragraph (2) that are no less stringent than applicable State or local licensing requirements that are related to the provision of child care in the State or locality involved; or

(ii) obtain the applicable State or local licenses, as appropriate, for the facility.

(B) COMPLIANCE.—Not later than 6 months after the date of enactment of this Act—

(i) the entity shall comply, or make substantial progress (as determined by the Administrator) toward complying, with subparagraph (A); and

(ii) any contract or licensing agreement used by an Executive agency for the provision of child care services in the child care facility shall include a condition that the child care be provided by an entity that complies with the standards described in subparagraph (A)(i) or obtains the licenses described in subparagraph (A)(ii).

(2) HEALTH, SAFETY, AND FACILITY STANDARDS.—The Administrator shall by regulation establish standards relating to health, safety, facilities, facility design, and other aspects of child care that the Administrator determines to be appropriate for child care in executive facilities, and require child care facilities, and entities sponsoring child care facilities, in executive facilities to comply with the standards. The standards shall include requirements that child care facilities be inspected for, and be free of, lead hazards.

(3) ACCREDITATION STANDARDS.—

(A) IN GENERAL.—The Administrator shall issue regulations requiring, to the maximum extent possible, any entity sponsoring an eligible child care facility (as defined by the Administrator) in an executive facility to comply with standards of a child care accreditation entity.

(B) COMPLIANCE.—The regulations shall require that, not later than 3 years after the date of enactment of this Act—

(i) the entity shall comply, or make substantial progress (as determined by the Administrator) toward complying, with the standards; and

(ii) any contract or licensing agreement used by an Executive agency for the provision of child care services in the child care facility shall include a condition that the child care be provided by an entity that complies with the standards.

(4) EVALUATION AND COMPLIANCE.—

(A) IN GENERAL.—The Administrator shall evaluate the compliance, with the requirements of paragraph (1) and the regulations issued pursuant to paragraphs (2) and (3), as appropriate, of child care facilities, and entities sponsoring child care facilities, in executive facilities. The Administrator may conduct the evaluation of such a child care facility or entity directly, or through an agreement with another Federal agency or private entity, other than the Federal agency for which the child care facility is providing services. If the Administrator determines, on the basis of such an evaluation, that the child care facility or entity is not in compliance with the requirements, the Administrator shall notify the Executive agency.

(B) EFFECT OF NONCOMPLIANCE.—On receipt of the notification of noncompliance issued by the Administrator, the head of the Executive agency shall—

(i) if the entity operating the child care facility is the agency—

(I) not later than 2 business days after the date of receipt of the notification, correct any deficiencies that are determined by the Administrator to be life threatening or to present a risk of serious bodily harm;

(II) not later than 4 months after the date of receipt of the notification, develop and provide to the Administrator a plan to correct any other deficiencies in the operation of the facility and bring the facility and entity into compliance with the requirements;

(III) provide the parents of the children receiving child care services at the child care facility and employees of the facility with a notification detailing the deficiencies described in subclauses (I) and (II) and actions that will be taken to correct the deficiencies, and post a copy of the notification in a conspicuous place in the facility for 5 working days or until the deficiencies are corrected, whichever is later;

(IV) bring the child care facility and entity into compliance with the requirements and certify to the Administrator that the facility and entity are in compliance, based on an onsite evaluation of the facility conducted by an individual with expertise in child care health and safety; and

(V) in the event that deficiencies determined by the Administrator to be life threatening or to present a risk of serious bodily harm cannot be corrected within 2 business days after the date of receipt of the notification, close the child care facility, or the affected portion of the facility, until the deficiencies are corrected and notify the Administrator of the closure; and

(ii) if the entity operating the child care facility is a contractor or licensee of the Executive agency—

(I) require the contractor or licensee, not later than 2 business days after the date of receipt of the notification, to correct any deficiencies that are determined by the Administrator to be life threatening or to present a risk of serious bodily harm;

(II) require the contractor or licensee, not later than 4 months after the date of receipt of the notification, to develop and provide to the head of the agency a plan to correct any other deficiencies in the operation of the child care facility and bring the facility and entity into compliance with the requirements;

(III) require the contractor or licensee to provide the parents of the children receiving child care services at the child care facility and employees of the facility with a notification detailing the deficiencies described in subclauses (I) and (II) and actions that will be taken to correct the deficiencies, and to post a copy of the notification in a conspicuous place in the facility for 5 working days or until the deficiencies are corrected, whichever is later;

(IV) require the contractor or licensee to bring the child care facility and entity into compliance with the requirements and certify to the head of the agency that the facility and entity are in compliance, based on an onsite evaluation of the facility conducted by an independent entity with expertise in child care health and safety; and

(V) in the event that deficiencies determined by the Administrator to be life threatening or to present a risk of serious bodily harm cannot be corrected within 2 business days after the date of receipt of the notification, close the child care facility, or the affected portion of the facility, until the deficiencies are corrected and notify the Administrator of the closure, which closure may be grounds for the immediate termination or suspension of the contract or license of the contractor or licensee.

(C) COST REIMBURSEMENT.—The Executive agency shall reimburse the Administrator for the costs of carrying out subparagraph (A) for child care facilities located in an executive facility other than an executive facility of the General Services Administration. If an entity is sponsoring a child care facility for 2 or more Executive agencies, the Administrator shall allocate the reimbursement costs with respect to the entity among the agencies in a fair and equitable manner, based on the extent to which each agency is eligible to place children in the facility.

(5) DISCLOSURE OF PRIOR VIOLATIONS TO PARENTS AND FACILITY EMPLOYEES.—

(A) IN GENERAL.—The Administrator shall issue regulations that require that each entity sponsoring a child care facility in an executive facility, upon receipt by the child care facility or the entity (as applicable) of a request by any individual who is—

(i) a parent of any child enrolled at the facility;

(ii) a parent of a child for whom an application has been submitted to enroll at the facility; or

(iii) an employee of the facility;

shall provide to the individual the copies and description described in subparagraph (B).

(B) COPIES AND DESCRIPTION.—The entity shall provide—

(i) copies of all notifications of deficiencies that have been provided in the past with respect to the facility under clause (i)(III) or (ii)(III), as applicable, of paragraph (4)(B); and

(ii) a description of the actions that were taken to correct the deficiencies.

(b) LEGISLATIVE FACILITIES.—

(1) ACCREDITATION.—The Chief Administrative Officer of the House of Representatives, the Librarian of Congress, and the head of a designated entity in the Senate shall ensure that, not later than 1 year after the date of enactment of this Act, the corresponding child care facility obtains accreditation by a child care accreditation entity, in accordance with the accreditation standards of the entity.

(2) REGULATIONS.—

(A) IN GENERAL.—If the corresponding child care facility does not maintain accreditation status with a child care accreditation entity, the Chief Administrative Officer of the House of Representatives, the Librarian of Congress, or the head of the designated entity in the Senate shall issue regulations governing the operation of the corresponding child care facility, to ensure the safety and quality of care of children placed in the facility. The regulations shall be no less stringent in content and effect than the requirements of subsection (a)(1) and the regulations issued by the Administrator under paragraphs (2) and (3) of subsection (a), except to the extent that appropriate administrative officers make the determination described in subparagraph (B).

(B) MODIFICATION MORE EFFECTIVE.—The determination referred to in subparagraph (A) is a determination, for good cause shown and stated together with the regulations, that a modification of the regulations would be more effective for the implementation of the requirements and standards described in subsection (a) for the corresponding child care facilities, and entities sponsoring the corresponding child care facilities, in legislative facilities.

(3) CORRESPONDING CHILD CARE FACILITY.—In this subsection, the term ''corresponding child care facility'', used with respect to the Chief Administrative Officer, the Librarian, or the head of a designated entity described in paragraph (1), means a child care facility operated by, or under a contract or licensing agreement with, an office of the House of Representatives, the Library of Congress, or an office of the Senate, respectively.

(c) JUDICIAL BRANCH STANDARDS AND COMPLIANCE.—

(1) STATE AND LOCAL LICENSING REQUIREMENTS HEALTH, SAFETY, AND FACILITY STANDARDS, AND ACCREDITATION STANDARDS.—The Director of the Administrative Office of the United States Courts shall issue regulations for child care facilities, and entities sponsoring child care facilities, in judicial facilities, which shall be no less stringent in content and effect than the requirements of subsection (a)(1) and the regulations issued by the Administrator under paragraphs (2) and (3) of subsection (a), except to the extent that the Director may determine, for good cause shown and stated together with the regulations, that a modification of such regulations would be more effective for the implementation of the requirements and standards described in paragraphs (1), (2), and (3) of subsection (a) for child care facilities, and entities sponsoring child care facilities, in judicial facilities.

(2) EVALUATION AND COMPLIANCE.—

(A) DIRECTOR OF THE ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS.—The Director of the Administrative Office of the United States Courts shall have the same authorities and duties with respect to the evaluation of, compliance of, and cost reimbursement for child care facilities, and entities sponsoring child care facilities, in judicial facilities as the Administrator has under subsection (a)(4) with respect to the evaluation of, compliance of, and cost reimbursement for such centers and entities sponsoring such centers, in executive facilities.

(B) HEAD OF A JUDICIAL OFFICE.—The head of a judicial office shall have the same authorities and duties with respect to the compliance of and cost reimbursement for child care facilities, and entities sponsoring child care facilities, in judicial facilities as the head of an Executive agency has under subsection (a)(4) with respect to the compliance of and cost reimbursement for such centers and entities sponsoring such centers, in executive facilities.

(d) APPLICATION.—Notwithstanding any other provision of this section, if 8 or more child care facilities are sponsored in facilities owned or leased by an Executive agency, the Administrator shall delegate to the head of the agency the evaluation and compliance responsibilities assigned to the Administrator under subsection (a)(4)(A).

(e) TECHNICAL ASSISTANCE, STUDIES, AND REVIEWS.—The Administrator may provide technical assistance, and conduct and provide the results of studies and reviews, for Executive agencies, and entities sponsoring child care facilities in executive facilities, on a reimbursable basis, in order to assist the entities in complying with this section. The Chief Administrative Officer of the House of Representatives, the Librarian of Congress, the head of the designated Senate entity described in subsection (b), and the Director of the Administrative Office of the United States Courts, may provide technical assistance, and conduct and provide the results of studies and reviews, or request that the Administrator provide technical assistance, and conduct and provide the results of studies and reviews, for legislative offices and judicial offices, as appropriate, and entities operating child care facilities in legislative facilities or judicial facilities, as appropriate, on a reimbursable basis, in order to assist the entities in complying with this section.

(f) INTERAGENCY COUNCIL.—

(1) COMPOSITION.—The Administrator shall establish an interagency council, comprised of—

(A) representatives of all Executive agencies described in subsection (d) and other Executive agencies at the election of the heads of the agencies;

(B) a representative of the Chief Administrative Officer of the House of Representatives, at the election of the Chief Administrative Officer;

(C) a representative of the head of the designated Senate entity described in subsection (b), at the election of the head of the entity;

(D) a representative of the Librarian of Congress, at the election of the Librarian; and

(E) a representative of the Director of the Administrative Office of the United States Courts, at the election of the Director.

(2) FUNCTIONS.—The council shall facilitate cooperation and sharing of best practices, and develop and coordinate policy, regarding the provision of child care, including the provision of areas for nursing mothers and other lactation support facilities and services, in the Federal Government.

(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $900,000 for fiscal year 2000 and such sums as may be necessary for each subsequent fiscal year.

SEC. 704. FEDERAL CHILD CARE EVALUATION. (a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Administrator and the Director of the Office of Personnel Management shall jointly prepare and submit to Congress a report that evaluates child care provided by entities sponsoring child care facilities in executive facilities, legislative facilities, or judicial facilities.

(b) CONTENTS.—The evaluation shall contain, at a minimum—

(1) information on the number of children receiving child care described in subsection (a), analyzed by age, including information on the number of those children who are age 6 through 12;

(2) information on the number of families not using child care described in subsection (a) because of the cost of the child care; and

(3) recommendations for improving the quality and cost effectiveness of child care described in subsection (a), including recommendations of options for creating an optimal organizational structure and using best practices for the delivery of the child care.

SEC. 705. CHILD CARE SERVICES FOR FEDERAL EMPLOYEES. (a) IN GENERAL.—In addition to services authorized to be provided by an agency of the United States pursuant to section 616 of the Act of December 22, 1987 (40 U.S.C. 490b), an Executive agency that provides or proposes to provide child care services for Federal employees may use agency funds to provide the child care services, in a facility that is owned or leased by an Executive agency, or through a contractor, for civilian employees of the agency.

(b) AFFORDABILITY.—Funds so used with respect to any such facility or contractor shall be applied to improve the affordability of child care for lower income Federal employees using or seeking to use the child care services offered by the facility or contractor.

(c) REGULATIONS.—The Administrator after consultation with the Director of the Office of Personnel Management, shall, within 180 days after the date of enactment of this Act, issue regulations necessary to carry out this section.

(d) DEFINITION.—For purposes of this section, the term ''Executive agency'' has the meaning given the term by section 105 of title 5, United States Code, but does not include the General Accounting Office.

SEC. 706. MISCELLANEOUS PROVISIONS RELATING TO CHILD CARE PROVIDED BY FEDERAL AGENCIES. (a) AVAILABILITY OF FEDERAL CHILD CARE CENTERS FOR ONSITE CONTRACTORS; PERCENTAGE GOAL.—Section 616 of the Act of December 22, 1987 (40 U.S.C. 490b) is amended—

(1) in subsection (a)—

(A) by striking ''officer or agency of the United States'' and inserting ''Federal agency or officer of a Federal agency''; and

(B) by striking paragraphs (2) and (3) and inserting the following:

''(2) the officer or agency determines that the space will be used to provide child care and related services to—

''(A) children of Federal employees or onsite Federal contractors; or

''(B) dependent children who live with Federal employees or onsite Federal contractors; and

''(3) the officer or agency determines that the individual or entity will give priority for available child care and related services in the space to Federal employees and onsite Federal contractors.''; and

(2) by adding at the end the following:

''(e)(1)(A) The Administrator of General Services shall confirm that at least 50 percent of aggregate enrollment in Federal child care centers governmentwide are children of Federal employees or onsite Federal contractors, or dependent children who live with Federal employees or onsite Federal contractors.

''(B) Each provider of child care services at an individual Federal child care center shall maintain 50 percent of the enrollment at the center of children described under subparagraph (A) as a goal for enrollment at the center.

''(C)(i) If enrollment at a center does not meet the percentage goal under subparagraph (B), the provider shall develop and implement a business plan with the sponsoring Federal agency to achieve the goal within a reasonable timeframe.

''(ii) The plan shall be approved by the Administrator of General Services based on—

''(I) compliance of the plan with standards established by the Administrator; and

''(II) the effect of the plan on achieving the aggregate Federal enrollment percentage goal.

''(2) The Administrator of General Services Administration may enter into public-private partnerships or contracts with nongovernmental entities to increase the capacity, quality, affordability, or range of child care and related services and may, on a demonstration basis, waive subsection (a)(3) and paragraph (1) of this subsection.''.

(b) PAYMENT OF COSTS OF TRAINING PROGRAMS.—Section 616(b)(3) of such Act (40 U.S.C. 490b(b)(3)) is amended to read as follows:

''(3) If a Federal agency has a child care facility in a Federal space, or is a sponsoring agency for a child care facility in a Federal space, the agency or the General Services Administration may pay accreditation fees, including renewal fees, for that center to be accredited. Any Federal agency that provides or proposes to provide child care services for children referred to in subsection (a)(2), may reimburse any Federal employee or any person employed to provide the services for the costs of training programs, conferences, and meetings and related travel, transportation, and subsistence expenses incurred in connection with those activities. Any per diem allowance made under this section shall not exceed the rate specified in regulations prescribed under section 5707 of title 5, United States Code.''.

(c) TECHNICAL AND CONFORMING AMENDMENTS.—Section 616(c) of such Act (40 U.S.C. 490b(c)) is amended—

(1) by inserting ''Federal'' before ''child care centers''; and

(2) by striking ''Federal workers'' and inserting ''Federal employees''.

(d) PROVISION OF CHILD CARE BY PRIVATE ENTITIES.—Section 616(d) of such Act (40 U.S.C. 490b(d)) is amended to read as follows:

''(d)(1) If a Federal agency has a child care facility in a Federal space, or is a sponsoring agency for a child care facility in a Federal space, the agency, the child care center board of directors, or the General Services Administration may enter into an agreement with 1 or more private entities under which the private entities would assist in defraying the general operating expenses of the child care providers including salaries and tuition assistance programs at the facility.

''(2)(A) Notwithstanding any other provision of law, if a Federal agency does not have a child care program, or if the Administrator of General Services has identified a need for child care for Federal employees at a Federal agency providing child care services that do not meet the requirements of subsection (a), the agency or the Administrator may enter into an agreement with a non-Federal, licensed, and accredited child care facility, or a planned child care facility that will become licensed and accredited, for the provision of child care services for children of Federal employees.

''(B) Before entering into an agreement, the head of the Federal agency shall determine that child care services to be provided through the agreement are more cost effectively provided through the arrangement than through establishment of a Federal child care facility.

''(C) The Federal agency may provide any of the services described in subsection (b)(3) if, in exchange for the services, the facility reserves child care spaces for children referred to in subsection (a)(2), as agreed to by the parties. The cost of any such services provided by a Federal agency to a Federal child care facility on behalf of another Federal agency shall be reimbursed by the receiving agency.

''(3) This subsection does not apply to residential child care programs.''.

(e) PILOT PROJECTS.—Section 616 of such Act (40 U.S.C. 490b) is further amended by adding at the end the following:

''(f)(1) Upon approval of the agency head, a Federal agency may conduct a pilot project not otherwise authorized by law for no more than 2 years to test innovative approaches to providing alternative forms of quality child care assistance for Federal employees. A Federal agency head may extend a pilot project for an additional 2-year period. Before any pilot project may be implemented, a determination shall be made by the agency head that initiating the pilot project would be more cost-effective than establishing a new Federal child care facility. Costs of any pilot project shall be paid solely by the agency conducting the pilot project.

''(2) The Administrator of General Services shall serve as an information clearinghouse for pilot projects initiated by other Federal agencies to disseminate information concerning the pilot projects to the other Federal agencies.

''(3) Within 6 months after completion of the initial 2-year pilot project period, a Federal agency conducting a pilot project under this subsection shall provide for an evaluation of the impact of the project on the delivery of child care services to Federal employees, and shall submit the results of the evaluation to the Administrator of General Services. The Administrator shall share the results with other Federal agencies.''.

(f) BACKGROUND CHECK.—Section 616 of such Act (40 U.S.C. 490b) is further amended by adding at the end the following:

''(g) Each Federal child care center located in a Federal space shall ensure that each employee of the center (including any employee whose employment began before the date of enactment of this subsection) shall undergo a criminal history background check consistent with section 231 of the Crime Control Act of 1990 (42 U.S.C. 13041).''.

(g) DEFINITIONS.—Section 616 of such Act (40 U.S.C. 490b) is further amended by adding at the end the following:

''(h) In this section:

''(1) The term 'Federal agency' has the meaning given the term 'Executive agency' in section 702 of the Federal Employees Child Care Act.

''(2) The terms 'Federal building' and 'Federal space' have the meanings given the term 'executive facility' in such section 702.

''(3) The term 'Federal child care center' means a child care center in an executive facility, as defined in such section 702.

''(4) The terms 'Federal contractor' and 'Federal employee' mean a contractor and an employee, respectively, of an Executive agency, as defined in such section 702.''.

This Act may be cited as the ''Treasury and General Government Appropriations Act, 2000''.

REGISTRATION OF MASS MAILINGS

The filing date for 1999 second quarter mass mailings is July 26, 1999. If your office did no mass mailings during this period, please submit a form that states ''none.''

Mass mailing registrations, or negative reports, should be submitted to the Senate Office of Public Records, 232 Hart Building, Washington, D.C. 20510–7116.

The Public Records office will be open from 8:00 a.m. to 6:00 p.m. on the filing date to accept these filings. For further information, please contact the Public Records office at (202) 224–0322.

1999 MID YEAR REPORT

The mailing and filing date of the 1999 Mid Year Report required by the Federal Election Campaign Act, as amended, is Saturday, July 31, 1999. All Principal Campaign Committees supporting Senate candidates must file their reports with the Senate Office of Public Records, 232 Hart Building, Washington, D.C. 20510–7116. You may wish to advise your campaign committee personnel of this requirement.

The Public Records office will be open from 12:00 noon until 4:00 p.m. on the filing date for the purpose of receiving these filings. For further information, please do not hesitate to contact the Office of Public Records on (202) 224–0322.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. JEFFORDS. Mr. President, I ask unanimous consent the Senate immediately proceed to executive session to consider the following nominations en bloc on the Executive Calendar, Nos. 157, 158, 161, 162, and 163.

I finally ask unanimous consent that the nominations be confirmed en bloc, the motion to reconsider be laid upon the table, and any statements related to the nominations appear in the RECORD, the President be immediately notified of the Senate's action, and the Senate then return to legislative business.

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

The nominations considered and confirmed en bloc are as follows:

DEPARTMENT OF ENERGY

David L. Goldwyn, of the District of Columbia to be an Assistant Secretary of Energy (International Affairs).

James B. Lewis, of New Mexico, to be Director of the Office of Minority Economic Impact, Department of Energy.

THE JUDICIARY

T. John Ward, of Texas, to be United States District Judge for the Eastern District of Texas.

DEPARTMENT OF THE TREASURY

Stuart E. Eizenstat, of Maryland, to be Deputy Secretary of the Treasury.

Lewis Andrew Sachs, of Connecticut, to be an Assistant Secretary of the Treasury.

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will resume legislative session.

TREASURY AND GENERAL GOVERNMENT APPROPRIATIONS ACT, 2000

AMENDMENT NO. 1240

Mr. JEFFORDS. Mr. President, I send to the desk an amendment to Calendar No. 169, previously passed by the Senate. I ask unanimous consent it be immediately adopted and the motion to reconsider be laid upon the table.

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

The amendment (No. 1240) was agreed to, as follows:

Amend page 57, line 14 by reducing the dollar figure by $17,000,000.

On page 11, line 16 strike ''$569,225,000'' and insert in lieu thereof ''$570,345,000''.

REMOVAL OF INJUNCTION OF SECRECY—TREATY DOCUMENT NO. 106–4

Mr. JEFFORDS. Mr. President, as in executive session, I ask unanimous consent that the injunction of secrecy be removed from the following treaty transmitted to the Senate on July 13, 1999, by the President of the United States: Extradition Treaty with Paraguay (Treaty Document No. 106–4).

I further ask that the treaty be considered as having been read the first time; that it be referred, with accompanying papers, to the Committee on Foreign Relations and ordered to be printed; and that the President's message be printed in the RECORD.

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

The message of the President is as follows:

To the Senate of the United States:

With a view to receiving the advice and consent of the Senate to ratification, I transmit herewith the Extradition Treaty between the Government of the United States of America and the Government of the Republic of Paraguay, signed at Washington on November 9, 1998.

In addition, I transmit, for the information of the Senate, the report of the Department of State with respect to the Treaty. As the report states, the Treaty will not require implementing legislation.

The provisions in this Treaty follow generally the form and content of extradition treaties recently concluded by the United States.

Upon entry into force, this Treaty would enhance cooperation between the law enforcement authorities of both countries, and thereby make a significant contribution to international law enforcement efforts. The Treaty would supersede the Extradition Treaty between the United States of America and the Republic of Paraguay signed at Asuncion on May 24, 1973.

I recommend that the Senate give early and favorable consideration to the Treaty and give its advice and consent to ratification.

WILLIAM J. CLINTON.

THE WHITE HOUSE, *July 13, 1999.*

ORDERS FOR WEDNESDAY, JULY 14, 1999

Mr. JEFFORDS. Mr. President, I ask unanimous consent that when the Senate complete its business today it stand in adjournment until the hour of 9:30 a.m. on Wednesday, July 14. Further, I ask unanimous consent that on Wednesday, immediately following the prayer, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate stand in a period of morning business until 10 a.m., with Senators speaking for up to 5 minutes each with the following exceptions: Senator GRAMS of Minnesota, 15 minutes; Senator DASCHLE, or his designee, for 15 minutes.

Mr. REID. Reserving the right to object, Mr. President, I ask the minority's morning business be set aside, 10 minutes for the Senator from Wisconsin, Mr. FEINGOLD, and 5 minutes for the Senator from Rhode Island, Mr. REED.

The PRESIDING OFFICER. Is that in lieu of Senator DASCHLE's time?

Mr. REID. That is in lieu of the time for Senator DASCHLE.

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

PROGRAM

Mr. JEFFORDS. For the information of all Senators, the Senate will convene at 9:30 and be in a period of morning business until 10 a.m. Following morning business, the Senate will immediately resume consideration of S. 1344, the Patients' Bill of Rights legislation. Debate will continue on the pending amendment until all time has expired. Additional amendments are expected to be offered and debated throughout tomorrow's session of the Senate. Therefore, Senators should anticipate votes throughout the day on Wednesday. As always, Senators will be notified as votes are scheduled.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. JEFFORDS. If there is no further business to come before the Senate, I now ask unanimous consent the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 8:41 p.m., adjourned until Wednesday, July 14, 1999, at 9:30 a.m.

CONFIRMATIONS

Executive nominations confirmed by the Senate July 13, 1999:

DEPARTMENT OF ENERGY

DAVID L. GOLDWYN, OF THE DISTRICT OF COLUMBIA TO BE AN ASSISTANT SECRETARY OF ENERGY (INTERNATIONAL AFFAIRS).

JAMES B. LEWIS, OF NEW MEXICO, TO BE DIRECTOR OF THE OFFICE OF MINORITY ECONOMIC IMPACT, DEPARTMENT OF ENERGY.

DEPARTMENT OF THE TREASURY

STUART E. EIZENSTAT, OF MARYLAND, TO BE DEPUTY SECRETARY OF THE TREASURY.

LEWIS ANDREW SACHS, OF CONNECTICUT, TO BE AN ASSISTANT SECRETARY OF THE TREASURY.

THE ABOVE NOMINATIONS WERE APPROVED SUBJECT TO THE NOMINEES' COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

THE JUDICIARY

T. JOHN WARD, OF TEXAS, TO BE UNITED STATES DISTRICT JUDGE FOR THE EASTERN DISTRICT OF TEXAS.