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Senate

The Senate met at 9:30 a.m. and was called to order by the President pro tempore [Mr. THURMOND].

PRAYER

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

Gracious Father, we begin this day with the amazing assurance of Your lovingkindness. We hear Your word to us through Jeremiah, ''I have loved you with an everlasting love; therefore with lovingkindness have I drawn you''.—Jeremiah 31:3.—We respond with the grateful words of the psalmist: ''How precious is Your lovingkindness, O God''.—Psalm 36:7. ''Because Your lovingkindness is better than life, my lips shall praise You.''—Psalm 63:3.

As Your lovingkindness captures our thinking, we feel Your acceptance, forgiveness, and compassion. There is nothing we can do that will make You stop loving us but there is something we can do to realize Your love for us. We can love ourselves as loved and forgiven by You, and we can dedicate this day to communicating Your lovingkindness to the people around us. Remind us that practical, positive acts of lovingkindness heal the one who does them and those who receive them. Alert us to people who need Your lovingkindness through us and make this a ''do it and say it'' kind of day. Through our Lord and Savior. Amen.

PLEDGE OF ALLEGIANCE

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

The Honorable SPENCER ABRAHAM, a Senator from the State of Michigan, led the Pledge of Allegiance, as follows:

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

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDENT pro tempore. The acting majority leader, Senator ABRAHAM, is recognized.

SCHEDULE

Mr. ABRAHAM. Mr. President, today the Senate will immediately begin debate on cloture to the Social Security lockbox legislation for 1 hour, with a vote to occur at approximately 10:30 a.m. For the information of all Senators, that vote will be the only rollcall vote during today's session of the Senate.

Following the vote, Senator COVERDELL will be recognized for 1 hour of morning business. Senators KERREY and BREAUX will be in control of the second hour.

I thank my colleagues for their attention.

The PRESIDING OFFICER (Mr. SANTORUM). The Senator from Michigan.

PRIVILEGE OF THE FLOOR

Mr. ABRAHAM. Mr. President, before we proceed, I ask unanimous consent that privileges of the floor be granted to Sandy Davis, a detailee from the Congressional Budget Office working with the staff of the Budget Committee, during consideration of S. 557.

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

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

GUIDANCE FOR THE DESIGNATION OF EMERGENCIES AS A PART OF THE BUDGET PROCESS—Resumed

The PRESIDING OFFICER. Under the previous order, there will now be 1 hour of debate evenly divided between the two leaders prior to the cloture vote on amendment No. 297 to the instructions to the motion to recommit the bill S. 557.

Pending:

Lott (for Abraham) amendment No. 254, to preserve and protect the surpluses of the social security trust funds by reaffirming the exclusion of receipts and disbursement from the budget, by setting a limit on the debt held by the public, and by amending the Congressional Budget Act of 1974 to provide a process to reduce the limit on the debt held by the public.

Abraham amendment No. 255 (to amendment No. 254), in the nature of a substitute.

Lott motion to recommit the bill to the Committee on Governmental Affairs, with instructions and report back forthwith.

Lott amendment No. 296 (to the instructions of the Lott motion to recommit), to provide for Social Security surplus preservation and debt reduction.

Lott amendment No. 297 (to amendment No. 296), in the nature of a substitute (Social Security Lockbox).

Mr. ABRAHAM. Mr. President, I yield myself such time as I might need.

We find ourselves once again on the Senate floor. As I said to the Senator from New Jersey, some years back there was a movie called ''Groundhog Day'' in which the main character in the movie kept waking up each day in the same exact setting in which he found himself the previous day. Somehow that movie's theme seems to be playing itself out in this debate about the lockbox. We are once again to have a cloture vote to simply try to obtain the opportunity to have a vote on the amendment which was offered by myself, along with Senator DOMENICI and Senator ASHCROFT, to the underlying legislation.

We have previously tried to accomplish this without success. It is very frustrating because if we obtain cloture today, we would get this vote, but this legislation would then be open to further amendment by any Senator who wished to change its composition.

So I start the debate by pointing out to all my colleagues that all we are

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

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asking for is a chance to have a vote on one amendment.

Now, this past 4 days we have been debating the Patients' Bill of Rights. I remember back a few weeks ago the entire Senate was virtually shut down so a group of Senators who wanted to have that issue considered could have the entire issue considered and a full range of amendments brought up and voted on, and we did that. Here all we are asking for is a chance to have a vote on one amendment to a broader bill. I hope we will get the chance to do so.

The reason for that is very simple. Across my State, and I think across this country, Americans continue to want to see their Social Security dollars protected. They want to make sure every single dollar they send to Washington in their payroll taxes for Social Security is preserved and not spent on other programs or used for tax cuts or for any other purpose but for their Social Security protection. They want to make sure today's beneficiaries are protected. They want to make sure future beneficiaries are protected. So do the advocates of this amendment. It is not just one side that advocates this, as far as I can tell, because just in the last few weeks we have heard from the White House that the President, too, shares our view that we ought to have a Social Security lockbox.

It does not seem to me very clear why, as a result of that, we cannot have a vote on this proposal. If others have additions or deletions or counterproposals, they will have their chance because the underlying bill will still be subject to further amendment. But those of us who think this is the right approach want to have a chance to have this approach ultimately debated and be voted on. We have been trying and trying without success. I hope today we can continue down the path we started just a few days ago when we ultimately obtained cloture on the motion to proceed.

As I open this debate, I implore Members on both sides of the aisle to give those of us who are advocating this amendment a chance to have a vote on it. If you have your own ideas, bring those, too, and once we have voted on this amendment, we will vote on yours. But let us at least get the ball rolling. If everybody is as strongly for a lockbox as they profess, then let us have a chance to start the debate, and let us start with this amendment which was the first one offered.

Mr. President, at this point I yield the floor.

The PRESIDING OFFICER (Mr. VOINOVICH). Who yields time? The Senator from New Jersey.

Mr. LAUTENBERG. I thank the Chair.

As stated by our colleague and friend from the State of Michigan, we are kind of looking at the same thing again. He likened it to ''Groundhog Day.'' I would say it is ''deja vu all over again.'' That was said by a great philosopher in New Jersey, Yogi Berra.

What are we talking about? What we are discussing is whether or not the people on this side of the aisle and the people up there and the people out there will have a right to have their views included in this debate.

It is pretty simple. We are talking about a lockbox. A lockbox is a place where you can preserve treasure, where you can preserve family records, jewelry, et cetera. But I never heard of a lockbox where they put in one article of value and leave out the rest.

What we are hearing is that we are going to protect Social Security's surpluses, but we are not going to do anything, according to the majority, to extend the solvency of Social Security. We are not going to do anything to include Medicare's solvency. People do not get into these programs until they are 65 years old. At that time, do you want to have to worry about whether or not health insurance is going to be available? Do you want to worry whether that retirement fund is going to be there for your children who are now hard at work trying to take care of their needs while they also prepare for their retirement? The Republicans are saying: Leave it to us; we will figure out a way to take care of it some day off in Wonderland.

The fact of the matter is, yes, we want to engage in an honest debate about this. It is not just let us have our vote. Let them have their vote means that under the proposal they have offered, this side gets no votes and the people we represent across this country get no opinion expressed. Look at the polls and see what they think about who is going to do the best job to protect Social Security and Medicare. They are going to say the Democrats are the people who worry most about it.

We are beginning to look at an examination of process, a process that a lot of people do not understand, even some in this body, but certainly across the country people do not understand it: Cloture motions.

Amendments, allow us to discuss them. Pure and simple, that is the way the American people want us to talk to them. Will they allow us, the Democrats, to register our view of how this Social Security so-called lockbox is going to look? Does it do the job the American people want? Or are we using terminology that has a certain ring to it that has no value?

That is the question. I say to my friend from Michigan, let us have some amendments so that we do not have to, up or down, just take what the Republicans have offered. Let us debate it. It is a big enough proposal, I think.

Yes, it has reared its ugly head several times. The fact of the matter is, we have not yet gotten to see the whole body there. We do not understand all the ramifications. At least the public does not understand them.

Give us a chance to have some amendments. They are saying: No, the first thing we are going to do is move on to the Abraham-Domenici-Ashcroft proposal.

We do not want to do it that way. We are going to do our darndest to protect the American people. We are going to insist we have a lockbox that includes solvency for Medicare extended by 20 years, extend Social Security by 30 years or 40 years, and try during that period of time to work it out so it is extended for 75 years.

That is what our mission ought to be—look ahead and not simply try to shut things down and offer as a juicy incentive a tax cut that is best for the wealthiest in this country.

It is $1 trillion for the cost of the House Republican tax cut. Out of that, they take $55 billion away from Social Security to help it along. They take $964 billion of the surplus to help that tax cut along. The American people are more interested in putting food on the table, providing for their education, and protecting their parents' health care in the future than they are about that kind of tax cut.

We want to give a tax cut, too. Everybody loves tax cuts. The difference is, we love them for the majority of the people where it counts. We love them because we want people to receive adequate child care, and we want to know they can take care of the elderly when medical services are necessary. It is not just tax cuts for tax cuts. No, tax cuts for political purposes is what we are looking at—tax cuts for the wealthy.

This economy is boiling. You cannot get help to do this. You cannot get help to do that. You want to buy a house. The housing market is exploding. If you want to go into fancy items such as boats and airplanes, you have to wait 3 years to get delivery on them. I do not feel sorry for a guy who has to wait 3 years for a new airplane. The fact of the matter is, that is where that money will go with a tax cut, and not into the homes of people who worked all their lives to save a few bucks and provide for their retirement, as well as for their medical care needs.

That is what this debate is about, and I hope that our colleagues will stick together on this side and insist that we have a chance to offer people's amendments. That is what we are discussing. We are not discussing anything else. There is no trickery. Let us express a view that maybe, if people listen to it, they will consider it and, if not, then we have the votes. They are the majority. They are going to get their way; we know that, but I do not think that is a good way to serve the public.

Mr. President, I ask the distinguished Senator from Michigan, shall we switch sides?

Mr. ABRAHAM. That will be fine, back and forth.

Mr. LAUTENBERG. I yield the floor.

Mr. ABRAHAM. Mr. President, before I yield the floor, I, once again, for all Senators, make the following point: We are not seeking cloture on the underlying bill. It will still be subject to

amendments that I believe the Senator from New Jersey is referencing. I do not know what those amendment are. They can be brought up if we obtain cloture. All we get is a chance to vote on our amendment. I cannot figure out why we are not being allowed a chance to vote on our amendment. I will continue to make that point today.

I yield such time as he may need to the Senator from Pennsylvania.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I thank the Senator. The Senator from New Jersey said, ''This side gets no votes.'' I wrote it down word for word. The Senator from New Jersey said, ''This side,'' meaning the Democratic side, ''gets no votes.'' Does the Senator from New Jersey realize that this is a cloture motion on the amendment? This is not a cloture motion on the bill. The cloture motion on the amendment simply says that we get a vote on our amendment. After the amendment is adopted or rejected, the bill is still there, and it is open for amendment. The amendment which we adopt, if we adopt it, will be open to amendment. The Senator can amend it. He can substitute it. He can eliminate it. He can do whatever he wants. He will get all the votes he wants.

The Senator from New Jersey said, ''Let us have some amendments.'' How many amendments does the Senator want? I will be happy to listen. How many amendments would the Senator from New Jersey like?

Mr. LAUTENBERG. I cannot speak for our leadership, but he has been waiting for a response from the majority leader as to whether or not amendments are going to be permitted. The Senator from Pennsylvania knows only too well that when we talk about this amendment, we are talking about the bill; we are talking about the issue. We are not talking about some abstract condition.

Mr. SANTORUM. Mr. President, reclaiming my time, the Senator knows, once we put the amendment in the underlying bill, it is then open and subject to amendment which the Senator can offer. In fact, he has an unlimited right in the Senate to offer amendments to the underlying amendment. All we are doing is asking to put in this budget bill an underlying amendment for the membership to then amend to its heart's content, vote as many times as the Senator from New Jersey wants to vote.

As we have seen in the last 4 days, we had multiple amendments. We had, what? We had an underlying bill. We had an underlying bill that was a Democratic bill and an underlying bill that was a Republican bill. All I am saying is let us put our underlying bill in place, and then my colleagues can have all the fun they want in trying to craft different amendments to that or substituting their own version of it.

The Senator from New Jersey said: All we want is an honest debate. We are trying to get an honest debate.

Let's put the measure in the underlying bill and have at it. Let's have a full and open debate. Maybe we can get a unanimous consent agreement to be on this for a couple of days and allow amendments on both sides. That is the way we do things in this body. All of us are willing to do that. I am certainly willing to do that. I am certainly willing to give the Democrats the opportunity to put forward their lockbox proposal and willing to put forward amendments to our lockbox proposal.

I welcome an open, honest, and fair debate, but we cannot get there, as the Senator from New Jersey knows, unless we have a bill with which to start. We cannot start amending nothing. We have to amend something. What we are trying to do is put something in place to start the ball rolling.

I understand the Senator would like to have a Democratic bill start the process. I understand that. As he knows, we have to start somewhere, and putting our bill up first, as the majority, is not an irrational thing to suggest as a starting point, as long as we give you the right to amend, which we do.

This vote does not limit your rights at all. It limits no rights on your side. You have all the full rights that a Senator has and that the minority has under the current set of rules. So this idea that this side has no votes or this side has no amendments is not factual. You have unlimited amendments and unlimited rights to amend this proposal.

This proposal simply says: Every dollar coming into Social Security should be used for Social Security. The Senator from New Jersey said: Well, the House tax cut uses Social Security money. If it does, guess what. We will have a vote right here on the Senate floor in which 60 Senators will have to say: We want to spend Social Security for that tax cut.

I do not think you will get 60 votes. I know you will not get 60 votes. This Senator will not vote for it. I know a lot of Senators over here who will not vote for using Social Security surplus funds for any tax relief.

I am perfectly willing—in fact, advocating—to use the onbudget surplus to give relief to the taxpayers of America. In fact, giving them that relief will help to buy the food and the medicines and other things the Senator just talked about. It is important to do that. We do not have to do everything for everybody. We can actually let people keep their own money and do it themselves. I think people would have the preference of doing it that way.

As to the idea that we have the power right now to stop raids on Social Security, we do not. We do not. We saw that last October. What happened last October was that the President got together with the leaders over there, and they raided the surplus, the Social Security surplus. We did not have the courage or the opportunity with a vote to stop it.

If we pass this lockbox proposal, any Senator has the right to ask for a vote, and 60 Senators would have to get up and say: I would rather spend that money on whatever program or spend that money, in a sense, on tax relief. And you need 60 votes. That is a real protection for Social Security.

I, for the life of me, cannot understand why the Senate Democrats are now the only group of people in Washington, DC—and I daresay the country—who are opposing this. You have the President of the United States, a Democrat, who wants this. You have 99 percent of the Democrats in the House of Representatives who voted for it. You have every Republican who is supporting it.

The only group of people in the country, that I can see, who are against having Social Security money for just Social Security are 45 Members on the other side of the aisle. I am not too sure they understand what the American public wants and what everybody else has figured out is the right policy for America.

So I encourage the Senator—maybe his staff did not give him the correct information—to look at what this cloture motion does. It limits no rights for the minorities—none. You have unlimited right of amendment after this cloture motion is agreed to and we vote on this amendment. Then we can have the full and fair debate.

I am sure our majority leader, who cares very deeply about this bill—Social Security is very important to him—would devote as much time as necessary on the Senate floor to have that kind of debate, to get the kind of measure that can pass and be signed by the President, and we can begin the process of protecting Social Security.

I reserve the remainder of our time.

Mr. LAUTENBERG addressed the Chair.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. Before recognizing the Senator from South Carolina, I will tell you, the Senator from Pennsylvania has been here long enough that he has knowledge of the process. I have been here longer. I, too, have a knowledge of the process.

No matter what you say, if you are going to shut down the amendment process—which the majority has successfully done—you are not going to get amendments. You can say, we will take all the amendments.

I just heard the Senator from Pennsylvania make a commitment, I assume for the Republican majority, when he said: I have no objection to any amendments you want to offer.

Did I mischaracterize the Senator from Mr. Pennsylvania?

Mr. SANTORUM. I would have no objection to any amendments you have with respect to the Social Security lockbox, absolutely. Let's have a debate on Social Security. Let's have a debate on the Social Security lockbox.

Mr. LAUTENBERG. I thank the Senator.

UNANIMOUS-CONSENT REQUEST

Mr. LAUTENBERG. I ask unanimous consent that the cloture vote be vitiated, that the motion to recommit and the amendments be withdrawn, and that the bill be considered under the following time limitations:

That there be up to a dozen amendments for each leader, or his designee; that the amendments deal with the subject of lockbox protections for Social Security and Medicare, budget reform, and the availability of prescription drugs for seniors; and that the amendments be subject to relevant second-degree amendments.

Mr. SANTORUM. Reserving the right to object.

The PRESIDING OFFICER. Is there objection?

Mr. SANTORUM. Reserving the right the object. That unanimous-consent request does not focus on the Social Security lockbox; it focuses on everything in the world; thereby, I would have to object because it is not about the Social Security lockbox. So I object.

The PRESIDING OFFICER. Objection is heard.

Mr. LAUTENBERG. With all respect, then with the subject of lockbox protections for Social Security and Medicare reform—and we can leave it at that—that the amendments be subject to relevant second-degree amendments.

Mr. SANTORUM. Reserving the right to object, the Senator from New Jersey knows Medicare is not funded out of the Social Security trust fund.

Mr. LAUTENBERG. That is exactly the problem.

Mr. SANTORUM. So to expand the debate——

Mr. LAUTENBERG. I thank the Senator. That is exactly the problem.

The PRESIDING OFFICER. Is there objection?

Mr. SANTORUM. So I would have to object.

Mr. ASHCROFT. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. LAUTENBERG. You heard it. Medicare is not included.

Finally, we have a frank admission on the floor of the Senate. Medicare is left out. So all of you who are like Senator HOLLINGS and I, with blonde hair up top, may not be concerned at all about where we go with our Medicare solvency—it may be too late for us—but there are other people in the line who may want to use it.

Mr. President, I yield 5 minutes to my friend from South Carolina.

Mr. HOLLINGS. Mr. President, you heard the objection. We asked for 12 amendments—just a dozen, not unlimited—and there was objection.

I have three amendments. One is a true lockbox. I made the motion back in 1990, as a member of the Budget Committee, for the lockbox. We reported it out 19 to 1. I then went on the other side of the aisle and got the late Senator John Heinz from Pennsylvania, and he and I joined together, and by 98 votes—when the present distinguished Senator from Pennsylvania said everybody, that was everybody then; all except 2—98 Senators voted for the lockbox, passed it, it passed the House, and it was signed on November 5, 1990, by President George Bush.

But they do not obey it; they do just as the Abraham amendment presently before the body. When you use that expression, ''paying down the debt,'' what they do is take the Social Security money and use it for any and every thing but Social Security. That is what is occurring.

We presently owe Social Security $857 billion. That is why I have three amendments.

The true lockbox is to keep a reserve, as we require under the 1994 Pension Reform Act for corporate America; I say we are going to do the same thing for Government America.

I have a second amendment with respect to actually getting a return since we are using Social Security money. We only get a 5-percent return on these special Treasury securities. Standard & Poor's shows from 1990 to 1998 the real return on private securities is 14 percent and the nominal return is 18 percent.

Since we passed this in 1926, over the 72-year period, including the Depression, we have a 10.9-percent return on average.

So I think if you are going to use our money, do not use it on the cheap, do not get a free ride. Pay in the 10.9 percent rather than the 5.6 percent, and we begin to rejuvenate Social Security rather than drain it. Otherwise, I want to cut out the monkeyshines of the chairman of the Budget Committee, calling over to the Congressional Budget Office and saying: Give me $10 billion more. How does he do it? He uses different economic assumptions.

Under the law, under section 301(g) of the Budget Act, they are required to use the same economic assumptions as contained in the budget resolution. But rather than maintaining those particular assumptions, they just make new assumptions. We had nothing to do with it. I am on the Budget Committee. We were never called or notified or anything else of the kind. All of a sudden we find out there is $10 billion left for defense. There is another $3 billion for transportation, another $1 billion. Already we have busted the caps, just by a telephone call, $14 billion.

I have three amendments. I am ready to offer them, but they won't let us offer them. That is why I am not voting for cloture. Everybody ought to understand what is going on. They won't let it be treated as an unlimited measure, as we always have had discourse in the Senate in my almost 33 years, until this kind of control. We had to fight to get up the Patients' Bill of Rights. We had to hold up all the appropriations bills. Now we can't even get an objective discussion of Social Security because they know how to gear it. They have it geared where they are going to pay down the debt, always talking lockbox, lockbox, lockbox.

They are in violation right now of the 13301 lockbox, and they will continue to do so. It is all politics, election 2000.

I thank my distinguished colleague. I yield the floor and reserve the remainder of our time.

Mr. SANTORUM addressed the Chair.

The PRESIDING OFFICER (Mr. HAGEL). The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, before I yield to the Senator from Missouri, one of the sponsors of this legislation, I remind the Senator from New Jersey and the Senator from South Carolina, the President spoke in favor of the Social Security lockbox. He said he wanted a Social Security lockbox, period. He didn't talk about Medicare.

Nobody is talking about Medicare. No one in this town has talked about commingling two separate trust funds. I don't know what kind of great admission the Senator from Pennsylvania supposedly made. It is something that is obvious to every taxpayer. There are two separate trust funds, one for Medicare and one for Social Security.

To suggest that we should commingle those funds is a very dangerous suggestion. I think that is what the Senator from New Jersey is intimating. That is not what the President wants. That is not what the House wants, Democrats and Republicans. It is certainly not what we want.

If the Senator from New Jersey is suggesting that, I think he is alone on a very dangerous suggestion and one that is not healthy for either fund. That is certainly something we will not allow to have happen in the Senate.

I yield 5 minutes to the Senator from Missouri.

Mr. ASHCROFT. Mr. President, I thank the Senator from Pennsylvania for his insightful comments. There are two distinct funds. To commingle those funds would be irresponsible—not only irresponsible, but it would go against the intentions of the American people in developing those two separate funds for separate purposes. I believe we should proceed to do what we responsibly should do with the money we have taken from the American people for Social Security, and that is to make sure that we spend the money for Social Security, for which we taxed the American people saying we would use it for Social Security.

We have spent a little time this morning in the Senate jargon of exchanges on procedure. It is enough to make the head of a Philadelphia lawyer swim, with all deference to the Senator from Pennsylvania. The American people are not interested in convoluted explanations of Senate procedure. They want to know why is it that this body alone stands between them and the integrity of protecting Social Security resources for the exclusive use of Social Security.

They have heard the President of the United States come forward—belatedly come forward, but he has come forward—and say: I want a lockbox for Social Security. Those are his words. Not a lockbox for Social Security that starts doing other things for other trust accounts, a lockbox for Social Security.

They have watched as the House of Representatives voted 416 to 12. Talk about bipartisan support; talk about a near unanimous vote. You have it in the House of Representatives. They see on the Republican side of the Senate a very strong desire, reflected now in our sixth effort to get the Democrats to break the filibuster against reserving Social Security taxes for the use of Social Security. We are determined to keep voting to break this logjam. The American people have seen that everyone wants this: The President, the overwhelming majority of House Democrats, and Republicans, all but 12 of a 435–Member body want a lockbox, and we need it in the Senate.

President Clinton's budget this year, prior to his endorsement of the lockbox, would have spent $158 billion out of the Social Security trust fund over the next 5 years. That is the kind of thing we need to guard against. The President has now said we need to guard against that.

In March, Senator DOMENICI and I introduced S. 502, the Protect Social Security Benefits Act, which would have instituted a point of order preventing Congress from spending any Social Security dollars for non-Social Security purposes. In April, the Senate budget resolution included language endorsing the idea of locking away the Social Security surplus. The language in the Budget Act passed unanimously. Those on the other side of the aisle have passed this language already, including the point of order process. Also in April, Senators ABRAHAM, DOMENICI, and I introduced the Social Security lockbox amendment, about which we have been talking today.

In May, the House of Representatives overwhelmingly passed Congressman HERGER's measure to protect the Social Security surplus, and the vote there was 416 to 12. That is an amazing vote for the House of Representatives.

In late June, after Senate Democrats had blocked four efforts to proceed to the lockbox, after Senate Democrats had said, we won't let you move to this, President Clinton announced that he had changed his position and that he finally supported a lockbox that would protect 100 percent of the Social Security surplus. His quote is this: ''Social Security taxes should be saved for Social Security, period.'' Not Social Security taxes should be saved for Social Security and tax cuts, no, and Medicare, no, and anything else; it is Social Security, period. That happens to be what Senator ABRAHAM, along with Senator DOMENICI and I, has brought to the floor as an amendment. That happens to be what we are asking Senate Democrats to allow us to move forward on.

A few days after the President's announcement, we obtained a motion to proceed on the lockbox. But now we are faced, again, with the prospect of Senate Democrats blocking a forward motion on this lockbox concept. The House has voted for it. The President has come out in favor of it. Senate Republicans support it. The American people are demanding it. Senate Democrats still stand in the way.

Over the next 5 years, Social Security taxes will bring in an estimated $776 billion in surpluses—not just in revenue, $776 billion in surpluses. The lockbox would protect every dollar of those current Social Security surpluses for future obligations to America's retirees.

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

Mr. ABRAHAM. Would the Senator from Missouri like additional time?

Mr. ASHCROFT. Thirty seconds.

Mr. ABRAHAM. The Senator from Missouri is yielded whatever time he needs.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. ASHCROFT. Mr. President, we have five times previously been denied this, in spite of the House vote, in spite of the President's endorsement, in spite of the overwhelming support of the American people. I ask Members of this body to vote to give us the opportunity to make the progress necessary to protect 100 percent of the Social Security surpluses so they can be used to strengthen, and provide integrity to, the Social Security system.

I thank the Senator from Michigan for this opportunity to speak, and I thank the Chair.

The PRESIDING OFFICER. Who yields time? Who seeks recognition?

Mr. LAUTENBERG. Mr. President, under a quorum call, how is the time charged?

The PRESIDING OFFICER. It will be charged to the side that requests the quorum call.

Mr. ABRAHAM. Mr. President, I gather the Senator from New Jersey does not choose to yield time at this point.

Mr. LAUTENBERG. That is correct.

Mr. ABRAHAM. Then I yield up to 5 minutes to the Senator from Wyoming.

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

Mr. THOMAS. Mr. President, I won't even take 5 minutes. I want to share some of the frustration I have about where we are, trying to move forward with what I think is one of the most important issues before us and, of course, that is Social Security. Everybody is talking about it, of course, and they say, oh, yes, we want to do something. When the time comes, how many times have we been frustrated in trying to get to what is essentially the first step to do something about Social Security? That, of course, is to have a lockbox, take the money coming in for Social Security and put it there so that we can do something with Social Security.

So this is clearly the first step that we have to take. I think this is the fifth time we have been trying to move forward with this. Each time all the people on the other side of the aisle say they are for Social Security, and the President says he is for Social Security, but they never want to do anything. I guess maybe this is part of the frustration that has been building up over the last month or so, and this week there has been frustration.

I think it is time to invoke cloture and move forward on the lockbox issue to make sure the American people who are paying into Social Security, particularly young people who are starting to work and putting their money aside, will have some hope that there will be benefits for them. And we do that only by moving forward with our lockbox. I suggest that we do that. I thank the Senator for the time.

I yield the floor.

The PRESIDING OFFICER. Who seeks recognition? Who yields time? If no one yields time, time will be charged equally to both sides.

Mr. ABRAHAM. Mr. President, I inquire as to how much time remains on each side. We want to reserve some time for the Senator from New Mexico to close on our side, and I wanted to know how much that would be because we do want to make a closing argument.

The PRESIDING OFFICER. The majority has 10 minutes remaining, and the Democrats have almost 16 minutes remaining.

Mr. DOMENICI. 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. ABRAHAM. 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. ABRAHAM. Mr. President, I suggest the absence of a quorum and ask that the time be charged equally to both sides.

Mr. LAUTENBERG. I object.

The PRESIDING OFFICER. Objection is heard.

The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. DOMENICI. 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. DOMENICI. Mr. President, it is my understanding that the Republicans have 10 minutes and the minority has 16 minutes.

The PRESIDING OFFICER. The Republicans have 9 minutes 30 seconds; the minority has 15 minutes remaining.

Mr. DOMENICI. I would like to use 3½ minutes, if I might.

The PRESIDING OFFICER. The Senator is recognized for 3 minutes.

Mr. DOMENICI. Mr. President, this is a very simple proposition. The American people, by overwhelming odds, would like us to take every single penny of the Social Security that belongs to the Social Security trust fund and lock it up so it can't be spent. The issue is not only a Republican issue; the President of the United States has said we should lock it up. He didn't say lock up something for Medicare; he said lock up the trust funds for Social Security, period.

Senator DASCHLE, leader of the minority, said very recently that there ought to be some common ground. We ought to lock up the Social Security trust fund. What are we doing on the floor? We have six times tried to get an amendment up—not a bill, not a final action but an amendment, after which you can have amendments to your heart's desire.

We can't get the other side to agree that we will do that. We will have limited debate on that amendment, after which they can have all the debate and all the amendments they wish. It is only the amendment that we would like to get voted on. Why? Because it is time that, rather than talking about making sure we don't spend under the pressure of emergencies and all kinds of other things, we don't spend the Social Security trust fund money.

Now, the President of the United States came our way already. He said lock up 100 percent. At one time in his budget, he said lock up 62 percent. He came with us and said lock up every single penny.

That is what we are trying to do. We are trying to get a vote on doing that, after which time, if the Democrats see fit, they can muddy the water and bring up amendments on other issues, and if we had time today, we could debate the foolhardy issue that even Democrats think makes no sense—that we should take the surplus that belongs to the people of the United States and put it into the Medicare trust fund with IOUs to be paid for by increased taxes on our children later on. We can debate that if you would like. But that is not the issue.

The issue is Social Security money, the senior citizens' pension money. Time is wasting. The pressures to use it are growing. The opportunities to come to the floor and say let's spend it, with the passage of each day, are getting closer and closer. Somebody will say we need this for something. Who knows what. It could be agricultural policy for America or any kind of thing you can dream up.

I say to my friends on the other side, let's get on with it and let's close the debate on the amendment. Then we can open the debate after that vote occurs on anything you wish.

I yield the floor.

Mr. THURMOND addressed the Chair.

The PRESIDING OFFICER. The Senator from South Carolina is recognized.

Mr. THURMOND. Mr. President, I commend the able Senator from New Mexico on what he has said. Social Security money is for Social Security. It should not be used for anything else. Now is the time to nail this thing down so no question will arise in the future. There are demands now for everything, but this is a particular trust fund. It belongs to the Social Security fund, and we should keep it there and not let it get away. I again commend the able Senator from New Mexico.

Mr. DOMENICI. I thank the distinguished Senator.

The PRESIDING OFFICER. Who yields time?

Mr. LAUTENBERG. Mr. President, we are debating a proposition that I think probably lends some confusion to the recognition of what it is we are attempting to do. One can call it a lockbox, a safe deposit box; call it what you will. I say we want a lockbox, too, but we want a lockbox that is without holes, without rust, without a broken lock on it. We want a lockbox that is secure, that holds our valuables, and that no one can get their hands on, and that is the Social Security lockbox that cannot be used.

Our friends over there say they want to keep it from being a pot for people to reach into when they want to spend money. The fact of the matter is that they create a condition as a result of the structure of their bill, their proposal, that says that if the economy turns sour, in fact, perhaps this country could be put into default, unless Social Security is used, because of overarching criteria, then that is what is going to happen. Social Security will be that safe deposit box that is now open for other purposes in Government.

I hear the plea for letting the debate get started. But we have been waiting to hear from the majority leader—our leader and the majority leader; that is where these discussions take place—that he has a commitment that we can offer amendments.

We have a commitment from the Senator from Pennsylvania. He said he had no objection to our having amendments. But we haven't heard that from the top.

That is what we are asking for; that is what I tried to do with a unanimous consent agreement.

I said: OK. Let's talk about a dozen amendments that our two leaders can agree upon. Let's talk about that. Let's put that aside, and then we can end the debate. But they do not want to do that.

The majority has the upper hand. That is life in the Senate. They are not going to let us get our amendments up because—even though they say, yes, you will have all the amendments you want—the fact is there is a system here. Everybody in this Chamber knows there is a system. It is called the amendment tree. Once you fill it up with first-degree amendments followed by second-degree amendments, the majority leader always has the privilege of initial recognition, and you shut down the amendment possibilities.

Let's stop fooling each other. Let's stop trying to fool the people out there in the countryside. Do they want Medicare included as a security measure, as a safe deposit measure, as a lockbox measure? Ask them. Let's have a vote on that. Let's have it straight up or down. Do you want Medicare?

I heard a statement made today that, no, the Republicans don't want Medicare included. Let the public hear that. Let the public hear that the one measure for protecting health may not be of concern to them. It is fine with me. I just want to make sure the record is clear that people understand what we are saying.

Look at this. The Republican House committee proposes a tax cut of $1.19 trillion. In order to accomplish that, they are going to have to take $55 billion from the Social Security surplus and $964 billion from the onbudget surplus.

We are using arcane language to try to pull the wool over the people's eyes.

Say it straight. They on that side of the line don't want Medicare included. We want Medicare included on this side of the line. We want to lock up Social Security, and we all agree a lockbox is a desirable thing, a place where those funds are going to be protected. We are saying you can't touch the Social Security surplus.

Remember this: In 10 years, forecasts being as they are, we expect to have almost a $1 trillion surplus in non-Social Security funds. That is pretty astounding. Imagine, we could be out of public debt in 2015, barely 15 years from now—not only the public debt but anything. It would be an unheard of condition in terms of a major government around the world. The fact of the matter is it would be certainly a benchmark that people never thought would arrive.

We are trying to do it. We are saying we support a modest tax cut for those who really need it—a targeted tax cut for child care, savings accounts, and health care for the elderly. But friends over here want to use it to spread the tax cut around for all of the benefit. It would go largely to the wealthiest in the country.

I once again ask if we can get an agreement. It can be done away from the microphones or it can be done in front of the microphones. Give us the assurance that we can have amendments and not be barred by second-degree amendments and not barred by other parliamentary procedures. We would be happy to consider a different position, but we are not going to do it knowing full well that once we step over the line we are in a trap that is going to silence our voices in terms of any modifications. We are talking about just the motion to proceed. Just let us get started.

The fact of the matter is this amendment would be a substitute for an underlying bill. It would be the bill itself. We have to be on guard for the public

interest. That is where we are going to stand.

I urge my colleagues to vote against cloture until we understand fully what this debate is about for the benefit of the public.

It has been suggested that we are filibustering it. We just had a major bill go through this Chamber yesterday, and we were allowed a limited number of amendments. In 3 days, we had 11 amendments that were considered. That was it. That was the most we could negotiate, instead of as it used to be with an open process. If it took a long time, it took a long time.

I remember working through the night until 6 in the morning. We don't do that anymore. We shut down nice and early so we are not too tired at the end of the day.

But I say the time is the property of the public. They let us use it. We ought to use it fully instead of shutting down the debate and shutting down the opportunity for the American people to understand what is really taking place.

It is tough. It is tough because the route that is being used is kind of inside-the-beltway stuff.

How much time remains on both sides?

The PRESIDING OFFICER. The Senator has 6 minutes on his side, and the majority side has 6 minutes as well.

Mr. LAUTENBERG. Mr. President, the unanimous consent that we are operating under had a call for a vote at 10:30. Is that right?

The PRESIDING OFFICER. That is correct.

Mr. ABRAHAM. Mr. President, I yield 2 minutes to the Senator from Pennsylvania.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized for 2 minutes.

Mr. SANTORUM. I thank the Chair.

Mr. President, the Senator from New Jersey said we should have Medicare included in this lockbox proposal. The President of the United States said: I can't believe the Republicans don't want to include it. He just finds that incredulous.

The Senator should talk to his own President. His own President doesn't want Medicare included in this lockbox proposal. The President has been clear.

Social Security money should be used for Social Security, and once you say it can be used for Medicare, it can be used for Medicare, it can be used for education, or for whatever.

I can tell you that Social Security recipients want Social Security to be used for Social Security. They do not want to expand the program to include other things. In fact, one of the biggest complaints I hear from seniors is that if you would quit taking money out of Social Security for every program that comes down the line, Social Security would be OK.

I think if we took a poll it would be overwhelming not to include any program—any program—other than Social Security in Social Security.

I also find it incredulous that he said there is a hole in the Social Security lockbox.

We wrote a provision in this bill; if we were in a recession, because we hold the debt limit, there could be a default on the credit of the United States. Is the Senator suggesting we should allow the United States to default? Isn't that what the provision says? I ask the Senator from New Mexico if he can explain that.

Mr. DOMENICI. Absolutely. The Secretary of the Treasury made some objections to the original bill because it was too rigidly drawn in case of emergencies. We took care of that.

We also took care of the problem we had with reference to the end of the year and the way the surpluses come and go because of the way you collect taxes in large quantities in other parts of the year a little bit.

We fix that, too.

Mr. SANTORUM. So the Senator from New Jersey, when he objected to our ''hold'' on the lockbox, his objection is counter to what the administration demanded of us to fix in our lockbox?

Mr. DOMENICI. Absolutely.

Mr. LAUTENBERG. Mr. President, I don't know why it is not clear, but we have said and we mean that Social Security funds, surpluses, are sacrosanct. They are untouchable.

The Medicare solvency we want to create comes out of the non-Social Security budget surplus. We have talked about this 60 times. Apparently the message has not gotten through. We want to do it. We want to deal with it.

By the admission of some on that side, Medicare isn't part of the thinking in this. If it is not part of the thinking now, I wonder when it will be.

There is also an opportunity, if I may suggest with a degree of temerity, that Social Security funds can be used in the name of Social Security reform. That is kind of a catch-all. It says if we can't get it one way, we will get it another way. We face the specter of a huge tax cut that is being proposed. It is not much different here from on the House side. We are talking about something close to $800 billion.

We understand each other very clearly. The question is, Does the public understand why we are? We want to save Social Security, and we want to save Medicare. We want to increase the solvency of Medicare, and we are committed to a reform of both programs. During that period, it is said by the President that we will extend the life of both of these programs even longer than the 50-some years for Social Security and the 20 years for Medicare.

That is where we are, my friends.

If we are ready to conclude the debate, I am prepared to yield back our time—if we are prepared.

Mr. ABRAHAM. We are not.

The PRESIDING OFFICER. The Senator from Michigan.

Mr. ABRAHAM. Mr. President, how much time does the majority have?

The PRESIDING OFFICER. The majority has 3 minutes 53 seconds.

Mr. ABRAHAM. I yield to the Senator from New Mexico such time as he consumes.

Mr. DOMENICI. Mr. President, I want to clarify this from the standpoint of what a Democrat on the other side who is well versed in this had to say about this issue. On March 22, 1999, Senator BREAUX, on a CBS newscast, avoided criticism of Clinton. Senator BREAUX said: Some people want an issue of Medicare rather than solving the problem. They talk about wedge issues.

Senator BREAUX added that one of the problems is that some people want an issue out of Medicare rather than solving the problem. They talk about wedge issues.

Are you going to have a tax cut or are you going to save Medicare?

That is old politics, he said. I think the American people are tired of it. They want us to solve the problem, not give them political slogans.

Now, to stand on the floor of the Senate and even imply that the proposed tax cuts in the budget resolution of $782 billion over a decade would in any way infringe upon the Social Security trust funds is to confuse the public of America, and it is exactly what the distinguished Senator from Louisiana is saying—sloganizing, making an issue by slogans.

Secondly, if there is any implication that there are not sufficient reserves in our budget to take care of Medicare, that is an absolute error and an untruth. There are huge amounts of money left over after the tax cut. In fact, it approaches $450 billion that is not allocated to anything during the next decade other than what we choose to use it for in the Congress.

I remind everyone, the President said we can fix Medicare with how much? Forty-eight billion dollars will give us prescription drugs, he said. We had $90 billion left over in our budget resolution that was unspent, and now, with the new estimates, there is more money there. We can fix Medicare, put this money in a lockbox, have the tax cut, do that by the end of this year, and fix things for American seniors on both fronts: Lock up the money that is theirs and fix Medicare.

To talk about this trust fund as if it has something to do with fixing Medicare is an absolutely erroneous stating of the situation in the Senate and in the fiscal policy of America.

Mr. LOTT. Mr. President, I will wrap up by using leader time.

Mr. LAUTENBERG. Then I can use the rest of our time.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, the overwhelming recommendation by the House Republicans says use Social Security funds if necessary.

But there is an issue beyond that. It is quite apparent, if you use $792 billion for tax cuts, it reduces the possibility

that you can pay down the debt. That is where we would like to go. We want to get rid of this constant threat of higher interest rates. We want to be able to be free to take care of the needs we have to operate our society, our country.

There is no confusion about where we are. We want to protect Social Security. We want to protect Medicare out of non-Social Security surpluses. That is where we are. One ought not confuse it with discussions about other things: A, Do you want to protect Medicare? B, How? That is the question. That is what we would like to have answered.

I hope my colleagues will stick together and say we want to have an open debate, we want to continue to discuss the issues, and not to be shut down on this pretense that this cloture vote will take care of the problems.

The majority leader is on the floor. We all have great respect for him. We would love to be able to be assured of amendments. I know our leader has been interested in a discussion of that and is awaiting the majority leader's response. If we knew that, perhaps we could be reacting differently.

The PRESIDING OFFICER. The Senate majority leader.

Mr. LOTT. Mr. President, I yield myself such time as I might need for leader time. I know Members expect to vote at 10:30. I will try to be brief.

I am compelled to make a couple of points. First of all, our Republican budget plan reduced the national debt by $1.9 trillion. That is the most significant and the only real contribution of reducing the debt in our lifetime. The point I want to make is, the American people overwhelmingly support the idea of the Social Security lockbox.

After resistance, the President even adopted that exact word, that he supported a Social Security lockbox. I don't know what the numbers are but in the high seventies, 80 percent of the American people think this is something we should do: Take all of the Social Security taxes, the FICA tax, and set them aside for what they were intended—Social Security, and only Social Security, a lockbox.

OK, so we advocated that—Senators DOMENICI, ABRAHAM, SANTORUM, and others. And finally the President apparently checked the polls and said: Oh, yeah, me, too; I want a lockbox.

Then the House voted for a lockbox—not as tight as this one, not as good as this one—with a vote of 415–12. Even the Democrats in the House of Representatives voted overwhelmingly without a lot of shenanigans, playing around, distractions, and a dozen amendments. They voted for the lockbox. Apparently they got serious.

Now, here comes the point: We go down in our bipartisan meeting to the White House on Monday to meet with the President. I am hopeful. I am optimistic. In fact, I come out and say: Yes, maybe we can have a lockbox; work together on Medicare reform; we can get some tax relief.

Let me tell Members what happened. We go in there. The first subject I brought up was the Social Security lockbox. The President said: We need to do that. I'm with you. We can do that.

Senator DASCHLE said: Yeah, we ought to do that.

What happened?

I go out and say: We are going to get this done.

The President hasn't lifted a pinkie since—nothing. All he has done is run around and whine and threaten that he is going to veto a legitimate Patients' Bill of Rights bill, the health care needs of the people of this country. That is all he has done all week—maybe a fundraiser or two, but he has done nothing to help us get a Social Security lockbox.

So I invite, in fact I challenge, the President: Talk to the Democrats in the Senate, Mr. President. They are the only obstacle to setting aside Social Security in a lockbox for Social Security.

That is what I have to deal with all the time. I get a lot of soft soap: Oh, yes, we will work together; we will get it done. And then nothing. If the President wants a Social Security lockbox, make one call, Mr. President, one call. Call Senator DASCHLE and say: Get it done. And we will get it done next Monday.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. We yield back our time.

CLOTURE MOTION

The PRESIDING OFFICER (Mr. ROBERTS). All time is yielded back. Under the previous order, the Chair directs the clerk to read the motion to invoke cloture.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the pending amendment No. 297 to Calendar No. 89, S. 557, a bill to provide guidance for the designation of emergencies as a part of the budget process:

Trent Lott, Pete Domenici, Rod Grams, Michael Crapo, Bill Frist, Michael Enzi, Ben Nighthorse Campbell, Judd Gregg, Strom Thurmond, Chuck Hagel, Thad Cochran, Rick Santorum, Paul Coverdell, James Inhofe, Bob Smith, Wayne Allard.

CALL OF THE ROLL

The PRESIDING OFFICER. By unanimous consent, the quorum call has been waived.

VOTE

The PRESIDING OFFICER. The question is, Is it the sense of the Senate that debate on amendment No. 297 to Calendar No. 89, S. 557, a bill to provide guidance for the designation of emergencies as part of the budget process, shall be brought to a close?

The yeas and nays are required under the rule.

The clerk will now call the roll.

The legislative assistant called the roll.

Mr. NICKLES. I announce that the Senator from Arizona (Mr. MCCAIN) and the Senator from Montana (Mr. BURNS) are necessarily absent.

I further announce that, if present and voting, the Senator from Montana (Mr. BURNS) would vote ''yea.''

Mr. REID. I announce that the Senator from California (Mrs. BOXER), the Senator from Connecticut (Mr. DODD), and the Senator from Massachusetts (Mr. KERRY) are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The yeas and nays resulted—yeas 52, nays 43, as follows:

[Rollcall Vote No. 211 Leg.]

YEAS—52

Abraham	Frist	Murkowski
Allard	Gorton	Nickles
Ashcroft	Gramm	Roberts
Bennett	Grams	Santorum
Bond	Grassley	Sessions
Brownback	Gregg	Shelby
Bunning	Hagel	Smith (NH)
Campbell	Hatch	Smith (OR)
Chafee	Helms	Snowe
Cochran	Hutchinson	Specter
Collins	Hutchison	Stevens
Coverdell	Inhofe	Thomas
Craig	Jeffords	Thompson
Crapo	Kyl	Thurmond
DeWine	Lott	Voinovich
Domenici	Lugar	Warner
Enzi	Mack	
Fitzgerald	McConnell	

NAYS—43

Akaka	Feinstein	Mikulski
Baucus	Graham	Moynihan
Bayh	Harkin	Murray
Biden	Hollings	Reed
Bingaman	Inouye	Reid
Breaux	Johnson	Robb
Bryan	Kennedy	Rockefeller
Byrd	Kerrey	Roth
Cleland	Kohl	Sarbanes
Conrad	Landrieu	Schumer
Daschle	Lautenberg	Torricelli
Dorgan	Leahy	Wellstone
Durbin	Levin	Wyden
Edwards	Lieberman	
Feingold	Lincoln	

NOT VOTING—5

Boxer	Dodd	McCain
Burns	Kerry	

The PRESIDING OFFICER. Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected.

Mr. LOTT addressed the Chair.

The PRESIDING OFFICER. The distinguished majority leader is recognized.

Mr. LOTT. I thank the Chair.

UNANIMOUS CONSENT REQUEST—H.R. 1555

Mr. LOTT. Mr. President, I ask unanimous consent that the Senate now turn to H.R. 1555, the intelligence authorization bill, and under the provisions of the agreement of May 27, 1999, following the reporting of the bill by the clerk, I would send an amendment to the desk regarding national security at the DOE.

The PRESIDING OFFICER. Is there objection?

Mr. REID. There is an objection.

The PRESIDING OFFICER. Objection is heard.

Mr. LOTT. Mr. President, I am surprised by this objection by our Democratic colleagues. This issue concerns two very important matters: one, the intelligence authorization for the year, and also the very important Department of Energy reforms as a result of the Chinese espionage that has occurred during the last several years within the Department of Energy.

Needless to say, this issue needs to be debated in the Senate. I am truly sorry our Democratic colleagues do not want to debate it at this time.

I have urged the President, the National Security Adviser, Sandy Berger, and the Secretary of Energy to engage this issue. The headline should read: Senate resolves how in the future the Department of Energy will handle these matters to stop the leaks of very important nuclear weapons information from our labs.

That should be the headline, that we are working together to resolve this problem, instead of the situation where the Secretary of the Department of Energy is still trying to have a diffused system of reporting. There should be only one person who is reported to on the matters of national security at our nuclear labs, and that is the Secretary of Energy, and it should go straight to him and from him to the President of the United States. Surely we can work this out.

Having said that, I now move to proceed to H.R.——

Mr. REID. Will the Senator yield?

Mr. LOTT. I will be glad to yield.

Mr. REID. I say to the majority leader, there are ongoing discussions. There was a hearing today in the Senate on this very issue. There are meetings that are going to take place today on that issue. I have spoken to the Secretary of Energy as recently as last evening.

We are really trying to work something out. I think parties on both sides are trying to work something out. I think it would be to everyone's best interest that when we do bring this up, there is some degree of certainty that it will be resolved.

We also understand, without any question, the importance of the intelligence authorization bill. Senator KERREY, the ranking member of this committee, has expressed, on numerous occasions, how important it is we move this legislation. So I say to the leader and Members of this body, we are doing our utmost to resolve this issue as quickly as possible.

Mr. LOTT. I am glad to hear that.

INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2000—MOTION TO PROCEED

CLOTURE MOTION

Mr. LOTT. But having said that, I now move to proceed to H.R. 1555, and I have sent a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the motion to proceed to H.R. 1555, the intelligence authorization Bill:

Trent Lott, Pete V. Domenici, Paul Coverdell, Jesse Helms, Chuck Hagel, Judd Gregg, Slade Gorton, Craig Thomas, James Inhofe, Frank Murkowski, Jon Kyl, Jim Bunning, Tim Hutchinson, Connie Mack, Rick Santorum, Richard Shelby.

CALL OF THE ROLL

Mr. LOTT. Mr. President, I ask unanimous consent that there be 1 hour for debate, beginning at 9:30 a.m. on Tuesday, to be equally divided, of course, in the usual fashion between Senator DOMENICI and Senator DASCHLE, or their designees, and that the cloture vote occur at 10:30 a.m. on Tuesday, July 20, and the mandatory quorum under rule XXII be waived.

The PRESIDING OFFICER. Is there objection?

Mr. REID. There is not.

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

Mr. LOTT. I now withdraw the motion to proceed.

The PRESIDING OFFICER. The motion is withdrawn.

MORNING BUSINESS

Mr. LOTT. Mr. President, I ask unanimous consent that the Senate 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.

ORDER OF PROCEDURE

Mr. WARNER addressed the Chair.

The PRESIDING OFFICER. The distinguished Senator from Virginia is recognized.

Mr. WARNER. Mr. President, I understand the distinguished Senator from Georgia has time allocated this morning. I am asking his indulgence that I might speak for a period not to exceed 5 minutes and to yield within that period a brief moment or two to our distinguished colleague, Senator HAGEL.

Mr. COVERDELL. Mr. President, it is my understanding we do have an hour under my control, or my designee. I will designate up to 5 minutes. I ask the indulgence of the Senator from Virginia because I have a flight to accommodate as quickly as we can.

The PRESIDING OFFICER. The Senator from Virginia is recognized.

NOMINATION OF RICHARD HOLBROOKE

Mr. WARNER. Mr. President, I address the Senate regarding Executive Calendar No. 135, the nomination by the President of the United States of Richard Holbrooke of New York to be the Representative of the United States of America to the sessions of the General Assembly. That was presented to the Senate by the distinguished chairman of the Foreign Relations Committee, Mr. HELMS, on June 30, 1999. Following the favorable reporting by the Committee. It is now pending.

I have been in this magnificent body, privileged by the State of Virginia, for 21 years. I fully recognize the rights of Senators to place holds on nominations. I respect that right. I respect them for the reasons they have done it. I have done it myself, although sparingly. But in my judgment, the urgency for the Senate to address this nomination is increasing daily. I urge the Senate to proceed to an up-or-down vote because the United States of America, in my judgment, is increasingly in need of having a very powerful voice at the U.N.

Ambassador Holbrooke, in my judgment, is eminently qualified. He is well experienced with the complex issues in the Balkans.

I ask unanimous consent that at the end of my remarks there be printed an article in today's Washington Post.

The PRESIDING OFFICER. Without objection, it is ordered.

(See Exhibit 1.)

Mr. WARNER. It covers the following:

> Five weeks after the end of bitter ethnic war and the arrival of NATO troops in Kosovo, growing confusion among Western officials, local politicians and Kosovo's population about who controls the province is hampering efforts to begin rebuilding its tattered economy and political structure and social services.

The essence of this article captures a concern of this Senator, that the men and women in the Armed Forces, be they wearing the uniform of the United States or the uniform of our other NATO allies, all under the command of an American officer, General Clark, are at increasing personal risk because the United Nations is not able, perhaps for valid reasons, perhaps for invalid reasons, to take up their allocation of responsibilities and relieve the burdens from the troops so they can restrict their responsibilities to professional military duties.

I believe we should proceed with this nomination, have a vote up or down. Hopefully, this nomination will be approved by the Senate, and we can have a strong voice to enter into this very serious situation in Kosovo. We have invested billions of dollars. We have put at risk tens of thousands of lives, the men and women of the Armed Forces of this country and other countries, to reach the conclusion we now have of relative stability, in clear contrast to the cruel ethnic cleansing inflicted upon the people of Kosovo.

I think the time has come. I ask those who have reasons to be further considering this nomination—I am actively working to resolve those problems—to weigh the risk to the men and women of the armed forces of all nations involved in Kosovo.

EXHIBIT 1

[From the Washington Post, July 16, 1999]

KOSOVO'S NEW ADVERSARY: CONFUSION

(By R. Jeffrey Smith)

PRISTINA, Yugoslavia, July 15—Five weeks after the end of a bitter ethnic war and the arrival of NATO troops in Kosovo, growing confusion among Western officials, local politicians and Kosovo's population about who controls the province is hampering efforts to begin rebuilding its tattered economy, political structures and social services.

The Western allies are preparing an ambitious multibillion-dollar program to repair war damage and bring stability to Kosovo and the surrounding region for the first time in at least a decade. But the effort has already become bogged down by major disagreements among the rival claimants to power in the Serbian province.

In the resulting power vacuum, Kosovo's myriad problems are multiplying. Thousands of vacant buildings, homes and businesses are being taken over by squatters, some of whom are investing in new, unlicensed enterprises whose legal basis is unresolved. No one is sure who owns public enterprises or who is to benefit from their revenues now that most Serbian officials have left and hundreds of thousands of ethnic Albanian refugees have returned.

With municipal offices otherwise unoccupied, former members of the rebel Kosovo Liberation Army are taking up positions as local administrators even though they lack any legal authority. Even so, the former rebels are making decisions and issuing edicts whose long-term viability is open to question.

In the meantime, fire departments have no trucks, hospitals have no ambulances or equipment, gas stations have no fuel. Electricity and water supplies function only intermittently, and telephone service is available only in parts of Pristina, the Kosovo capital, and a few other towns. Without a trained police force, ''the level of lawlessness is stable on the high side,'' one senior Western official said.

But no one knows who to complain to—or where.

According to NATO, the United Nations—officially in charge of reestablishing a civilian government—is the top authority. But almost no one here seems to heed, or even recognize, the U.N. presence. Many civilians still regard NATO and its 32,400 troops as the ultimate arbiter on civil matters. Other residents say unelected ethnic Albanian representatives, led by KLA members, are in charge.

Moreover, the KLA and the United Nations have begun to joust over matters both large and small. In one such encounter, Jay Carter, the senior U.N. official in charge of civilian government here, told a senior KLA official that all state-owned property in Kosovo is now under U.N. control. But Visar Reka, the KLA official, said he responded that ''You're not the owner, you're just the manager; Albanians are the owners.''

Reka and others who work in the offices of KLA political leader Hashim Thaqi, who has been named prime minister of a provisional government, say they have the authority to run the province until elections next spring. But U.N. officials refuse to recognize this claim. ''To me, [Thaqi] represents the KLA, not the government; we are clear on this,'' said Brazilian diplomat Sergio Vieira de Mello, the interim U.N. administrator in Kosovo.

Even so, the United Nations itself is unsure how far its legal mandate extends and recently asked its lawyers to review what authority its officials are entitled to assert. In particular, the lawyers are looking at whether revenues from state-owned enterprises, such as electric and water utilities, must be placed in escrow until Kosovo's legal status is resolved or can be spent without input from authorities in Belgrade, the capital of both Yugoslavia and its dominant republic, Serbia. Kosovo's final legal status—whether it will remain part of Serbia, for example—is likely to take years to resolve.

For now, no one knows for sure what Yugoslavia—and its Serbian leadership—owns or is entitled to control in Kosovo. ''Ownership is one of the toughest problems we face,'' said de Mello, who is being replaced this week by Bernard Kouchner of France. ''If it is state-owned, it is the U.N.'s, at least during the interim administration. If it's private, we are in serious trouble.''

Kosovo's ethnic Albanian majority is reasserting itself in the wake of the withdrawal of Serb-led forces and the flight of tens of thousands of Serbs from the province. More than 660,000—or roughly 85 percent—of the ethnic Albanians who fled or were expelled from the province have now returned, each expecting to have considerably more say in Kosovo's governance.

Meanwhile, the government in Belgrade has complained repeatedly that provisions in the June 12 cease-fire accord offering Serbia at least a token role in policing borders and monuments in Kosovo have not been respected. It has also denounced talk of creating an independent currency for the province and has claimed rights to revenues from state-owned mines and power plants.

Much of the confusion stems from the uncertain status of the agreement signed by ethnic Albanian leaders and Western officials in France last March, which set out in dozens of pages what the new government here would look like. But Serbian officials never accepted the document, and nothing was written to replace it when the cease-fire accord was signed. Since then, the United Nations, NATO and local leaders have had to renegotiate which of its provisions will be followed.

KLA officials, for example, complain that the United Nations got off on the wrong foot by demanding that jobs at city halls, utilities and state-owned media be apportioned equally among Serbs and ethnic Albanians. The intent was to demonstrate even-handedness and to help persuade Kosovo Serbs to stay here. But the plan angered ethnic Albanians, who expected that jobs would be divided according to their proportion of the overall population—now hovering at 95 percent.

''It means a new slavery,'' said Ram Buje, a KLA political official now employed in Thaqui's office, of the proposed 50–50 split. When asked about the split last Friday, de Mello indicated he was unaware of it and called inappropriate. By Sunday, U.N. officials agreed that 330 ethnic Albanians will eventually work alongside just 60 Serbs at the city hall in Pristina, a likely model for other towns. But the city hall was closed Tuesday after the most prominent Serb there was badly beaten by an ethnic Albanian mob, which claimed he had committed atrocities during the war.

The ethnic Albanian leadership has not been the only source of friction for the U.N. mission. A U.N.-appointed consultative council was to have been established Tuesday, which would have the power to confirm the selection of mayors for each of Kosovo's 29 municipalities. It was supposed to have two representatives from longstanding ethnic Albanian political parties, one from the KLA, two independent ethnic Albanians, two Serbs, a Turk and a Muslim. The Belgrade government's local representative was not invited, de Mello said, ''because the others won't come if he is there.''

But some KLA officials last week created a new party that will not be represented, and the two Serbs picked by de Mello—Serbian Orthodox Church Bishop Artemije Radosavljevic and Serbian Resistance Movement leader Momcilo Trajkovic—announced last weekend they would boycott the commission on grounds that Serbs and Serbian interest are not being adequately protected. As a result the council has yet to get off the ground.

De Mello acknowledged that it remains to be seen how the council will be replicated ''at the district or . . . municipal level, where democratic institutions will truly be tested.'' Buje, the Thaqi aide, has in the meantime stepped into the vacuum by appointing mayors for 25 municipalities—all but the four in which Serbs compose a majority of the local population.

''We are the people who know all the business,'' Buje said, but the government ''is a mosaic. We know this is an international protectorate, but it's all mixed.''

WHO'S RUNNING KOSOVO?

The U.N.? Bernard Kouchner, the U.N. administrator in Kosovo, faces a situation in which disputes over control have bogged down reconstruction efforts.

NATO? Many in Kosovo still regard NATO, commanded by Gen. Wesley K. Clark, as the ultimate arbiter on civic matters, but NATO says it's the United Nations.

The KLA? Kosovo Liberation Army leader Hashim Thaqi says the rebels have authority over Kosovo for now, but the United Nations refuses to recognize this claim.

Mr. WARNER. Mr. President, I yield to my distinguished colleague, Senator HAGEL.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. HAGEL. Mr. President, I echo what my friend, the distinguished chairman of the Senate Armed Services Committee, has said.

It is not wise policy nor responsible governance for the greatest power on earth to hold captive one of the most important and responsible positions in this government, a position that has an effect and consequence to all of our allies as well as our adversaries. It is a constitutional mandate for this body to act with responsibility, aside from dispatch, and to move on this. I personally think holds are irresponsible. I understand the tradition of this body. I am new to this body, but I would go so far as to say, if you wish to hold someone, have the courage to take a stand on the floor of the Senate. Come before the American public and say why that hold is to be put on and why it is so important to hold captive such a critical position for this country, for our allies, for the representation of American values and standards across the world.

To put in jeopardy our men and women in uniform who defend this Nation, as the distinguished chairman of the Armed Services Committee has so directly stated, is irresponsible. I support strongly what the senior Senator from Virginia is saying. This body

should have the courage to bring this nomination up and vote straight up or down. Let every Member be recorded.

I yield the floor.

Mr. MOYNIHAN. Mr. President, I rise to continue the remarks so forcefully made by our beloved chairman of the Armed Forces Committee, the Senator from Virginia, and the Senator from Nebraska, as regards the nomination before us on the calendar for the position of permanent representative to the United Nations.

I would like to make the point—and I have served in that role—that this is a Cabinet position. It has been from the time of President Eisenhower when Henry Cabot Lodge was in the Cabinet. It is one of the oldest traditions of this body that a President is entitled to and must have his own counselors. Be they right-minded or wrong-minded, they are the President's judgment and they are his responsibility.

This office is a Cabinet office of the highest importance, as the Senator from Virginia has said, in mediating urgent international issues. But there is an awesome principle. Once, almost a half century ago, the Senate did reject a Cabinet nomination of President Eisenhower. It was not a proud moment for the Senate. We have not done it since, for the good reason that we ought not to do it ever.

I plead with the Senate to respect this prerogative of the other branch. I hope I will not seem mischievous if I repeat the remarks of my friend from Nebraska who said the day may come when there is a President of the other party. And indeed that could come very shortly. I do not predict it, but that is the way we work here. That President would want to choose his Cabinet members and would be entitled to do so, for all the errors they may make or not. That is the constitutional form of government in which we live. Let us, sir, support that regime of two centuries, unparalleled in the history of democratic government, based upon this principle of the separation of powers and the President's right to choose.

I yield the floor.

Mr. WARNER. Mr. President, I thank my colleagues.

Yesterday, the Armed Services Committee had a briefing on the Balkan Task Force from the Department of Defense. I put the question to the uniformed officers: Is there a correlation between the absence of strong leadership in the U.N. and risk to our troops? Their response was a definitive yes.

I thank the distinguished Senator from Georgia.

The PRESIDING OFFICER. The Senator from Georgia is recognized.

TAX CUTS

Mr. COVERDELL. Mr. President, I recognize the distinguished Senator from Missouri for up to 10 minutes.

The PRESIDING OFFICER. The Senator from Missouri is recognized.

Mr. ASHCROFT. I thank the Chair, and I thank the Senator from Georgia. I thank the Senator from New York for his allowing me to accommodate a previously developed schedule. When I had asked for time during this special order, I had anticipated being able to begin at about 11, so I appreciate the indulgence of my colleagues.

This morning the Senate voted on a Social Security lockbox to protect every dollar of Social Security, protect the surplus and the integrity of Social Security. We were not able to do that. We had a majority of the Senate vote in favor of it, but there is still the filibuster on the part of others who are unwilling to guarantee a vote on this issue.

The supporters of the lockbox believe the money Americans pay for Social Security ought to go for Social Security, period. That happens to be the language of the President of the United States who has endorsed that position. But Social Security taxes are only one of the many taxes, as we all know, that are placed upon the American people. Too many taxes, forms of taxation, proliferate in this place. These taxes place an enormous $1.8 trillion burden on the American people annually. That is 1.8 trillion, trillion being a thousand billions and a billion being a thousand millions. It is more money than one can virtually imagine.

These taxes also bring in more money than the Government needs. It is amazing. What we have is a Government which is charging more in taxes than it needs in order to provide services. I find it interesting that over the next 10 years there will be a trillion dollars more than are needed to provide the services we now provide.

Normally, if you go into a store and you give them $20 and you are buying something worth $8, they give you change. When you pay in excess of what you need to buy the product you are getting, they give you change. I think the U.S. Government ought to do that. We ought to say: There is a surplus coming in. The people have paid more than is needed for these services. We ought to give the money back.

If a store owner came to me and said: You have bought two bottles of milk and you get some change from your $10 bill, but instead of the change, I want to give you six more bottles of milk, I would say: Wait a second.

I think the American people want some change. They want change in the way Government is consuming their resources. I believe it is time for us to begin to address the idea that we have tax relief for the American people.

Never before in history have we paid as high a tax as we pay today—State, local, Federal taxes—and a lot of the State taxes are really disguised Federal taxes. I say that because the Federal Government forces the State governments to do things. Then the State government has to charge the people for that. The truth of the matter is, it is a mandate from the Federal Government. It is an expense occasioned by the demand of the Federal Government through the system. And when you put all of our taxes together, they are higher than any time in the history of the country—higher than in wartime, the First World War, Second World War, Korean war, Vietnamese war, Gulf war; you name it, we are higher than ever before. Now, it seems to me we ought to be asking ourselves with whom we are at war. I had one taxpayer say to me: I think you are at war with the American people, because we are taxing them the way we are.

I think the American people deserve a break. The Republicans in Congress agree with that. We believe we should return the tax overpayment. Senator ROTH has offered an $800 billion tax cut over the next 10 years. This tax cut is deserved; it has been earned. The American people are the ones who are responsible. This Congress didn't create the surplus. The American people earned the surplus. It is just as if you hand $20 to the grocer and you are entitled to change; it is money you earned.

It is the same with the American people who are overpaying for Government services now, creating a surplus. It is money they earned. They earned it, and we should return it. So we should change the slogan of Washington from, ''You send it, we spend it,'' to, ''You earned it, we returned it.''

I think one of the things we ought to do as we begin to provide relief to the American people is to scrub out of our system those things that are discriminatory and those things that are harmful, pernicious punishments in the Tax Code, especially punishments for things that are very important to our culture. One of those things is marriage.

I don't believe there is an institution in this country more important to the future of America than marriage. We want people to be married. We want the durable, lasting commitments of families to undergird this culture with the kind of principles and responsibilities and values that will keep us from having really serious social problems. I believe we will minimize the difficulties and trauma we have in this culture if we have strong marriages, things we need to minimize such as the tragedies we experience.

What we find out when we look at our Tax Code is, for the last several years Americans have been paying a tremendous penalty in taxes merely because they are married; $29 billion is paid by people as a penalty to the Tax Code simply because they are married, and 21 million couples pay that penalty. It is an average of $1,400 per couple, per year. That is over $100 a month. Think of the food, the shoes, the schoolbooks, the entertainment that could pay for. That is at least a very nice vacation for that family. Think of the relief to families if we simply say, we are not going to punish you for being married.

It is time for us in Congress to say that among those items of tax relief,

we sure ought to be doing something about the marriage penalty. This CRS study projected that over the next 10 years the average household will be paying $5,000 extra in taxes than it needs to pay. We ought to address that.

I think the Roth plan will return that hard-earned money to those who earned it, the American people. I urge the American people to call the Congress and urge us to give them the change they deserve, give them their money back. They earned it, and we should return it. It is time for us to get together with Senator ROTH and support an idea that he has, and get our ideas in that measure, of refunding the $800 billion in tax overpayments that the American people are scheduled to make in just a very few years.

I thank the Senator from Georgia.

Mr. COVERDELL. Mr. President, I yield now to the distinguished Senator from Idaho up to 10 minutes.

The PRESIDING OFFICER. The Senator from Idaho is recognized.

Mr. CRAIG. Mr. President, I thank Senator COVERDELL of Georgia for asking for a special order this morning to talk about taxes, where we are with taxes in our country, and where the Senate Finance Committee and the House Ways and Means Committee are at this moment as we begin, within a few weeks, a very important national debate on reducing the overall tax burden for the American people.

For a few moments this morning, let me talk about that tax burden and try to put it in context with other times in our history when the American people cried out for tax relief and the Congress heard them and the Congress respectfully responded.

Today's total tax burden is the highest since World War II, according to the Office of Management and Budget. I know when I came here in the 1980s, the World War II tax level was always used as the index. It was less than we had to pay during the wartime tax of World War II. At that time, that was the highest ever registered in our Nation. But now we have broken that mark. I will repeat that. The OMB now says that the peacetime tax burden of the average American taxpayer is higher than it has been at any time since World War II.

Tax receipts as a percentage of the gross domestic product amounted to 20.5 percent last year, will grow to 20.6 percent this year, and will reach 20.7 percent next year.

Recently a new administration estimate predicted the largest budget surplus in the history of our country, with the highest taxes ever, and the highest budget surplus ever.

The Congressional Budget Office has confirmed this optimistic forecast.

According to the President's estimates, last year's was the largest surplus in history. It will be larger this year, and will extend for the next 15 years.

That is a lot of optimism. But even conservative economists suggest that the budget surplus, as we now know it, is going to extend well into the future.

Over the next 10 years, a non-Social Security surplus will be at approximately $1.1 trillion. Over the next 15 years, the non-Social Security surplus could get as high as $2.9 trillion. Once again, these are reasonably conservative estimates on reasonably conservative growth in the Federal budget. Growing surpluses, but still no net tax cut? That is what our President is saying. Look at all of this money we are going to have to spend beyond what would be considered a reasonable level of spending at the Federal level. President Clinton won't recognize the income taxpayers' burdens, despite a $2.9 trillion overpayment over the next 15 years.

I am not going to talk about surpluses anymore. I am going to talk about overpayment. The American taxpayer is overpaying what they should have to pay for the Government they are getting at this moment. Yet from the White House there is not one word about reasonable and responsible tax relief for the American taxpayer. That is why our Senate Finance Committee and the House Ways and Means Committee are fashioning tax reductions at this moment.

The income taxpayers' burden is the heaviest in history, in terms of a total tax burden. The personal income tax burden stands at 9.9 percent of the gross domestic product, and, that is not just the highest since World War II, but the highest ever. It is higher than the 7.9 level when the President took office. It is higher than the 7.8 level of the gross domestic product when John Kennedy, a new President, came into office, and said: Let's stimulate the economy by producing a major tax cut. Of course, we remember the history of that. It was not unlike the model that Ronald Reagan brought to office and convinced the Congress to produce a tax cut to stimulate the economy.

Our President thinks this economy is so good that you don't need to do that. That is not the issue. Our economy is strong, and we want to keep it strong, growing, and providing jobs. The way you do that is to insure that you don't drain the American public of their ability to spend for their families, and to save and invest in the growth of that future economy.

The tax burden we have today is higher than the 9 percent level Jimmy Carter left office with, which produced the tax cuts, or at least the stimulus for the tax cuts, that Ronald Reagan brought to this Congress in the early 1980s.

It is the highest level since World War II, and that was 1946 when it was 7.2 percent, and we were taxing at a high level to finance a war effort, the most major war effort ever conducted in the history of this country.

According to Clinton's own budget office, his 9.9 percent level is the highest recorded level of personal income tax receipts ever reached in the history of this country. Clinton is the undisputed champion of personal income tax burden.

You are the undisputed champion of that personal income tax burden and not one word from you, Mr. President, on a right and responsible level of tax reduction on the highest burden ever in the history of our country.

Under President Clinton, personal income tax receipts have grown at an average annual rate of 9.7 percent. That is 75 percent faster than the economy's average annual growth rate of 5.3 percent. That is faster than the wages' and salaries' average annual growth rate of 5.6 percent. In other words, Mr. President, your tax rate increase is outstripping all levels of growth in this country—both personal and public. That is faster than personal income's average annual growth rate of 5.2 percent. That is faster than payroll taxes' annual growth rate of 5.6 percent. That is 4½ times faster than the 2 percent average annual growth rate of gross private savings of this country.

Highest surpluses in high history; highest non-Social Security surplus in history; highest non-payroll tax surplus in history; highest personal income tax receipt burden in history.

What should we do? Cut personal income taxes, is what we ought to be doing. Yet, Mr. President, not a word from you.

What about the marriage penalty that the Senator from Missouri was talking about a few moments ago? What about death tax relief? Every time I walk off from a plane in my home State of Idaho, I hear from the small businessperson, or a farmer, or a rancher, who are at a time in their lives when they want to transfer the ownership of their life's work to their son, or to their daughter, and can't because the Federal Government steps in and destroys the American dream by saying: Give me at least 50 percent of the value of the life's work, and then I will let you pass the rest of it on to your family; and, in doing that, the son, or the daughter, or the son-in-law or the daughter-in-law spends the rest of their life trying to pay once again for that business, for that farm, for that ranch, and, in the end, they have to sell it just to pay the tax.

Mr. President, please. What about the American dream? Join with us in eliminating the death tax.

The fact that we have a $2.9 trillion surplus totally apart from Social Security means we can still protect Social Security and buy down the public debt. In addition to these things, we could cut income taxes and return income tax surpluses to the overburdened taxpayer.

Everyone can see this connection. It is not a difficult thing to understand the highest income tax burden and the highest surplus in our country's history. When I say it is easy to see, that is everyone except President Clinton. Right on this Hill, his defenders won't even talk about a tax reduction.

Clinton wants to raise taxes. Understand me. Here is the President, after all of the statistics and facts I have just given you, who brings the budget to the Hill this year, and in it are tax increases. According to the Congressional Budget Office, President Clinton's budget raises $96 billion in new taxes over the next decade. I mean, Mr. President, where in the heck are you coming from? With surpluses unlike we have ever had before, certainly in this Senator's history, and you want to raise taxes? That is roughly a 10-percent surplus surcharge over the next 10 years on the American taxpayer.

In case you haven't forgotten, let me give you a little of the Clinton tax history. It is important the Senate understand this is a President who campaigned in 1992 on the promise to cut taxes. Then, in 1993, once elected, he raised taxes by $240 billion. After that, in 1995, President Clinton confessed—I was not in the room at that time, but here is the quote: ''People in this room are still mad at me at that budget because you think I raised your taxes too much.''

His own quote: ''Well, it might surprise you to know I think I raised them too much.''

That is the inconsistency of this President on this issue, and now with 2 years of a budget surplus under our belt, and with $2.9 trillion over the next 15 years in non-Social Security budget surpluses, Mr. President, join us in reducing the overall tax burden on the American people, and work with us to give a strong, responsible tax reduction to the taxpayers and to the economy of this country.

Bill Clinton breaks promises to cut taxes and makes promises to raise them.

No wonder Bill Clinton is the undisputed champion of personal income taxes.

Bill Clinton may have a choice—whether to keep his word or not, whether to raise taxes when there is a surplus or whether to veto a tax cut when there is a surplus.

For this Congress there should be no choice.

This Congress should cut taxes on the overtaxed American people.

We should do it if we had to cut spending to do it—as we have before.

We do not even have to cut spending to cut taxes when there is trillions more than is necessary to run an already bloated government.

When not one cent of this surplus comes from Social Security.

We have nothing short of a moral imperative to return the money to the taxpayers who sent it.

While it may be Clinton-able, it is unconscionable to do otherwise.

Mr. COVERDELL. Mr. President, I commend the Senator from Idaho for his very illuminating remarks.

I now yield to the distinguished Senator from Minnesota for up to 10 minutes.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. GRAMS. I congratulate the Senator from Georgia for putting together this special order on taxes. If we don't talk about it, if we don't act on it, as sure as day follows night, Washington will spend this surplus unless we do something. It is a very important issue, and I appreciate the opportunity to join in.

A few minutes ago the Senate cast another important vote in an attempt to lock away every penny of the Social Security surplus for Americans' retirement security. If enacted, this lockbox legislation would effectively end the practice of allowing the Government to spend Social Security money on other Washington ''wish list'' programs.

I take this opportunity also to commend Leader LOTT, Chairman DOMENICI, and Senators ABRAHAM and ASHCROFT for their leadership on this very important issue. I believe stopping the Government from raiding the Social Security trust fund is an essential first step to ensure Social Security will be there for current beneficiaries, the baby boomers, as well as their children and grandchildren. I am pleased this remains our No. 1 priority.

We will protect Social Security, preserve Medicare, and dramatically reduce the national debt, while providing major tax relief. Republicans are pleased that President Clinton agrees that shoring up Social Security and Medicare should be our Nation's top priority. But the difference is that President Clinton talks about it and Republicans are ready to act on it.

A good example is the President's commitment to work out a Social Security lockbox compromise when talking with the leadership this past Monday. Yet here we are again, another cloture vote, and no agreement. Where is the action to back up that type of commitment?

The Republicans are determined to achieve these goals. We have locked in every penny of the estimated $1.9 trillion Social Security surplus over the next 10 years—not for Government programs, not for tax relief, but exclusively to protect all Americans' retirement.

We have been working hard to reform Medicare to ensure it will be there for seniors. Prescription drug coverage for the needy will be part of our commitment to seniors, to protect their Medicare benefits. Had the White House and the Democrats cooperated, we could have fixed Medicare by now.

We have reduced the national debt and will continue to dramatically reduce it. Debt held by the public will decrease to $0.9 trillion by 2009. The interest payment to service the debt will drop from $229 billion in 1999 to $71 billion in 2009. We will eliminate the entire debt held by the public by 2012.

We have not ignored spending needs to focus on tax cuts as has been charged. We not only have funded all the functions of the government, but also significantly increased funding for our budget priorities, such as defense, education, Medicare, agriculture, and others.

Meanwhile, Republicans are committed to providing nearly $800 billion of the projected non-Social Security surplus—the tax overpayments of working Americans—for tax relief.

This is the largest tax relief since President Reagan and it does not come at the expense of seniors, farmers, women, children, or any other deserving group.

However, despite our healthy economy expanding our on-budget surplus, which, again, is not the Social Security surplus, President Clinton still denies meaningful tax relief for working Americans. He and his aides accuse our tax relief plan of being ''dangerous'' and ''risky,'' squandering your money by giving it back to you, worried that you won't spend it right. The administration believes you are smart enough to earn your money but you are not smart enough to know how to spend it—Washington is.

He believes public opinion polls show less interest in tax relief. No wonder! How many people do you know like paying taxes and actually expect a refund? Most people have given up any thought of tax relief—but they still constantly remind me how important it is when I travel around Minnesota.

To tell the public they don't deserve tax relief is just plain wrong. The Bureau of Census just released a report last week that finds 49 million hard-working Americans—nearly one person in every five—lived in a household that had trouble paying for their basic needs.

They are going further into debt each month trying to make ends meet. Credit cards are charged to the limit. They need tax relief.

What's even more shocking, Mr. President, is that not all of these 49 million are underprivileged people, over 8 million Americans are from middle-class families, families that earn more than $45,000 a year.

Let me repeat, Mr. President, a significant number, 8.1 million, to be exact, of middle-class and well-off families today have difficulties making their ends meet. They even have trouble paying rent, medical bills or other basic daily needs. A family night at the movies, a dinner out, braces, piano lessons are often out of reach to average income families.

Mr. President, this is not my data, nor is it data from think tanks. This is the data produced by the government of the United States.

Some experts attribute this financial hardship to lack of savings, which is true, but there is much more.

Our personal savings rate has dropped from 9.4 percent in 1981 to only six-tenths of a percent last year. This year the government reported that the rate actually dipped below zero for the first time since the Great Depression.

In fact, in the past 70 years, including the Great Depression, our savings rate has dropped as low as it is today

only twice before. The personal savings rate has remained low for more than a decade, and net personal savings other than pensions have virtually disappeared over the past ten years.

But why? My answer is that government tax bites have been getting bigger and more cruel. Americans have been struggling to pay basic bills. After paying Uncle Sam and paying for basic family needs, there is nothing left for working Americans to save, or for money even to provide for the basics.

Americans should be able to save for their future, but they also should be able to pay for what most of us here take for granted—the family's night out, the lessons, camps, etc.,—the things that improve our quality of life. Tax relief can improve the quality of life of middle-class American families.

Mr. President, I remind you the total tax burden on working Americans is at an all-time high. The government's own data shows that the average household pays $9,445 in federal income taxes alone—twice what it paid in 1985.

Federal taxes take a huge bite out of Americans' hard-earned paycheck and consumes about 21 percent of the national income, the highest proportion since World War II. And it's still growing. Total taxes from all levels of government—federal, state, and local taxes—stand at a record 32 percent of national income.

Mr. President, according to the Census report, the income of the average American family has grown only 6.3 percent in constant dollars between 1969 to 1996. However, federal tax revenue increased nearly 800 percent during the same period of time.

Studies show that if government spending in this country had remained at the 1960 level, the average income of an American family of four, even accounting for inflation, would be $23,000 higher today than it is. That could certainly improve the quality of life for those families.

The tax burden has become even more excessive since 1993. Over the course of President Clinton's administration, Washington's income has grown faster than our economy and twice as fast as the income of working Americans. In fact, federal taxes have grown by over 54 percent. That's nearly $4,000 a year more per person.

Because of the unfair tax system, millions of middle-income Americans who have worked hard to get ahead have been pushed from the 15-percent bracket into the 28-percent bracket. Hundreds of thousands of others have been pushed from the 28-percent bracket into the 31- and 36-percent brackets. No one can escape this growing tax burden, not even low-income and minimum wage workers.

Since payroll taxes are levied against everyone, as low-income and minimum wage workers work harder and earn more, their payroll taxes also increase, taking a huge bite out of their hard-earned dollars that are most needed to keep families above the poverty line. As a result, Americans today are working harder and longer but taking less home. A larger share of the earned income of working Americans is siphoned off to Washington, and isn't available to spend on family—not Washington—priorities. No wonder working Americans have trouble making their ends meet. No wonder they cannot save for emergencies. No wonder they work two or three jobs but still cannot get ahead.

President Clinton himself at one time admitted that Americans were taxed too much. But he still refuses to return the tax overpayments back to them because he does not think working Americans will spend it right. Instead, President Clinton has decided he will spend much of the surplus for his own government programs.

President Clinton and some of our Democratic colleagues insist we should have Social Security and Medicare first before we have tax cuts. In my view, this is nothing but an effort to deny working Americans tax relief.

Republicans have saved Social Security and have tried to create interest in Medicare reform. Tax relief only detracts from the need to spending more to bring home the bacon for many of our colleagues on the other side. Even after we've set aside and protected $2 trillion for Social Security and Medicare, he and my Democratic colleagues in the Senate still insist the tax relief is unachievable.

Over the next 10 years, the federal government will collect over $22.7 trillion in taxes. Excluding the Social Security tax surplus, the government will take $17 trillion from Americans' paychecks while it needs only $16 trillion to operate the government. In other words, the average U.S. household will pay approximately $5,307 more than the government needs over the next 10 years, according to the Congressional Research Service.

One question we should ask ourselves before we decide how to spend any non-Social Security surplus is where the budget surplus comes from. Do we have a budget surplus because the government is spending less or because it is taking more of our money? The CBO has showed us precisely where we will get our revenues in the next ten years. The data indicates that the greatest share of the projected budget surplus comes directly from income tax increases, primarily from the capital gains realizations and increase of effective income tax rates.

Clearly, Mr. President, as I have argued repeatedly our revenue windfall did not just fall from the sky, nor has it come from any belt tightening in Washington. It comes directly from American taxpayers.

Again, my point is, Mr. President, that this non-Social Security surplus is nothing but tax over-payments. It is the American taxpayers' money and it should be returned.

Like the Chairman of the Federal Reserve Alan Greenspan, my biggest fear is that if we don't give the non-Social Security surplus back to the taxpayers, Washington will soon spend it all. Such spending will only expand the government, making it even more expensive to support in the future, creating an even higher tax burden than working Americans bear today and a higher federal debt. That's why Chairman Greenspan says ''If we have to get rid of the surpluses—I would far prefer reducing taxes than [increasing] spending, and, indeed, I don't think it's a close call.''

Major tax relief as we have proposed will help all Americans keep a little more of their own money. It will give middle class families relief from the tax squeeze. It will help farmers and small business owners pass their hard-earned legacies onto their children. It will help to reduce self-employed medical costs, and correct the injustice of the marriage penalty tax. It will encourage working Americans to save and invest more. It will reward people who work hard to get ahead. It will benefit all Americans and ensure our economy continues to grow. But more importantly, it will give working Americans more freedom to control their own fate and decide what's best for themselves and their families. This is exactly what President Clinton and our Democratic colleagues fear will happen. They simply cannot let go of their misconceived belief that higher taxes and more government spending are the best answers to America's challenges. That's the fundamental difference between the two parties. That is what this debate on tax relief is all about.

The PRESIDING OFFICER. The Senator from Georgia.

Mr. COVERDELL. Mr. President, I thank the Senator from Minnesota. I appreciate his accommodating the somewhat tight schedule. The remarks he made are very pertinent to what we are going to be hearing a lot about over the next 3 weeks.

I now turn to the distinguished Senator from Colorado for up to 10 minutes.

The PRESIDING OFFICER. The Senator from Colorado is recognized.

Mr. ALLARD. Mr. President, I thank the Senator from Georgia, Mr. COVERDELL, for leading the discussion this morning on the need to have tax cuts for all Americans. I agree with my colleague from Missouri, Senator ASHCROFT, and his call to action. He said: Americans have earned it; Uncle Sam ought to return it.

I agree with my colleague from Idaho, Senator CRAIG, who pointed out that right now Americans are facing the highest tax burden since World War II. I also would like to associate myself with the comments of my colleague from Minnesota, Senator GRAMS, who says we can save Social Security, we can pay down the public debt, and we can still provide tax cuts for Americans. My colleague from Kansas, Senator BROWNBACK, will probably talk about the need of cutting taxes for the benefit of American families.

These are all very good points on why we should cut taxes. In talking with my constituents in town meetings across Colorado, one thing I hear in every meeting is that Congress should cut taxes. The legislature in the State of Colorado, and the Republican Governor in the State of Colorado, have heard the same message. This year there were some major tax cut provisions for the people of Colorado. The Governor of Colorado, Governor Owens, has pointed out that he plans on making another major tax cut for the people of Colorado next year. They recognize that government is receiving a windfall with our good economy, and we ought to cut taxes to give people the power to determine how they want to spend that money.

The government in Colorado or the Government in Washington should not be spending those dollars. The power really does belong with the people, not with the government in Colorado or, particularly, with the Government in Washington, DC.

People of all ages, professions, and positions in life believe they send too much of their paycheck to Washington. I happen to agree with that. Taxes are currently at a record high level. According to the Tax Foundation, Tax Freedom Day, the day in the year to which the typical American family must work to pay their combined Federal, State, and local taxes, was May 11 this year. This is the latest day ever, but it is hardly surprising in light of the fact that the combined effective tax rate is also the highest ever. When you add in the cost of Government regulations, Americans did not finish paying for the cost of Government until June 22nd. I believe Congress should downsize Government and return power to the States, localities, and individuals.

Part of the effort to downsize Government must also include a tax cut. I believe Americans should be able to keep more of their own money. American workers already pay 38 percent of their income in taxes, which is more than they spend on food, clothing, and housing combined. For the average family, this translates to a large percentage of their paycheck going straight to Uncle Sam.

A tax cut means they could keep more of their money to use for their priorities, not Washington's priorities. Some families may choose to use that money for a downpayment on a house, others, for education, and other families will now have the money to work fewer hours and spend more time together. The important point is, they know their own family needs and we, in Washington, do not.

I realize some question the wisdom of tax cuts. We always hear from those, sometimes I think louder than we do from others, except when it comes to election time, and then their voice is heard. They believe the budget cannot be balanced or Social Security cannot be saved if they return taxpayer money. However, according to a recent Congressional Research Service study, there will be an additional $800 billion on budget surplus over the next 10 years, even after assuring that all our obligations to Social Security and Medicare have been met.

The study also found the average household will pay $5,000 more in taxes than the Government needs to operate over the next 10 years. This money belongs to the American people. We must refund the excess in the form of tax cuts and not spend it. At the very least, we should reduce the excessive recent growth of the Federal tax burden.

During the Clinton administration, Federal tax receipts have increased by over 54 percent. Tax revenues have grown twice as fast as our economy and twice as fast as economic growth for working Americans. Clinton tax hikes have left each American $4,000 per year poorer, yet the President is not done. His budget for Fiscal Year 2000 proposes $96 billion in new taxes. Congress should reject new taxes and new spending in favor of meaningful tax relief.

In conclusion, I point out that it is time we return Government money to its rightful owner, and that is the American people.

I thank the Senator from Georgia for allowing me to join with him and my other colleagues in the Senate to deliver this very important message.

The PRESIDING OFFICER. The Senator from Georgia.

Mr. COVERDELL. Mr. President, I know our time has been scheduled to conclude at noon.

The PRESIDING OFFICER. The Senator has 14 minutes remaining.

Mr. COVERDELL. Do I have 14 minutes remaining? Thank you.

Mr. President, let me, first of all, thank all of these speakers. In their own way, each pointed out the effect of a circumstance in which working American families are paying the highest taxes they have ever paid. These numbers begin to back into each other, but if you get down to the bottom line, what we are talking about is that American workers today are keeping just over half their paycheck—about 52 cents. If they kept two-thirds of their paycheck, which I think everybody in the country would agree at a minimum would be appropriate, they would have about $7,000 a year in their checking accounts.

We have just spent a fierce week of debate arguing about how people deal with prescription drugs and the Patients' Bill of Rights and the needs of American families. The problem is, we have taken so much out of those folks' checking accounts they do have to start looking to some other place to take care of these problems. Obviously, if every working family had $7,000 more in their checking accounts, the problem of a $2,000 drug bill or an additional educational requirement could be facilitated.

We have created, by these enormous tax levels, massive pressure on American working families. I will give you two immediate manifestations of what this does, and there are many.

One of them is that American families this year, for the first time, have a negative savings rate.

In other words, they are in the red in terms of the amount of money they are saving each year. The reason is, if somebody—the Government—goes into their checking account and takes over half what they make, there is not enough left to save. In fact, there is not enough disposable income left to do what that family is supposed to do. Education, housing, transportation, and health needs are all impaired because we have taken those resources and moved them away.

There are people in this city who believe they can make better decisions about where that money ought to go. If you are interested in tax relief, economic relief, leaving those funds in those families' checking accounts, you are a person who believes they make a better decision about what they need, they make a more efficient decision, they make a more intelligent decision about what the requirements are in that family than some bureaucrat buried in the basement of one of these buildings in Washington, DC.

They know whether they have a special education problem. They know whether they can afford and need more health insurance or not. They know whether or not they have a housing requirement or transportation requirement.

There is absolutely no way this city, despite all the intellect, can figure out what are the specific needs of an individual family. The best thing we can do for middle America, the best policy we can enact, is to get more resources into their checking accounts. They worked for it; they earned it.

If Thomas Jefferson were here today, he would faint that we had come to the point where nearly half the resources of working families are sent off to the Government. If he woke up, he would be furious that this condition had ever been imposed. So American families are not saving.

Also, we have the highest bankruptcy rates in contemporary history. Why is that? Once again, it is a reaction to all the pressures we put on working families across the country. We are taking too much of their paychecks and moving those resources away from them to Washington for others to decide what to do with it, leaving those families without the resources necessary to do what they have always done for America.

Mr. President, I am going to conclude. I know there are several other Senators who have remarks to make on other subjects.

In my judgment, there is no single policy more deserving of our attention than that of focusing on how to lower the highest tax levels in American history, how to return resources to the

checking accounts of our average American families so they are empowered to do the things they need to do to make America great.

There are three pillars of American freedom. One is economic opportunity, the second is safety of persons and property, and the third is an educated mind. We have ratcheted down economic opportunity to a point where it is changing the behavior and the way Americans function and act. It is robbing them of the dreams and the visions that have been such a special part of America.

This is the time, the perfect time, for us to be conscious of this, to leave those resources in those checking accounts and empower those families to build not only their family, their community, but their Nation, the United States of America.

I yield the floor, and I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. BUNNING). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. KERREY. 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. KERREY. Mr. President, first of all, I did not hear everything the Senator from Georgia said. As I understand it, he was talking about income tax cuts; is that correct?

Mr. COVERDELL. That is correct.

BIPARTISAN SOCIAL SECURITY REFORM ACT OF 1999

Mr. KERREY. Mr. President, the Senator from Georgia does not have to stay for this, but I agree with the fundamental principle the Senator from Georgia laid out. I may come at it slightly differently.

There have been a lot of arguments about income tax cuts and why they are needed. I call to my colleagues' attention, one of the biggest reasons is the total amount of taxes we are currently taking from the American people which totals 20.7 percent of U.S. income. That is the highest it has been since 1945, and it continues to go up.

I believe we need to measure and look at that very carefully as we decide how much in taxes we are going to take from the American people. I put myself on the side of I believe at least the fundamental principle about which the Senator from Georgia talked. There are many ways to cut taxes, and I want to talk about one way to do so this afternoon.

I rise today to talk about the introduction of a bipartisan bill called the Bipartisan Social Security Reform Act of 1999. It is the only bipartisan, bicameral—it has been introduced in the House as well—Social Security reform bill, and it is the only bill that can claim to cut taxes, cut programmatic costs, leave current retirees' benefits untouched, and it substantially increases the benefit checks of women and low- and moderate-income workers. This reform plan is a reform plan for all generations.

First, in our bill, current seniors—those who are eligible either for the old age, survivor, or disability benefits who have not had time to financially prepare for benefit changes—will not face any benefit cuts.

Second, current workers—the baby boomers and the generation Xers—will participate in a modernized and strengthened Social Security program. Our proposal gives all current and future workers a 2-percentage point payroll tax cut which they can invest in individual investment accounts. That is a $928 billion tax cut over the next 10 years.

Indeed, as I will illustrate with my presentation, what Congress should consider, when we consider the payroll tax, is do we want to take that payroll tax and pay off the national debt.

I favor a substantial debt reduction. Under our proposal, instead of going all for debt reduction, that $928 billion will be accumulated as an asset in 137 million working American households. That will add to the net worth of American working families. It is, in my view, a preferable way of dealing with the payroll taxes. It gives the baby boomers and generation Xers who have time to plan under our proposal not only a payroll tax cut, but it gives them an opportunity to invest in their future. At retirement, these workers will receive the traditional monthly benefit check. We preserve not only the old age benefit, but we preserve intact the survivor and disability benefit. This traditional defined benefit will be supplemented by the retirement wealth they have accumulated in their individual savings accounts.

Third, future workers—that is, those who are born after 1995—will not only get to participate in individual savings accounts, but they will get to start saving for their retirement at birth through our bill's KidSave account program.

Through KidSave accounts, all children will be given a stake in the American economy and a chance to build substantial retirement wealth at the same time. Each child born in the United States will receive $3,500 to invest in their retirement. When a child takes his or her first job, he or she will be able to contribute 2 percentage points of their payroll tax to the KidSave account.

Not only is this a plan for all generations—it is a plan for all income levels. Our plan has something for every wage earner. It will result in substantially higher benefit checks for low- and moderate-income workers. It will result in substantially lower taxes for high-income workers, and it has a combination of higher benefits and lower taxes for middle-income workers.

I have brought with me some examples of how real Nebraskans would be affected by our legislation. These charts compare Social Security benefit checks under current law with Social Security benefit checks under the Senate bipartisan Social Security reform plan.

The first example is a friend of mine by the name of Verner Magnuson, a retired farmer from Oakland, NE. This chart says, 75-plus. I do not think Verner would object to me telling you he was born in 1915. So Verner obviously is an individual who says: Well, what do I benefit from additional savings? He is exactly right. He does not have time to save and benefit from the buildup in cash that can occur by taking advantage of compounding interest rates.

So under current law, Verner receives a benefit check of approximately $1,500 per month. Under our bill, his check will be exactly the same, $1,500—and it will continue to grow with inflation from year to year. We make no adjustment in Verner's CPI nor in anybody's CPI over the age of 62.

The second example shows an Omaha resident and the divisional social services director for the Salvation Army, Linda Burkle. Linda, who has a relatively high income—although she may object to that description—demonstrates how higher income individuals will experience somewhat lower monthly benefits under our Social Security plan—at least during the transition period. These temporary benefit reductions for high-income people will only occur until the new Social Security program—that is to say, with individual accounts—is fully phased in. At that point high-income people will not experience reductions in overall benefits. These are temporary benefit reductions for higher income people, and they will only occur until a new program with individual accounts is fully phased in.

You can see from this chart that a baby boomer with a low or moderate income will still have a higher income benefit in our plan than under current law. A moderate-income worker, for example, will receive a monthly benefit check of $673 under current law. Since Linda will become eligible to retire for old-age benefits in 2020, her benefit check will not reflect the large benefit cuts that are expected to occur in 2034 under current law.

I will not spend a great deal of time on this point, but one thing we all need to understand is if we do not change the law, people who are under the age of 45, under current law, according to the trustees of the Social Security Administration, will experience a 25- to 33-percent cut in benefits. Ask them. If any citizen doubts that, call the Social Security Administration. If you are under the age of 45, call them up and ask them: What will my benefits be unless Congress changes the law? And they will tell you that your benefits are going to be cut 25 to 33 percent.

I have listened to my colleagues from time to time who say: Gosh, it is not going to run out of money until 2034,

and that is a long time away. Why do anything now? Why should we act now, especially when the choices are hard and people are apt to get upset with you?

The answer is, in 1983, when Congress fixed Social Security as it was about ready to not be able to pay benefits, it made a radical departure from the previous plan. In 1983, what Congress said is that we are not going to only fund current beneficiaries; we are going to fund all beneficiaries.

That is what the 75-year mark does. It is not just 75 years; we are trying to write the law so that whatever your age, whether you are born this year or you are 16 years old or you are 76 years old, that we can keep the promise we have on the table.

We cannot keep the promise we have on the table to the people under the age of 45. It is not just a small haircut they are going to take; it is a big haircut they are going to take. Or there is going to have to be a comparable—actually, a larger tax increase on their children and grandchildren. That is the current law—a big benefit cut for people under the age of 45.

You can see from this chart that a baby boomer with a low- or moderate-income will have a higher benefit under our plan than under current law. A moderate-income worker will receive a monthly benefit check of $673 under current law. Under our plan, a low-income worker will receive a benefit of $813. That is a very important point.

We believe that the current Social Security Program is not very generous to low- and moderate-income workers. We add what is called under law an additional benefit point. So for that lower wage individual, in my view, not only are there many of them today, but there are apt to be many of them in the future, who are both an important force for economic reasons as well as for moral reasons. We have to make sure that that defined benefit program is sufficient so they can live with some dignity in their retirement years.

This plan not only provides them a higher benefit check, it also provides them the thing that I think produces real financial independence, and that is ownership of some financial assets.

My third example shows how Kelly Walters, a 20-something generation Xer from Columbus, NE, will fare under our Social Security reform bill. Generation X is the first generation that will experience very significant benefit increases from our Social Security reform plan. If Kelly earns the average wage over her lifetime, she can expect to get a benefit check, under current law—assuming no tax increases—of $884 per month. Under our reform plan, she can expect to get a Social Security benefit check worth $1,329 per month. That is a 50-percent increase in benefits over current law. If she turns out to be a low-income worker throughout her lifetime, Kelly can expect to get a $536 monthly check under current law but a $1,115 benefit under our new plan. That is more than double the benefit under current law.

One of the very difficult things we are experiencing, as the occupant of the Chair knows—he was on the Ways and Means Committee in the House, and I look forward to the day when he is on the Finance Committee as well—but as the occupant of the Chair understands, what we have is a situation where people are living longer. Generation Xers are probably going to be looking forward to living to the age of 85 or 90. So it is very important that that defined benefit program be solid for them. It is also very important that they have the financial assets and wealth that allows them to sustain themselves through to the course of their old-age years.

My fourth and final example shows how the next generation of children will fare under our Social Security reform plan.

Erin Kuehl, who is only 2 years old today, will benefit not only from the 2-percent account but also from the KidSave account I described earlier. Under the current Social Security system, Erin can expect to have a Social Security benefit worth $1,037 if she earns the average pay. Under our plan, she will receive a monthly benefit worth $2,693. If she becomes a low-income worker, Erin will receive a benefit worth $629 under the current system and $1,631 under the new system—again, more than one and a half times her current expected benefit.

Many people get confused about this because they will look at the existing benefit plan and they will say: Well, that is not true. Under what shows up on her benefits, Erin is going to get a much larger check. But that assumes that Congress is going to raise taxes. The President said he is against raising payroll taxes. That presumes that Congress somehow is going to come up with some additional money. If anybody wants to do that, let them come down and argue for that. Let them come down and make a presentation or a proposal to raise taxes even more on people who get paid by the hour than we have under current law.

The message with our proposal is very clear: Our bill provides better benefits for low- and moderate-income workers. And although some high-income individuals will temporarily experience slightly lower benefits during the transition from the old system to the new system, all workers in America will eventually experience higher benefits and lower taxes than current law provides. In Nebraska alone, there are over 283,000 Social Security beneficiaries: 182,000 have an old-age benefit; 35,000 are taking the survivor or widower benefit; and the balance are in the disability program. The average monthly check under the old-age benefit is $753 for retired workers. For the widower, it is $740.

Not only is $753 not a livable monthly benefit, that is an average. That means many are getting substantially lower than that. Even in Nebraska, that is not adequate, unless it is supplemented by additional wealth and income from pensions and personal savings. This is an even lower amount and not likely to provide that individual with what they are going to need, especially with longer lifespans projected out into the future.

Our bill will ensure workers have larger benefits. Our bill also ensures they have wealth with which to supplement their retirement income.

There are tradeoffs in our bill. Although our reforms will ensure lower taxes and higher benefits from future workers, our bill does call for programmatic changes which will lower the guaranteed defined benefit check for some middle and upper workers in the future.

I don't want to sugarcoat this. Unless you are for a tax increase, if you want to walk out on the floor and say, let's raise taxes, you also favor at some point lowering benefit checks. If you don't like the idea that we are making some adjustments out in the future in benefit checks—and again, for emphasis, if you are watching this and you are over the age of 62, please don't call my office and say I am cutting your benefits. I am not. This proposal does not cut benefits for people over the age of 62. It makes adjustments out in the future. Again, if you don't like those adjustments, come down to the floor and say you want to raise taxes because that is the only option to making these kinds of adjustments.

Our bill includes a provision which instructs the Bureau of Labor Statistics to study overestimates in the CPI and correct them accordingly. When the recommendation was made well over a year ago now, it was a commission that studied this. They came back and said that the CPI was overstated 1.1 and we ought to make an adjustment, and nothing happened. I guarantee you, if they had come back and said that it is understated 1.1, there would have been 535 votes for it. It would have been unanimous in the House and Senate. But because it is overstated, we recognize that the adjustment is going to mean somebody is going to have to give up something. We make that adjustment for beneficiaries out into the future.

We think this will result in a downward adjustment in the CPI and COLAs of .5 percent. It brings the CPI much more closely in line with what real cost-of-living increases are. It doesn't reduce the cost-of-living increase. It brings us a much more accurate cost of living. In addition, the CPI adjustments will affect income tax revenues. I do not argue that it will not. But our bill allows the Social Security Administration to recapture these initial income tax revenues for the Social Security trust fund.

Another benefit change in our bill is the indexation of benefits to life expectancy. Earlier I introduced a bill with Senator MOYNIHAN that would

have moved the eligibility age. It set off a howl, a protest, and concern. I listened to those concerns. By the way, in 1997, we had 1.3 million old-age beneficiaries who became eligible for Social Security's old-age benefit. Of those 1.3 million, 1.1 million took the early benefits at 62. So when news commentators try to figure out what this does, they typically say: KERREY is proposing to move the retirement age. Not true. We are talking about eligibility age, when you are eligible for the benefit. By the way, this bill would also eliminate the earnings test that is still present. That earnings test is gone. So whenever you are eligible, if you want to continue working, that is fine under our proposal.

But this change to index benefits to life expectancy is a response to people saying: Don't move the eligibility age. We keep the eligibility age exactly as it is under current law. We do accelerate the move from 65 to 67.

Once the retirement age increases to 67, as under current law, our bill will provide for benefits that track the life expectancy of your birth cohort. I think we made that adjustment so we do not accelerate it until 67, or do we? We do? I was right the first time.

Our bill will provide for benefits, as I said, that track the life expectancy of your birth cohort. The longer your birth cohort lives, the more years over which your benefits must be spread. This may mean that retirees far in the future may experience a lower defined benefit under our program, but again, it does not affect the value of their individual account.

We have several other benefit changes in our bill, but those are the two big ones. I disclose them up front.

There is a price. Again, I say, for the third time, for those who object to it, what is your alternative? What else do you want to do? I graduated from the University of Nebraska in 1965 with a B.S. in pharmacy. It is a land grant college. I am not a Rhodes scholar. I didn't go to Yale University. I don't have a Ph.D. behind my name.

This is not difficult to figure out. The difficulty is looking at the 10 or 12 options and saying: Oh, my gosh, I don't want to pick any of those because somebody is going to get mad at me. Somebody will object to it. Somebody will criticize it.

Criticize the changes if you want, and there will be many who do, but if you are an elected official, if you are an elected representative, I hope people outside, after they have leveled their criticism will say: What is your solution? Or are you suggesting that people under the age of 45 should just be basically out of luck because we don't expect to have to worry about them in our political lifetimes or perhaps even in our physical lifetimes.

Ultimately, the public must decide whether it is willing to risk some benefit adjustments and some benefit uncertainty for the long-term gains that come with a Social Security program that includes individual accounts. Furthermore, the public must weigh the costs and benefit adjustments against the cost of doing nothing. As I said, the cost of doing nothing, if you favor doing nothing, if you favor delay, what that means is you favor, unless you have an alternative, you favor a 25 to 33 percent cut in benefits for people under the age of 45 because that is what current law provides.

This is a reform proposal that Republicans and Democrats are supporting and should be supporting. If Congress wants to get serious about Social Security reform, this is the bill to mark up. If Members want to stop talking about saving Social Security—we just had a cloture vote on the lockbox proposal. Democrats have a lockbox proposal. Everybody wants to save Social Security. If you want to save Social Security, this is the bill to rally behind. If the President, who cannot run for reelection, wants to save Social Security, this is the bill for him to embrace as well. If the public wants the politicians to enact Social Security reform legislation that shares costs across generations, protects benefits and lowers tax burdens, this is the bill to write their Congressman about.

You may detect frustration in my voice. I have been frustrated in recent weeks by our difficulty to come to a resolution of this problem. We do talk a great deal about it. I understand the difficulty. I do not underestimate the political difficulties of solving this problem. The difficulty, in my judgment, is not picking the solution. This is not like Medicare. This is not like youth violence. There are lots of things out there that are extremely complicated, that are very difficult to figure out. This one is not difficult to figure out. You just, in the end, must select which proposals, which solutions you want.

The Congressional Budget Office, the office that dictates what we do far too often around here, and the Office of Management and Budget, the executive office, recently released their midsession review that projected surpluses of $2.9 trillion over the next 10 years, 65 percent of which comes from excess FICA taxes.

What I find to be odd in our current debate is that from 1983 to 1999, after we raised taxes on working people in 1983 to prefund all Americans who were going to be eligible in the future, we raised taxes then. Every single year what Treasury does is, any excess tax, it credits the Social Security Administration with a treasury bond, an asset that has real value. This year at the start of the year, that is about $860 billion that the Social Security Administration owns for future beneficiaries. It will be over $1 trillion at the end of this year because there will be $130 billion of revenue taxes, taxation of benefits and the interest off these bonds that flow into the Social Security trust fund. The Social Security trust fund will own over $1 trillion of the bonds. It will build up to $4.5 trillion in the year 2014. From 1983 to 1999, what we did was, we ended up, after the trust fund owns bonds, Treasury ends up with cash. It ends up with cash. And it has been using that cash for all sorts of things. It has to buy something.

So basically what this excess did was made the deficit look smaller. So from 1983 to 1999, people who got paid by the hour—and 80 percent of Americans have higher FICA taxes than they have in income taxes—people who get paid by the hour shouldered a disproportionate share of deficit reduction.

Now, in 1999, that the deficit is gone and we are at a surplus, what the lockbox says is that people who get paid by the hour are going to shoulder all of the debt reduction. Every single penny of debt reduction under the President's proposal, the Democratic proposal, and the Republican proposal is paid for with payroll taxes, FICA taxes. So what we say with our proposal is not only do we want to give a tax cut to people who get paid by the hour—almost $1 trillion over a 10-year period—but what it effectively does is say that rather than paying down the national debt all of us owe, we will increase the net worth of Americans by transferring that to the asset side of their balance statement. That is basically what it does. At the end of the 10-year period, 137 million working families will have at least $1 trillion of new assets. That assumes no interest, no accumulation on that ownership.

Furthermore, each day we let go by means this problem gets harder to solve. This body rarely takes the opportunity to solve future crises. I understand that. I have been in the situation many times before. I urge and beg my colleagues to let the issue of Social Security reform be the exception to the rule. This bipartisan, bicameral bill represents a real effort to work in a truly bipartisan fashion, not just to save Social Security, but to modernize it, strengthen it, and improve it.

I urge my fellow Senators to cosponsor this bill and join with us in urging the chairman of the Finance Committee, the chairman of the Ways and Means Committee, and the President to take up and endorse a Social Security reform bill this year.

In addition, I announce that I intend, when we mark up a tax bill in the Finance Committee, to offer this piece of legislation as a way to cut substantially more taxes than anybody is currently proposing.

I thank my colleagues who are on this bill, including Senator GREGG and Senator BREAUX who are both on the floor today. I am proud to be a cosponsor of it. I praise them for their leadership. They have been fearless and future-looking. When we talk about our kids and grandkids, sometimes we don't often back those words with actions. I praise them for being willing to back, in a very courageous way, their words with action.

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

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

[From the Concord Coalition, June 9, 1999]

CONCORD COALITION COMMENDS BIPARTISAN SOCIAL SECURITY PLANS THAT MAKE TOUGH CHOICES AND OFFER REAL REFORM

WASHINGTON.—With the U.S. House Committee on Ways and Means holding hearings today and tomorrow on plans to reform Social Security, The Concord Coalition commends the Members of Congress who had the courage to submit bipartisan Social Security proposals that are both fiscally responsible and generationally sound. Concord singled out for praise the sponsors of the Kolbe-Stenholm bill (21st Century Retirement Security Act, H.R. 1793) and the Gregg-Breaux plan (the Senate Bipartisan Social Security Agreement).

Concord Coalition Co-Chairs and former U.S. Senators Warren Rudman (R–NH) and San Nunn (D–GA) draw three conclusions in letters addressed to Congressmen Jim Kolbe (R–AZ) and Charlie Stenholm (D–TX), and Senators Judd Gregg (R–NH), John Breaux (D–LA), Bob Kerrey (D–NE) and Charles Grassley (R–IA). ''First, changing demographics make the current pay-as-you-go benefit structure unsustainable. Absent change, the system will either burden future workers with steep tax hikes, or betray future retirees with deep benefit cuts.

''Second, there are only two roads to genuine reform, and a workable plan must pursue both. Reform must reduce Social Security's long-term burden by reducing its long-term costs. And it must make the remaining burden more bearable by increasing national savings, and hence the size of tomorrow's economic pie. Doing so requires the hard choices of fiscal discipline. In short, there are no magic bullets. . . . Third, the time for action is now. The longer reform is delayed, the worse the problem will become and the more draconian the solutions will be.

''The Concord Coalition commends your efforts because your plan recognizes each of these conclusions. We are particularly pleased that you have resisted the temptation to rely on speculative gains such as projected budget surpluses and higher market returns to close Social Security's fiscal gap. Either strategy is fraught with peril,'' Rudman and Nunn warn.

''The Concord Coalition supports the approach taken by Kolbe-Stenholm and by Gregg-Breaux because both plans are powerful antidotes to the free lunch disease that is gripping the Social Security debate. Compared with the other proposals being considered, these plans come closest to meeting the Concord Coalition's criteria. They reduce future benefits on a progressive basis, modestly raise the eligibility age, provide a more accurate Consumer Price Index, create individually owned retirement accounts without relying on projected budget surpluses, and they have bipartisan support,'' said Concord Coalition Policy Director Robert Bixby.

''The Concord Coalition also commends Chairman Archer and all of the witnesses at this week's hearings for putting forth the specifics of their Social Security reform plans. The safest place is always on the sidelines. However, if the end result of the Social Security debate is to avoid all the hard choices, we might as well launch a new government program to find the fountain of youth because otherwise we will never be able to meet all of our future benefit obligations,'' Bixby said.

THE CONCORD COALITION,
Washington DC, June 9, 1999.

Hon. JUDD GREGG,
Hon. JOHN BREAUX,
Hon. ROBERT KERREY,
Hon. CHARLES GRASSLEY,
U.S. Senate,
Washington, DC.

DEAR MR. GREGG, MR. BREAUX, MR. KERREY, AND MR. GRASSLEY: The Concord Coalition heartily commends you and the other co-sponsors of the Bipartisan Social Security Agreement. Together, you have demonstrated political courage by making the kind of hard choices that must be made to preserve Social Security in a fiscally responsible and generationally fair manner.

For the past two years the Concord Coalition has devoted much of its time and resources to promoting bipartisan dialogue on the key long-term challenges facing Social Security, and evaluating potential solutions.

Three conclusions stand out:

First, changing demographics make the current pay-as-you-go benefit structure unsustainable. Absent change, the system will either burden future workers with steep tax hikes, or betray future retirees with deep benefit cuts. Take the year 2033 as an example. While the Social Security trust fund will still be officially solvent in that year, the program is projected to be running a cash deficit of some $280 billion in today's dollars—an amount roughly equal to this year's entire budget for national defense. Closing the gap that year would require a Social Security payroll tax hike of 40% or a nearly 30% cut in benefits.

Second, there are only two roads to genuine reform, and a workable plan must pursue both. Reform must reduce Social Security's long-term burden by reducing its long-term costs. And it must make the remaining burden more bearable by increasing national savings, and hence the size of tomorrow's economic pie. Doing so requires the hard choices of fiscal discipline. In short, there are no magic bullets.

Third, the time for action is now. The longer reform is delayed, the worse the problem will become and the more draconian the solutions will be. Moreover, delay risks losing a valuable opportunity to act while the economy remains strong, the huge baby boom generation is still in its peak earning years, and the Social Security trust fund is running an ample cash surplus.

The Concord Coalition commends your efforts because the Bipartisan Agreement recognizes each of these conclusions. We are particularly pleased that you have resisted the temptation to rely on speculative gains such as projected budget surpluses and higher returns to close Social Security's fiscal gap. Either strategy is fraught with peril.

Projected budget surpluses may never come to pass. And even if they do, there are many other competing claims on this hoped for windfall. Market gains can certainly help workers earn a higher return on their payroll contributions. But it would be irresponsible to ignore structural reforms in favor of simply ''playing the spread'' between the expected returns on stocks and bonds.

Another advantage of your plan is that it does not rely on double counting assets by crediting funds both to the Social Security trust fund and to some other purpose such as debt reduction or individual accounts. Money cannot be spent twice. Plans that purport to do so are ducking the real question of how future benefits will actually be paid.

As the President's Office of Management and Budget (OMB) has observed about the trust funds:

. . . [T]hey are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing benefits or other expenditures. The existence of large trust fund balances, therefore, does not, by itself, have any impact on the Government's ability to pay benefits.

Analytical Perspectives, Budget of the United States Government, Fiscal Year 2000 p. 337.

Given the difficult choices ahead, it is all too easy for elected officials to lament the problems while remaining silent on the solutions. Clearly, the authors of the Bipartisan Social Security Agreement have answered this challenge.

The Concord Coalition is currently developing its own Social Security reform proposals. While in the end Concord may not endorse every element of your plan, we recognize that there is no such thing as a ''perfect'' plan. Trade-offs will always need to be made. But we fully support the bipartisan, fiscally responsible, generationally fair path you have chosen. As the process of Social Security reform moves forward we hope that an increasing number of your colleagues will do what you have done—make the hard choices.

The Concord Coalition stands ready to assist in any way that we can.

Sincerely,

WARREN RUDMAN,
Co-Chairman.
SAM NUNN,
Co-Chairman.

NATIONAL ASSOCIATION OF MANUFACTURERS,
Washington, DC, June 3, 1999.

Hon. JUDD GREGG,
U.S. Senate,
Washington, DC.

DEAR SENATOR GREGG: American workers and future retirees would have much to gain under your bipartisan Social Security modernization plan that would allow workers the opportunity to invest a portion of their Social Security payroll taxes in personal retirement accounts. Not only does the plan help workers accumulate adequate resources for retirement, but it also restores the 75-year solvency of the Social Security Trust Fund. Individuals would own the accounts and could pass the money on to their heirs.

Thank you for your outstanding leadership as an original cosponsor of this plan; it would achieve real Social Security reform without a tax increase, accounting gimmicks or dependence on budget surpluses. This reform plan will help prepare for the retirement of the baby boom generation when the Trust Fund begins paying out more than it received in payroll taxes by 2014. At the same time, the plan would maintain a safety net for all workers, while establishing a guaranteed minimum benefit for low-income workers not available under current law.

The NAM and its 14,000 member companies appreciate your leadership of the 1997–98 bipartisan National Commission on Retirement Policy, on S. 2313 and your work this year to broaden cosponsors for the 1999 plan. Thank you for your commitment to reform and we look forward to working with you toward passage of Social Security legislation that assures retirement security for all workers and promises a viable economy for America's future.

Sincerely,

SHARON F. CANNER,
Vice President.

ALLIANCE FOR WORKER RETIREMENT SECURITY,
Washington, DC, July 15, 1999.

Hon. JUDD GREGG,
U.S. Senate,
Washington, DC.

DEAR SENATOR GREGG: On behalf of the thirty organizations that comprise the

AWRS, I would like to extend congratulations on the introduction of your Bipartisan Social Security Reform bill. While acknowledging the financial shortfall ahead, you and the other co-sponsors have succeeded in developing a plan that saves Social Security and is fair for American workers, employers, and retirees alike.

The members of AWRS are committed to the responsible reform of Social Security—not just accounting gimmicks. We are pleased to see that your bill meets all of the principles for reform set forth by the AWRS, including the creation of Personal Retirement Accounts from a portion of the FICA taxes with no FICA tax increases, no government ownership of private enterprise, and a strong safety net for all retirees while preserving the benefits of existing retirees. In fact, your bill is *more* progressive than the existing system and will result in more of our elderly being lifted out of poverty. As the debate moves forward, we will have suggestions for modest changes or elaborations, but we support your bill as an excellent staring point for reform.

We are especially pleased that your legislation restructures the existing system and reduces the huge unfunded liabilities ahead of us. Workers and employers already pay an astounding 12.4% of earnings to fund Social Security. They cannot be asked to also carry the burden of a projected $20 trillion shortfall over the next 75 years! The weight of this burden would certainly have a very negative impact on wage growth, workers' ability to save, and the overall economy.

Instead, you have wisely chosen to follow the course already charted by countries all over the world that have faced similar demographic problems in their public pension systems. More than fifteen countries—who were also facing huge future funding shortfalls—have voted to restructure their pay-as-you-go system to allow workers to invest their payroll taxes in the growing economic market. And, *no* country has chosen to simply raise taxes, create a new entitlement system, or hide the problem behind accounting gimmicks.

Along with your other co-sponsors, we commend for your courage and your ability to find responsible answers to difficult entitlements' problems. We will urge your colleagues in the Senate to get involved with you and work in a bi-partisan manner to achieve reform now. There is no better time—and the children, the workers, and the elderly in our country deserve nothing less.

Sincerely,

LEANNE J. ABDNOR.

NATIONAL ASSOCIATION FOR THE SELF-EMPLOYED,
Washington, DC, July 13, 1999.

Hon. JUDD GREGG,
U.S. Senate,
Washington, DC.

DEAR SENATOR GREGG: On behalf of the more than 330,000 members of the National Association for the Self-Employed, as well as millions of other independent entrepreneurs in America, we commend you for introducing the Senate Bipartisan Social Security Plan.

The bill that you and six of your Senate colleagues are introducing meets the criteria that the NASE has long sought for Social Security reform:

It does not increase payroll taxes or add to the current Social Security tax inequities of the self-employed.

It avoids changing retirement benefits for current and near retirees.

It actually increases the defined benefit safety net for future retirees.

It reduces the huge unfunded liability of the Social Security system, and

It permits a portion of Social Security taxes to be allocated to personal retirement accounts that workers themselves would own and control.

In addition to these noteworthy achievements, your bill would keep Social Security solvent for at least 75 years, according to the Social Security Administration's own actuaries. And it would do so without raising the retirement age, creating an entirely new entitlement system, or relying on government IOU's to prop up the Social Security Trust Fund.

This is genuine and thorough reform. It would put the nation's moral obligation to its retirees on the soundest financial footing that it's had in at least a generation.

We hope your bill will lead the way in the forthcoming effort to reform Social Security.

Sincerely,

BERNIE L. THAYER,
President and CEO.

ECONOMIC SECURITY 2000,
Washington, DC, July 15, 1999.

Hon. JUDD GREGG,
Hon. JOHN BREAUX,
Hon. BOB KERREY,
Hon. CHARLES GRASSLEY,
Washington, DC.

DEAR SENATORS GREGG, BREAUX, KERREY AND GRASSLEY: Economic Security 2000 applauds the introduction of your comprehensive, fiscally responsible Bipartisan Social Security Agreement. This plan saves Social Security for 75 years and beyond, without placing future tax burdens on younger generations. More importantly, it addresses the broader issue of retirement security by creating Personal Retirement Accounts, which open up meaningful savings and ownership to all Americans.

We commend the Bipartisan Social Security Agreement for strengthening the safety net guarantees that have been the bedrock of Social Security. In maintaining the progressive structure of the guaranteed Social Security benefit, the plan increases the defined benefit for lower-income workers whom otherwise have little or no opportunity for saving.

The Bipartisan Agreement provides a real opportunity for working Americans to build a nest egg for themselves and their children. Fifty-three percent of Americans earn less than $18,000. Yet, the $18,000 workers pays over $2,200 in payroll taxes each year. By allowing a portion of the current FICA tax to be diverted into an individually owned and controlled savings account, every American is given the opportunity to accumulate meaningful savings and real retirement security. Moreover, these accounts mirror the progressive nature of Social Security through government savings matches for lower-wage workers.

As a grassroots organization, we have a unique understanding of the American public's desire for a Social Security solution that provides real ownership and control over their retirement assets. You have demonstrated great leadership and courage by making the tough decisions necessary to preserve Social Security for today's seniors as well as future generations. We thank you for your efforts.

Sincerely,

SAM BEARD,
Founder/President.

NATIONAL ASSOCIATION OF WOMEN BUSINESS OWNERS,
Silver Springs, MD, July 14, 1999.

Hon. JUDD GREGG,
Hon. JOHN BREAUX,
Hon. BOB KERREY,
Hon. CHARLES GRASSLEY,
U.S. Senate, Washington, DC.

DEAR SENATORS GREGG, BREAUX, KERREY, AND GRASSLEY: The National Association of Women Business Owners (NAWBO) commends you for the introduction of the Senate Bi-Partisan Social Security Reform Bill. NAWBO's membership represents 9.1 million women business owners who employ 27.5 million workers, and we believe this legislation would be good for all those whom we represent.

NAWBO has extensively reviewed the Social Security reform measures being discussed in Congress, and developed a set of principles which include giving all workers the opportunity to use a portion of their FICA taxes to create Personal Retirement Accounts. No one knows better the importance of personal ownership and control than the millions of women who own businesses. We strongly support extending this principle of ownership and control to all workers through the creation of thes PRAs. Likewise, we believe the Social Security Administration must continue to provide a strong safety net-guaranteed minimum benefit-for all retirees. We must lift even more of our elderly, most of whom are women, out of poverty.

Your legislation achieves these goals and more. It reduces the unfunded liability of the Social Security System (currently set by SSA at $20 trillion over the next 75 years), saves Social Security and puts it on a permanently sustainable path. Your bill is strongly bi-partisan, which is required for any reform measure to pass Congress. In other words, it is fair to all constituencies, not just a segment of the population.

NAWBO is a member of the Alliance for Worker Retirement Security. We will continue to work with AWRS and you to secure our future.

Sincerely,

TERRY NEESE,
Past President, Corporate & Public Policy Advisor.

THE BUSINESS ROUNDTABLE,
Washington, DC, July 16, 1999.

Hon. JUDD GREGG,
U.S. Senate, Washington, DC.

DEAR SENATOR GREGG: I would like to congratulate you on your efforts to move forward this critical debate on the future of Social Security. The ''Senate Bi-Partisan Social Security Bill'' is largely consistent with the principles The Business Roundtable developed to guide its members as we participate in this important debate.

Based on the information we have reviewed, there are several positive elements of your plan that deserve special recognition. The plan is more progressive than the current system in that low-wage workers will receive a higher defined benefit than is promised from the current Social Security system. It insures that general revenues would be used responsibly to save Social Security, not create a new entitlement system. You have also stepped up to the plate and addressed the hard choices we all know must be faced. The bill would reduce the unfunded liability of the Social Security System, currently set by the Social Security Administration at $20 trillion, over the next 75 years. In addition, all workers under age 62 would receive Personal Retirement Accounts that they own, control, and can pass on to their heirs.

Of course, there are issues we would like to explore in more depth as this and other proposals are debated. For example, we have concerns about how individual accounts are invested, and would like to learn more about your proposal to model the accounts on the federal Thrift Savings Plan. We would encourage as many investment options as possible to allow individuals to diversify their accounts and prevent undue market concentration. It also is inclear how corporate governance concerns, such as the voting of

proxies, would be handled. Finally, we would like to explore the interaction between individuals accounts and employer-sponsored retirement plans. The ability of individuals to make additional voluntary contributions to their accounts under your plan may inadvertently have a negative impact on private plans. Again, this is an issue we would like to discuss with you as your proposal is fleshed out.

These issues are not meant to overshadow the critical contribution you have made to advance this debate. Most importantly, the proposal enjoys bipartisan support. The only way we will, or should, adopt comprehensive Social Security reform is if we all work together as a nation to develop a plan that keeps its promises to current retirees and those near retirement while meeting the needs of future generations.

The Business Roundtable looks forward to working with you, and with every other member of Congress as well as the Clinton Administration, to promote responsible reform of our Social Security system.

Sincerely,

M. ANTHONY BURNS,
Chairman & CEO, Ryder System, Inc., Chairman, Health and Retirement Task Force, The Business Roundtable.

COUNCIL FOR GOVERNMENT REFORM,
Arlington, VA, July 8, 1999.

Senator JUDD GREGG,
Senator JOHN BREAUX,
Senator BOB KERREY,
Senator CHARLES GRASSLEY,
Washington, DC

DEAR SENATORS GREGG, BREAUX, KERREY, AND GRASSLEY: On behalf of the Council for Government Reform's 350,000 supporters, let me congratulate you on your hard work and diligence in preparing the Senate Bipartisan Social Security bill. You are very courageous to offer a detailed plan that actually addresses some of the long-term structural and demographic problems that unquestionably confront our current pay-as-you-go system. The Council for Government Reform strongly agrees with many of the principles put forth in your legislation.

The introduction of your legislation indicates that prospects for true Social Security reform are not dead in the 106th Congress. Rather, you offer the hope that some short-sighted, new entitlement system that would even further saddle our most recently born children, as well as future generations, with high taxes will not be adopted.

Although this is not the first major proposal in the 106th Congress, the Senate Bipartisan Social Security bill actually addresses some of the underlying programs in the Social Security system. It avoids the pitfalls of adding-on additional taxes, creating new entitlement programs, or sabotaging personal retirement accounts. This legislation will spark the Social Security reform debate towards a dynamic, solvent, and efficient Social Security system for the 21st century.

The keys to bipartisan legislative potential are individual ownership of retirement accounts, guaranteed minimum benefits, and a reliance on a ''carve-out,'' rather than an ''add-on.'' The carve-out vs. add-on distinction is crucial because add-ons carry with them implicit tax increases while carve-outs allow for better investment of funds already taxed away from American workers.

The Council for Government Reform is very pleased that the Senate Bipartisan Social Security bill would eliminate the earning test. This is important to CGR's supporters nationwide, many of whom want to continue to earn income without suffering a loss in their Social Security benefits.

Equally important, this is a bipartisan bill which indicates its appeal can cross party lines and gain widespread support on Capital Hill. Given the poisonous political environment and the election coming up, only bipartisan bills stand a chance of going anywhere. The only question is whether common sense, political courage, and the public interest can prevail in bringing this debate to the forefront.

Gentleman, on behalf of the Council, I sincerely thank you for your efforts and stand ready to assist you in creating a retirement income security system that protects current retirees while saving our children and grandchildren from bankruptcy.

Very truly yours,

CHARLES G. HARDIN,
President.

UNITED SENIORS ASSOCIATION, INC.,
Fairfax, VA, July 15, 1999.

Hon. JOHN BREAUX,
Hon. JUDD GREGG,
Hon. CHARLES GRASSLEY,
Hon BOB KERREY,
U.S. Senate,
Washington, DC.

DEAR SENATORS BREAUX, GREGG, GRASSLEY, AND KERREY: United Seniors Association (USA) greatly appreciates your efforts to save Social Security. The legislation you are introducing is timely and a significant step toward improving the program.

With Social Security in serious financial trouble, you recognize that the status quo is unacceptable. No later than 2014—just 15 years away—the program will begin to pay out more than it collects in payroll tax revenue. That is when Social Security's financial crisis really begins.

According to the 1999 Trustees Report, to keep Social Security solvent for the next 75 years will require raising the payroll tax to over 18% (a 50% increase), reducing benefits by at least one-third, or some combination of the two.

USA has long advocated that the current pay-as-you-go system must be redesigned to maintain solvency and to assure higher benefits for future retirees. The creation of Personal Retirement Accounts (PRAs), owned and controlled by workers, will help achieve these goals. While we favor allowing workers to privately invest at least 5 percentage points of their payroll taxes, your legislation is an excellent start.

There are many other attractive features of the legislation that will draw widespread support. These include: protecting current beneficiaries to whom promises have been made; rewarding work by eliminating the earnings test; and encouraging workers to increase savings.

On behalf of USA's 685,000 members, thank you for your concern about the retirement security of all Americans. We look forward to working with you to pass this important legislation.

Sincerely,

DORCAS R. HARDY,
Former Commissioner of Social Security and Policy Advisor to USA.

THE 60 PLUS ASSOCIATION,
Arlington, VA, July 13, 1999.

Hon. JUDD GREGG,
U.S. Senate,
Washington, DC.

DEAR SENATOR GREGG: The 60 Plus Association strongly endorses your proposal to safeguard Social Security. Especially significant, we believe, is that your proposal is bipartisan co-sponsored by your colleagues Senators Bob Kerrey, John Breaux and Charles Robb. Clearly, any reform must be palatable to both parties. Your measure reduces the unfunded liability of the Social Security system (currently set by the Social Security system) and saves Social Security for 75 years and even longer.

Significantly, all workers under the age of 62 would receive Personal Retirement Accounts that they own, control, and, most importantly, can pass on to their heirs.

60 Plus believes it is more progressive than the current system in that low-wage workers will receive a higher defined benefit than is promised from Social Security.

Your proposal doesn't raise the age at which you can get benefits although it accelerates the current law increase to 67. Also, it does not rely on IOUs in the Social Security Trust Fund. We hope that Congress will act on it soon.

Sincerely,

JAMES L. MARTIN,
President.

Mr. GREGG. Mr. President, I rise today to introduce what I truly believe is Congress's ''last, best hope'' to place Social Security on a course of long-term health in this session of Congress. I strongly urge my colleagues to look carefully at this bipartisan, bicameral, fiscally responsible plan, and to give their support to this, our best chance to meet our important responsibility to take action so as to enable Social Security to continue to meet its historic mission of providing senior citizens with insurance against poverty in old age.

The proposal that I will discuss was negotiated over several months between a bipartisan group of committed reformers in the Senate. It already has more cosponsors than any other competing proposal. Those cosponsors include myself, Senator BOB KERREY, Senator JOHN BREAUX, Senator CHUCK GRASSLEY, Senator FRED THOMPSON, Senator CHUCK ROBB, and Senator CRAIG THOMAS.

What I want to do in my remarks is to describe what our proposal would achieve, and then to provide some details as to how it achieves these goals. It would: s

Make Social Security solvent. Not simply for 75 years, but perpetually, as far as SSA can estimate. Our proposal would leave the system on a permanently sustainable path.

Increase Social Security benefits beyond what the current system can fund. I will follow up with some details as to why and how.

It would drastically reduce taxes below current-law levels. Again, I will provide details as to why and how it does this.

It will make the system far less costly than current law, and also less costly than competing reform proposals.

It will not touch the benefits of current retirees.

It will strengthen the ''safety net'' against poverty and provide additional protections for the disabled, for widows, and for other vulnerable sectors of the population.

It will vastly reduce the federal government's unfunded liabilities.

It would use the best ideas provided by reformers across the political spectrum, and thus offers a practical opportunity for a larger bipartisan agreement.

It will provide for fairer treatment across generations, across demographic

groups. It would improve the work incentives of the current system.

I would like now to explain how our proposal achieves all of these objectives:

Our system would make the system solvent for as far as the Social Security Actuaries are able to estimate.

How does it do this? Above all else, it accomplishes this through advance funding.

As the members of this Committee know, our population is aging rapidly. Currently we have a little more than 3 workers paying into the system for every 1 retiree taking out of it. Within a generation, that ratio will be down to 2:1.

As a consequence, if we did nothing, future generations would be assessed skyrocketing tax rates in order to meet benefit promises. The projected cost (tax) rate of the Social Security system, according to the Actuaries, will be almost 18% by 2030.

The Trust Fund is not currently scheduled to become insolvent until 2034, but as most acknowledge, the existence of the Trust Fund has nothing to do with the government's ability to pay benefits. President Clinton's submitted budget for this year made the point as well as I possibly could:

> These balances are available to finance future benefit payments and other trust fund expenditures—but only in a bookkeeping sense . . . They do not consist of real economic assets that can be drawn down in the future to fund benefits. Instead, they are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing benefits or other expenditures. The existence of large Trust Fund balances, therefore, does not, by itself, have any impact on the Government's ability to pay benefits.

In other words, we have a problem that arises in 2014, not in 2034, and it quickly becomes an enormous one unless we find a way to put aside savings today. This does not mean simply adding a series of credits to the Social Security Trust Fund, which would have no positive impact, as the quote from the President's budget clearly shows.

What we have to do is begin to advance fund the current system, and that means taking some of that surplus Social Security money today out of the federal coffers and into a place where it can be saved, invested—owned by individual beneficiaries. That money would belong to them immediately, even though they could not withdraw it before retirement. But it would be a real asset in their name.

By doing this, we can reduce the amount of the benefit that needs to be funded in the future by raising taxes on future generations. This is the critical objective, but it allows for flippant political attacks. If you give someone a part of their benefit today, in their personal account, and less of it later on, some will say that it is a ''cut'' in benefits. It is no such thing. Only in Washington can giving people ownership rights and real funding for a portion of their benefits, and increasing their total real value, be construed as a cut. Accepting such terminology can only lead to one conclusion—that we can't advance fund, because we simply have to be sure that every penny of future benefits comes from taxing future workers. So we need to get out of that rhetorical trap.

Our proposal has been certified by the actuaries as attaining actuarial solvency, and in fact it goes so far as to slightly overshoot. We are ''overbalanced'' in the years after 2050, and have some room to modify the proposal in some respects and yet still stay in balance.

I would note the consensus that has developed for some form of advance funding. This was one of the few recommendations that united an otherwise divided Social Security Advisory Council in 1996. The major disagreements today among policymakers consist only in the area of who should control and direct the investment opportunities created within Social Security. I believe strongly, and I believe a Congressional majority agrees, that this investment should be directed by individual beneficiaries, not by the federal government or any other public board.

We have worked with the Social Security actuaries and the Congressional Research Service to estimate the levels of benefits provided under our plan.

There are certain bottom-line points that should be recognized about our plan. Among them:

(1) Low-wage earners in every birth cohort measured would experience higher benefits under our plan than current law can sustain, even without including the proceeds from personal accounts.

(2) Average earners in every birth cohort measured would experience higher benefits under our plan than current law can sustain, even if their personal accounts only grew at the projected bond rate of 3.0%.

(3) Maximum earners in some birth cohorts would need either to achieve the historical rate of return on stocks, or to put in additional voluntary contributions, in order to exceed benefit levels of current law. However, the tax savings to high-income earners, which I will outline in the next section, will be so great that on balance they would also benefit appreciably from our reform plan.

Under current law, a low-wage individual retiring in the year 2040 at the age of 65 would be promised a monthly benefit of $752. However, due to the pending insolvency of the system, only $536 of that can be funded. We cannot know in advance how future generations would distribute the program changes between benefit cuts and tax increases. But we do know that our plan, thanks to advance funding, would offer a higher benefit to that individual, from a fully solvent system that would eliminate the need for those choices.

I will provide tables that are based on the research of the Congressional Research Service that make clear all of the above points. The CRS makes projections that assume that under current law, benefits would be paid in full until 2034, and then suddenly cut by more than 25% when the system becomes insolvent. CRS can make no other presumption in the absence of advance knowledge of how Congress would distribute the pain of benefit reductions among birth cohorts. In order to translate the CRS figures into a more plausible outcome, we added a column showing the effects that would come from the benefit reductions under current law being shared equally by all birth cohorts.

BENEFIT TABLE NO. 1.—THE BIPARTISAN PLAN'S BENEFITS WOULD BE HIGHER FOR LOW-INCOME WORKERS EVEN WITHOUT COUNTING PERSONAL ACCOUNTS

[(Assumes Steady Low-Wage Worker) (Monthly Benefit, 1999 Dollars) (Assumes Retirement at Age 65)]

Yr. and current law (benefit cuts begin in 2034)		Current law sustainable*	Bipartisan plan (bond rate no vol. contrib.)	Bipartisan plan (w/o account benefits)	Bipartisan plan (w/ 1% voluntary contributions)
2000	626	517	615	606	627
2005	624	515	620	601	645
2010	652	539	698	667	738
2015	673	556	733	687	790
2020	660	545	754	691	832
2030	690	570	776	694	877
2035	512	595	798	693	926
2040	536	621	821	689	981
2050	582	678	869	710	1051
2060	611	739	920	749	1107

*The Congressional Research Service, in the left-hand column, assumes that all of the burden of benefit changes under current law will commence in 2034. In order to produce a more realistic prediction of how the changes required under current law would be spread, the ''current law sustainable'' column assumes that they have been spread equally among birth cohorts throughout the valuation period.

BENEFIT TABLE NO. 2: THE BIPARTISAN PLAN'S BENEFITS WOULD BE HIGHER FOR AVERAGE-INCOME WORKERS EVEN IF ACCOUNTS EARN ONLY A BOND RATE OF RETURN (3.0%)

[(Assumes Steady Average-Wage Worker) (Monthly Benefit, 1999 Dollars) (Assumes Retirement at Age 65)]

Yr and current law (benefit cuts begin in 2034)		Current law sustainable*	Bipartisan plan (bond rate, no voluntary	Bipartisan plan (stock rate)	Bipartisan plan (w/ 1% vol. contributions, bond rate)
2000	1032	852	1014	1016	1029
2005	1031	852	973	982	1006
2010	1076	889	991	1014	1046
2015	1111	918	977	1024	1057
2020	1090	900	1005	1092	1115
2030	1139	941	1083	1183	1179
2035	845	982	1063	1307	1250
2040	884	1026	1093	1476	1329
2050	961	1119	1157	1672	1442
2060	1007	1221	1225	1778	1531

*The Congressional Research Service, in the left-hand column, assumes that all of the burden of benefit changes under current law will commence in 2034. In order to produce a more realistic prediction of how the changes required under current law would be spread, the ''current law sustainable'' column assumes that they have been spread equally among birth cohorts throughout the valuation period.

The alternative course is that current benefit promises would be met in full by raising taxes, both under current law and under proposals to simply transfer credits to the Social Security Trust Fund. I have also provided a table that shows the size of these tax costs, and will comment further upon them in the next portion of my statement.

I would like to point out that these figures apply to individuals retiring at

the age of 65. Thus, even with the increased actuarial adjustment for early retirement under our plan, and even though our plan would accelerate the pace at which the normal retirement age would reach its current-law target of 67, benefits under our proposal for individuals retiring at 65 would still be higher.

Our tables also show that the progressive match program for low-income individuals will also add enormously to the projected benefits that they will receive.

If there is a single most obvious and important benefit of enacting this reform, it is in the tax reductions that will result from it.

I am not referring to the most immediate tax reduction, the payroll tax cut that will be given to individuals in the form of a refund into a personal account.

The greatest reduction in taxes would come in the years from 2015 on beyond. At that time, under current law—and under many reform plans—enormous outlays from general revenues would be needed to redeem the Social Security Trust Fund, or to fund personal accounts. The net cost of the system would begin to climb. The federal government would have to collect almost 18% of national taxable payroll in the year 2030, more than 5 points of that coming from general revenues.

The hidden cost of the current Social Security system is not the payroll tax increases that everyone knows would be required after 2034, but the general tax increases that few will admit would be required starting in 2014.

With my statement, I include a table showing the effective tax rate costs of current law as well as the various actuarially sound reform proposals that have been placed before the Congress. These figures come directly from the Social Security actuaries. They include the sum of the costs of paying OASDI benefits, plus any mandatory contributions to personal accounts. (Under our proposal, additional voluntary contributions would also be permitted. But any federal ''matches'' of voluntary contributions from general revenues would be contingent upon new savings being generated.)

Let me return to our individual who is working in the year 2025 under current law. In that year, a tax increase equal to 3.61% of payroll would effectively need to be assessed through general revenues in order to pay promised benefits. As a low-income individual, his share of that burden would be less than if it were assessed through the payroll tax, but it would still be real. Under current law, his income tax burden comes to about $241 annually.

COMPARISON OF COST RATES OF CURRENT LAW AND ALTERNATIVE PLANS

[(As a percentage of taxable payroll) (Annual cost includes OASDI outlays plus contributions to personal accounts.) Peak cost year in italic]

Year	and current law	Archer/ Shaw	Senate Bipartisan	Kolbe/ Stenholm	Gramm	Nadler
2000	10.8	12.8	12.7	12.9	15.0	10.4*
2005	11.2	13.3	13.2	13.0	15.2	10.6
2010	11.9	13.9	13.4	13.4	15.6	11.2
2015	13.3	15.0	14.0	14.0	16.4	12.5
2020	15.0	16.4	14.7	14.8	17.3	12.8 (14.2)
2025	16.6	17.4	15.4	15.6	*17.6*	14.4 (15.8)
2030	17.7	*17.8*	*15.7*	*15.7*	17.1	15.5 (16.9)
2035	18.2	17.3	15.5	15.2	16.4	15.9 (17.4)
2040	18.2	16.2	14.8	14.5	15.2	16.0 (17.5)
2045	18.2	14.9	14.3	13.8	14.1	16.1 (17.5)
2050	18.3	13.8	13.9	13.3	13.4	16.3 (17.7)
2055	18.6	13.1	13.7	13.2	13.0	16.6 (18.0)
2060	19.1	12.6	13.7	13.1	12.8	16.9 (18.5)
2065	19.4	12.3	13.6	13.4	12.5	17.1 (18.8)
2070	*19.6*	12.1	13.5	13.7	12.4	*17.3 (19.0)*

(Figures come from analyses completed of each plan by Social Security actuaries. Archer/Shaw plan memo of April 29, 1999. Senate bipartisan plan (Gregg/Kerrey/Breaux/Grassley et al) memo of June 3, 1999. Kolbe/Stenholm plan memo of May 25, 1999. Gramm plan memo of April 16, 1999. Nadler plan memo of June 3, 1999. Nadler plan total cost given in parentheses, cost estimate given on assumption that stock sales reduce amount of bonds that must be redeemed from tax revenue. Due to construction of plans, cost rates for the Archer/Shaw, Gramm, and Nadler plans would vary according to rate of return received on stock investments.)

*Tax rate of Nadler plan is lower than current law not because total costs are less but because amount of national income subject to tax is greater. In order to compare total costs of Nadler plan to other plans, cost rate given in Nadler column must be multiplied by a factor that varies through time. This factor would be close to 1.06 in the beginning of the valuation period, and would gradually decline to 1.03 at the end. For example, the tax rate given as 11.2% in 2010 under the Nadler column would equate to the same total tax cost as the 11.9% figure in the current law column.

PART II—COMPARISON OF COST RATES OF CURRENT LAW AND ALTERNATIVE PLANS

[As a percentage of taxable payroll—annual cost includes OASDI outlays plus contributions to personal accounts—peak cost year in italic]

Year	Current law	Moynihan/ Kerrey
2000	10.8	*11.1 (13.1)
2005	11.2	11.0 (13.0)
2010	11.9	10.9 (12.9)
2015	13.3	11.5 (13.5)
2020	15.0	12.2 (14.2)
2025	16.6	13.2 (15.2)
2030	17.7	13.8 (15.8)
2035	18.2	14.0 (16.0)
2040	18.2	14.0 (16.0)
2045	18.2	14.0 (16.0)
2050	18.3	14.2 (16.2)
2055	18.6	14.5 (16.5)
2060	19.1	14.7 (16.7)
2065	19.4	14.8 (16.8)
2070	*19.6*	*14.9 (16.9)*

* (Analysis of Moynihan/Kerrey plan is based on SSA actuaries' memo of January 11, 1999, and is listed separately because it is the only projection provided here based on the 1998 Trustees' Report. 1999 re-estimates would vary. Unlike the other personal account proposals, the accounts in Moynihan/Kerrey plan are voluntary. The figure without parentheses assumes no contributions to, and thus no income from, personal accounts. The figure inside parentheses assumes universal participation in 2% personal accounts, for comparison with other personal account plans.)

*—Like the Nadler plan, the Moynihan/Kerrey plan would increase the share of national income subject to Social Security taxation, but to a lesser degree. Thus, tax rates will appear lower than would an equivalent amount of tax revenue collected under the Archer/Shaw, Gramm, or Kolbe/Stenholm plans. The correction factor required to translate one cost rate into another would be between 1.03–1.06 for the Nadler proposal, 1.01–1.02 for the Senate bipartisan proposal, and 1.01–1.04 for the Moynihan/Kerrey proposal.

Under our proposal, that tax burden would drop by roughly 37%, from $241 to $153.

Middle and high-income workers would not experience benefit increases as generous as those provided to low-income individuals under our plan. But we have determined that by the year 2034, an average wage earner would save the equivalent of $650 a year (1999 dollars) in income taxes, and a maximum-wage earner, $2,350 a year. I want to stress that these savings are net of any effects of re-indexing CPI upon the income tax rates. These are net tax reductions, even including our CPI reforms.

I would also stress that 2025 is not a particularly favorable example to select. Our relative tax savings get much larger after that point, growing steadily henceforth.

A look at our chart showing total costs reveals how quickly our proposal, as well as the Kolbe-Stenholm proposal, begins to reduce tax burdens.

A plan as comprehensive as ours can be picked apart by critics, provision by provision. It is easy to criticize a plan's parts in isolation from the whole, and to say that one of them is disadvantageous, heedless of the other benefits and gains provided. One reason for the specific choices that we made is revealed in this important table. The result of not making them is simply that, by the year 2030, the effective tax rate of the system will surpass 17%, an unfortunate legacy to leave to posterity.

How would current retirees be affected by our proposal?

Only in one way. Their benefits would come from a solvent system, and therefore, political pressure to cut their benefits will be reduced. Our proposal would not affect their benefits in any way. Even the required methodological corrections to the Consumer Price Index would not affect the benefits of current retirees.

Under current law, there is no way of knowing what future generations will do when the tax levels required to support this system begin to rise in the year 2014. We do not know whether future generations will be able to afford to increase the tax costs of the system to 18% of the national tax base by the year 2030, or whether other pressing national needs, such as a recession or an international conflict will make this untenable. Current law may therefore contain the seeds of political pressure to cut benefits. Moreover, as general revenues required to sustain the system grow to the levels of hundreds of billions each year, there is the risk that upper-income individuals will correctly diagnose that the system has become an irretrievably bad deal for them, and that they will walk away from this important program.

By eliminating the factors that might lead to pressure to cut benefits, our proposal would keep the benefits of seniors far more secure.

Poverty would be reduced under our proposal, even if the personal accounts do not grow at an aggressive rate. The reason for this is that our proposal would increase the progressivity of the basic defined, guaranteed Social Security benefit. It would also gradually phase in increased benefits for widows.

Moreover, our plan would protect the disabled. They would be unaffected by the changes made to build new saving into the system. Their benefits would not be impacted by the benefit offsets proportional to personal account contributions. If an individual becomes disabled prior to retirement age, they would receive their current-law benefit.

It is important to recognize that we do not face a choice between maintaining Social Security as a ''social insurance'' system and as an ''earned benefit.'' It has always served both functions, and it must continue to do so in order to sustain political support. The system must retain some features of being an ''earned benefit'' so as not be reduced to a welfare program only. This is why proposals to simply bail out the system through general revenue transfusions alone—to turn it into, effectively, another welfare program in which contributions and benefits are not related—are misguided and undermine the system's ethic.

Again, I would repeat that our proposal contains important benefits for all individuals. Guaranteed benefits on the low-income end would be increased. High income earners would be spared the large current-law tax increases that would otherwise be necessary. If we act responsibly and soon, we can accomplish a reform that serves the interests of all Americans.

By putting aside some funding today, and reducing the proportion of benefits that are financed solely by taxing future workers, our proposal would vastly reduce the system's unfunded liabilities.

Consider such a year as 2034. Under current law, the government would have a liability from general revenues to the Trust Fund equal to an approximately 5 point payroll tax increase. By advance funding benefits, our plan would reduce the cost of OASDI outlays in that year from more than 18% to less than 14%. The pressure on general revenue outlays would be reduced by more than half.

The Social Security system would be left on a sustainable course. The share of benefits each year that are unfunded liabilities would begin to go down partway through the retirement of the baby boom generation. By the end of the valuation period, the actuaries tell us, the system would have a rising amount of assets in the Trust Fund.

Mr. President, I would stress to you that our plan is not the work of any one single legislator. It is the product of painstaking negotiations conducted over several months. The seven names that you see on the proposal are not the only ones who contributed to it. We took the best ideas that we could find from serious reform plans presented across the political spectrum. Each of us had to make concessions that we did not like. But we did this in the interest of reaching a bipartisan accord.

We believe that our plan is indicative of the product that would result from a larger bipartisan negotiation in the Congress. Accordingly, we believe that it provides the best available vehicle for negotiations with the President if he chooses to become substantively involved. It was our hope to put forth a proposal on a bipartisan basis, so that the President would not have to choose between negotiating with a ''Republican plan'' or a ''Democratic plan.'' Stalemate will not save our Social Security system.

The changes effected in our bipartisan bill do not, all of them, relate solely to fixing system solvency.

One area of reforms includes improved work incentives. Our proposal would eliminate the earnings limit for retirees. It would also correct the actuarial adjustments for early and late retirement so that beneficiaries who continue to work would receive back in benefits the value of the extra payroll taxes they contributed. The proposal would also change the AIME formula so that the number of earnings years in the numerator would no longer be tied to the number of years in the denominator. In other words, every year of earnings, no matter how small, would have the effect of increasing overall benefits (Under current law, only the earnings in the top earnings years are counted towards benefits, and the more earnings years that are counted, the lower are is the resulting benefit formula.)

We also included several provisions designed to address the needs of specific sectors of the population who are threatened under current law. For example, we gradually would increase the benefits provided to widows, so that they would ultimately be at least 75% of the combined value of the benefits that husband and wife would have been entitled to on their own.

We also recognized the poor treatment of two-earner couples relative to one-earner couples under the current system. Our proposal includes five ''dropout years'' in the benefit formula pertaining to two earner couples, in recognition of the time that a spouse may have had to take out of the work force.

Unveiling a proposal as comprehensive as ours invariably creates misunderstanding as to the effect of its various provisions.

First, let me address the impact of our reforms on the Consumer Price Index. Most economists agree that further reforms are necessary to correct measures of the Consumer Price Index, and our proposal would instruct BLS to make them. Correcting the CPI would have an effect on government outlays as well as revenues. This is not a ''benefit cut'' or a ''tax increase,'' it is a correction. We would take what was incorrectly computed before and compute it correctly from now on. No one whose income stays steady in real terms would see a tax increase. No one's benefits would grow more slowly than the best available measure of inflation.

However, we wanted to be doubly certain that any effects of the CPI change upon federal revenues not become a license for the government to spend these revenues on new ventures. Accordingly, we included a ''CPI recapture'' provision to ensure that any revenues generated by this reform be returned to taxpayers as Social Security benefits, rather than being used to finance new government spending. This is the reason for the ''CPI recapture'' provision in the legislation.

Our proposal would not increase taxes in any form. The sum total of the effects of all provisions in the legislation that might increase revenues are greatly exceeded by the effects of the legislation that would cut tax levels. The chart showing total cost rates makes this clear.

Our provision to re-index the wage cap is an important compromise between competing concerns. Fiscal conservatives are opposed to arbitrarily raising the cap on taxable wages. The case made from the left is that, left unchanged, the proportion of national wages subject to Social Security taxation would actually drop.

Our proposal found a neat bipartisan compromise between these competing concerns. It would maintain the current level of benefit taxation of 86% of total national wages. This would only have an effect on total revenues if the current-law formulation would have actually caused a decrease in tax levels. If total wages outside the wage cap grow in proportion to national wages currently subject to taxation, there would be no substantive effect. This proposal basically asks competing concerns in this debate to ''put their money where their mouth is.'' If the concern is that we would otherwise have an indexing problem, this proposal would resolve it. If the concern is that we should not increase the proportion of total wages subject to taxation, this proposal meets that, too. I would further add that the figure we choose—86%—is the current-law level. Some proposals would raise this to 90%, citing the fact that at one point in history it did rise to 90%. The historical average has actually been closer to 84%, and we did not find the case for raising it to 90% to be persuasive. Keeping it at its current level of 86% is a reasonable bipartisan resolution of this issue.

In conclusion, this proposal represents our best hope to achieve meaningful and responsible bipartisan reform of Social Security in this Congress. It does not represent a partisan

''statement.'' It has not been drawn up in the spirit of ideological ''purity.'' Rather, it combines the best ideas of the most committed reformers in the Senate. I am grateful to the other negotiators who worked so hard to put together this package, and I thank them—Senator BOB KERREY, Senator JOHN BREAUX, Senator CHUCK GRASSLEY, Senator FRED THOMPSON, Senator CHUCK ROBB, and Senator CRAIG THOMAS—for their tireless efforts to get this job done.

It is not the plan that I would have drawn up by myself. It is not the plan that Senator KERREY would have drawn up by himself. Each of us had to give up something in the interest of crafting a proposal that truly represented a bipartisan compromise. Without such compromise, we will never be able to take action to safeguard benefits for our senior citizens.

I hope that my colleagues will join our bipartisan team and cosponsor this critically important legislation to reduce the unfunded liabilities of our Social Security system and to put critical funding and investment behind the benefits that it promises. I thank my colleagues and 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. 1383

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Bipartisan Social Security Reform Act of 1999.''

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—INDIVIDUAL SAVINGS ACCOUNTS

Sec. 101. Individual savings accounts.
Sec. 102. Social security KidSave Accounts.
Sec. 103. Adjustments to primary insurance amounts under part A of title II of the Social Security Act.

TITLE II—SOCIAL SECURITY SYSTEM ADJUSTMENTS

Sec. 201. Adjustments to bend points in determining primary insurance amounts.
Sec. 202. Adjustment of widows' and widowers' insurance benefits.
Sec. 203. Elimination of earnings test for individuals who have attained early retirement age.
Sec. 204. Gradual increase in number of benefit computation years; use of all years in computation.
Sec. 205. Maintenance of benefit and contribution base.
Sec. 206. Reduction in the amount of certain transfers to Medicare Trust Fund.
Sec. 207. Actuarial adjustment for retirement.
Sec. 208. Improvements in process for cost-of-living adjustments.
Sec. 209. Modification of increase in normal retirement age.
Sec. 210. Modification of PIA factors to reflect changes in life expectancy.
Sec. 211. Mechanism for remedying unforeseen deterioration in social security solvency.

TITLE I—INDIVIDUAL SAVINGS ACCOUNTS

SEC. 101. INDIVIDUAL SAVINGS ACCOUNTS.

(a) ESTABLISHMENT AND MAINTENANCE OF INDIVIDUAL SAVINGS ACCOUNTS.—Title II of the Social Security Act (42 U.S.C. 401 et seq.) is amended—

(1) by inserting before section 201 the following:

''PART A—INSURANCE BENEFITS'';

and

(2) by adding at the end the following:

''PART B—INDIVIDUAL SAVINGS ACCOUNTS

''INDIVIDUAL SAVINGS ACCOUNTS

''SEC. 251. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT IN ABSENCE OF KIDSAVE ACCOUNT.—Except as provided in subparagraph (B), the Commissioner of Social Security, within 30 days of the receipt of the first contribution received pursuant to subsection (b) with respect to an eligible individual, shall establish in the name of such individual an individual savings account. The individual savings account shall be identified to the account holder by means of the account holder's Social Security account number.

''(B) USE OF KIDSAVE ACCOUNT.—If a KidSave Account has been established in the name of an eligible individual under section 262(a) before the date of the first contribution received by the Commissioner pursuant to subsection (b) with respect to such individual, the Commissioner shall redesignate the KidSave Account as an individual savings account for such individual.

''(2) DEFINITION OF ELIGIBLE INDIVIDUAL.—In this part, the term 'eligible individual' means any individual born after December 31, 1937.

''(b) CONTRIBUTIONS.—

''(1) AMOUNTS TRANSFERRED FROM THE TRUST FUND.—The Secretary of the Treasury shall transfer from the Federal Old-Age and Survivors Insurance Trust Fund, for crediting by the Commissioner of Social Security to an individual savings account of an eligible individual, an amount equal to the sum of any amount received by such Secretary on behalf of such individual under section 3101(a)(2) or 1401(a)(2) of the Internal Revenue Code of 1986.

''(2) OTHER CONTRIBUTIONS.—For provisions relating to additional contributions credited to individual savings accounts, see sections 531(c)(2) and 6402(l) of the Internal Revenue Code of 1986.

''(c) DESIGNATION OF INVESTMENT TYPE OF INDIVIDUAL SAVINGS ACCOUNT.—

''(1) DESIGNATION.—Each eligible individual who is employed or self-employed shall designate the investment type of individual savings account to which the contributions described in subsection (b) on behalf of such individual are to be credited.

''(2) FORM OF DESIGNATION.—The designation described in paragraph (1) shall be made in such manner and at such intervals as the Commissioner of Social Security may prescribe in order to ensure ease of administration and reductions in burdens on employers.

''(3) SPECIAL RULE FOR 2000.—Not later than January 1, 2000, any eligible individual that is employed or self-employed as of such date shall execute the designation required under paragraph (1).

''(4) DESIGNATION IN ABSENCE OF DESIGNATION BY ELIGIBLE INDIVIDUAL.—In any case in which no designation of the individual savings account is made, the Commissioner of Social Security shall make the designation of the individual savings account in accordance with regulations that take into account the competing objectives of maximizing returns on investments and minimizing the risk involved with such investments.

''(d) TREATMENT OF INCOMPETENT INDIVIDUALS.—Any designation under subsection (c)(1) to be made by an individual mentally incompetent or under other legal disability may be made by the person who is constituted guardian or other fiduciary by the law of the State of residence of the individual or is otherwise legally vested with the care of the individual or his estate. Payment under this part due an individual mentally incompetent or under other legal disability may be made to the person who is constituted guardian or other fiduciary by the law of the State of residence of the claimant or is otherwise legally vested with the care of the claimant or his estate. In any case in which a guardian or other fiduciary of the individual under legal disability has not been appointed under the law of the State of residence of the individual, if any other person, in the judgment of the Commissioner, is responsible for the care of such individual, any designation under subsection (c)(1) which may otherwise be made by such individual may be made by such person, any payment under this part which is otherwise payable to such individual may be made to such person, and the payment of an annuity payment under this part to such person bars recovery by any other person.

''DEFINITION OF INDIVIDUAL SAVINGS ACCOUNT; TREATMENT OF ACCOUNTS

''SEC. 252. (a) INDIVIDUAL SAVINGS ACCOUNT.—In this part, the term 'individual savings account' means any individual savings account in the Individual Savings Fund (established under section 254) which is administered by the Individual Savings Fund Board.

''(b) TREATMENT OF ACCOUNT.—Except as otherwise provided in this part and in section 531 of the Internal Revenue Code of 1986, any individual savings account described in subsection (a) shall be treated in the same manner as an individual account in the Thrift Savings Fund under subchapter III of chapter 84 of title 5, United States Code.

''INDIVIDUAL SAVINGS ACCOUNT DISTRIBUTIONS

''SEC. 253. (a) DATE OF INITIAL DISTRIBUTION.—Except as provided in subsection (c), distributions may only be made from an individual savings account of an eligible individual on and after the earliest of—

''(1) the date the eligible individual attains normal retirement age, as determined under section 216 (or early retirement age (as so determined) if elected by such individual), or

''(2) the date on which funds in the eligible individual's individual savings account are sufficient to provide a monthly payment over the life expectancy of the eligible individual (determined under reasonable actuarial assumptions) which, when added to the eligible individual's monthly benefit under part A (if any), is at least equal to an amount equal to 1/12 of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2) and determined on such date for a family of the size involved) and adjusted annually thereafter by the adjustment determined under section 215(i).

''(b) FORMS OF DISTRIBUTION.—

''(1) REQUIRED MONTHLY PAYMENTS.—Except as provided in paragraph (2), beginning with the date determined under subsection (a), the balance in an individual savings account available to provide monthly payments not in excess of the amount described in subsection (a)(2) shall be paid, as elected by the account holder (in such form and manner as shall be prescribed in regulations of the Individual Savings Fund Board), by means of the purchase of annuities or equal monthly payments over the life expectancy of the eligible

individual (determined under reasonable actuarial assumptions) in accordance with requirements (which shall be provided in regulations of the Board) similar to the requirements applicable to payments of benefits under subchapter III of chapter 84 of title 5, United States Code, and providing for indexing for inflation.

''(2) PAYMENT OF EXCESS FUNDS.—To the extent funds remain in an eligible individual's individual savings account after the application of paragraph (1), such funds shall be payable to the eligible individual in such manner and in such amounts as determined by the eligible individual, subject to the provisions of subchapter III of chapter 84 of title 5, United States Code.

''(c) DISTRIBUTION IN THE EVENT OF DEATH BEFORE THE DATE OF INITIAL DISTRIBUTION.—If the eligible individual dies before the date determined under subsection (a), the balance in such individual's individual savings account shall be distributed in a lump sum, under rules established by the Individual Savings Fund Board, to the individual's heirs.

''INDIVIDUAL SAVINGS FUND

''SEC. 254. (a) ESTABLISHMENT.—There is established and maintained in the Treasury of the United States an Individual Savings Fund in the same manner as the Thrift Savings Fund under sections 8437, 8438, and 8439 (but not section 8440) of title 5, United States Code.

''(b) INDIVIDUAL SAVINGS FUND BOARD.—

''(1) IN GENERAL.—There is established and operated in the Social Security Administration an Individual Savings Fund Board in the same manner as the Federal Retirement Thrift Investment Board under subchapter VII of chapter 84 of title 5, United States Code.

''(2) SPECIFIC INVESTMENT AND REPORTING DUTIES.—

''(A) IN GENERAL.—The Individual Savings Fund Board shall manage and report on the activities of the Individual Savings Fund and the individual savings accounts of such Fund in the same manner as the Federal Retirement Thrift Investment Board manages and reports on the Thrift Savings Fund and the individual accounts of such Fund under subchapter VII of chapter 84 of title 5, United States Code.

''(B) STUDY AND REPORT ON INCREASED INVESTMENT OPTIONS.—

''(i) STUDY.—The Individual Savings Fund Board shall conduct a study regarding ways to increase an eligible individual's investment options with respect to such individual's individual savings account and with respect to rollovers or distributions from such account.

''(ii) REPORT.—Not later than 2 years after the date of enactment of the Bipartisan Social Security Reform Act of 1999, the Individual Savings Fund Board shall submit a report to the President and Congress that contains a detailed statement of the results of the study conducted pursuant to clause (i), together with the Board's recommendations for such legislative actions as the Board considers appropriate.

''BUDGETARY TREATMENT OF INDIVIDUAL SAVINGS FUND AND ACCOUNTS

''SEC. 255. The receipts and disbursements of the Individual Savings Fund and any accounts within such fund shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.''.

(b) MODIFICATION OF FICA RATES.—

(1) EMPLOYEES.—Section 3101(a) of the Internal Revenue Code of 1986 (relating to tax on employees) is amended to read as follows:

''(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—

''(1) IN GENERAL.—

''(A) INDIVIDUALS COVERED UNDER PART A OF TITLE II OF THE SOCIAL SECURITY ACT.—In addition to other taxes, there is hereby imposed on the income of every individual who is not a part B eligible individual a tax equal to 6.2 percent of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b)).

''(B) INDIVIDUALS COVERED UNDER PART B OF TITLE II OF THE SOCIAL SECURITY ACT.—In addition to other taxes, there is hereby imposed on the income of every part B eligible individual a tax equal to 4.2 percent of the wages (as defined in section 3121(a)) received by such individual with respect to employment (as defined in section 3121(b)).

''(2) CONTRIBUTION OF OASDI TAX REDUCTION TO INDIVIDUAL SAVINGS ACCOUNTS.—

''(A) IN GENERAL.—In addition to other taxes, there is hereby imposed on the income of every part B eligible individual an individual savings account contribution equal to the sum of—

''(i) 2 percent of the wages (as so defined) received by such individual with respect to employment (as so defined), plus

''(ii) so much of such wages (not to exceed $2,000) as designated by the individual in the same manner as described in section 251(c) of the Social Security Act.

''(B) INFLATION ADJUSTMENT.—

''(i) IN GENERAL.—In the case of any calendar year beginning after 2000, the dollar amount in subparagraph (A)(ii) shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 1999' for 'calendar year 1992' in subparagraph (B) thereof.

''(ii) ROUNDING.—If any dollar amount after being increased under clause (i) is not a multiple of $10, such dollar amount shall be rounded to the nearest multiple of $10.''.

(2) SELF-EMPLOYED.—Section 1401(a) of the Internal Revenue Code of 1986 (relating to tax on self-employment income) is amended to read as follows:

''(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—

''(1) IN GENERAL.—

''(A) INDIVIDUALS COVERED UNDER PART A OF THE SOCIAL SECURITY ACT.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual who is not a part B eligible individual for the calendar year ending with or during such taxable year, a tax equal to 12.40 percent of the amount of the self-employment income for such taxable year.

''(B) INDIVIDUALS COVERED UNDER PART B OF TITLE II OF THE SOCIAL SECURITY ACT.—In addition to other taxes, there is hereby imposed for each taxable year, on the self-employment income of every part B eligible individual, a tax equal to 10.4 percent of the amount of the self-employment income for such taxable year.

''(2) CONTRIBUTION OF OASDI TAX REDUCTION TO INDIVIDUAL SAVINGS ACCOUNTS.—

''(A) IN GENERAL.—In addition to other taxes, there is hereby imposed for each taxable year, on the self-employment income of every individual, an individual savings account contribution equal to the sum of—

''(i) 2 percent of the amount of the self-employment income for each individual for such taxable year, and

''(ii) so much of such self-employment income (not to exceed $2,000) as designated by the individual in the same manner as described in section 251(c) of the Social Security Act.

''(B) INFLATION ADJUSTMENT.—

''(i) IN GENERAL.—In the case of any taxable year beginning after 2000, the dollar amount in subparagraph (A)(ii) shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 1999' for 'calendar year 1992' in subparagraph (B) thereof.

''(ii) ROUNDING.—If any dollar amount after being increased under clause (i) is not a multiple of $10, such dollar amount shall be rounded to the nearest multiple of $10.''.

(3) PART B ELIGIBLE INDIVIDUAL.—

(A) TAXES ON EMPLOYEES.—Section 3121 of such Code (relating to definitions) is amended by inserting after subsection (s) the following:

''(t) PART B ELIGIBLE INDIVIDUAL.—For purposes of this chapter, the term 'part B eligible individual' means, for any calendar year, an individual who is an eligible individual (as defined in section 251(a)(2) of the Social Security Act) for such calendar year.''.

(B) SELF-EMPLOYMENT TAX.—Section 1402 of such Code (relating to definitions) is amended by adding at the end the following:

''(k) PART B ELIGIBLE INDIVIDUAL.—The term 'part B eligible individual' means, for any calendar year, an individual who is an eligible individual (as defined in section 251(a)(2) of the Social Security Act) for such calendar year.''.

(4) EFFECTIVE DATES.—

(A) EMPLOYEES.—The amendments made by paragraphs (1) and (3)(A) apply to remuneration paid after December 31, 1999.

(B) SELF-EMPLOYED INDIVIDUALS.—The amendments made by paragraphs (2) and (3)(B) apply to taxable years beginning after December 31, 1999.

(c) MATCHING CONTRIBUTIONS.—

(1) IN GENERAL.—Part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to credits against tax) is amended by adding at the end the following:

''Subpart H—Individual Savings Account Credits

''Sec. 54. Individual savings account credit.''.

''SEC. 54. INDIVIDUAL SAVINGS ACCOUNT CREDIT.

''(a) ALLOWANCE OF CREDIT.—Each part B eligible individual is entitled to a credit for the taxable year in an amount equal to the sum of—

''(1) $100, plus

''(2) 100 percent of the designated wages of such individual for the taxable year, plus

''(3) 100 percent of the designated self-employment income of such individual for the taxable year.

''(b) LIMITATIONS.—

''(1) AMOUNT.—The amount determined under subsection (a) with respect to such individual for any taxable year may not exceed the excess (if any) of—

''(A) an amount equal to 1 percent of the contribution and benefit base for such taxable year (as determined under section 230 of the Social Security Act), over

''(B) the sum of the amounts received by the Secretary on behalf of such individual under sections 3101(a)(2)(A)(i) and 1401(a)(2)(A)(i) for such taxable year.

''(2) FAILURE TO MAKE VOLUNTARY CONTRIBUTIONS.—In the case of a part B eligible individual with respect to whom the amount of wages designated under section 3101(a)(2)(A)(ii) plus the amount self-employment income designated under section 1401(a)(2)(A)(ii) for the taxable year is less

that $1, the credit to which such individual is entitled under this section shall be equal to zero.

''(c) DEFINITIONS.—For purposes of this section—

''(1) PART B ELIGIBLE INDIVIDUAL.—The term 'part B eligible individual' means, for any calendar year, an individual who—

''(A) is an eligible individual (as defined in section 251(a)(2) of the Social Security Act) for such calendar year, and

''(B) is not an individual with respect to whom another taxpayer is entitled to a deduction under section 151(c).

''(2) DESIGNATED WAGES.—The term 'designated wages' means with respect to any taxable year the amount designated under section 3101(a)(2)(A)(ii).

''(3) DESIGNATED SELF-EMPLOYMENT INCOME.—The term 'designated self-employment income' means with respect to any taxable year the amount designated under section 1401(a)(2)(A)(ii) for such taxable year.

''(d) CREDIT USED ONLY FOR INDIVIDUAL SAVINGS ACCOUNT.—For purposes of this title, the credit allowed under this section with respect to any part B eligible individual—

''(1) shall not be treated as a credit allowed under this part, but

''(2) shall be treated as an overpayment of tax under section 6401(b)(3) which may, in accordance with section 6402(l), only be transferred to an individual savings account established under part B of title II of the Social Security Act with respect to such individual.''.

(2) CONTRIBUTION OF CREDITED AMOUNTS TO INDIVIDUAL SAVINGS ACCOUNT.—

(A) CREDITED AMOUNTS TREATED AS OVERPAYMENT OF TAX.—Subsection (b) of section 6401 of such Code (relating to excessive credits) is amended by adding at the end the following:

''(3) SPECIAL RULE FOR CREDIT UNDER SECTION 54.—Subject to the provisions of section 6402(l), the amount of any credit allowed under section 54 for any taxable year shall be considered an overpayment.''.

(B) TRANSFER OF CREDIT AMOUNT TO INDIVIDUAL SAVINGS ACCOUNT.—Section 6402 of such Code (relating to authority to make credits or refunds) is amended by adding at the end the following:

''(l) OVERPAYMENTS ATTRIBUTABLE TO INDIVIDUAL SAVINGS ACCOUNT CREDIT.—In the case of any overpayment described in section 6401(b)(3) with respect to any individual, the Secretary shall transfer for crediting by the Commissioner of Social Security to the individual savings account of such individual, an amount equal to the amount of such overpayment.''.

(4) CONFORMING AMENDMENTS.—

(A) Section 1324(b)(2) of title 31, United States Code, is amended by inserting before the period at the end '', or enacted by the Bipartisan Social Security Reform Act of 1999''.

(B) The table of subparts for part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''Subpart H. Individual Savings Account Credits.''.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to refunds payable after December 31, 1999.

(d) TAX TREATMENT OF INDIVIDUAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subchapter F of chapter 1 of the Internal Revenue Code of 1986 (relating to exempt organizations) is amended by adding at the end the following:

''PART IX—INDIVIDUAL SAVINGS FUND AND ACCOUNTS

''Sec. 531. Individual Savings Fund and Accounts.

''SEC. 531. INDIVIDUAL SAVINGS FUND AND ACCOUNTS.

''(a) GENERAL RULE.—The Individual Savings Fund and individual savings accounts shall be exempt from taxation under this subtitle.

''(b) INDIVIDUAL SAVINGS FUND AND ACCOUNTS DEFINED.—For purposes of this section, the terms 'Individual Savings Fund' and 'individual savings account' means the fund and account established under sections 254 and 251, respectively, of part B of title II of the Social Security Act.

''(c) CONTRIBUTIONS.—

''(1) IN GENERAL.—No deduction shall be allowed for contributions credited to an individual savings account under section 251 of the Social Security Act or section 6402(l).

''(2) ROLLOVER OF INHERITANCE.—Any portion of a distribution to an heir from an individual savings account made by reason of the death of the beneficiary of such account may be rolled over to the individual savings account of the heir after such death.

''(d) DISTRIBUTIONS.—

''(1) IN GENERAL.—Any distribution from an individual savings account under section 253 of the Social Security Act shall be included in gross income under section 72.

''(2) PERIOD IN WHICH DISTRIBUTIONS MUST BE MADE FROM ACCOUNT OF DECEDENT.—In the case of amounts remaining in an individual savings account from which distributions began before the death of the beneficiary, rules similar to the rules of section 401(a)(9)(B) shall apply to distributions of such remaining amounts.

''(3) ROLLOVERS.—Paragraph (1) shall not apply to amounts rolled over under subsection (c)(2) in a direct transfer by the Commissioner of Social Security, under regulations which the Commissioner shall prescribe.''.

(2) CLERICAL AMENDMENT.—The table of parts for subchapter F of chapter 1 of such Code is amended by adding after the item relating to part VIII the following:

''Part IX. Individual savings fund and accounts.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1999.

SEC. 102. SOCIAL SECURITY KIDSAVE ACCOUNTS.

Title II of the Social Security Act (42 U.S.C. 401 et seq.), as amended by section 101(a), is amended by adding at the end the following:

''PART C—KIDSAVE ACCOUNTS

''KIDSAVE ACCOUNTS

''SEC. 261. (a) ESTABLISHMENT.—The Commissioner of Social Security shall establish in the name of each individual born on or after January 1, 1995, a KidSave Account upon the later of—

''(1) the date of enactment of this part, or

''(2) the date of the issuance of a Social Security account number under section 205(c)(2) to such individual.

The KidSave Account shall be identified to the account holder by means of the account holder's Social Security account number.

''(b) CONTRIBUTIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated and are appropriated such sums as are necessary in order for the Secretary of the Treasury to transfer from the general fund of the Treasury for crediting by the Commissioner to each account holder's KidSave Account under subsection (a), an amount equal to the sum of—

''(A) in the case of any individual born on or after January 1, 2000, $1,000, on the date of the establishment of such individual's KidSave Account, and

''(B) in the case of any individual born on or after January 1, 1995, $500, on the 1st, 2nd, 3rd, 4th, and 5th birthdays of such individual occurring on or after January 1, 2000.

''(2) ADJUSTMENT FOR INFLATION.—For any calendar year after 2009, each of the dollar amounts under paragraph (1) shall be increased by the cost-of-living adjustment determined under section 215(i) for the calendar year.

''(c) DESIGNATIONS REGARDING KIDSAVE ACCOUNTS.—

''(1) INITIAL DESIGNATIONS OF INVESTMENT VEHICLE.—A person described in subsection (d) shall, on behalf of the individual described in subsection (a), designate the investment vehicle for the KidSave Account to which contributions on behalf of such individual are to be deposited. Such designation shall be made on the application for such individual's Social Security account number.

''(2) CHANGES IN INVESTMENT VEHICLES.—The Commissioner shall by regulation provide the time and manner by which an individual or a person described in subsection (d) on behalf of such individual may change 1 or more investment vehicles for a KidSave Account.

''(d) TREATMENT OF MINORS AND INCOMPETENT INDIVIDUALS.—Any designation under subsection (c) to be made by a minor, or an individual mentally incompetent or under other legal disability, may be made by the person who is constituted guardian or other fiduciary by the law of the State of residence of the individual or is otherwise legally vested with the care of the individual or his estate. Payment under this part due a minor, or an individual mentally incompetent or under other legal disability, may be made to the person who is constituted guardian or other fiduciary by the law of the State of residence of the claimant or is otherwise legally vested with the care of the claimant or his estate. In any case in which a guardian or other fiduciary of the individual under legal disability has not been appointed under the law of the State of residence of the individual, if any other person, in the judgment of the Commissioner, is responsible for the care of such individual, any designation under subsection (c) which may otherwise be made by such individual may be made by such person, any payment under this part which is otherwise payable to such individual may be made to such person, and the payment of an annuity payment under this part to such person bars recovery by any other person.

''DEFINITIONS AND SPECIAL RULES

''SEC. 262. (a) KIDSAVE ACCOUNTS.—In this part, the term 'KidSave Account' means any KidSave Account in the Individual Savings Fund (established under section 254) which is administered by the Individual Savings Fund Board.

''(b) TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), any KidSave Account described in subsection (a) shall be treated in the same manner as an individual savings account under part B.

''(2) DISTRIBUTIONS.—Notwithstanding any other provision of law, distributions may only be made from a KidSave Account of an individual on or after the earlier of—

''(A) the date on which the individual begins receiving benefits under this title, or

''(B) the date of the individual's death.''.

SEC. 103. ADJUSTMENTS TO PRIMARY INSURANCE AMOUNTS UNDER PART A OF TITLE II OF THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—Section 215 of the Social Security Act (42 U.S.C. 415) is amended by adding at the end the following:

''Adjustment of Primary Insurance Amount in Relation to Deposits Made to Individual Savings Accounts and KidSave Accounts

''(j)(1) Except as provided in paragraph (2), an individual's primary insurance amount as determined in accordance with this section (before adjustments made under subsection (i)) shall be equal to the excess (if any) of—

''(A) the amount which would be so determined without the application of this subsection, over

''(B) the monthly amount of an immediate life annuity, determined on the basis of the sum of—

''(A) the total of all amounts which have been credited pursuant to section 251(b) (indexed in the same manner as is applicable with respect to average indexed monthly earnings under subsection (b)) to the individual savings account held by such individual, plus

''(B) 50 percent of the accumulated value of the KidSave Account (established on behalf of such individual under section 261(a)) determined on the date such KidSave Account is redesignated as an individual savings account held by such individual under section 251(a)(1)(B), plus

''(C) accrued interest on such amounts compounded annually—

''(i) assuming an interest rate equal to the projected interest rate of the Federal Old-Age and Survivors Trust Fund, and

''(ii) using the mortality table used under 412(*l*)(7)(C)(ii) of the Internal Revenue Code of 1986.

''(2) In the case of an individual who becomes entitled to disability insurance benefits under section 223, such individual's primary insurance amount shall be determined without regard to paragraph (1).

''(3) For purposes of this subsection, the term 'immediate life annuity' means an annuity—

''(A) the annuity starting date (as defined in section 72(c)(4) of the Internal Revenue Code of 1986) of which commences with the first month following the date of the determination, and

''(B) which provides for a series of substantially equal monthly payments over the life expectancy of the individual.''.

(b) CONFORMING AMENDMENT TO RAILROAD RETIREMENT ACT OF 1974.—Section 1 of the Railroad Retirement Act of 1974 (45 U.S.C. 231) is amended by adding at the end the following:

''(s) In applying applicable provisions of the Social Security Act for purposes of determining the amount of the annuity to which an individual is entitled under this Act, section 215(j) of the Social Security Act and part B of title II of such Act shall be disregarded.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to computations and recomputations of primary insurance amounts occurring after December 31, 1999.

TITLE II—SOCIAL SECURITY SYSTEM ADJUSTMENTS

SEC. 201. ADJUSTMENTS TO BEND POINTS IN DETERMINING PRIMARY INSURANCE AMOUNTS.

(a) ADDITIONAL BEND POINT.—Section 215(a)(1)(A) of the Social Security Act (42 U.S.C. 415(a)(1)(A)) is amended—

(1) in clause (ii), by striking ''and'' at the end;

(2) in clause (iii)—

(A) by striking ''15 percent'' and inserting ''32 percent'';

(B) by striking ''clause (ii),'' and inserting the following: ''clause (ii) but do not exceed the amount established for purposes of this clause by subparagraph (B), and''; and

(3) by inserting after clause (iii) the following:

''(iv) 15 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause (iii),''.

(b) INITIAL LEVEL OF ADDITIONAL BEND POINT.—Section 215(a)(1)(B)(i) of such Act (42 U.S.C. 415(a)(1)(B)(i)) is amended—

(1) by striking ''clause (i) and (ii)'' and inserting ''clauses (i) and (iii)''; and

(2) by adding at the end the following: ''For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefit), in the calendar year 2000, the amount established for purposes of clause (ii) of subparagraph (A) shall be equal to 197.5 percent of the amount established for purposes of clause (i).''.

(c) ADJUSTMENTS TO PIA FORMULA FACTORS.—Section 215(a)(1)(B) of such Act (42 U.S.C. 415(a)(1)(B)) is amended further—

(1) by redesignating clause (iii) as clause (iv);

(2) by inserting after clause (ii) the following:

''(iii) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in any calendar year after 2005, effective for such calendar year—

''(I) the percentage in effect under clause (ii) of subparagraph (A) shall be equal to the percentage in effect under such clause for calendar year 2005 increased the applicable number of times by 3.8 percentage points,

''(II) the percentage in effect under clause (iii) of subparagraph (A) shall be equal to the percentage in effect under such clause for calendar year 2005 decreased the applicable number of times by 1.2 percentage points, and

''(III) the percentage in effect under clause (iv) of subparagraph (A) shall be equal to the percentage in effect under such clause for calendar year 2005 decreased the applicable number of times by 0.5 percentage points.

For purposes of the preceding sentence, the term 'applicable number of times' means a number equal to the lesser of 10 or the number of years beginning with 2006 and ending with the year of initial eligibility or death.''; and

(3) in clause (iv) (as redesignated), by striking ''amount'' and inserting ''dollar amount''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to primary insurance amounts of individuals attaining early retirement age (as defined in section 216(l) of the Social Security Act), or dying, after December 31, 1999.

SEC. 202. ADJUSTMENT OF WIDOWS' AND WIDOWERS' INSURANCE BENEFITS.

(a) WIDOW'S BENEFIT.—Section 202(e)(2)(A) of the Social Security Act (42 U.S.C. 402(e)(2)(A)) is amended by striking ''equal to'' and all that follows and inserting ''equal to the greater of—

''(i) the primary insurance amount (as determined for purposes of this subsection after application of subparagraphs (B) and (C)) of such deceased individual, or

''(ii) the applicable percentage of the joint benefit which would have been received by the widow or surviving divorced wife and the deceased individual for such month if such individual had not died.

For purposes of clause (ii), the applicable percentage is equal to 50 percent in 2000, increased (but not above 75 percent) by 1 percentage point in every second year thereafter.''.

(b) WIDOWER'S BENEFIT.—Section 202(f)(3)(A) of the Social Security Act (42 U.S.C. 402(b)(3)(A)) is amended by striking ''equal to'' and all that follows and inserting ''equal to the greater of—

''(i) the primary insurance amount (as determined for purposes of this subsection after application of subparagraphs (B) and (C)) of such deceased individual, or

''(ii) the applicable percentage of the joint benefit which would have been received by the widow or surviving divorced husband and the deceased individual for such month if such individual had not died.

For purposes of clause (ii), the applicable percentage is equal to 50 percent in 2000, increased (but not above 75 percent) by 1 percentage point in every second year thereafter.''.

SEC. 203. ELIMINATION OF EARNINGS TEST FOR INDIVIDUALS WHO HAVE ATTAINED EARLY RETIREMENT AGE.

(a) IN GENERAL.—Section 203 of the Social Security Act (42 U.S.C. 403) is amended—

(1) in subsection (c)(1), by striking ''the age of seventy'' and inserting ''early retirement age (as defined in section 216(l))'';

(2) in paragraphs (1)(A) and (2) of subsection (d), by striking ''the age of seventy'' each place it appears and inserting ''early retirement age (as defined in section 216(l))'';

(3) in subsection (f)(1)(B), by striking ''was age seventy or over'' and inserting ''was at or above early retirement age (as defined in section 216(l))'';

(4) in subsection (f)(3)—

(A) by striking ''33⅓ percent'' and all that follows through ''any other individual,'' and inserting ''50 percent of such individual's earnings for such year in excess of the product of the exempt amount as determined under paragraph (8),''; and

(B) by striking ''age 70'' and inserting ''early retirement age (as defined in section 216(l))'';

(5) in subsection (h)(1)(A), by striking ''age 70'' each place it appears and inserting ''early retirement age (as defined in section 216(l))''; and

(6) in subsection (j)—

(A) in the heading, by striking ''Age Seventy'' and inserting ''Early Retirement Age''; and

(B) by striking ''seventy years of age'' and inserting ''having attained early retirement age (as defined in section 216(l))''.

(b) CONFORMING AMENDMENTS ELIMINATING THE SPECIAL EXEMPT AMOUNT FOR INDIVIDUALS WHO HAVE ATTAINED AGE 62.—

(1) UNIFORM EXEMPT AMOUNT.—Section 203(f)(8)(A) of the Social Security Act (42 U.S.C. 403(f)(8)(A)) is amended by striking ''the new exempt amounts (separately stated for individuals described in subparagraph (D) and for other individuals) which are to be applicable'' and inserting ''a new exempt amount which shall be applicable''.

(2) CONFORMING AMENDMENTS.—Section 203(f)(8)(B) of the Social Security Act (42 U.S.C. 403(f)(8)(B)) is amended—

(A) in the matter preceding clause (i), by striking ''Except'' and all that follows through ''whichever'' and inserting ''The exempt amount which is applicable for each month of a particular taxable year shall be whichever'';

(B) in clauses (i) and (ii), by striking ''corresponding'' each place it appears; and

(C) in the last sentence, by striking ''an exempt amount'' and inserting ''the exempt amount''.

(3) REPEAL OF BASIS FOR COMPUTATION OF SPECIAL EXEMPT AMOUNT.—Section 203(f)(8)(D) of the Social Security Act (42 U.S.C. 403(f)(8)(D)) is repealed.

(c) ADDITIONAL CONFORMING AMENDMENTS.—

(1) ELIMINATION OF REDUNDANT REFERENCES TO RETIREMENT AGE.—Section 203 of the Social Security Act (42 U.S.C. 403) is amended—

(A) in subsection (c), in the last sentence, by striking ''nor shall any deduction'' and

all that follows and inserting ''nor shall any deduction be made under this subsection from any widow's or widower's insurance benefit if the widow, surviving divorced wife, widower, or surviving divorced husband involved became entitled to such benefit prior to attaining age 60.''; and

(B) in subsection (f)(1), by striking clause (D) and inserting the following: ''(D) for which such individual is entitled to widow's or widower's insurance benefits if such individual became so entitled prior to attaining age 60,''.

(2) CONFORMING AMENDMENT TO PROVISIONS FOR DETERMINING AMOUNT OF INCREASE ON ACCOUNT OF DELAYED RETIREMENT.—Section 202(w)(2)(B)(ii) of the Social Security Act (42 U.S.C. 402(w)(2)(B)(ii)) is amended—

(A) by striking ''either''; and

(B) by striking ''or suffered deductions under section 203(b) or 203(c) in amounts equal to the amount of such benefit''.

(3) PROVISIONS RELATING TO EARNINGS TAKEN INTO ACCOUNT IN DETERMINING SUBSTANTIAL GAINFUL ACTIVITY OF BLIND INDIVIDUALS.—The second sentence of section 223(d)(4) of such Act (42 U.S.C. 423(d)(4)) is amended by striking ''if section 102 of the Senior Citizens' Right to Work Act of 1996 had not been enacted'' and inserting the following: ''if the amendments to section 203 made by section 102 of the Senior Citizens' Right to Work Act of 1996 and by the Bipartisan Social Security Reform Act of 1999 had not been enacted''.

(d) STUDY OF THE EFFECT OF TAKING EARNINGS INTO ACCOUNT IN DETERMINING SUBSTANTIAL GAINFUL ACTIVITY OF DISABLED INDIVIDUALS.—

(1) IN GENERAL.—Not later than February 15, 2001, the Commissioner of Social Security shall conduct a study on the effect that taking earnings into account in determining substantial gainful activity of individuals receiving disability insurance benefits has on the incentive for such individuals to work and submit to Congress a report on the study.

(2) CONTENTS OF STUDY.—The study conducted under paragraph (1) shall include the evaluation of—

(A) the effect of the current limit on earnings on the incentive for individuals receiving disability insurance benefits to work;

(B) the effect of increasing the earnings limit or changing the manner in which disability insurance benefits are reduced or terminated as a result of substantial gainful activity (including reducing the benefits gradually when the earnings limit is exceeded) on—

(i) the incentive to work; and

(ii) the financial status of the Federal Disability Insurance Trust Fund;

(C) the effect of extending eligibility for the Medicare program to individuals during the period in which disability insurance benefits of the individual are gradually reduced as a result of substantial gainful activity and extending such eligibility for a fixed period of time after the benefits are terminated on—

(i) the incentive to work; and

(ii) the financial status of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund; and

(D) the relationship between the effect of substantial gainful activity limits on blind individuals receiving disability insurance benefits and other individuals receiving disability insurance benefits.

(3) CONSULTATION.—The analysis under paragraph (2)(C) shall be done in consultation with the Administrator of the Health Care Financing Administration.

(e) EFFECTIVE DATE.—The amendments and repeals made by subsections (a), (b), and (c) shall apply with respect to taxable years ending after December 31, 2002.

SEC. 204. GRADUAL INCREASE IN NUMBER OF BENEFIT COMPUTATION YEARS; USE OF ALL YEARS IN COMPUTATION.

(a) IN GENERAL.—Section 215(b)(2)(A) of the Social Security Act (42 U.S.C. 415(b)(2)(A)) is amended—

(1) in clause (i), by striking ''5 years'' and inserting ''the applicable number of years for purposes of this clause''; and

(2) by striking ''Clause (ii),'' in the matter following clause (ii) and inserting the following:

''For purposes of clause (i), the applicable number of years is the number of years specified in connection with the year in which such individual reaches early retirement age (as defined in section 216(l)(2)), or, if earlier, the calendar year in which such individual dies, as set forth in the following table:

''If such calendar year is:	The applicable number of years is:
2002	4.
2003	4.
2004	3.
2005	3.
2006	2.
2007	2.
2008	1.
2009	1.
After 2009	0.

Notwithstanding the preceding sentence, the applicable number of years is 5, in the case of any individual who is entitled to old-age insurance benefits, and has a spouse who is also so entitled (or who died without having become so entitled) who has greater total wages and self-employment income credited to benefit computation years than the individual. Clause (ii),''.

(b) USE OF ALL YEARS IN COMPUTATION.—

(1) IN GENERAL.—Section 215(b)(2)(B) of the Social Security Act (42 U.S.C. 415(b)(2)(B)) is amended by striking clauses (i) and (ii) and inserting the following:

''(i)(I) for calendar years after 2001 and before 2010, the term 'benefit computation years' means those computation base years equal in number to the number determined under subparagraph (A) plus the applicable number of years determined under subclause (III), for which the total of such individual's wages and self-employment income, after adjustment under paragraph (3), is the largest;

''(II) for calendar years after 2009, the term 'benefit computation years' means all of the computation base years; and

''(III) for purposes of subclause (I), the applicable number of years is the number of years specified in connection with the year in which such individual reaches early retirement age (as defined in section 216(l)(2)), or, if earlier, the calendar year in which such individual dies, as set forth in the following table:

''If such calendar year is:	The applicable number of years is:
Before 2002	0.
2002	1.
2003	1.
2004	2.
2005	2.
2006	3.
2007	3.
2008	4.
2009	4.

''(ii) the term 'computation base years' means the calendar years after 1950, except that such term excludes any calendar year entirely included in a period of disability; and''.

(2) CONFORMING AMENDMENT.—Section 215(b)(1)(B) of the Social Security Act (42 U.S.C. 415(b)(1)(B)) is amended by striking ''in those years'' and inserting ''in an individual's computation base years determined under paragraph (2)(A)''.

(c) EFFECTIVE DATE.—

(1) SUBSECTION (a).—The amendments made by subsection (a) shall apply with respect to individuals attaining early retirement age (as defined in section 216(l)(2) of the Social Security Act) after December 31, 2001.

(2) SUBSECTION (b).—The amendment made by subsection (b) shall apply to benefit computation years beginning after December 31, 1999.

SEC. 205. MAINTENANCE OF BENEFIT AND CONTRIBUTION BASE.

(a) IN GENERAL.—Section 230 of the Social Security Act (42 U.S.C. 430) is amended to read as follows:

MAINTENANCE OF THE CONTRIBUTION AND BENEFIT BASE

''SEC. 230. (a) The Commissioner of Social Security shall determine and publish in the Federal Register on or before November 1 of each calendar year the contribution and benefit base determined under subsection (b) which shall be effective with respect to remuneration paid after such calendar year and taxable years beginning after such year.

''(b) For purposes of this section, for purposes of determining wages and self-employment income under sections 209, 211, 213, and 215 of this Act and sections 54, 1402, 3121, 3122, 3125, 6413, and 6654 of the Internal Revenue Code of 1986, and for purposes of section 4022(b)(3)(B) of Public Law 93–406, the contribution and benefit base with respect to remuneration paid in (and taxable years beginning in) any calendar year is an amount equal to 86 percent of the total wages for the preceding calendar year (within the meaning of section 209).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to remuneration paid in (and taxable years beginning in) any calendar year after 1999.

SEC. 206. REDUCTION IN THE AMOUNT OF CERTAIN TRANSFERS TO MEDICARE TRUST FUND.

Subparagraph (A) of section 121(e)(1) of the Social Security Amendments of 1983 (42 U.S.C. 401 note), as amended by section 13215(c)(1) of the Omnibus Budget Reconciliation Act of 1993, is amended—

(1) in clause (ii), by striking ''the amounts'' and inserting ''the applicable percentage of the amounts''; and

(2) by adding at the end the following: ''For purposes of clause (ii), the applicable percentage for a year is equal to 100 percent, reduced (but not below zero) by 10 percentage points for each year after 2004.''.

SEC. 207. ACTUARIAL ADJUSTMENT FOR RETIREMENT.

(a) EARLY RETIREMENT.—

(1) IN GENERAL.—Section 202(q) of the Social Security Act (42 U.S.C. 402(q)) is amended—

(A) in paragraph (1)(A), by striking ''5/9'' and inserting ''the applicable fraction (determined under paragraph (12))''; and

(B) by adding at the end the following:

''(12) For purposes of paragraph (1)(A), the 'applicable fraction' for an individual who attains the age of 62 in—

''(A) any year before 2001, is 5/9;

''(B) 2001, is 7/12;

''(C) 2002, is 11/18;

''(D) 2003, is 23/36;

''(E) 2004, is 2/3; and

''(F) 2005 or any succeeding year, is 25/36.''.

(2) MONTHS BEYOND FIRST 36 MONTHS.—Section 202(q) of such Act (42 U.S.C. 402(q)(9)) (as amended by paragraph (1)) is amended—

(A) in paragraph (9)(A), by striking ''five-twelfths'' and inserting ''the applicable fraction (determined under paragraph (13))''; and

(B) by adding at the end the following:

''(13) For purposes of paragraph (9)(A), the 'applicable fraction' for an individual who attains the age of 62 in—

''(A) any year before 2001, is 5/12;

''(B) 2001, is 16/36;

''(C) 2002, is 16/36;

''(D) 2003, is 17/36;

''(E) 2004, is 17/36; and

''(F) 2005 or any succeeding year, is 1/2.''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to individuals who attain the age of 62 in years after 1999.

(b) DELAYED RETIREMENT.—Section 202(w)(6) of the Social Security Act (42 U.S.C. 402(w)(6)) is amended—

(1) in subparagraph (C), by striking ''and'' at the end;

(2) in subparagraph (D), by striking ''2004.'' and inserting ''2004 and before 2007;''; and

(3) by adding at the end the following:

''(E) 17/24 of 1 percent in the case of an individual who attains the age of 62 in a calendar year after 2006 and before 2009;

''(F) 3/4 of 1 percent in the case of an individual who attains the age of 62 in a calendar year after 2008 and before 2011;

''(G) 19/24 of 1 percent in the case of an individual who attains the age of 62 in a calendar year after 2010 and before 2013; and

''(H) 5/6 of 1 percent in the case of an individual who attains the age of 62 in a calendar year after 2012.''.

SEC. 208. IMPROVEMENTS IN PROCESS FOR COST-OF-LIVING ADJUSTMENTS.

(a) ANNUAL DECLARATIONS OF PERSISTING UPPER LEVEL SUBSTITUTION BIAS, QUALITY-CHANGE BIAS, AND NEW-PRODUCT BIAS.—Not later than December 1, 1999, and annually thereafter, the Commissioner of the Bureau of Labor Statistics shall publish in the Federal Register an estimate of the upper level substitution bias, quality-change bias, and new-product bias retained in the Consumer Price Index, expressed in terms of a percentage point effect on the annual rate of change in the Consumer Price Index determined through the use of a superlative index that accounts for changes that consumers make in the quantities of goods and services consumed.

(b) MODIFICATION OF COST-OF-LIVING ADJUSTMENT.—Notwithstanding any other provision of law, for each calendar year after 1999 any cost-of-living adjustment described in subsection (f) shall be further adjusted by the greater of—

(1) 0.5 percentage point, or

(2) the correction for the upper level substitution bias, quality-change bias, and new-product bias (as last published by the Commissioner of the Bureau of Labor Statistics pursuant to subsection (a)).

(c) FUNDING FOR CPI IMPROVEMENTS.—

(1) IN GENERAL.—There is hereby appropriated to the Bureau of Labor Statistics in the Department of Labor, for each of fiscal years 2000, 2001, and 2002, $60,000,000 for use by the Bureau for the following purposes:

(A) Research, evaluation, and implementation of a superlative index to estimate upper level substitution bias, quality-change bias, and new-product bias in the Consumer Price Index.

(B) Expansion of the Consumer Expenditure Survey and the Point of Purchase Survey.

(2) REPORTS.—The Commissioner of the Bureau of Labor Statistics shall submit reports regarding the use of appropriations made under paragraph (1) to the Committee on Appropriations of the House of Representative and the Committee on Appropriations of the Senate upon the request of each Committee.

(d) INFORMATION SHARING.—The Commissioner of the Bureau of Labor Statistics may secure directly from the Secretary of Commerce information necessary for purposes of calculating the Consumer Price Index. Upon request of the Commissioner of the Bureau of Labor Statistics, the Secretary of Commerce shall furnish that information to the Commissioner.

(e) ADMINISTRATIVE ADVISORY COMMITTEE.—The Bureau of Labor Statistics shall, in consultation with the National Bureau of Economic Research, the American Economic Association, and the National Academy of Statisticians, establish an administrative advisory committee. The advisory committee shall periodically advise the Bureau of Labor Statistics regarding revisions of the Consumer Price Index and conduct research and experimentation with alternative data collection and estimating approaches.

(f) COST-OF-LIVING ADJUSTMENT DESCRIBED.—A cost-of-living adjustment described in this subsection is any cost-of-living adjustment for a calendar year after 1999 determined by reference to a percentage change in a consumer price index or any component thereof (as published by the Bureau of Labor Statistics of the Department of Labor and determined without regard to this section) and used in any of the following:

(1) The Internal Revenue Code of 1986.

(2) The provisions of this Act (other than programs under title XVI and any adjustment in the case of an individual who attains early retirement age before January 1, 2000).

(3) Any other Federal program.

(g) RECAPTURE OF CPI REFORM REVENUES DEPOSITED INTO THE FEDERAL OLD-AGE AND SURVIVORS INSURANCE TRUST FUND.—Section 201 of the Social Security Act (42 U.S.C. 401) is amended by adding at the end the following:

''(n) On July 1 of each calendar year specified in the following table, the Secretary of the Treasury shall transfer, from the general fund of the Treasury to the Federal Old-Age and Survivors Insurance Trust Fund, an amount equal to the applicable percentage for such year, specified in such table, of the total wages paid in and self-employment income credited to such year.

''For a calendar year—	The applicable percentage for the year is—
After 1999 and before 2020	0.6 percent.
After 2019 and before 2040	0.8 percent.
After 2039 and before 2060	1.0 percent.
After 2059	1.2 percent.''.

SEC. 209. MODIFICATION OF INCREASE IN NORMAL RETIREMENT AGE.

(a) IN GENERAL.—Section 216(l)(1) of the Social Security Act (42 U.S.C. 416(l)(1)) is amended—

(1) in subparagraph (B)—

(A) by striking ''2005'' and inserting ''2011''; and

(B) by adding ''and'' at the end; and

(2) by striking subparagraphs (C), (D), and (E) and inserting the following:

''(C) With respect to an individual who attains early retirement age after December 31, 2010, 67 years of age.''.

(b) CONFORMING AMENDMENT.—Paragraph (3) of section 216(l) of the Social Security Act (42 U.S.C. 416(l)) is amended to read as follows:

''(3) The age increase factor for any individual who attains early retirement age in the period consisting of the calendar years 2000 through 2010, the age increase factor shall be equal to two-twelfths of the number of months in the period beginning with January 2000 and ending with December of the year in which the individual attains early retirement age.''.

SEC. 210. MODIFICATION OF PIA FACTORS TO REFLECT CHANGES IN LIFE EXPECTANCY.

(a) MODIFICATION OF PIA FACTORS.—Section 215(a)(1) of the Social Security Act (42 U.S.C. 415(a)(1)(B)) is amended by redesignating subparagraph (D) as subparagraph (F) and by inserting after subparagraph (C) the following:

''(D)(i) For individuals who initially become eligible for old-age insurance benefits in any calendar year after 2011, each of the percentages under clauses (i), (ii), (iii), and (iv) of subparagraph (A) shall be multiplied the applicable number of times by the applicable factor.

''(ii) For purposes of clause (i)—

''(I) the term 'applicable number of times' means a number equal to the lesser of 54 or the number of years beginning with 2012 and ending with the year of initial eligibility; and

''(II) the term 'applicable factor' means .988 with respect to the first 6 applicable number of times and .997 with respect to the applicable number of times in excess of 6.

''(E) For any individual who initially becomes eligible for disability insurance benefits in any calendar year after 2011, the primary insurance amount for such individual shall be equal to the greater of—

''(i) such amount as determined under this paragraph, or

''(ii) such amount as determined under this paragraph without regard to subparagraph (D) thereof.''.

(b) STUDY OF THE EFFECT OF INCREASES IN LIFE EXPECTANCY.—

(1) STUDY PLAN.—Not later than February 15, 2001, the Commissioner of Social Security shall submit to Congress a detailed study plan for evaluating the effects of increases in life expectancy on the expected level of retirement income from social security, pensions, and other sources. The study plan shall include a description of the methodology, data, and funding that will be required in order to provide to Congress not later than February 15, 2006—

(A) an evaluation of trends in mortality and their relationship to trends in health status, among individuals approaching eligibility for social security retirement benefits;

(B) an evaluation of trends in labor force participation among individuals approaching eligibility for social security retirement benefits and among individuals receiving retirement benefits, and of the factors that influence the choice between retirement and participation in the labor force;

(C) an evaluation of changes, if any, in the social security disability program that would reduce the impact of changes in the retirement income of workers in poor health or physically demanding occupations;

(D) an evaluation of the methodology used to develop projections for trends in mortality, health status, and labor force participation among individuals approaching eligibility for social security retirement benefits and among individuals receiving retirement benefits; and

(E) an evaluation of such other matters as the Commissioner deems appropriate for evaluating the effects of increases in life expectancy.

(2) REPORT ON RESULTS OF STUDY.—Not later than February 15, 2006, the Commissioner of Social Security shall provide to Congress an evaluation of the implications of the trends studied under paragraph (1), along with recommendations, if any, of the extent to which the conclusions of such evaluations indicate that projected increases in life expectancy require modification in the social security disability program and other income support programs.

SEC. 211. MECHANISM FOR REMEDYING UNFORESEEN DETERIORATION IN SOCIAL SECURITY SOLVENCY.

(a) IN GENERAL.—Section 709 of the Social Security Act (42 U.S.C. 910) is amended—

(1) by redesignating subsection (b) as subsection (c); and

(2) by striking ''SEC. 709. (a) If the Board of Trustees'' and all that follows through ''any

such Trust Fund'' and inserting the following:

''SEC. 709. (a)(1)(A) If the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund determines at any time, using intermediate actuarial assumptions, that the balance ratio of either such Trust Fund for any calendar year during the succeeding period of 75 calendar years will be zero, the Board shall promptly submit to each House of the Congress and to the President a report setting forth its recommendations for statutory adjustments affecting the receipts and disbursements of such Trust Fund necessary to maintain the balance ratio of such Trust Fund at not less than 20 percent, with due regard to the economic conditions which created such inadequacy in the balance ratio and the amount of time necessary to alleviate such inadequacy in a prudent manner. The report shall set forth specifically the extent to which benefits would have to be reduced, taxes under section 1401, 3101, or 3111 of the Internal Revenue Code of 1986 would have to be increased, or a combination thereof, in order to obtain the objectives referred to in the preceding sentence.

''(B) In addition to any reports under subparagraph (A), the Board shall, not later than May 30, 2001, prepare and submit to Congress and the President recommendations for statutory adjustments to the disability insurance program under title II of this Act to modify the changes in disability benefits under the Bipartisan Social Security Reform Act of 1999 without reducing the balance ratio of the Federal Disability Insurance Trust Fund. The Board shall develop such recommendations in consultation with the National Council on Disability, taking into consideration the adequacy of benefits under the program, the relationship of such program with old age benefits under such title, and changes in the process for determining initial eligibility and reviewing continued eligibility for benefits under such program.

''(2)(A) The President shall, no later than 30 days after the submission of the report to the President, transmit to the Board and to the Congress a report containing the President's approval or disapproval of the Board's recommendations.

''(B) If the President approves all the recommendations of the Board, the President shall transmit a copy of such recommendations to the Congress as the President's recommendations, together with a certification of the President's adoption of such recommendations.

''(C) If the President disapproves the recommendations of the Board, in whole or in part, the President shall transmit to the Board and the Congress the reasons for that disapproval. The Board shall then transmit to the Congress and the President, no later than 60 days after the date of the submission of the original report to the President, a revised list of recommendations.

''(D) If the President approves all of the revised recommendations of the Board transmitted to the President under subparagraph (C), the President shall transmit a copy of such revised recommendations to the Congress as the President's recommendations, together with a certification of the President's adoption of such recommendations.

''(E) If the President disapproves the revised recommendations of the Board, in whole or in part, the President shall transmit to the Board and the Congress the reasons for that disapproval, together with such revisions to such recommendations as the President determines are necessary to bring such recommendations within the President's approval. The President shall transmit a copy of such recommendations, as so revised, to the Board and the Congress as the President's recommendations, together with a certification of the President's adoption of such recommendations.

''(3)(A) This paragraph is enacted by Congress—

''(i) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a joint resolution described in subparagraph (B), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

''(ii) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

''(B) For purposes of this paragraph, the term 'joint resolution' means only a joint resolution which is introduced within the 10-day period beginning on the date on which the President transmits the President's recommendations, together with the President's certification, to the Congress under subparagraph (B), (D), or (E) of paragraph (2), and—

''(i) which does not have a preamble;

''(ii) the matter after the resolving clause of which is as follows: 'That the Congress approves the recommendations of the President as transmitted on ___ pursuant to section 709(a) of the Social Security Act, as follows: _____', the first blank space being filled in with the appropriate date and the second blank space being filled in with the statutory adjustments contained in the recommendations; and

''(iii) the title of which is as follows: 'Joint resolution approving the recommendations of the President regarding social security.'.

''(C) A joint resolution described in subparagraph (B) that is introduced in the House of Representatives shall be referred to the Committee on Ways and Means of the House of Representatives. A joint resolution described in subparagraph (B) introduced in the Senate shall be referred to the Committee on Finance of the Senate.

''(D) If the committee to which a joint resolution described in subparagraph (B) is referred has not reported such joint resolution (or an identical joint resolution) by the end of the 20-day period beginning on the date on which the President transmits the recommendation to the Congress under paragraph (2), such committee shall be, at the end of such period, discharged from further consideration of such joint resolution, and such joint resolution shall be placed on the appropriate calendar of the House involved.

''(E)(i) On or after the third day after the date on which the committee to which such a joint resolution is referred has reported, or has been discharged (under subparagraph (D)) from further consideration of, such a joint resolution, it is in order (even though a previous motion to the same effect has been disagreed to) for any Member of the respective House to move to proceed to the consideration of the joint resolution. A Member may make the motion only on the day after the calendar day on which the Member announces to the House concerned the Member's intention to make the motion, except that, in the case of the House of Representatives, the motion may be made without such prior announcement if the motion is made by direction of the committee to which the joint resolution was referred. All points of order against the joint resolution (and against consideration of the joint resolution) are waived. The motion is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the respective House shall immediately proceed to consideration of the joint resolution without intervening motion, order, or other business, and the joint resolution shall remain the unfinished business of the respective House until disposed of.

''(ii) Debate on the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 2 hours, which shall be divided equally between those favoring and those opposing the joint resolution. An amendment to the joint resolution is not in order. A motion further to limit debate is in order and not debatable. A motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order. A motion to reconsider the vote by which the joint resolution is agreed to or disagreed to is not in order.

''(iii) Immediately following the conclusion of the debate on a joint resolution described in subparagraph (B) and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the appropriate House, the vote on final passage of the joint resolution shall occur.

''(iv) Appeals from the decisions of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure relating to a joint resolution described in subparagraph (B) shall be decided without debate.

''(F)(i) If, before the passage by one House of a joint resolution of that House described in subparagraph (B), that House receives from the other House a joint resolution described in subparagraph (B), then the following procedures shall apply:

''(I) The joint resolution of the other House shall not be referred to a committee and may not be considered in the House receiving it except in the case of final passage as provided in subclause (II).

''(II) With respect to a joint resolution described in subparagraph (B) of the House receiving the joint resolution, the procedure in that House shall be the same as if no joint resolution had been received from the other House, but the vote on final passage shall be on the joint resolution of the other House.

''(ii) Upon disposition of the joint resolution received from the other House, it shall no longer be in order to consider the joint resolution that originated in the receiving House.

''(b) If the Board of Trustees of the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund determines as any time that the balance ratio of either such Trust Fund''.

(b) CONFORMING AMENDMENTS.—

(1) Section 709(b) of the Social Security Act (as amended by subsection (a) of this section) is amended by striking ''any such'' and inserting ''either such''.

(2) Section 709(c) of such Act (as redesignated by subsection (a) of this section) is amended by inserting ''or (b)'' after ''subsection (a)''.

Mr. GREGG. Mr. President, I have enjoyed working with the Senators from Nebraska and Louisiana and, recently the Senator from Iowa, in developing this bipartisan plan. The Senator from Nebraska and the Senator from Louisiana have truly done an extraordinary job of bringing to the attention

of the American public the essential needs to address soon, quickly, and substantively the issue of Social Security reform.

I had the pleasure of serving 15 months as cochair, along with the Senator from Louisiana, of a commission of folks put together—a large cross-section of people—who are truly expert in the area of Social Security. As a result of that commission, we produced a bill that was an excellent piece of legislation. We were joined, in a bipartisan way, by Congressmen KOLBE and STENHOLM, Members of the House, on that bill.

The Senator from Nebraska has been on his own bill, along with the Senator from New York. They have developed another bill here. Months ago, we decided to get together and see if we could develop an even bigger coalition of membership around one concept of how to reform the Social Security system. That is what we accomplished. It has been accomplished because of the strong and vibrant leadership of those two Senators who are on the floor today, Senators BREAUX and KERREY, and also Senator GRASSLEY, who is not here but may be coming in on a number of other issues that are involved in the Social Security reform matter. His leadership has been excellent.

So, first of all, we do have a bipartisan bill. It has been pointed out by the Senator from Nebraska that this bill goes across the aisle, across ideology, and it is a substantive bill. It is a proposal that has been scored by the Social Security actuaries as creating solvency in the Social Security system for the next 100 years, at a minimum. It goes to infinity, but I like to say the next century because it is a more definable event. That is very important. It is a bipartisan effort, which shows it can be done. Second, it works, as scored by the Social Security actuaries.

Why is it important? You don't have to look very far to see why. I notice we have many Senate pages with us. These folks are juniors in high school who come here to work. They are either rising juniors, or have completed their junior year in most instances. They come here to work and see Congress in action. When they get finished with their schooling, most of them will go to college. When they get out of college, they are going to go to work. They are going to find that probably the biggest amount that comes out of their paychecks is the FICA tax, a big chunk that comes out of paychecks. They are going to pay that for all their working lives. What are they going to get back under the present system? These wonderful young people are probably hoping I won't speak too long so they can get off for the weekend. But what are they going to get out of this? Actually, they are going to get very little out of it. They will pay out a tremendous amount of taxes during their working lives and they will virtually get nothing back for it.

In fact, a person coming into the workforce in their early twenties today—the rate of return on what they pay into Social Security taxes over their working lives, or how much they get back for the amount of taxes they pay, is essentially a wash. They are not going to get any more back than they pay in. That is not much of a return for all the taxes they will pay over all those years. If you happen to be an African American, you actually will get less back, as a group of individuals, than you will end up paying.

So the system is broken. Why? It is broken because we have this huge bubble in our society, this huge population bubble called the postwar baby boom generation, of which Bill Clinton is a member, I am a member, the Senator in the Chair is a member, and the Senator from Louisiana is a member. This postwar baby boom generation is the largest demographic group in the history of our country. When Social Security was originally designed, and for all the years it has worked so well, it has always been conceived as a pyramid. It was essentially perceived that there would be many more people paying into the system than would be taking out. So you would have many people earning in order to support the people getting the benefit—a pyramid.

In fact, as late as 1950, there were about 15 people paying into the system for every 1 person taking out. By the late part of this century—right about now, in fact—we are down to about 3½ people paying in for every 1 person taking out. When the baby boomers retire, beginning in the year 2008, it starts to accelerate and it becomes an acute situation by 2014, where 2 people will be paying into the system for every 1 taking out.

In that sort of a structure, you can see we simply can't support the benefits. Instead of having a pyramid, we basically have some sort of rectangle. The older generation that will be retired—myself included—will be demanding too much in the way of benefits for the younger generation to support. As a result, we end up bankrupting the system. To express it in another way, even though there is a lot of debt in the trust fund, even though the Social Security trust fund, as the Senator from Nebraska pointed out, has literally billions of dollars of IOUs in it, they are simply that; they are paper IOUs.

What drives the Social Security problem is the fact that when the baby boom generation retires, there is a benefit that is guaranteed, a defined benefit. As a retiree, under Social Security, when we hit 2010, or whenever I take retirement, I am guaranteed a benefit, a fixed sum of money that I will get under our system of Social Security, a defined benefit.

Is there something there to pay that benefit? No, nothing. There are notes held by the Social Security trust, but those notes are not assets in the sense that there is something to back them up that is a physical asset. What backs it up is the taxing of power of the United States. The only way you can pay that defined benefit is to raise taxes on the earners of America to pay the benefits of the retired in America.

Because this generation is so huge and the defined benefit becomes so huge, we will have a massive tax increase on the earners of America, starting about the year 2014, and it accelerates radically to the point where we are literally talking, under the President's proposal on Social Security, about $1 trillion annually in new taxes, simply to support those people who are retired by the year 2035—I think it might be a little later. The fact is, it is a huge tax increase. Where do the taxes come from? The earnings of American people. They will come from the general fund, and they will end up essentially bankrupting this country.

Something needs to be done. Why have we put this plan forward? You say: It won't happen until the year 2014; that is a long way away; I don't have to worry about that.

We have to worry today because we can't answer this type of problem when it happens. We have to anticipate; we have to work to try to correct the problem before we hit the problem. Unfortunately, we are not doing much to get ready for this problem.

To address this, we have put forward this bill. What is the basic theme of this bill? The basic theme of this bill is that the way to address the problem of the Social Security liability in the outyears is to begin to save in the early years, say to the American worker today: Start saving for retirement and have some ownership in that savings. Today you think you are saving for retirement under Social Security because you are paying the Social Security taxes, but that doesn't mean anything. The Social Security taxes are being spent by the Federal Government. There is no asset we are building up which the retiree will own.

We say under our bill to the wage earner, people earning money in the marketplace—whether the job is a restaurant, a computer store, or whether they are working for the Government—we are going to let you start to save some of the assets you are paying in taxes today for your Social Security. We will allow you to start saving and owning those assets. We will take 2 percent of your present payroll tax and put it in a savings account which you control—you, the wage earner control, which you own. You own that account. You make the decision in a broad term as to how that is invested.

We do put limitations on the investment structure so you can't take high-risk investments or speculate. We take an asset, for all Americans paying Social Security tax, which they will physically have and own throughout their earning life, which will grow as they put more into it and which, when they retire, will be available to support

their retirement and to support the costs of the Social Security system.

This concept, which is called personal savings accounts, is at the core of what we are proposing as a solution to the problem. These personal savings accounts don't solve the problem completely. I wish we could do it completely with these accounts, but we can't.

As the Senator from Nebraska so eloquently and effectively pointed out—I won't retread that water—the fact is, you have to make decisions on the benefit side or you have to make decisions on the tax increase side. That is the only way you can get long-term solvency, unless you have the capacity to refund liability dramatically at a level you can't do because of the cost of supporting the present beneficiaries under the system.

There are three ways to solve the Social Security outyear problem: You can raise taxes, cut benefits, or ''prefund'' the liability. What we do is combine two of those. We prefund the liability and adjust the benefit structure. We adjust it in a constructive and effective way, as pointed out by the Senator from Nebraska.

The fundamental philosophical change in our bill is giving people ownership over part of their Social Security taxes. We say to folks: You can invest that, you can save it, and when you retire, it will be yours. In fact, it will be yours before you retire.

Under the present law, you pay all these Social Security taxes, and if you are unlucky enough to get hit by a train when you are 59 years old, you get nothing, absolutely nothing, from all the taxes you have paid in. What an unfair system that is.

We say to people: You are going to have that asset; it will be yours. If you are, unfortunately, hit by a train when you are 59, your family will own that asset. Whoever you want to pass it on to will own that—your wife, your children, cousins, nephews. We give people the opportunity to participate in that extraordinary thing called American capitalism, the marketplace where people can create wealth.

Is there a risk? Very little. The way we structured this, we tracked what Federal employees have been doing for years in the Federal Thrift Savings Plan. Any Federal employee can participate in it and have an option of placing some of their pension plan into the marketplace by choosing four different funds in which to invest. Those funds are managed by trustees under the Federal Thrift Savings Plan. One is very conservative, one is a moderate investment, and one is a more aggressive investment.

We will use the same type of structure. It will be the Social Security trustees investing these funds. Wage earners will have the right to choose whether they want to aggressively invest, moderately invest, or very conservatively invest. It is your choice. In any event, the rate of return on those assets is going to be dramatically better than the rate of return on the amount of taxes presently paid in the Social Security system. The average rate of return on taxes paid into Social Security is 2.7 percent. As I mentioned, for an earner in their twenties it is essentially zero, and for certain groups it is negative. Under our bill, the lowest rate of return possible is the rate of return of Treasury bills, which is about 3 percent. One could get significantly better than that, obviously. The average rate of return of the equities market over any 20-year period, including the Depression period, has been about 5½ percent. So presume 5½ percent is a number by which one reasonably assumes their assets will increase.

That is the essence of what we are doing. We are setting up a plan which, first, is bipartisan; second, it creates solvency in the trust fund for 100 years, the next century; third, it gives people ownership over parts of the assets which they are now paying in taxes over which they have absolutely no ownership.

A couple of other points should be made. We do not impact anybody presently in the Social Security system or about to come in the Social Security system. We say to those folks: The system is in place; you are comfortable with it; that is your system; we are not going to touch you in any way.

When the scare letters come out from the various groups which use Social Security as a way to try to raise money so people can drive around the city in their limousines and go to fancy restaurants, when the scare letters come out in envelopes looking like Social Security checks, and the letters say they will devastate your Social Security benefits, and they are directed at people already on Social Security, unfortunately, we don't have the wherewithal to send a counter letter. But if people have time to listen, they will know that is not case. We don't impact anyone presently on the Social Security system.

Our bill, more than any other that is presently pending on Social Security reform, is progressive. In other words, people at the lower income levels get a much better benefit under the proposal we put forward than people at the higher levels, and they get a better benefit than they would get in the present Social Security system or under any other Social Security proposal out there today, whether they have been scored as solvent or not. It is a progressive system.

In fact, a low-income person not only gets to save 2 percent, they can save about 3½ percent in the personal savings account because we set up a system for the next dollar after the 2 percent. They get a $100 match by the Federal Government. It works out so you basically can almost save 3.5 percent if you are in a low-income bracket, and that is a big increase in your net worth over 40 years, a huge increase in your net worth over 40 years, which is the average earning experience in America today.

In addition, our plan most importantly treats generations fairly. We are headed into a period, when our generation retires, the baby boom generation retires, when we are simply going to be unfair to younger generations. What we are going to do to them under the present Social Security system is absolutely wrong. We are going to tax this younger generation into a much lower level quality of life in order to support our retirement. Is that right? Of course, it is not right, but that is exactly what is going to happen if we do not address the Social Security problem and address it soon so we can start to build the assets necessary to prefund the liabilities, as I mentioned earlier.

Our bill addresses that issue. Our bill tries to right that shift of fairness between our generation and the younger generation, and it does it very effectively, and it is an important effort.

Importantly, our bill creates an atmosphere where people will have confidence in the Social Security system. There are a lot of people who say: I am not going to get anything when I retire. I am just going to pay a lot of taxes. I am not going to get anything.

And they are right if they happen to be a certain ethnic group or certain age level. Our bill will restore the confidence in the Social Security system, and that is absolutely critical.

In addition, we understand women have especially been disproportionately impacted by the present system. They are not treated as fairly as they should be. There are two reasons: No. 1, because many women weren't in the workforce, and No. 2, because they live longer. Our bill makes some very significant efforts in order to address the special needs of women, especially widows, in the Social Security benefits area. These were put together by the Senator from Iowa, to a large extent.

They are positive efforts to give women the opportunity to get the benefit structure that is fair to them and also encourage women to raise children at home. It could be a man, of course, but in most cases it would be a woman who wants to leave her job and raise her child for up to 5 years. She will be able to do that without being penalized by the Social Security system for having taken those 5 years out of the workforce and then coming back into the workforce. It is a very important step towards fairness towards women and especially women who decide to raise children.

I know the Senator from Louisiana wants to speak on this. He has certainly been a core player, a key player on this issue, as well as so many others. But on Medicare specifically, let me say this. We, as policy people, have an absolute obligation to pursue and accomplish Social Security reform in this Congress. There is no way we can justify passing up this opportunity. We have a President who does not have to

run for reelection, so he is under no political pressure to make a political decision. He has the flexibility and freedom to make the decisions that should be made in order to resolve this type of problem.

We know if we do not act, we will begin to run out of time quickly. We know if we cannot set up these personal accounts to start creating assets and letting those assets grow through compounded interest—which Einstein said was the greatest force known to mankind—we know if we do not get those assets started and get those accounts begun, we are going to end up running out of time, and we will not be able to solve the problem effectively. So we know we have to act. It is similar to that old oil filter ad, ''You can pay me now or pay me later.'' We know we have to act now, so we should be taking action.

We know it can be done because this bill proves it. It can be done in a bipartisan way and it can be done in a way that can be scored and approved by the Social Security trustees as working, so there is no argument about doing it and being able to do it. All we need now is the political will to do it, and that is going to take Presidential leadership.

Although the President has spoken on this issue a number of times, he has not given us the type of leadership we need to accomplish the goal. But if he wants to step forward, this is a great opportunity to do it. This bill gives him the vehicle to do it. I certainly hope he will take advantage of that chance.

In any event, I thank my fellow Senators who have worked so hard on this. I believe we have laid out a method that can control and move this forward in a positive way. I hope we can move from only the academic discussion of a bill to the passage of a law.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. BREAUX. Mr. President, I yield myself 10 minutes under the previous order.

Mr. GRAHAM. Will the Senator from Louisiana yield for purposes of a unanimous consent request?

Mr. BREAUX. I yield.

Mr. GRAHAM. I ask unanimous consent immediately after completion of the time controlled by the Senator from Louisiana, that I be given 10 minutes as in morning business.

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

Mr. BREAUX. Mr. President, let me first congratulate the distinguished Senator from New Hampshire for his remarks and his major contribution in this effort to bring to the floor of the Senate a proposal on reforming Social Security that, first of all, is real; it is serious, it is bipartisan. A lot of the credit goes to the Senator from New Hampshire for his diligent work in this area.

Previous to the work of the Senator from New Hampshire, we had the words of Senator BOB KERREY of Nebraska, who also joins with all of us as lead sponsors on this Social Security reform legislation. Senator KERREY has been involved in this issue of entitlement reform for a long time. He chaired the Entitlement Reform Commission and his work in the Social Security area has truly been outstanding.

It is interesting that what is happening today on the floor is this is the first time, certainly in my memory and probably in a long time, we have actually had a bipartisan proposal on reforming Social Security introduced in the Senate. Not only is it unique that it is the first time in this body, it is also even more surprising that this proposal, in addition to being bipartisan, is also bicameral. By that, of course, I mean the same proposal has also been introduced on the other side of the Capitol, over in the House, by our colleagues over there, also in a bipartisan fashion.

This is truly historic in the sense that Members of both parties and both Houses can join together in addressing an issue as important, yet at the same time as politically divisive, as Social Security has been. Yet we have been able to do that and have been joined by a number of our colleagues, particularly on the Senate Finance Committee. We have come together to make a recommendation on Social Security which I think is one that bears favorable consideration of our colleagues.

We just had a very strenuous and sometimes somewhat heated debate on the question of the Social Security lockbox, which we just voted on. We will have future debate on that. I think it is very important for all Americans to know that while we debated on this concept of a lockbox, it does not do a single thing to restore the Social Security program. It does not change the program in any way. It does not make any structural changes to Social Security. It does not increase any American's retirement options. It does not give them any additional choices about how they want to plan for their retirement future. It does not increase widows' benefits. It does not address the problems the Senator just spoke of regarding the female population in the country and the special concerns they have. It does not allow low- and middle-income workers to access any Government contributions to help them in their retirement planning and to build up a larger nest egg. The lockbox does not do anything regarding the current unfunded liabilities in the Social Security program. It certainly doesn't restore the confidence in the Social Security system.

We have heard the statements that more young people believe in flying saucers than believe Social Security is going to be there for them. So while we had a great, interesting debate on this lockbox concept, it is very important to know it does not do a single thing to take care of the problems that are facing this country in regard to the Social Security system. But this bill does. This bill has been scored by the people who have to do this for us professionally as restoring solvency to the Social Security program to the year 2075, and that is a fact. There is no debate about that. How we do it, I think, is the substance of our bill. I think it is very positive.

Let me point out, why do we have a problem in Social Security? We have been rocking along since 1935 in a pretty fortunate situation. Most people got their Social Security benefits, everything they contributed, back very quickly.

If someone retired in 1980, for instance, they got back everything they put into the Social Security system in a little over 2 years. They got back everything they put into the program. Retirees in 1980, at the age of 65, took 2.8 years to recover everything they put into the program. That is a heck of a deal for anyone. I know my father has said many times: I will never get back what I put into Social Security. He got it back in about 2.8 years. It was a very good deal for most Americans, and that is changing.

The question is, Why? Very simple: People live a lot longer and there are a lot more of them. Life expectancy—thank goodness and thank medical science and thank God—has dramatically increased over the years so people live a lot longer than they used to.

The second point is there are a lot more people. There are 77 million people in the so-called baby boom generation, those Americans born between 1946 and 1964. We have about 40 million people on Social Security today. We are getting ready to add 77 million more people into this program. It does not take rocket science to figure out why we are having problems.

We have a lot more people who are living a lot longer and earning retirement benefits through Social Security. We have fewer and fewer people left who are working to pay for those benefits. When Social Security was passed under Franklin Roosevelt, there were about 16 people working for every 1 person who was retiring. Because people live a lot longer now and there are a lot more of them, it is now down to about 3 people working for every 1 person who is earning retirement benefits and getting retirement benefits. We cannot continue on this trend. The so-called lockbox does not do a single thing to help reform the program or allow it to generate more funds to make sure the program is going to be there for the 77 million baby boomers.

For those who are on Social Security retirement now, the good news for them is it is there; they do not have to worry about it. We have never missed a payment. They will be guaranteed their payments.

Unless we do something, we are in danger of letting the program go broke. We have presented to the Senate today, and it had been presented to the other

body earlier, our recommendation in the form of a specific bill that has been scored by the people who do this work as restoring the solvency to this program to the year 2075.

How do we do it? It is not that complicated. One of the things we have done is to say that every American who pays Social Security will be required to divert 2-percentage points of their payroll tax—which is 12.4 percent payroll tax of which they pay 6.2 percent—to an individual retirement account, which is strongly supported by most Americans.

Almost two-thirds of Americans in the polls I have seen have said yes to the question: Would you like to be able to save a portion of your payroll tax in an individual retirement account that you would be able to control? There is strong support for that. I do not think they want to privatize the whole program, but they would like to have some of the money to invest for themselves, as we do as Federal employees.

I do not know if a lot of Americans realize it, those who are not Federal employees, but I can do that as a Member of the Senate. We establish our own Federal employees Thrift Savings Plan, and we can put up to 10 percent in that savings plan. We can earn interest on the market, and we get a lot better return than we get as a Government with Social Security funds. The Federal Government invests the Social Security surplus in Government bonds. It has been earning about 3 percent. That is not a good return in today's market. We need to allow individuals to do a better job with their own tax dollars.

Our plan creates a savings plan for people on Social Security where they can put 2 percent of their payroll tax into an individual retirement account which they will own, and when they pass away, it can be inherited. It will be theirs and they can invest it and hopefully get 10 percent or 15 percent or more return on their money, and they will be able to get the advantage of that higher investment when they retire and add it to the rest of their Social Security program.

It will put more money into the program. It will strengthen the program. It will allow people to become more involved in their own retirement. A lot of young people do not think it is going to be there. They think the Government does not do it very well.

This changes all of that and, I think, in a very important way. Individuals will own those proceeds, and I believe that is extremely important.

That is one of the features of our program I wanted to highlight.

In addition, we also say you can do more than that. People in lower- and middle-income brackets will be able to put an additional amount of money for an additional $1 over this 2 percent that they would put into their account. The Federal Government would match it with $100.

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

Mr. BREAUX. Mr. President, I yield myself 2 additional minutes.

The Government will match it with $100. They can make additional voluntary contributions, up to 1 percent of the total wage base of $72,600, which means they will be able to get a maximum contribution of about $626 from the Federal Government.

This is a good plan. It is a solid plan. It restores Social Security viability to the year 2075, and it is something of which we need to take advantage and do it in this Congress. We cannot continue to wait.

The big problem is this has always been a political football. This effort, this bill, is bipartisan and it is bicameral. I urge my colleagues to look at the substance of our legislation. I think they, too, will find, when they review it carefully, that this is the right approach, it makes sense, it is balanced and one that can be considered favorably by this Congress this year.

Mr. President, I yield the floor.

Mr. ROBB. Mr. President, I am pleased to join my colleagues on the floor today to introduce the Bipartisan Social Security Reform Act of 1999. As one who has been involved in various reform efforts over the past three Congresses, I can honestly say that the legislation we are introducing today is, in my view, the best product we have submitted to date.

I would like to take a moment to talk about the dedication of the members who are here on the floor today. They have all demonstrated a tireless commitment to get this body to take seriously solving the tough issue of financing this program through the Baby Boom generation and beyond. This is not an easy task. Under current law, the program faces a shortfall that would require either an 18 percent payroll tax rate or a 30 percent cut in benefits. Either option would be devastating to the future workers financing the program or the future Social Security beneficiary.

This group has united around a common purpose. Instead of trying to dress up so-called lock-boxes as Social Security reform, and instead of undertaking massive Federal borrowing to finance individual accounts on top of the current system, and instead of committing future taxpayers to fix the problem, we have actually sought to solve the long-term financing dilemma in this important program. And I'm proud to say that we have done this without adopting any payroll tax increase.

By allowing all workers to take 2 percentage points of their payroll tax into individual retirement savings accounts that workers own, we ensure that not only is today's Social Security surplus being set aside for today's workers who will become tomorrow's retirees, but we also advance fund some of our future liabilities. In addition, we also use some of the surplus to boost contributions for lower income workers, ensuring that these individuals have a comparable opportunity to build wealth in their personal savings accounts. The accumulation in these accounts will supplement future Social Security benefits under the traditional program.

While we make some revisions to future benefits to bring down the financing cost of the program, we do so in a way that doesn't affect anyone currently over the age of 62, that increases the traditional Social Security benefit for low income earners, that protects women who have taken time out to raise children, and that increases the benefit for widows and widowers.

Mr. President, this is a credible plan that solves the financing challenge presented by Social Security in a truly progressive manner. I hope other colleagues who are serious about tackling the issue will not only take a close look at this proposal, but will also help us make real reform a top priority.

Mr. THOMAS. Mr. President, I am pleased to join my colleagues today in introducing a bipartisan bill to protect, preserve and improve the Social Security system for the challenges of the 21st Century.

We all know that Social Security faces massive demographic changes. For example, our population is aging rapidly. As a result, the ratio between the number of workers paying taxes into the system as compared to the number of retirees taking funds out of the system is falling swiftly. Soon, we will have fewer than two workers for each retiree. Other demographic trends are that Americans are living longer and retiring earlier.

The combined effect of these changes is that future generations will face tremendous tax burdens or massive benefit cuts in order to preserve Social Security. The longer Congress waits before reforming the law, the more painful and difficult these changes will be.

That's why I am pleased this bipartisan group has come together with credible reform legislation that will preserve Social Security in perpetuity. It achieves this important goal in large part through advance funding of the program. The bill allows workers to divert a portion of their existing Social Security taxes into a personal retirement account that they would own. This feature would enable all Americans to accumulate a cash nest egg for their retirement and would improve the rate of return on their Social Security taxes.

Currently, Congress is considering legislation to create a ''Lockbox'' that would reserve Social Security surplus revenues for Social Security alone, not other government spending as is currently the case. I support this legislation and believe it is an important first step toward saving Social Security. But to me, the true ''Lockbox'' is private retirement accounts. These accounts ensure that individual Americans, not the Federal Government, are in charge of their retirement nest egg. If the worker dies before retirement,

the accounts could be left to his or her heirs. In addition, these private accounts ensure that the Federal Government can't come back at a later time and reduce benefits. Another key feature of these accounts is that low income workers, most for the first time, will have an opportunity to own assets and create wealth.

Another way the bill makes Social Security more progressive is by increasing the guaranteed benefits for those with low incomes. Other important provisions in the legislation will improve the Social Security benefits of widows, repeal the earnings test, and correct perverse work incentives inherent in the current system.

Finally, our proposal doesn't affect current retirees. They would continue under the current system. But by reducing the tremendous unfunded liability the system faces and restoring solvency to Social Security, current retirees are protected from the potential tax increases and benefit cuts that would be necessary to preserve the system. Seniors' benefits are far more secure under this plan than they are under current law.

Again, I am pleased to join Senators GREGG, KERREY, BREAUX, GRASSLEY, THOMPSON and ROBB in introducing this important legislation. And I encourage the rest of our colleagues to examine this bill carefully because I think it has the elements necessary to achieve a bipartisan agreement to save Social Security. The sooner we act, the better. Time is not on our side.

Mr. GRASSLEY. Mr. President, I rise today to join my colleagues in introducing the Bipartisan Social Security Reform Act of 1999.

We have crafted a responsible plan to save Social Security for generations to come. By making incremental, steady changes to the Social Security system, we will be able to ensure the long-term solvency of the program without taking Draconian measures.

Not only have we designed a responsible plan, but a bipartisan plan as well. No change to the Social Security system can be made without support from both sides of the aisle. Our bill represents a true bipartisan effort to save Social Security. The Bipartisan Social Security Reform Act is co-sponsored by four Republicans and three Democrats. Similar legislation has been introduced in the House of Representatives by Congressmen KOLBE and STENHOLM. This bipartisan, bicameral support is an excellent foundation on which to build, ensuring that the basis of the American retirement system remains financially sound for future generations.

The bipartisan plan would maintain a basic floor of protection through a traditional Social Security benefit, but two percentage points of the 12.4 percent payroll tax would be redirected to individual accounts. Individuals could invest their personal accounts in any combination of the funds offered through the Social Security system. An individual who invested his or her personal account in a bond fund would receive a guaranteed interest rate. However, individuals who wish to pursue a higher rate of return through investment in a fund including equities could do so.

Our proposal would eliminate the need for future payroll tax increases by advance funding a portion of future benefits through personal accounts. With individual accounts, we provide Americans with the tools necessary to build financial independence in retirement—especially to those who previously had limited opportunities to create wealth. Under our plan, they will be able to save for retirement and benefit from economic growth.

In putting together this legislation, this group has been conscious of how changes to Social Security would affect different populations. One group that I have been particularly concerned about is women. Let me explain how our bill addresses women's needs:

Women are more likely to move in and out of the workforce to care for children or elderly parents. They should not be punished for the time that they dedicate to dependents. Our proposal provides five ''drop-out'' years to the spouse with lower earnings in every two-earner couple.

Women, on average, earn less than men. The Bipartisan Social Security Reform Act would ensure that workers with wages below the national average would receive an additional $100 contribution annually to their personal accounts when they make a contribution of at least $1. Any subsequent contributions would receive a dollar-for-dollar match so that all workers would be guaranteed a minimum contribution of one percent of the taxable wage base. For this year, that contribution would be $726. Furthermore, all wage-earners would be permitted to save up to an additional $2,000 annually through voluntary contributions to personal accounts.

In addition, our proposal creates an additional bend point to the benefit formula to boost the replacement rate for low-income workers, many of whom are women.

Women live longer than men. At age 65, men are expected to live 15 more years, whereas women are expected to live almost 20 more. Our proposal addresses that reality by allowing money accumulated in individual accounts to be passed on to surviving spouses and children. Furthermore, our proposal would increase the widow's benefit to 75 percent of the combined benefits that a husband and wife would be entitled to based on their own earnings.

Congressional Republicans and Democrats and the administration all have established saving Social Security as a top priority. Now we must move ahead with the process and provide leadership. Each year that we wait to enact legislation to save Social Security, the changes must be more pronounced to make up for the lost time. I urge my colleagues to cosponsor the Bipartisan Social Security Reform Act.

The PRESIDING OFFICER. The Senator from Florida is under a previous order to speak for up to 10 minutes.

Mr. DOMENICI. Parliamentary inquiry. Is there any order subsequent to that?

The PRESIDING OFFICER. Yes. The Senator from New Mexico will be recognized, following the Senator from Florida, for up to 10 minutes.

Mr. DOMENICI. I thank the Chair.

The PRESIDING OFFICER. The Senator from Florida is recognized for 10 minutes.

Mr. DORGAN. Mr. President, I ask unanimous consent to follow the Senator from New Mexico.

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

PATIENTS' BILL OF RIGHTS

Mr. GRAHAM. Mr. President, I come to the floor to voice my strong objection to hidden provisions which were inserted in the so-called last amendment during the consideration of the HMO Patients' Bill of Rights.

Last night, at approximately 8 o'clock, an amendment was offered which had over 250 pages. It had been represented throughout the debate that this amendment would be of a corrective, technical nature. There were several statements made on the floor that alterations, which had been agreed to verbally, would be incorporated in that final amendment. What we find is that quite a different thing has occurred.

First, I have found that several of the areas in which I had clear representations that refinements would be made were not made. In the area, for instance, of the emergency room, one of the key issues we spent considerable time debating had to do with poststabilization coverage. It was my understanding we had arrived at an agreement as to how to correct the language which all parties had appeared to agree would be an undue restriction on the rights of patients to receive proper care in an emergency room. I am sad to have to report that those changes were not incorporated in the final version of the legislation.

I am even more offended by the fact that while the changes we thought would be there were, at least in this instance, not obtained, but more so there were extraneous issues inserted, issues that had never been considered on the floor, never considered by a committee, never debated and unknown until they were unearthed, in the case of the issue I was to raise on page 252 and 253 of the so-called manager's amendment.

What is the provision I am so concerned about? It is section 901, ''Medicare Competitive Pricing Demonstration Project.'' If you want to get the full flavor of this, let me just quote:

(a) FINDING.—The Senate finds that implementing competitive pricing in the medicare program . . . of the Social Security Act is an important goal.

I could not agree more with that statement. So that would cause your heart to beat, your level of anticipation to be excited as you want to go on to what is the next paragraph that will implement that goal.

What is the next paragraph? It says: Notwithstanding what has been said above, the Secretary of Health and Human Services may not implement the Medicare demonstration project on competitive bidding; and, furthermore, notwithstanding any other provision, the Secretary of Health and Human Services may not implement any other competitive pricing project before January 1, 2001.

An absolute outrage.

Let me give you a little history of this.

When the Medicare program began to move beyond fee for service and to accept modern ways of health care, it did so in a rather cumbersome way. It said that we will reimburse a health maintenance organization on a formula; and the formula is 95 percent of the fee for service payments to Medicare beneficiaries within that community.

That may have some superficial rationale, but let me tell you what really happens.

First, if you happen to be in a community that has, for instance, a large teaching hospital or other complex medical center that serves a larger region, you are going to have high fee-for-service payments because of the nature of the health care that is delivered in that community. I would imagine that Rochester, MN, is a community that has relatively high fee for service because it has that great Mayo Clinic. I can tell you that Miami, FL, has high fee-for-service charges because it has a number of tertiary care hospitals. So because of that aberration that has nothing to do with what an HMO should be reimbursed, HMOs in those communities get 95 percent of fee for service.

There were some modifications made of that in the 1997 Balanced Budget Act, but the basic principle of a formula-based reimbursement which relates back to fee for service is still largely in place.

There is a second sequence of that in that we have very erratic fee levels for HMOs. The community that is immediately adjacent to the high fee-for-service community can have very low fee-for-service medicine delivered there, and therefore the HMOs get a much lower fee.

In my State, the differential from the highest to the lowest community is probably on the order of at least 100 percent from the highest to the lowest community that has an HMO program.

What is the consequence of that? The consequence of that is reported in today's Washington Post on page A–2. I ask unanimous consent to have that article printed in the RECORD immediately following my remarks.

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

(See Exhibit 1.)

Mr. GRAHAM. It states: ''HMOs Will Drop 327,000 Medicare Beneficiaries Next Year.''

We have just spent 4 days of debate on trying to avoid having people dropped from their HMOs, and we now have an announcement that just in the Medicare program alone—the Medicare program has 39 million participants, and approximately 4 million of those are in HMOs—out of that relatively small number of HMO beneficiaries, 327,000 are being dropped.

What does it say? It says that of those who are being dropped, 79,000 will be unable to enroll in another HMO because there are no other HMOs in their area.

When the industry was asked, why is this happening, their answer was: The managed care industry says HMOs are pulling out of Medicare because the Government isn't paying them enough.

You would think the industry would therefore want to have an alternative system that would provide adequate reimbursement, but not excessive reimbursement, and that the place to achieve that is the marketplace.

We heard a lot of talk this week about how we ought to have deference to the marketplace. I think what the HMOs want is to have free enterprise when it relates to service to the patients, and they want to have socialism when it relates to how much revenue they get paid.

So in 1997, in the face of all of these factors, the Congress, by a very strong vote—I think it was 76 votes in the Senate—passed the Balanced Budget Act which contained a provision that would actually start HMOs toward a competitive bidding process—the same process, incidentally, used by many other large HMO users, State and local governments, and in the private sector.

It was started very modestly, with a demonstration plan so that we could learn about what was involved in competitive bidding for HMOs. I, frankly, thought that was excessive caution, that we could have taken advantage of the experience that was already available by many other large users, but the thought was, let's go slow, let's do a demonstration project.

So since 1997, HCFA, the Federal agency with responsibility for managing Medicare, has been organizing this demonstration project. They selected Kansas City and Phoenix as the two sites for the demonstration project. They are about to start, and all of a sudden, on the 252nd page of what is supposed to be a corrective manager's amendment, we not only bar the demonstration projects that are about to commence but bar any other demonstration projects that may be suggested. Yet we started with a finding that we support competitive bidding.

Boy, I tell you, if this is the way they support the principle, you do not want them to be your parents and say they are going to give you good care.

Mr. DORGAN. Will the Senator yield for a short question?

Mr. GRAHAM. Mr. President, I ask unanimous consent for an additional 5 minutes.

The PRESIDING OFFICER. The Senator has 28 seconds remaining.

Mr. GRAHAM. I ask unanimous consent for an additional 5 minutes.

The PRESIDING OFFICER. If there is no objection.

Without objection, it is so ordered.

Mr. DORGAN. I want to inquire. I was unaware that that provision was in the package that was presented. Was the Senator from Florida aware, did he know of anyone else who was aware of that except perhaps the folks who wrote it?

Mr. GRAHAM. We have not found anybody who was aware of it except some diligent soul who actually got to page 252 of the bill sometime late last night or this morning and discovered this. I might say, it is very difficult to even get copies of this amendment.

We have known for several years that the HMO industry did not want competitive bidding. They like the socialized formula system that exists today. They are attempting in any way they can, including this stealth attack late last night on page 252, to kill competitive bidding.

Unfortunately, just as with the issue of the HMO bill we have been debating, on the issue of patients versus the bottom line of the HMOs, the HMOs won in the Patients' Bill of Rights, and they have won again by killing competitive bidding. I say they have won. I think it is a Pyrrhic victory.

I think the Senator from North Dakota might recall an event that, as Yogi Berra said, it is deja vu all over again. I think it was just about 3 years ago, in a similar stealth maneuver, that we discovered there was embedded in a large bill a provision that would have given the tobacco industry a $50 billion tax break. Once that issue surfaced, it could not stand the light of day. It slowly withered, died, and has not been resurrected.

I suggest the light of day will be shed on what the HMO industry has done by inserting this amendment on page 252 of a technical amendment, the fact they are using this as a means of avoiding the rigors of the marketplace, they are using this to avoid a rationalization of the compensation that HMOs receive from their patients so that we don't continue this pattern of 32,700 people being dropped. I can tell my colleagues, most of these people are people who come from rural areas. They come from small towns where they don't have high fee-for-service medicine. The HMOs want to skim off those areas that have high fee-for-service, where they can get a formula that results in a very rushed reimbursement level. They don't want to provide services, and they don't even want to have a competitive bidding process that can arrive at what the marketplace says they should be paying for those HMO

beneficiaries in smaller communities of America.

What we are seeing, again, is the bottom line winning out over the rights, the interests, and the health of patients. We are watching as Medicare patients are dumped on the street. Is that the HMO industry's idea of reform? It is my idea of a travesty, and it is one that we need to bring to the attention of America. And we, as the Senate, need to expunge this dark page, page 252, and its companion, page 253, from our records. I hope we will, at the first opportunity, do so.

I thank the Chair.

EXHIBIT 1

[From the Washington Post, July 16, 1999]

HMOs WILL DROP 327,000 MEDICARE BENEFICIARIES NEXT YEAR

(By David S. Hilzenrath)

About 327,000 of the 6.2 million Medicare beneficiaries nationwide who belong to HMOs will be abandoned by their health plans next year, the government said yesterday.

Of those, 79,000 will be unable to enroll in another health maintenance organization as 41 health plans withdraw from the federal health insurance program for the elderly and disabled and another 58 stop serving Medicare beneficiaries in particular areas, according to the agency that runs Medicare.

Medicare beneficiaries who lose their HMO coverage have two or three alternatives: They can choose another HMO, if one is available; they can revert to standard fee-for-service Medicare coverage; and they can buy ''Medigap'' policies to supplement the standard benefits.

But there is no guarantee that they can find a Medigap policy with prescription drug coverage, which is one of the main reasons some Medicare beneficiaries choose HMOs.

In Maryland and Virginia, 33,000 beneficiaries—26.9 percent of those with HMO coveage—will lose their current coverage, and 27,000 will be unable to replace it with another HMO.

An HMO industry group recently predicted that more than 250,000 beneficiaries would be affected by the changes, but the Department of Health and Human Services released the final tally based on notices HMOs were required to submit by July 1.

This year, a larger number of beneficiaries—407,000—were abandoned by their HMOs, but a smaller number—51,000—were left without an HMO option.

The managed-care industry says HMOs are pulling out of Medicare because the government isn't paying them enough, but the government says the HMOs' actions reflect broader industry trends.

MANAGED HEALTH CARE REFORM—HMO LIABILITY

Mr. BINGAMAN. Mr. President, over the past few days, my Democratic colleagues and I presented a number of arguments which clearly laid out the need for managed health care reform.

The ability to hold insurance companies accountable for their decisions is a critical element in ensuring the overall quality of patient protections.

While we will continue to present our case in a variety of ways, I would like to take this opportunity to relate a story that was shared with me just a few weeks ago about a young girl from Albuquerque, New Mexico.

Anna, 6 years old at the time, was a very active and energetic young girl and excited about entering first grade that year. One evening, Anna went with her parents and her brothers and sisters to a softball game. She and other children went off to play in an area near the softball field. Suddenly, some of the children came running towards the adults, screaming for help. Anna had caught her foot in a gate. Her foot was bleeding profusely and she was in agonizing pain. She was immediately rushed to the local emergency room.

After Anna was examined by her doctor and after a conversation with her family's HMO, it was determined that Anna would not be admitted to the hospital that night.

Anna's family reluctantly took her home that night where she was in pain throughout the evening. Her family was forced to watch their small, frail daughter lay in bed in agony.

The next morning, her mother was worried because Anna's foot was purple, swollen, and cold. Anna was in tremendous pain and had a fever. Her parents did not hesitate any longer and Anna was rushed back to the emergency room.

This time she was admitted immediately and treated on an emergency basis, but it was too late and her family's worst fears were realized. Anna had a raging infection that had already destroyed half of her foot which had to be amputated.

Anna had two surgeries and spent 6 weeks in the hospital. She will live with this deformity forever.

Unbelievably, her family's HMO has delayed paying for the 6 weeks she was in the hospital to have her foot amputated and grated at a cost of $23,000.00.

Anna's family paid for the protection of health insurance. What they received in return was a possible delay of critical medical service which has left Anna disfigured and has ruined her family's credit.

To the amazement of anyone who hears this story, under current law, Anna's HMO will not be held accountable for their decisions.

Under the Democratic plan, Anna and her family would have legal recourse like any other American has in this country when they are wronged by a business.

The Democratic plan simply states that if a patient is injured or killed as a result of an insurance company's decision, the insurance company can be held liable under state law.

Let me be clear. This will not open the flood gates to more litigation and raise the cost of health insurance.

It doe not override states' rights. It simply says that whatever rights a given state chooses to grant shall not be blocked by federal legislation.

Without adoption of the Democratic plan, stories like Anna's will continue to be told. I understand Anna is quite a young girl and she will go on. But she and her family will struggle with this nightmare.

The Democratic plan is not about lawyers—it is about people like Anna and protecting their rights.

Anna, her family and millions like them in this country are waiting for us to do just that.

THE ILLEGAL PURCHASE OF FIREARMS

Mr. LEVIN. Mr. President, we've all heard the saying, ''if at first you don't succeed, try, try, again.'' It's a lesson we've been taught since childhood. It's a lesson used to teach children to be persistent and work hard if they want to achieve their goals. It is also a lesson that applies to the purchase of firearms, and it is one that Benjamin Smith knew all too well.

Over the Fourth of July weekend, the majority of Americans were celebrating the birth of our nation. But the long holiday weekend produced yet another tragedy, made possible by the free flow of deadly firearms. A single man, Benjamin Smith, with a hatred for life, allegedly used a .22 caliber handgun and a .380 caliber semi-automatic handgun to murder two people and wound nine before ending his own life.

The alleged gunman had a history of violence, a protection order filed against him, and belonged to an organization that espouses hatred toward minorities, yet, he was still able to purchase deadly firearms, all because he was persistent. Approximately one week before his killing spree, he had applied to purchase firearms from a licensed firearms dealer in Illinois. He obtained an owner identification card, filled out an application, and expected to retrieve his weapons shortly thereafter. A few days later, however, he returned to buy the weapons and was rejected by the licensed dealer after failing to pass the Illinois state background check. Unfortunately, Benjamin Smith knew his lesson, ''if at first you don't succeed, try, try again.''

Benjamin Smith knew of other means to obtain firearms. He knew that although he was not permitted to purchase a gun from a licensed dealer, he would have few problems buying a gun on the street, from an unlicensed dealer. He knew that federal law requires that background checks be conducted by licensed dealers, but he also knew of a large secondary market in the United States that permits the free flow of weapons in to the hands of those who can not pass background checks. And, because he knew how easy it is to obtain a gun in the United States, Benjamin Smith was able to try, again, to purchase firearms for his killing spree.

Smith's second attempt to purchase guns was successful and as a result, this dangerous young man was equipped with the two handguns believed to be used in the several Independence Day shootings. Because of this secondary market that allows easy accessibility of firearms, the nation is

again mourning the loss of innocent lives lost to gunfire. And although the American public expresses continual outrage that federal firearms laws are not strong enough to prevent persons like Benjamin Smith from purchasing guns, Congress has not yet responded. We need to try, try again to pass meaningful legislation that will put an end to this senseless slaughter.

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Thursday, July 15, 1999, the Federal debt stood at $5,625,473,322,843.46 (Five trillion, six hundred twenty-five billion, four hundred seventy-three million, three hundred twenty-two thousand, eight hundred forty-three dollars and forty-six cents).

One year ago, July 15, 1998, the Federal debt stood at $5,529,723,000,000 (Five trillion, five hundred twenty-nine billion, seven hundred twenty-three million).

Five years ago, July 15, 1994, the Federal debt stood at $4,624,152,000,000 (Four trillion, six hundred twenty-four billion, one hundred fifty-two million).

Twenty-five years ago, July 15, 1974, the Federal debt stood at $473,130,000,000 (Four hundred seventy-three billion, one hundred thirty million) which reflects a debt increase of more than $5 trillion—$5,152,343,322,843.46 (Five trillion, one hundred fifty-two billion, three hundred forty-three million, three hundred twenty-two thousand, eight hundred forty-three dollars and forty-six cents) during the past 25 years.

VETERANS' SMALL BUSINESS DEVELOPMENT LEGISLATION

Mr. ABRAHAM. Mr. President, I rise today in support of the ''Veterans' Entrepreneurship and Small Business Development Act.''

By establishing the National Veterans Business Development Corporation, this bill will provide significant assistance to entrepreneurial veterans. Additionally, this legislation works to aid veterans through networking, supervision, microloans and loans, disaster assistance, and data collection programs. This bill provides assistance to many veterans who have the skills, talent and motivation to successfully own and operate small businesses but may not have the right connections or the ability to hire consultants. This bill is a means by which the federal government can help veterans help themselves.

Veterans have fought and sacrificed to protect the United States and the freedoms Americans cherish. Veterans' programs such as this provide us, in a small way, the capability to repay those veterans for their extraordinary contributions to our nation. These veterans have already given so much to our country and many of them want to contribute even more by starting small businesses. I believe we owe it to them to do everything we can to help them in these endeavors.

Accordingly, I am proud to join The American Legion, the Disabled Veterans Association, the Reserve Officers Association, the Veterans of Foreign Wars, and the many other military and veteran service organizations in support of this bill.

ADOPTION AWARENESS ACT OF 1999

Mr. MCCAIN. Mr. President, yesterday, I introduced the Adoption Awareness Act of 1999. The objective of this legislation is to provide proactive support for adoption as an option for women with unplanned pregnancies, and for couples who are unable to conceive a child due to problems with infertility. The bill would require certain federally-funded health centers to provide adoption counseling by trained adoption counselors.

The Adoption Awareness Act makes grants available to national adoption organizations to provide staff training in adoption counseling to eligible health centers. These health centers include Title X funded clinics, community health centers, migrant health centers, centers for the homeless, school-based clinics, and crisis pregnancy centers. The objective is to ensure that woman and their families are provided professional, compassionate, and understanding counseling about adoption.

This legislation also provides that faith-based charities may receive grants to provide adoption counseling training services on the same basis as any other nongovernmental provider without impairing the religious character of such institutions and without diminishing the religious freedom of those receiving services.

Finally, this legislation authorizes the appropriation of $7,000,000 for fiscal year 2000 for purposes of providing adoption counseling training.

There are no unwanted babies in this country. Across America there are countless couples who cannot conceive a baby, and struggle, often hopelessly, to adopt a child. All the while, tragically, 1.5 million children are aborted every year. There are parents who desperately want the opportunity to provide these children with a loving home, and the gift of life itself.

The purpose of this legislation is not to incite a debate about abortion. The purpose of this legislation is to stress the value, indeed the sanctity of life, and the importance of adoption as an alternative to abortion. The purpose of this legislation is to ensure that a woman struggling with the tragic choice of abortion is provided professional and compassionate counseling on adoption. A mother deserves to know that there are millions of couples out there who are willing, indeed desperate, to provide her child with a loving home. A mother deserves to know that ending her child's life is not the only choice she has.

I speak from personal experience. I am an adoptive father. I am a staunch supporter of the choice of adoption. Every mother pondering the agony which is abortion deserves the hope this legislation offers. Every unborn child deserves the opportunity for life that this legislation offers.

I believe in the sanctity of human life. I have always fought for the rights of the unborn child, and the preservation of the intrinsic value of all human life. At approximately 1.5 million abortions every year, that is some 35 million children killed since the *Roe* v. *Wade* decision. Mr. President, regardless of your beliefs, pro-abortion, or pro-life, that is a staggering and tragic statistic. This legislation offers a chance at reducing that number. It is not the answer, but it does provide hope to couples struggling desperately to adopt children. As important, it provides hope to that mother or couple who is standing on the tragic precipice of abortion, ensuring that they know there is another choice.

Every child embodies the hope for our future. It is our children, in their purity and their innocence, that hope is born again in an increasingly cynical world. Abortion is the great tragedy of our time. America is not a country of kings. America is not defined by any single geographic characteristic, by any single race or creed. America is an idea, a collection of high ideals, eloquently articulated, inscribed in our Constitution, and embodied on our institutions.

Abraham Lincoln, in pondering the profound wisdom and our founding fathers, wrote of them: ''This was their majestic interpretation of the economy of the universe. This was their lofty, and wise, and noble understanding of the justice of the Creator to his creatures . . . In their enlightened belief, nothing stamped with the divine image and likeness was sent into the world to be trodden on . . . They grasped not only the whole race of man then living, but they reached forward and seized upon the farthest posterity. They erected a beacon to guide their children, and their children, and the countless myriads who would inhabit the Earth in other ages.''

Mr. President, confronting the tragic figures on abortion I have previously cited, I cannot help but question whether we can continue on this course and maintain hope that the intrinsic value of every human life, that principle out of which all the rights of man flow, can survive. The Adoption Awareness Act represents one step in the effort toward restoring the sanctity of life as the foundation of our system of human rights.

A COMPREHENSIVE NUCLEAR TEST BAN

Mr. DORGAN. Mr. President, today is an anniversary that almost no one will

recognize. It was 54 years ago today that the first nuclear explosion occurred at the Trinity Test Site in New Mexico. Mr. President, 54 years ago today we saw the first nuclear explosion on the face of the Earth. At that time, of course, we developed nuclear weapons because we were locked in a life and death struggle with the Axis powers. We developed nuclear weapons to end the most destructive war the world had ever seen, the Second World War. We then got involved in a cold war with the Soviets and we saw the buildup of thousands and thousands of tactical and strategic nuclear weapons, warheads, and delivery vehicles.

I want to tell you what President Dwight D. Eisenhower said towards the end of his term about the spread of nuclear weapons. He said not achieving a test ban—that is, a ban on the testing of nuclear weapons—''would have to be classified as the greatest disappointment of any administration of any decade of any time and of any party.'' That belief, expressed by President Eisenhower, was echoed by President John F. Kennedy, who stated that a comprehensive nuclear test ban would ''increase our security; it would decrease the prospects of war.'' He said, ''Surely this goal is sufficiently important to require our steady pursuit.''

That was the late 1950s and the early 1960s. We still do not have a Comprehensive Nuclear Test Ban Treaty in force, but we are close. Almost 3 years ago, this country, the United States, along with over 100 nations, signed a Comprehensive Nuclear Test Ban Treaty. The President sent that treaty to the Senate 662 days ago. What has happened? What has been done with that treaty? Nothing. Not a hearing. Not a minute, not an hour, not a day of hearings, not one hearing on the Comprehensive Nuclear Test Ban Treaty.

The only way another country in this world who wants to develop nuclear weapons can have some guarantee that they have nuclear weapons that work is if they can test them. That is true of China; it is true of any other country. A test ban treaty in which this country provides leadership, signs and ratifies it, is a significant step towards removing the dangers of the proliferation of nuclear weapons around the world. We ought to do this. We ought to be able to do it soon.

I used a chart on the floor of the Senate recently in which I showed the number of days it took to ratify treaties. No treaty that I am aware of languished here for over 600 days except this treaty.

We have a responsibility to lead in this country with respect to this treaty, and we are not leading. This treaty is before the Senate. The committee has a responsibility to hold a hearing and give the Senate the opportunity to debate the Comprehensive Nuclear Test Ban Treaty. There is precious little discussion about it. No one seems to know it is here. It has been here almost 2 years.

Next week, several of my colleagues and I are going to hold a press conference to announce the results of a recent bipartisan poll that will demonstrate, once again, overwhelming support for this treaty. This chart shows the support all across this country from last year's poll. Overwhelmingly, the American people support a Comprehensive Nuclear Test Ban Treaty.

It has been negotiated, it has been signed, but it has not been ratified. Why? Because it was sent to the Senate over 600 days ago and there has been no debate about it, no discussion of it to speak of, and there has not been 1 minute of hearings held on this treaty. This Senate ought to have the opportunity to debate and to vote on the Comprehensive Nuclear Test Ban Treaty.

I reach back to President Eisenhower to make the case only because I want to demonstrate how long the desire for a Comprehensive Nuclear Test Ban Treaty has been around—decade after decade.

Most recently, when India and Pakistan detonated nuclear weapons, virtually under each other's chins—and these are countries that do not like each other much—it should have sent a signal to all of us that we need to be concerned about the proliferation of nuclear weapons. How do we manifest concern? By expressing leadership. How do we express leadership? By bringing a Comprehensive Nuclear Test Ban Treaty that has been negotiated and signed before this body for ratification.

I yield the floor.

TOP AMERICAN HOSPITALS IN COLORADO

Mr. ALLARD. Mr. President, over the course of the last week the Senate has examined at great length many of health care's problems in America. On the floor we have discussed various legitimate problems and anecdotal horror stories to such an extent that I fear we may have obscured what is positive about health care in the United States.

Each year US News and World Report magazine recognizes American hospitals that practice health care that all Americans can be proud. These hospitals perform at the very highest levels, demonstrating excellence in general care and specific areas of medical specialty. This year the magazine analyzed each of our nation's 6,299 hospitals, and I am proud to rise today to recognize a number of hospitals from my home state of Colorado that have been recognized by US News and World Report for their outstanding work.

In Colorado we have long understood the value these fine institutions bring to their communities, our state, and the Rocky Mountain region.

I would like to recognize Children's Hospital in Denver, ranked 12th nationally in the specialty of Pediatrics, and 2nd in the Western Region.

I would like to recognize Craig Hospital in Denver, ranked 5th nationally in the specialty of Rehabilitation, and 2nd in the Western Region.

I would like to recognize University Hospital in Denver, ranked 37th nationally in the specialty of Ear Nose and Throat, 4th in the Western Region; ranked 23rd nationally in the specialty of Rheumatology, 4th in the Western Region; and ranked 15th nationally in the specialty of Rehabilitation, and 4th in the Western Region.

Finally, I would like to salute National Jewish in Denver, for their overall number one ranking as the finest American hospital for Respiratory Disorders.

I know I speak for all Coloradoans when I say that I am thankful to have these fine institutions in our state.

I congratulate Children's Hospital, University Hospital, Craig Hospital and National Jewish for this recognition of their exemplary work.

A MILITARILY STRONG ISRAEL

Mr. BOND. Mr. President, I have been very encouraged in recent days by the peace offensive initiated by the new government of Ehud Barak in Israel. The people of Israel long for peace. The new Prime Minister, in his first few days in office, has been energetically trying to lay the groundwork for a secure, lasting peace in the Middle East. I applaud his efforts and trust that Prime Minister Barak's actions will be fully discussed and carried forward in his upcoming talks in Washington during the next week.

While I applaud these steps toward peace, I also believe it is imperative that, at the same time, Israel remain militarily strong. The only way a durable peace will be successfully negotiated and maintained in this dangerous but vital region of the world is if Israel deals from a strong hand. Even if Israel is successful in reaching an accommodation with its closest neighbors, it will continue to face very serious strategic threats from Iran, Iraq, and Libya for the foreseeable future.

To counter these terrorist states which possess weapons of mass destruction and lie within easy striking distance of Israel's homeland, it is critical that Israel have an effective strategic strike capability that will provide effective deterrence. To do this and to move simultaneously forward in implementing the Wye River Agreement and pursuing peace initiatives with its neighbors, Israel will need more military assistance funding for aircraft purchases from the United States.

In this regard, I recently came across a thoughtful Lexington Institute Issue Brief, authored by well-known defense strategist Loren Thompson, ''Bolstering Israel's Strategic Air Power Serves America's Interests.'' In this essay, Dr. Thompson argues that helping Israel to increase it military strength at this time not only will help Israel and further Middle East peace but also help protect America's interests in the region, especially since the

US may have less access to bases in the region and more threats to American security interests in the future.

Dr. Thompson states, among other things, that:

It (Israel) needs enough money to buy and equip 15 more F–15's for a total force of 40. . . . Making such a purchase would nearly double the Israeli Air Force's capacity for long-range strikes. . . . The US economic and political interest in the Middle East-Persian Gulf region will continue to grow in the years ahead (and) Israel is the only stable, reliable US ally willing to take the necessary risks. Congress and the Clinton Administration need to equip it (Israel) so that it is ready when the time comes.

Mr. President, to share Dr. Thompson's thoughts with my colleagues, I ask unanimous consent that this essay be printed in the RECORD.

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

BOLSTERING ISRAEL'S STRATEGIC AIR POWER SERVES AMERICA'S INTERESTS

(By Loren B. Thompson, Ph.D.)

Israel's government is currently considering a major purchase of military aircraft from the United States. The pending sale has attracted media attention in the U.S. because it pits two highly-regarded tactical aircraft—the Boeing F–15 and Lockheed Martin F–16—against each other in a competition that may be the last opportunity to keep the F–15 in production.

The F–15 is more capable than the F–16 in some roles, but it is also more expensive. That is one reason why the F–16 has won most of the recent international arms-sale competitions in which both aircraft were offered. With global tensions greatly reduced from the Cold War period, many nations would prefer the operational flexibility of acquiring a larger number of planes for the same price.

Israel will probably be no exception. It is a foregone conclusion that the Israeli Air Force (IAF) will select one of the two planes because the U.S. government subsidizes Israeli arms purchases and the F–15 and F–16 are the only U.S. aircraft being offered in the current competition. But the IAF has over a hundred aging F–4 fighters and A–4 attack planes reaching the end of their useful life, and the multi role F–16 is a much more affordable replacement than the F–15, both in terms of up-front acquisition costs and later support costs. So the F–15 is likely to lose the competition.

THE STRATEGIC CONTEXT

The U.S. government should not try to dictate to Israel how it organizes or equips its military. On the other hand, Washington should be sensitive to the fact that Israel is one of America's few democratic allies in the Middle East, and its armed forces in the future may be called on to serve as substitutes for U.S. military power. This has happened in the past, most notably when the IAF destroyed Iraq's Osirak reactor in 1981—a facility the Iraqis planned to use for making weapons-grade nuclear material.

The Osirak mission was carried out by Israeli F–16 strike aircraft escorted by F–15 fighters. Its success was good news for every nation in the region, although few Arab states could publicly say so. Saddam Hussein's subsequent behavior demonstrated it was also good news for America, which avoided having to deal with a nuclear-capable dictatorship in a volatile, strategically-important region.

But things have changed in the Middle East since 1981. A number of countries other than Iraq—some of them more distant from Israel—have begun acquiring access to weapons of mass destruction. Iran is developing nuclear, chemical and biological weapons, along with the ballistic missiles to deliver such weapons over long distances (it tested the new Shahab medium-range ballistic missile in July 1998). Libya has made similar efforts. And Sudan has become a center of global terrorism, one suspected of sponsoring the manufacture of chem-bio weapons.

These trends, which are likely to grow worse, already pose a serious threat to both Israeli and Western interests in the region. But whereas policymakers in Washington have the luxury of seeing such developments in tactical terms, for Israel they are strategic: the very survival of the Jewish state is at stake. And although it is now fashionable to think of America as the world's policeman, it is clear that Israel will often have more incentive and latitude than the U.S. to respond expeditiously to such threats in the future.

ISRAEL'S STRATEGIC DILEMMA

Which is why the pending arms sale has a special significance: if the government of Prime Minister Ehud Barak decides its top air-power priority is to refresh its force structure with the improved version of the F–16 (the F–16I), Washington shouldn't dispute that decision. But the issue of Israel's strategic strike capability against emerging threats in distant states like Iran should not be neglected.One of the ways in which the F–15I is superior to the F–16I is in its ability to carry bigger bomb loads to greater distances. It would be easier to sustain a long-range bombing campaign against strategic targets near the Iranian capital of Teheran using F–15I's than F–16I's for the simple reason that the F–15I's have about a third more range.

A single F–16I has a maximum weapons carriage of four 2,000-pound bombs, which it can carry to a maximum unrefueled combat radius of over 700 nautical miles. An F–15I can carry the same bombload to a radius of about 1,100 nautical miles, or it can carry up to seven 2,000-pound bombs of lesser range. The performance of the F–15 results from the fact that each of its twin engines generate as much thrust (29,000 ponds) as the single engine on an F–16. Unfortunately the twin engines are also the biggest reason why each F–15I would cost the IAF about 30% more, not counting later support costs. In air warfare, the tradeoff between price and performance often is inescapable.

Fortunately for Israel, long-range strategic strike is a specialized mission that does not require a large number of aircraft, and the IAF already has 25 F–15Is suitable for the mission that it bought in 1995. Furthermore, it's not as though the F–16s can't hit remote targets: it was the strike aircraft against the Osirak reactor. But for truly distant targets, the F–16 imposes performance penalties. Conformal fuel tanks might have to be added at the expense of bombload, or aerial refueling might be necessary in hostile airspace. For these very distant targets, the F–15I is the safer choice.

The problem is that Israel doesn't have enough F–15I's today to prosecute a sustained bombing campaign over great distances, and within current budget constraints it can't afford to buy more—unless it decides to buy fewer F–16s, which would be a bad idea given the age of existing IAF assets and the myriad other missions the F–16Is are needed to cover.

THE BOTTOM LINE

The bottom line is that Israel needs more military assistance funding for aircraft purchases from the United States. Specifically, it needs enough money to buy and equip 15 more F–15Is for a total force of 40, without cutting its planned purchase of F–16s. Some F–15I proponents have called for a ''second squadron'' of F–15Is, but the U.S. should not be in the business of dictating the organization of the Israeli Air Force. What it should be doing is helping Israel meet the full range of its legitimate military needs.

Fifteen more F–15s for Israel is not enough to keep the F–15 line open for an extended period of time, but that's precisely the point: this may be the last chance for Israel to acquire an adequate strategic strike capability before the F–15 line closes. Making such a purchase would nearly double the IAF's capacity for long-range strikes while permitting more efficient use of the support infrastructure bought to support the 25 F–15Is already in the force. It would also free up F–16s for other missions, thus enhancing utilization of the entire tactical-aircraft inventory.

But the case for funding a viable IAF strategic force transcends Israeli military needs. The U.S. economic and political interest in the Middle East-Persian Gulf region will continue to grow in the years ahead as America becomes more dependent on foreign oil. Unfortunately, its access to bases and freedom to act militarily in the region will probably diminish, forcing it in some cases to rely on allies to achieve military goals. Israel is the only stable, reliable U.S. ally willing to take the necessary risks. Congress and the Clinton Administration need to equip it so that it is ready when the time comes.

MESSAGES FROM THE HOUSE

A message from the House of Representatives was received announcing that the Speaker signed the following enrolled bill on July 1, 1999:

H.R. 775. An act to establish certain procedures for civil actions brought for damages relating to the failure of any device or system to process or otherwise deal with the transition from year 1999 to the year 2000, and for other purposes.

MESSAGES FROM THE HOUSE RECEIVED DURING ADJOURNMENT

A message from the House of Representatives was received, during the adjournment of the Senate, announcing that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1691. An act to protect religious liberty.

H.R. 2466. An act making appropriations for the Department of the Interior and related agencies for the fiscal year ending September 30, 2000, and for other purposes.

The message further announced that the House agrees to the resolution (H. Res. 249) returning the Senate the bill (S. 254) to reduce violent juvenile crime, promote accountability by and rehabilitation of juvenile criminals, punish and deter violent gang crime, and for other purposes, in the opinion of this House, contravenes the first clause of the seventh section of the first article of the Constitution of the United States and is an infringement of the privileges of this House and that such bill be respectfully returned to the Senate with a message communicating this resolution.

Ths message also announced that the Speaker appoints the following Members as additional conferees in the conference on the disagreeing votes of the

House on the amendment of the House to the bill (S. 1059) to authorize appropriations for fiscal year 2000 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of the Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes: As additional conferees from the Committee on House Administration, for consideration of section 1303 of the Senate bill and modifications committed to conference: Mr. THOMAS, Mr. BOEHNER, and Mr. HOYER.

MEASURE PLACED ON THE CALENDAR

The following bill was read twice and placed on the calendar:

H.R. 2466. An act making appropriations for the Department of the Interior and related agencies for the fiscal year ending September 30, 2000, and for other purposes.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. ROTH, from the Committee on Finance, without amendment:

S. 1386. An original bill to amend the Trade Act of 1974 to extend the authorization for trade adjustment assistance.

S. 1387. An original bill to extend certain trade preferences to sub-Saharan African countries.

S. 1388. An original bill to extend the Generalized System of Preferences.

S. 1389. An original bill to provide additional trade benefits to certain beneficiary countries in the Caribbean.

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. GREGG (for himself, Mr. KERREY, Mr. BREAUX, Mr. GRASSLEY, Mr. THOMPSON, Mr. ROBB, and Mr. THOMAS):

S. 1383. A bill to amend title II of the Social Security Act to provide for individual savings accounts funded by employee and employer social security payroll deductions, to extend the solvency of the old-age, survivors, and disability insurance program, and for other purposes; to the Committee on Finance.

By Mr. ABRAHAM (for himself, Mr. BOND, and Mr. KOHL):

S. 1384. A bill to amend the Public Health Service Act to provide for a national folic acid education program to prevent birth defects, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. REED:

S. 1385. A bill to require that jewelry boxes imported from another country be indelibly marked with the country of origin; to the Committee on Finance.

By Mr. ROTH:

S. 1386. An original bill to amend the Trade Act of 1974 to extend the authorization for trade adjustment assistance; from the Committee on Finance; placed on the calendar.

S. 1387. An original bill to extend certain trade preferences to sub-Saharan African countries; from the Committee on Finance; placed on the calendar.

S. 1388. An original bill to extend the Generalized System of Preferences; from the Committee on Finance; placed on the calendar.

S. 1389. An original bill to provide additional trade benefits to certain beneficiary countries in the Caribbean; from the Committee on Finance; placed on the calendar.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. ABRAHAM (for himself, Mr. BOND, and Mr. KOHL):

S. 1384. A bill to amend the Public Health Service Act to provide for a national folic acid education program to prevent birth defects, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

THE FOLIC ACID PROMOTION AND BIRTH DEFECTS PREVENTION ACT OF 1999

Mr. ABRAHAM. Mr. President, I rise to introduce the Folic Acid Promotion and Birth Defects Prevention Act of 1999. I would also like to thank my colleagues Senator BOND and Senator KOHL for cosponsoring this important piece of legislation.

Mr. President, each year over 8,000 infants die from birth defects. The loss of these children, who could have grown up to be community leaders, teachers, doctors, or lawyers, weighs heavily upon our society. In addition, each year over 2,500 babies born live with serious birth defects of the brain and spine, called neural tube defects, and over 50 percent of these cases are preventable. In 1991, research proved that if pregnant women take as little as 400 micrograms of B vitamin folic acid each day, 50 to 70 percent of all cases of these serious birth defects of the brain and spine, such as spina bifida, would be prevented. Unfortunately, this information is not widely known by the public. According to a Gallup Poll conducted for the March of Dimes, only 32 percent of women of childbearing age reported taking a multivitamin with folic acid on a daily basis.

We must broaden public awareness about the prevention of these crippling defects. For this reason, I have introduced the Folic Acid Promotion and Birth Defects Prevention Act of 1999. This legislation authorizes $20 million for the Centers for Disease Control (CDC), in partnership with state and local public and private entities, to launch an education and public awareness campaign, conduct research to identify effective strategies for increasing folic acid consumption by women of reproducing age, and evaluate the effectiveness of these strategies.

Mr. President, this legislation is an effort to link great advances in research with everyday life. This life-saving information about the consumption of folic acid, which will prolong the health and well-being of women and infants, needs to be broadcast to families and individuals across the country. It is my firm belief that this legislation will be the vehicle to help bring this important message into every home in America.

I would like to take a moment to thank the March of Dimes for their involvement in this issue. Their work will be critical in getting this legislation passed and in helping spread the message of the benefits of folic acid. Mr. President, I yield the floor.

ADDITIONAL COSPONSORS

S. 324

At the request of Mr. HATCH, the name of the Senator from Delaware (Mr. BIDEN) was added as a cosponsor of S. 324, a bill to amend the Controlled Substances Act with respect to registration requirements for practitioners who dispense narcotic drugs in schedule IV or V for maintenance treatment or detoxification treatment.

S. 556

At the request of Mr. BAUCUS, the name of the Senator from Colorado (Mr. ALLARD) was added as a cosponsor of S. 556, a bill to amend title 39, United States Code, to establish guidelines for the relocation, closing, consolidation, or construction of post offices, and for other purposes.

S. 593

At the request of Mr. COVERDELL, the name of the Senator from New Mexico (Mr. DOMENICI) was added as a cosponsor of S. 593, a bill to amend the Internal Revenue Code of 1986 to increase maximum taxable income for the 15 percent rate bracket, to provide a partial exclusion from gross income for dividends and interest received by individuals, to provide a long-term capital gains deduction for individuals, to increase the traditional IRA contribution limit, and for other purposes.

S. 782

At the request of Mrs. FEINSTEIN, the name of the Senator from Hawaii (Mr. INOUYE) was added as a cosponsor of S. 782, a bill to amend title 18, United States Code, to modify the exception to the prohibition on the interception of wire, oral, or electronic communications to require a health insurance issuer, health plan, or health care provider obtain an enrollee's or patient's consent to their interception, and for other purposes.

S. 821

At the request of Mr. LAUTENBERG, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 821, a bill to provide for the collection of data on traffic stops.

S. 1007

At the request of Mr. JEFFORDS, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 1007, a bill to assist in the conservation of great apes by supporting and providing financial resources for the conservation programs of countries within the range of great apes and projects of persons with demonstrated expertise in the conservation of great apes.

S. 1150

At the request of Mr. CRAIG, his name was added as a cosponsor of S. 1150, a bill to amend the Internal Revenue Code of 1986 to more accurately codify the depreciable life of semiconductor manufacturing equipment.

S. 1155

At the request of Mr. ROBERTS, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 1155, a bill to amend the Federal Food, Drug, and Cosmetic Act to provide for uniform food safety warning notification requirements, and for other purposes.

S. 1207

At the request of Mr. CRAIG, his name was added as a cosponsor of S. 1207, a bill to amend the Internal Revenue Code of 1986 to ensure that income averaging for farmers not increase a farmer's liability for the alternative minimum tax.

S. 1289

At the request of Mr. CRAIG, his name was added as a cosponsor of S. 1289, a bill to amend the Internal Revenue Code of 1986 to provide that the capital gain treatment under section 631(b) of such Code shall apply to outright sales of timber held for more than 1 year.

S. 1301

At the request of Mr. STEVENS, the names of the Senator from Ohio (Mr. DEWINE), the Senator from Wisconsin (Mr. KOHL), and the Senator from Nevada (Mr. BRYAN) were added as cosponsors of S. 1301, a bill to provide reasonable and non-discriminatory access to buildings owned or used by the Federal government for the provision of competitive telecommunications services by telecommunications carriers.

S. 1303

At the request of Mr. MURKOWSKI, the name of the Senator from Idaho (Mr. CRAIG) was added as a cosponsor of S. 1303, a bill to amend the Internal Revenue Code of 1986 to modify certain provisions relating to the treatment of forestry activities.

S. 1351

At the request of Mr. CRAIG, his name was added as a cosponsor of S. 1351, a bill to amend the Internal Revenue Code of 1986 to extend and modify the credit for electricity produced from renewable resources.

NOTICE OF HEARING

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. MURKOWSKI. Mr. President, I would like to announce for the public that the hearing scheduled before the Energy and Natural Resources Committee to receive testimony regarding S. 1052, To implement further the Act (Public Law 94–241) approving the Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America, and for other purposes'', has been postponed.

The hearing was scheduled to take place on Tuesday, July 27, 1999, at 9:30 A.M., in room SD–366 of the Dirksen Senate Office Building in Washington, D.C., and is now scheduled to take place on Tuesday, August 3, 1999, at 9:30 A.M., in room SD–366 of the Dirksen Senate Office Building in Washington, D.C.

For further information, please call Jim Beirne, Deputy Chief Counsel (202) 224–2564 or Betty Nevitt, Staff Assistant at (202) 224–0765.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. GREGG. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be granted permission to meet during the session of the Senate on Friday, July 16, for purposes of conducting a full committee hearing which is scheduled to begin at 9:00 a.m. The purpose of this oversight hearing is to receive testimony on damage to the national security from Chinese espionage at DOE nuclear weapons laboratories.

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

COMMITTEE ON THE JUDICIARY

Mr. GREGG. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet for a hearing re Review of the Report by the Commission on Structural Alternatives for the Federal Courts of Appeals regarding the Ninth Circuit and S. 253, the Ninth Circuit Reorganization Act, during the session of the Senate on Friday, July 16, 1999, at 9:30 a.m., in SD628.

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

PATIENTS' BILL OF RIGHTS ACT OF 1999

The text of S. 1344, passed by the Senate on July 15, 1999, follows:

S. 1344

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patients' Bill of Rights Plus Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—PATIENTS' BILL OF RIGHTS

Subtitle A—Right to Advice and Care

Sec. 101. Patient right to medical advice and care.

''SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

''Sec. 721. Patient access to emergency medical care.
''Sec. 722. Offering of choice of coverage options.
''Sec. 723. Patient access to obstetric and gynecological care.
''Sec. 724. Patient access to pediatric care.
''Sec. 725. Timely access to specialists.
''Sec. 726. Continuity of care.
''Sec. 727. Protection of patient-provider communications.
''Sec. 728. Patient's right to prescription drugs.
''Sec. 729. Self-payment for behavioral health care services.
''Sec. 730. Coverage for individuals participating in approved cancer clinical trials.
''Sec. 730A. Prohibiting discrimination against providers.
''Sec. 730B. Generally applicable provision.''.

Sec. 102. Conforming amendment to the Internal Revenue Code of 1986.

''SUBCHAPTER C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

''Sec. 9821. Patient access to emergency medical care.
''Sec. 9822. Offering of choice of coverage options.
''Sec. 9823. Patient access to obstetric and gynecological care.
''Sec. 9824. Patient access to pediatric care.
''Sec. 9825. Timely access to specialists.
''Sec. 9826. Continuity of care.
''Sec. 9827. Protection of patient-provider communications.
''Sec. 9828. Patient's right to prescription drugs.
''Sec. 9829. Self-payment for behavioral health care services.
''Sec. 9830. Coverage for individuals participating in approved cancer clinical trials.
''Sec. 9830A. Prohibiting discrimination against providers.
''Sec. 9830B. Generally applicable provision.''.

Sec. 103. Effective date and related rules.

Subtitle B—Right to Information About Plans and Providers

Sec. 111. Information about plans.
Sec. 112. Information about providers.

Subtitle C—Right to Hold Health Plans Accountable

Sec. 121. Amendment to Employee Retirement Income Security Act of 1974.

TITLE II—WOMEN'S HEALTH AND CANCER RIGHTS

Sec. 201. Women's health and cancer rights.

TITLE III—GENETIC INFORMATION AND SERVICES

Sec. 301. Short title.
Sec. 302. Amendments to Employee Retirement Income Security Act of 1974.
Sec. 303. Amendments to the Public Health Service Act.
Sec. 304. Amendments to the Internal Revenue Code of 1986.

TITLE IV—HEALTHCARE RESEARCH AND QUALITY

Sec. 401. Short title.
Sec. 402. Amendment to the Public Health Service Act.

''TITLE IX—AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

''PART A—ESTABLISHMENT AND GENERAL DUTIES

''Sec. 901. Mission and duties.
''Sec. 902. General authorities.

''PART B—HEALTHCARE IMPROVEMENT RESEARCH

''Sec. 911. Healthcare outcome improvement research.
''Sec. 912. Private-public partnerships to improve organization and delivery.
''Sec. 913. Information on quality and cost of care.

''Sec. 914. Information systems for healthcare improvement.
''Sec. 915. Research supporting primary care and access in underserved areas.
''Sec. 916. Clinical practice and technology innovation.
''Sec. 917. Coordination of Federal government quality improvement efforts.
''PART C—GENERAL PROVISIONS
''Sec. 921. Advisory Council for Healthcare Research and Quality.
''Sec. 922. Peer review with respect to grants and contracts.
''Sec. 923. Certain provisions with respect to development, collection, and dissemination of data.
''Sec. 924. Dissemination of information.
''Sec. 925. Additional provisions with respect to grants and contracts.
''Sec. 926. Certain administrative authorities.
''Sec. 927. Funding.
''Sec. 928. Definitions.''.
Sec. 403. References.
TITLE V—ENHANCED ACCESS TO HEALTH INSURANCE COVERAGE
Sec. 501. Full deduction of health insurance costs for self-employed individuals.
Sec. 502. Full availability of medical savings accounts.
Sec. 503. Permitting contribution towards medical savings account through Federal employees health benefits program (FEHBP).
Sec. 504. Carryover of unused benefits from cafeteria plans, flexible spending arrangements, and health flexible spending accounts.
TITLE VI—PROVISIONS RELATING TO LONG-TERM CARE INSURANCE
Sec. 601. Inclusion of qualified long-term care insurance contracts in cafeteria plans, flexible spending arrangements, and health flexible spending accounts.
Sec. 602. Deduction for premiums for long-term care insurance.
Sec. 603. Study of long-term care needs in the 21st century.
TITLE VII—INDIVIDUAL RETIREMENT PLANS
Sec. 701. Modification of income limits on contributions and rollovers to Roth IRAs.
TITLE VIII—REVENUE PROVISIONS
Sec. 801. Modification to foreign tax credit carryback and carryover periods.
Sec. 802. Limitation on use of non-accrual experience method of accounting.
Sec. 803. Returns relating to cancellations of indebtedness by organizations lending money.
Sec. 804. Extension of Internal Revenue Service user fees.
Sec. 805. Property subject to a liability treated in same manner as assumption of liability.
Sec. 806. Charitable split-dollar life insurance, annuity, and endowment contracts.
Sec. 807. Transfer of excess defined benefit plan assets for retiree health benefits.
Sec. 808. Limitations on welfare benefit funds of 10 or more employer plans.
Sec. 809. Modification of installment method and repeal of installment method for accrual method taxpayers.
Sec. 810. Inclusion of certain vaccines against streptococcus pneumoniae to list of taxable vaccines.
TITLE IX—MISCELLANEOUS PROVISIONS
Sec. 901. Medicare competitive pricing demonstration project.

TITLE I—PATIENTS' BILL OF RIGHTS

Subtitle A—Right to Advice and Care

SEC. 101. PATIENT RIGHT TO MEDICAL ADVICE AND CARE.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is amended—

(1) by redesignating subpart C as subpart D; and

(2) by inserting after subpart B the following:

''Subpart C—Patient Right to Medical Advice and Care

''SEC. 721. PATIENT ACCESS TO EMERGENCY MEDICAL CARE.

''(a) COVERAGE OF EMERGENCY CARE.—

''(1) IN GENERAL.—To the extent that the group health plan (other than a fully insured group health plan) provides coverage for benefits consisting of emergency medical care (as defined in subsection (c)) or emergency ambulance services, except for items or services specifically excluded—

''(A) the plan shall provide coverage for benefits, without requiring preauthorization, for emergency medical screening examinations or emergency ambulance services, to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations or emergency ambulance services to be necessary to determine whether emergency medical care (as so defined) is necessary; and

''(B) the plan shall provide coverage for benefits, without requiring preauthorization, for additional emergency medical care to stabilize an emergency medical condition following an emergency medical screening examination (if determined necessary under subparagraph (A)), pursuant to the definition of stabilize under section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

''(2) REIMBURSEMENT FOR CARE TO MAINTAIN MEDICAL STABILITY.—

''(A) IN GENERAL.—In the case of services provided to a participant or beneficiary by a nonparticipating provider in order to maintain the medical stability of the participant or beneficiary, the group health plan involved shall provide for reimbursement with respect to such services if—

''(i) coverage for services of the type furnished is available under the group health plan;

''(ii) the services were provided for care related to an emergency medical condition and in an emergency department in order to maintain the medical stability of the participant or beneficiary; and

''(iii) the nonparticipating provider contacted the plan regarding approval for such services.

''(B) FAILURE TO RESPOND.—If a group health plan fails to respond within 1 hours of being contacted in accordance with subparagraph (A)(iii), then the plan shall be liable for the cost of services provided by the nonparticipating provider in order to maintain the stability of the participant or beneficiary.

''(C) LIMITATION.—The liability of a group health plan to provide reimbursement under subparagraph (A) shall terminate when the plan has contacted the nonparticipating provider to arrange for discharge or transfer.

''(D) LIABILITY OF PARTICIPANT.—A participant or beneficiary shall not be liable for the costs of services to which subparagraph (A) in an amount that exceeds the amount of liability that would be incurred if the services were provided by a participating health care provider with prior authorization by the plan.

''(b) IN-NETWORK UNIFORM COSTS-SHARING AND OUT-OF-NETWORK CARE.—

''(1) IN-NETWORK UNIFORM COST-SHARING.—Nothing in this section shall be construed as preventing a group health plan (other than a fully insured group health plan) from imposing any form of cost-sharing applicable to any participant or beneficiary (including co-insurance, copayments, deductibles, and any other charges) in relation to coverage for benefits described in subsection (a), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in subsection (c)) provided to such similarly situated participants and beneficiaries under the plan, and such cost-sharing is disclosed in accordance with section 714.

''(2) OUT-OF-NETWORK CARE.—If a group health plan (other than a fully insured group health plan) provides any benefits with respect to emergency medical care (as defined in subsection (c)), the plan shall cover emergency medical care under the plan in a manner so that, if such care is provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed any form of cost-sharing (including co-insurance, co-payments, deductibles, and any other charges) that would be incurred if the services were provided by a participating provider.

''(c) DEFINITION OF EMERGENCY MEDICAL CARE.—In this section:

''(1) IN GENERAL.—The term 'emergency medical care' means, with respect to a participant or beneficiary under a group health plan (other than a fully insured group health plan), covered inpatient and outpatient services that—

''(A) are furnished by any provider, including a nonparticipating provider, that is qualified to furnish such services; and

''(B) are needed to evaluate or stabilize (as such term is defined in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd)(e)(3)) an emergency medical condition (as defined in paragraph (2)).

''(2) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(A) placing the health of the participant or beneficiary (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(B) serious impairment to bodily functions, or

''(C) serious dysfunction of any bodily organ or part.

''SEC. 722. OFFERING OF CHOICE OF COVERAGE OPTIONS.

''(a) REQUIREMENT.—

''(1) OFFERING OF POINT-OF-SERVICE COVERAGE OPTION.—Except as provided in paragraph (2), if a group health plan (other than a fully insured group health plan) provides coverage for benefits only through a defined set of participating health care professionals, the plan shall offer the participant the option to purchase point-of-service coverage (as defined in subsection (b)) for all such benefits for which coverage is otherwise

so limited. Such option shall be made available to the participant at the time of enrollment under the plan and at such other times as the plan offers the participant a choice of coverage options.

''(2) EXCEPTION IN CASE OF LACK OF AVAILABILITY.—Paragraph (1) shall not apply with respect to a group health plan (other than a fully insured group health plan) if care relating to the point-of-service coverage would not be available and accessible to the participant with reasonable promptness (consistent with section 1301(b)(4) of the Public Health Service Act (42 U.S.C. 300e(b)(4))).

''(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term 'point-of-service coverage' means, with respect to benefits covered under a group health plan (other than a fully insured group health plan), coverage of such benefits when provided by a nonparticipating health care professional.

''(c) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan (other than a fully insured group health plan) of a small employer.

''(2) SMALL EMPLOYER.—For purposes of paragraph (1), the term 'small employer' means, in connection with a group health plan (other than a fully insured group health plan) with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of this paragraph, the provisions of subparagraph (C) of section 712(c)(1) shall apply in determining employer size.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring coverage for benefits for a particular type of health care professional;

''(2) as requiring an employer to pay any costs as a result of this section or to make equal contributions with respect to different health coverage options;

''(3) as preventing a group health plan (other than a fully insured group health plan) from imposing higher premiums or cost-sharing on a participant for the exercise of a point-of-service coverage option; or

''(4) to require that a group health plan (other than a fully insured group health plan) include coverage of health care professionals that the plan excludes because of fraud, quality of care, or other similar reasons with respect to such professionals.

''SEC. 723. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(a) GENERAL RIGHTS.—

''(1) WAIVER OF PLAN REFERRAL REQUIREMENT.—If a group health plan described in subsection (b) requires a referral to obtain coverage for specialty care, the plan shall waive the referral requirement in the case of a female participant or beneficiary who seeks coverage for obstetrical care and related follow-up obstetrical care or routine gynecological care (such as preventive gynecological care).

''(2) RELATED ROUTINE CARE.—With respect to a participant or beneficiary described in paragraph (1), a group health plan described in subsection (b) shall treat the ordering of other routine care that is related to routine gynecologic care, by a physician who specializes in obstetrics and gynecology as the authorization of the primary care provider for such other care.

''(b) APPLICATION OF SECTION.—A group health plan described in this subsection is a group health plan (other than a fully insured group health plan), that—

''(1) provides coverage for obstetric care (such as pregnancy-related services) or routine gynecologic care (such as preventive women's health examinations); and

''(2) requires the designation by a participant or beneficiary of a participating primary care provider who is not a physician who specializes in obstetrics or gynecology.

''(c) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of obstetric or gynecologic care described in subsection (a);

''(2) to preclude the plan from requiring that the physician who specializes in obstetrics or gynecology notify the designated primary care provider or the plan of treatment decisions;

''(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine obstetric or routine gynecologic care; or

''(4) to preclude a group health plan from permitting a physician who specializes in obstetrics and gynecology from being a primary care provider under the plan.

''SEC. 724. PATIENT ACCESS TO PEDIATRIC CARE.

''(a) IN GENERAL.—In the case of a group health plan (other than a fully insured group health plan) that provides coverage for routine pediatric care and that requires the designation by a participant or beneficiary of a participating primary care provider, if the designated primary care provider is not a physician who specializes in pediatrics—

''(1) the plan may not require authorization or referral by the primary care provider in order for a participant or beneficiary to obtain coverage for routine pediatric care; and

''(2) the plan shall treat the ordering of other routine care related to routine pediatric care by such a specialist as having been authorized by the designated primary care provider.

''(b) RULES OF CONSTRUCTION.—Nothing in subsection (a) shall be construed—

''(1) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of any pediatric care provided to, or ordered for, a participant or beneficiary;

''(2) to preclude a group health plan from requiring that a specialist described in subsection (a) notify the designated primary care provider or the plan of treatment decisions; or

''(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine pediatric care.

''SEC. 725. TIMELY ACCESS TO SPECIALISTS.

''(a) TIMELY ACCESS.—

''(1) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall ensure that participants and beneficiaries have timely, in accordance with the medical exigencies of the case, access to primary and specialty health care professionals who are appropriate to the condition of the participant or beneficiary, when such care is covered under the plan. Such access may be provided through contractual arrangements with specialized providers outside of the network of the plan.

''(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

''(A) to require the coverage under a group health plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants or beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan; or

''(B) to override any State licensure or scope-of-practice law.

''(b) TREATMENT PLANS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to prohibit a group health plan (other than a fully insured group health plan) from requiring that specialty care be provided pursuant to a treatment plan so long as the treatment plan is—

''(A) developed by the specialist, in consultation with the case manager or primary care provider, and the participant or beneficiary;

''(B) approved by the plan in a timely manner in accordance with the medical exigencies of the case; and

''(C) in accordance with the applicable quality assurance and utilization review standards of the plan.

''(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan from requiring the specialist to provide the case manager or primary care provider with regular updates on the specialty care provided, as well as all other necessary medical information.

''(c) REFERRALS.—Nothing in this section shall be construed to prohibit a plan from requiring an authorization by the case manager or primary care provider of the participant or beneficiary in order to obtain coverage for specialty services so long as such authorization is for an adequate number of referrals.

''(d) SPECIALTY CARE DEFINED.—For purposes of this subsection, the term 'specialty care' means, with respect to a condition, care and treatment provided by a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise (including age-appropriate expertise) through appropriate training and experience.

''SEC. 726. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan (other than a fully insured group health plan) and a health care provider is terminated (as defined in paragraph (2)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such group health plan, and an individual who is a participant or beneficiary in the plan is undergoing a course of treatment from the provider at the time of such termination, the plan shall—

''(A) notify the individual on a timely basis of such termination;

''(B) provide the individual with an opportunity to notify the plan of a need for transitional care; and

''(C) in the case of termination described in paragraph (2), (3), or (4) of subsection (b), and subject to subsection (c), permit the individual to continue or be covered with respect to the course of treatment with the provider's consent during a transitional period (as provided under subsection (b)).

''(2) TERMINATED.—In this section, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract by the group health plan, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

''(3) CONTRACTS.—For purposes of this section, the term 'contract between a group health plan (other than a fully insured group health plan) and a health care provider' shall include a contract between such a plan and an organized network of providers.

''(b) TRANSITIONAL PERIOD.—

''(1) GENERAL RULE.—Except as provided in paragraph (3), the transitional period under this subsection shall permit the participant or beneficiary to extend the coverage involved for up to 90 days from the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) INSTITUTIONAL CARE.—Subject to paragraph (1), the transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status if the care was scheduled before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such care.

''(3) PREGNANCY.—Notwithstanding paragraph (1), if—

''(A) a participant or beneficiary has entered the second trimester of pregnancy at the time of a provider's termination of participation; and

''(B) the provider was treating the pregnancy before the date of the termination;

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—Notwithstanding paragraph (1), if—

''(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) prior to a provider's termination of participation; and

''(B) the provider was treating the terminal illness before the date of termination;

the transitional period under this subsection shall be for care directly related to the treatment of the terminal illness and shall extend for the remainder of the individual's life for such care.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan (other than a fully insured group health plan) may condition coverage of continued treatment by a provider under subsection (a)(1)(C) upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or at the rates applicable under the replacement plan after the date of the termination of the contract with the group health plan) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

''(2) The provider agrees to adhere to the quality assurance standards of the plan responsible for payment under paragraph (1) and to provide to such plan necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

''(e) DEFINITION.—In this section, the term 'health care provider' or 'provider' means—

''(1) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

''(2) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

''(f) COMPREHENSIVE STUDY OF COST, QUALITY AND COORDINATION OF COVERAGE FOR PATIENTS AT THE END OF LIFE.—

''(1) STUDY BY THE MEDICARE PAYMENT ADVISORY COMMISSION.—The Medicare Payment Advisory Commission shall conduct a study of the costs and patterns of care for persons with serious and complex conditions and the possibilities of improving upon that care to the degree it is triggered by the current category of terminally ill as such term is used for purposes of section 1861(dd) of the Social Security Act (relating to hospice benefits) or of utilizing care in other payment settings in Medicare.

''(2) AGENCY FOR HEALTH CARE POLICY AND RESEARCH.—The Agency for Health Care Policy and Research shall conduct studies of the possible thresholds for major conditions causing serious and complex illness, their administrative parameters and feasibility, and their impact upon costs and quality.

''(3) HEALTH CARE FINANCING ADMINISTRATION.—The Health Care Financing Administration shall conduct studies of the merits of applying similar thresholds in Medicare+Choice programs, including adapting risk adjustment methods to account for this category.

''(4) INITIAL REPORT.—

''(A) IN GENERAL.—Not later than 12 months after the date of enactment of this section, the Medicare Payment Advisory Commission and the Agency for Health Care Policy and Research shall each prepare and submit to the Committee on Health, Education, Labor and Pensions of the Senate a report concerning the results of the studies conducted under paragraphs (1) and (2), respectively.

''(B) COPY TO SECRETARY.—Concurrent with the submission of the reports under subparagraph (A), the Medicare Payment Advisory Commission and the Agency for health Care Policy and Research shall transmit a copy of the reports under such subparagraph to the Secretary.

''(5) FINAL REPORT.—

''(A) CONTRACT WITH INSTITUTE OF MEDICINE.—Not later than 1 year after the submission of the reports under paragraph (4), the Secretary of Health and Human Services shall contract with the Institute of Medicine to conduct a study of the practices and their effects arising from the utilization of the category ''serious and complex'' illness.

''(B) REPORT.—Not later than 1 year after the date of the execution of the contract referred to in subparagraph (A), the Institute of Medicine shall prepare and submit to the Committee on Health, Education, Labor and Pensions of the Senate a report concerning the study conducted pursuant to such contract.

''(6) FUNDING.—From funds appropriated to the Department of Health and Human Services, the Secretary of Health and Human Services shall make available such funds as the Secretary determines is necessary to carry out this subsection.

''SEC. 727. PROTECTION OF PATIENT-PROVIDER COMMUNICATIONS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (other than a fully insured group health plan and in relation to a participant or beneficiary) shall not prohibit or otherwise restrict a health care professional from advising such a participant or beneficiary who is a patient of the professional about the health status of the participant or beneficiary or medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether coverage for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan (other than a fully insured group health plan) to provide specific benefits under the terms of such plan.

''SEC. 728. PATIENT'S RIGHT TO PRESCRIPTION DRUGS.

''To the extent that a group health plan (other than a fully insured group health plan) provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan shall—

''(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary; and

''(2) in accordance with the applicable quality assurance and utilization review standards of the plan, provide for exceptions from the formulary limitation when a nonformulary alternative is medically necessary and appropriate.

''SEC. 729. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE SERVICES.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) may not—

''(1) prohibit or otherwise discourage a participant or beneficiary from self-paying for behavioral health care services once the plan has denied coverage for such services; or

''(2) terminate a health care provider because such provider permits participants or beneficiaries to self-pay for behavioral health care services—

''(A) that are not otherwise covered under the plan; or

''(B) for which the group health plan provides limited coverage, to the extent that the group health plan denies coverage of the services.

''(b) RULE OF CONSTRUCTION.—Nothing in subsection (a)(2)(B) shall be construed as prohibiting a group health plan from terminating a contract with a health care provider for failure to meet applicable quality standards or for fraud.

''SEC. 730. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan (other than a fully insured group health plan) provides coverage to a qualified individual (as defined in subsection (b)), the plan—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsections (b), (c), and (d) 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

''(C) may not discriminate against the individual on the basis of the participant's or beneficiaries participation in such trial.

''(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan 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.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a

participant or beneficiary in a group health plan and who meets the following conditions:

''(1)(A) The individual has been diagnosed with cancer for which no standard treatment is effective.

''(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

''(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(2) Either—

''(A) 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 paragraph (1); or

''(B) the participant or beneficiary 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 paragraph (1).

''(c) PAYMENT.—

''(1) IN GENERAL.—Under this section a group health plan (other than a fully insured group health plan) shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(2) STANDARDS FOR DETERMINING ROUTINE PATIENT COSTS ASSOCIATED WITH CLINICAL TRIAL PARTICIPATION.—

''(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards relating to the coverage of routine patient costs for individuals participating in clinical trials that group health plans must meet under this section.

''(B) FACTORS.—In establishing routine patient cost standards under subparagraph (A), the Secretary shall consult with interested parties and take into account —

''(i) quality of patient care;

''(ii) routine patient care costs versus costs associated with the conduct of clinical trials, including unanticipated patient care costs as a result of participation in clinical trials; and

''(iii) previous and on-going studies relating to patient care costs associated with participation in clinical trials.

''(C) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this paragraph, the Secretary, after consultation with organizations representing cancer patients, health care practitioners, medical researchers, employers, group health plans, manufacturers of drugs, biologics and medical devices, medical economists, hospitals, and other interested parties, shall publish notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

''(D) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subparagraph (C), and for purposes of this paragraph, the 'target date for publication' (referred to in section 564(a)(5) of such title 5) shall be June 30, 2000.

''(E) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title 5 under this paragraph, '15 days' shall be substituted for '30 days'.

''(F) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(i) the appointment of a negotiated rulemaking committee under section 565(a) of such title 5 by not later than 30 days after the end of the comment period provided for under section 564(c) of such title 5 (as shortened under subparagraph (E)), and

''(ii) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

''(G) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subparagraph (F) shall report to the Secretary, by not later than March 29, 2000, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this paragraph through such other methods as the Secretary may provide.

''(H) FINAL COMMITTEE REPORT.—If the committee is not terminated under subparagraph (G), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

''(I) FINAL EFFECT.—The Secretary shall publish a rule under this paragraph in the Federal Register by not later than the target date of publication.

''(J) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

''(K) EFFECTIVE DATE.—The provisions of this paragraph shall apply to group health plans (other than a fully insured group health plan) for plan years beginning on or after January 1, 2001.

''(3) PAYMENT RATE.—In the case of covered items and services provided by—

''(A) a participating provider, the payment rate shall be at the agreed upon rate, or

''(B) a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—

''(1) IN GENERAL.—In this section, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

''(A) The National Institutes of Health.

''(B) A cooperative group or center of the National Institutes of Health.

''(C) Either of the following if the conditions described in paragraph (2) are met:

''(i) The Department of Veterans Affairs.

''(ii) The Department of Defense.

''(2) 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—

''(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's coverage with respect to clinical trials.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(1) IN GENERAL.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(2) CONSTRUCTION.—Nothing in this section shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(g) STUDY AND REPORT.—

''(1) STUDY.—The Secretary shall study the impact on group health plans for covering routine patient care costs for individuals who are entitled to benefits under this section and who are enrolled in an approved cancer clinical trial program.

''(2) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains an assessment of—

''(A) any incremental cost to group health plans resulting from the provisions of this section;

''(B) a projection of expenditures to such plans resulting from this section; and

''(C) any impact on premiums resulting from this section.

''SEC. 730A. PROHIBITING DISCRIMINATION AGAINST PROVIDERS.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This subsection shall not be construed as requiring the coverage under a plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants and beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

''(b) NO REQUIREMENT FOR ANY WILLING PROVIDER.—Nothing in this section shall be construed as requiring a group health plan that offers network coverage to include for participation every willing provider or health professional who meets the terms and conditions of the plan.

''SEC. 730B. GENERALLY APPLICABLE PROVISION.

''In the case of a group health plan that provides benefits under 2 or more coverage options, the requirements of this subpart shall apply separately with respect to each coverage option.''.

(b) RULE WITH RESPECT TO CERTAIN PLANS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, health insurance issuers may offer, and eligible individuals may purchase, high deductible health plans described in section 220(c)(2)(A) of the Internal Revenue Code of 1986. Effective for the 4-year period beginning on the date of the enactment of this Act, such health plans shall not be required to provide payment for any health care items or services that are exempt from the plan's deductible.

(2) EXISTING STATE LAWS.—A State law relating to payment for health care items and services in effect on the date of enactment of this Act that is preempted under paragraph (1), shall not apply to high deductible health plans after the expiration of the 4-year period described in such paragraph unless the State reenacts such law after such period.

(c) DEFINITION.—Section 733(a) of the Employee Retirement Income Security Act of 1974 (42 U.S.C. 1191(a)) is amended by adding at the end the following:

''(3) FULLY INSURED GROUP HEALTH PLAN.—The term 'fully insured group health plan' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.''.

(d) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended—

(1) in the item relating to subpart C, by striking ''Subpart C'' and inserting ''Subpart D''; and

(2) by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new items:

''SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

''Sec. 721. Patient access to emergency medical care.
''Sec. 722. Offering of choice of coverage options.
''Sec. 723. Patient access to obstetric and gynecological care.
''Sec. 724. Patient access to pediatric care.
''Sec. 725. Timely access to specialists.
''Sec. 726. Continuity of care.
''Sec. 727. Protection of patient-provider communications.
''Sec. 728. Patient's right to prescription drugs.
''Sec. 729. Self-payment for behavioral health care services.
''Sec. 730. Coverage for individuals participating in approved cancer clinical trials.
''Sec. 730A. Prohibiting discrimination against providers.
''Sec. 730B. Generally applicable provision.''.

SEC. 102. CONFORMING AMENDMENT TO THE INTERNAL REVENUE CODE OF 1986.

(a) IN GENERAL.—Chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subchapter C as subchapter D; and

(2) by inserting after subchapter B the following:

''Subchapter C—Patient Right to Medical Advice and Care

''Sec. 9821. Patient access to emergency medical care.
''Sec. 9822. Offering of choice of coverage options.
''Sec. 9823. Patient access to obstetric and gynecological care.
''Sec. 9824. Patient access to pediatric care.
''Sec. 9825. Timely access to specialists.
''Sec. 9826. Continuity of care.
''Sec. 9827. Protection of patient-provider communications.
''Sec. 9828. Patient's right to prescription drugs.
''Sec. 9829. Self-payment for behavioral health care services.
''Sec. 9830. Coverage for individuals participating in approved cancer clinical trials.
''Sec. 9830A. Prohibiting discrimination against providers.
''Sec. 9830B. Generally applicable provision.

''SEC. 9821. PATIENT ACCESS TO EMERGENCY MEDICAL CARE.

''(a) COVERAGE OF EMERGENCY CARE.—

''(1) IN GENERAL.—To the extent that the group health plan (other than a fully insured group health plan) provides coverage for benefits consisting of emergency medical care (as defined in subsection (c)) or emergency ambulance services, except for items or services specifically excluded—

''(A) the plan shall provide coverage for benefits, without requiring preauthorization, for emergency medical screening examinations or emergency ambulance services, to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations or emergency ambulance services to be necessary to determine whether emergency medical care (as so defined) is necessary; and

''(B) the plan shall provide coverage for benefits, without requiring preauthorization, for additional emergency medical care to stabilize an emergency medical condition following an emergency medical screening examination (if determined necessary under subparagraph (A)), pursuant to the definition of stabilize under section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

''(2) REIMBURSEMENT FOR CARE TO MAINTAIN MEDICAL STABILITY.—

''(A) IN GENERAL.—In the case of services provided to a participant or beneficiary by a nonparticipating provider in order to maintain the medical stability of the participant or beneficiary, the group health plan involved shall provide for reimbursement with respect to such services if—

''(i) coverage for services of the type furnished is available under the group health plan;

''(ii) the services were provided for care related to an emergency medical condition and in an emergency department in order to maintain the medical stability of the participant or beneficiary; and

''(iii) the nonparticipating provider contacted the plan regarding approval for such services.

''(B) FAILURE TO RESPOND.—If a group health plan fails to respond within 1 hours of being contacted in accordance with subparagraph (A)(iii), then the plan shall be liable for the cost of services provided by the nonparticipating provider in order to maintain the stability of the participant or beneficiary.

''(C) LIMITATION.—The liability of a group health plan to provide reimbursement under subparagraph (A) shall terminate when the plan has contacted the nonparticipating provider to arrange for discharge or transfer.

''(D) LIABILITY OF PARTICIPANT.—A participant or beneficiary shall not be liable for the costs of services to which subparagraph (A) in an amount that exceeds the amount of liability that would be incurred if the services were provided by a participating health care provider with prior authorization by the plan.

''(b) IN-NETWORK UNIFORM COSTS-SHARING AND OUT-OF-NETWORK CARE.—

''(1) IN-NETWORK UNIFORM COST-SHARING.—Nothing in this section shall be construed as preventing a group health plan (other than a fully insured group health plan) from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to coverage for benefits described in subsection (a), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in subsection (c)) provided to such similarly situated participants and beneficiaries under the plan, and such cost-sharing is disclosed in accordance with section 9814.

''(2) OUT-OF-NETWORK CARE.—If a group health plan (other than a fully insured group health plan) provides any benefits with respect to emergency medical care (as defined in subsection (c)), the plan shall cover emergency medical care under the plan in a manner so that, if such care is provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed any form of cost-sharing (including coinsurance, copayments, deductibles, and any other charges) that would be incurred if the services were provided by a participating provider.

''(c) DEFINITION OF EMERGENCY MEDICAL CARE.—In this section:

''(1) IN GENERAL.—The term 'emergency medical care' means, with respect to a participant or beneficiary under a group health plan (other than a fully insured group health plan), covered inpatient and outpatient services that—

''(A) are furnished by any provider, including a nonparticipating provider, that is qualified to furnish such services; and

''(B) are needed to evaluate or stabilize (as such term is defined in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd)(e)(3)) an emergency medical condition (as defined in paragraph (2)).

''(2) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(A) placing the health of the participant or beneficiary (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(B) serious impairment to bodily functions, or

''(C) serious dysfunction of any bodily organ or part.

''SEC. 9822. OFFERING OF CHOICE OF COVERAGE OPTIONS.

''(a) REQUIREMENT.—

''(1) OFFERING OF POINT-OF-SERVICE COVERAGE OPTION.—Except as provided in paragraph (2), if a group health plan (other than a fully insured group health plan) provides coverage for benefits only through a defined set of participating health care professionals, the plan shall offer the participant the option to purchase point-of-service coverage (as defined in subsection (b)) for all such benefits for which coverage is otherwise so limited. Such option shall be made available to the participant at the time of enrollment under the plan and at such other times as the plan offers the participant a choice of coverage options.

''(2) EXCEPTION IN CASE OF LACK OF AVAILABILITY.—Paragraph (1) shall not apply with respect to a group health plan (other than a fully insured group health plan) if care relating to the point-of-service coverage would not be available and accessible to the participant with reasonable promptness (consistent with section 1301(b)(4) of the Public Health Service Act (42 U.S.C. 300e(b)(4))).

''(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term 'point-of-service coverage' means, with respect to benefits covered under a group health plan (other than a fully insured group health plan), coverage of such benefits when provided by a nonparticipating health care professional.

''(c) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan (other than a fully insured group health plan) of a small employer.

''(2) SMALL EMPLOYER.—For purposes of paragraph (1), the term 'small employer' means, in connection with a group health plan (other than a fully insured group health plan) with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of this paragraph, the

provisions of subparagraph (C) of section 4980D(d)(2) shall apply in determining employer size.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring coverage for benefits for a particular type of health care professional;

''(2) as requiring an employer to pay any costs as a result of this section or to make equal contributions with respect to different health coverage options;

''(3) as preventing a group health plan (other than a fully insured group health plan) from imposing higher premiums or cost-sharing on a participant for the exercise of a point-of-service coverage option; or

''(4) to require that a group health plan (other than a fully insured group health plan) include coverage of health care professionals that the plan excludes because of fraud, quality of care, or other similar reasons with respect to such professionals.

''SEC. 9823. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(a) GENERAL RIGHTS.—

''(1) WAIVER OF PLAN REFERRAL REQUIREMENT.—If a group health plan described in subsection (b) requires a referral to obtain coverage for specialty care, the plan shall waive the referral requirement in the case of a female participant or beneficiary who seeks coverage for obstetrical care and related follow-up obstetrical care or routine gynecological care (such as preventive gynecological care).

''(2) RELATED ROUTINE CARE.—With respect to a participant or beneficiary described in paragraph (1), a group health plan described in subsection (b) shall treat the ordering of other routine care that is related to routine gynecologic care, by a physician who specializes in obstetrics and gynecology as the authorization of the primary care provider for such other care.

''(b) APPLICATION OF SECTION.—A group health plan described in this subsection is a group health plan (other than a fully insured group health plan), that—

''(1) provides coverage for obstetric care (such as pregnancy-related services) or routine gynecologic care (such as preventive women's health examinations); and

''(2) requires the designation by a participant or beneficiary of a participating primary care provider who is not a physician who specializes in obstetrics or gynecology.

''(c) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of obstetric or gynecologic care described in subsection (a);

''(2) to preclude the plan from requiring that the physician who specializes in obstetrics or gynecology notify the designated primary care provider or the plan of treatment decisions;

''(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine obstetric or routine gynecologic care; or

''(4) to preclude a group health plan from permitting a physician who specializes in obstetrics and gynecology from being a primary care provider under the plan.

''SEC. 9824. PATIENT ACCESS TO PEDIATRIC CARE.

''(a) IN GENERAL.—In the case of a group health plan (other than a fully insured group health plan) that provides coverage for routine pediatric care and that requires the designation by a participant or beneficiary of a participating primary care provider, if the designated primary care provider is not a physician who specializes in pediatrics—

''(1) the plan may not require authorization or referral by the primary care provider in order for a participant or beneficiary to obtain coverage for routine pediatric care; and

''(2) the plan shall treat the ordering of other routine care related to routine pediatric care by such a specialist as having been authorized by the designated primary care provider.

''(b) RULES OF CONSTRUCTION.—Nothing in subsection (a) shall be construed—

''(1) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of any pediatric care provided to, or ordered for, a participant or beneficiary;

''(2) to preclude a group health plan from requiring that a specialist described in subsection (a) notify the designated primary care provider or the plan of treatment decisions; or

''(3) to preclude a group health plan from allowing health care professionals other than physicians to provide routine pediatric care.

''SEC. 9825. TIMELY ACCESS TO SPECIALISTS.

''(a) TIMELY ACCESS.—

''(1) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall ensure that participants and beneficiaries have timely, in accordance with the medical exigencies of the case, access to primary and specialty health care professionals who are appropriate to the condition of the participant or beneficiary, when such care is covered under the plan. Such access may be provided through contractual arrangements with specialized providers outside of the network of the plan.

''(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

''(A) to require the coverage under a group health plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants or beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan; or

''(B) to override any State licensure or scope-of-practice law.

''(b) TREATMENT PLANS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to prohibit a group health plan (other than a fully insured group health plan) from requiring that specialty care be provided pursuant to a treatment plan so long as the treatment plan is—

''(A) developed by the specialist, in consultation with the case manager or primary care provider, and the participant or beneficiary;

''(B) approved by the plan in a timely manner in accordance with the medical exigencies of the case; and

''(C) in accordance with the applicable quality assurance and utilization review standards of the plan.

''(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan from requiring the specialist to provide the case manager or primary care provider with regular updates on the specialty care provided, as well as all other necessary medical information.

''(c) REFERRALS.—Nothing in this section shall be construed to prohibit a plan from requiring an authorization by the case manager or primary care provider of the participant or beneficiary in order to obtain coverage for specialty services so long as such authorization is for an adequate number of referrals.

''(d) SPECIALTY CARE DEFINED.—For purposes of this subsection, the term 'specialty care' means, with respect to a condition, care and treatment provided by a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise (including age-appropriate expertise) through appropriate training and experience.

''SEC. 9826. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan (other than a fully insured group health plan) and a health care provider is terminated (as defined in paragraph (2)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such group health plan, and an individual who is a participant or beneficiary in the plan is undergoing a course of treatment from the provider at the time of such termination, the plan shall—

''(A) notify the individual on a timely basis of such termination;

''(B) provide the individual with an opportunity to notify the plan of a need for transitional care; and

''(C) in the case of termination described in paragraph (2), (3), or (4) of subsection (b), and subject to subsection (c), permit the individual to continue or be covered with respect to the course of treatment with the provider's consent during a transitional period (as provided under subsection (b)).

''(2) TERMINATED.—In this section, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract by the group health plan, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

''(3) CONTRACTS.—For purposes of this section, the term 'contract between a group health plan (other than a fully insured group health plan) and a health care provider' shall include a contract between such a plan and an organized network of providers.

''(b) TRANSITIONAL PERIOD.—

''(1) GENERAL RULE.—Except as provided in paragraph (3), the transitional period under this subsection shall permit the participant or beneficiary to extend the coverage involved for up to 90 days from the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) INSTITUTIONAL CARE.—Subject to paragraph (1), the transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status if the care was scheduled before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such care.

''(3) PREGNANCY.—Notwithstanding paragraph (1), if—

''(A) a participant or beneficiary has entered the second trimester of pregnancy at the time of a provider's termination of participation; and

''(B) the provider was treating the pregnancy before the date of the termination;

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—Notwithstanding paragraph (1), if—

''(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) prior to a provider's termination of participation; and

''(B) the provider was treating the terminal illness before the date of termination;

the transitional period under this subsection shall be for care directly related to the treatment of the terminal illness and shall extend for the remainder of the individual's life for such care.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan (other than a fully insured group health plan) may condition coverage of continued treatment by a provider under subsection (a)(1)(C) upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or at the rates applicable under the replacement plan after the date of the termination of the contract with the group health plan) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

''(2) The provider agrees to adhere to the quality assurance standards of the plan responsible for payment under paragraph (1) and to provide to such plan necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to such plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

''(e) DEFINITION.—In this section, the term 'health care provider' or 'provider' means—

''(1) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

''(2) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

''(f) COMPREHENSIVE STUDY OF COST, QUALITY AND COORDINATION OF COVERAGE FOR PATIENTS AT THE END OF LIFE.—

''(1) STUDY BY THE MEDICARE PAYMENT ADVISORY COMMISSION.—The Medicare Payment Advisory Commission shall conduct a study of the costs and patterns of care for persons with serious and complex conditions and the possibilities of improving upon that care to the degree it is triggered by the current category of terminally ill as such term is used for purposes of section 1861(dd) of the Social Security Act (relating to hospice benefits) or of utilizing care in other payment settings in Medicare.

''(2) AGENCY FOR HEALTH CARE POLICY AND RESEARCH.—The Agency for Health Care Policy and Research shall conduct studies of the possible thresholds for major conditions causing serious and complex illness, their administrative parameters and feasibility, and their impact upon costs and quality.

''(3) HEALTH CARE FINANCING ADMINISTRATION.—The Health Care Financing Administration shall conduct studies of the merits of applying similar thresholds in Medicare+Choice programs, including adapting risk adjustment methods to account for this category.

''(4) INITIAL REPORT.—

''(A) IN GENERAL.—Not later than 12 months after the date of enactment of this section, the Medicare Payment Advisory Commission and the Agency for Health Care Policy and Research shall each prepare and submit to the Committee on Health, Education, Labor and Pensions of the Senate a report concerning the results of the studies conducted under paragraphs (1) and (2), respectively.

''(B) COPY TO SECRETARY.—Concurrent with the submission of the reports under subparagraph (A), the Medicare Payment Advisory Commission and the Agency for health Care Policy and Research shall transmit a copy of the reports under such subparagraph to the Secretary.

''(5) FINAL REPORT.—

''(A) CONTRACT WITH INSTITUTE OF MEDICINE.—Not later than 1 year after the submission of the reports under paragraph (4), the Secretary of Health and Human Services shall contract with the Institute of Medicine to conduct a study of the practices and their effects arising from the utilization of the category ''serious and complex'' illness.

''(B) REPORT.—Not later than 1 year after the date of the execution of the contract referred to in subparagraph (A), the Institute of Medicine shall prepare and submit to the Committee on Health, Education, Labor and Pensions of the Senate a report concerning the study conducted pursuant to such contract.

''(6) FUNDING.—From funds appropriated to the Department of Health and Human Services, the Secretary of Health and Human Services shall make available such funds as the Secretary determines is necessary to carry out this subsection.

''SEC. 9827. PROTECTION OF PATIENT-PROVIDER COMMUNICATIONS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (other than a fully insured group health plan and in relation to a participant or beneficiary) shall not prohibit or otherwise restrict a health care professional from advising such a participant or beneficiary who is a patient of the professional about the health status of the participant or beneficiary or medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether coverage for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan (other than a fully insured group health plan) to provide specific benefits under the terms of such plan.

''SEC. 9828. PATIENT'S RIGHT TO PRESCRIPTION DRUGS.

''To the extent that a group health plan (other than a fully insured group health plan) provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan shall—

''(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary; and

''(2) in accordance with the applicable quality assurance and utilization review standards of the plan, provide for exceptions from the formulary limitation when a nonformulary alternative is medically necessary and appropriate.

''SEC. 9829. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE SERVICES.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) may not—

''(1) prohibit or otherwise discourage a participant or beneficiary from self-paying for behavioral health care services once the plan has denied coverage for such services; or

''(2) terminate a health care provider because such provider permits participants or beneficiaries to self-pay for behavioral health care services—

''(A) that are not otherwise covered under the plan; or

''(B) for which the group health plan provides limited coverage, to the extent that the group health plan denies coverage of the services.

''(b) RULE OF CONSTRUCTION.—Nothing in subsection (a)(2)(B) shall be construed as prohibiting a group health plan from terminating a contract with a health care provider for failure to meet applicable quality standards or for fraud.

''SEC. 9830. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan (other than a fully insured group health plan) provides coverage to a qualified individual (as defined in subsection (b)), the plan—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsections (b), (c), and (d) 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

''(C) may not discriminate against the individual on the basis of the participant's or beneficiaries participation in such trial.

''(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan 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.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(1)(A) The individual has been diagnosed with cancer for which no standard treatment is effective.

''(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

''(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(2) Either—

''(A) 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 paragraph (1); or

''(B) the participant or beneficiary 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 paragraph (1).

''(c) PAYMENT.—

''(1) IN GENERAL.—Under this section a group health plan (other than a fully insured group health plan) shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

''(2) STANDARDS FOR DETERMINING ROUTINE PATIENT COSTS ASSOCIATED WITH CLINICAL TRIAL PARTICIPATION.—

''(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards relating to the coverage of routine patient costs for individuals participating in clinical trials that group health plans must meet under this section.

''(B) FACTORS.—In establishing routine patient cost standards under subparagraph (A), the Secretary shall consult with interested parties and take into account —

''(i) quality of patient care;

''(ii) routine patient care costs versus costs associated with the conduct of clinical trials, including unanticipated patient care costs as a result of participation in clinical trials; and

''(iii) previous and on-going studies relating to patient care costs associated with participation in clinical trials.

''(C) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this paragraph, the Secretary, after consultation with organizations representing cancer patients, health care practitioners, medical researchers, employers, group health plans, manufacturers of drugs, biologics and medical devices, medical economists, hospitals, and other interested parties, shall publish notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

''(D) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subparagraph (C), and for purposes of this paragraph, the 'target date for publication' (referred to in section 564(a)(5) of such title 5) shall be June 30, 2000.

''(E) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title 5 under this paragraph, '15 days' shall be substituted for '30 days'.

''(F) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(i) the appointment of a negotiated rulemaking committee under section 565(a) of such title 5 by not later than 30 days after the end of the comment period provided for under section 564(c) of such title 5 (as shortened under subparagraph (E)), and

''(ii) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

''(G) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subparagraph (F) shall report to the Secretary, by not later than March 29, 2000, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this paragraph through such other methods as the Secretary may provide.

''(H) FINAL COMMITTEE REPORT.—If the committee is not terminated under subparagraph (G), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

''(I) FINAL EFFECT.—The Secretary shall publish a rule under this paragraph in the Federal Register by not later than the target date of publication.

''(J) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

''(K) EFFECTIVE DATE.—The provisions of this paragraph shall apply to group health plans (other than a fully insured group health plan) for plan years beginning on or after January 1, 2001.

''(3) PAYMENT RATE.—In the case of covered items and services provided by—

''(A) a participating provider, the payment rate shall be at the agreed upon rate, or

''(B) a nonparticipating provider, the payment rate shall be at the rate the plan would normally pay for comparable services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—

''(1) IN GENERAL.—In this section, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

''(A) The National Institutes of Health.

''(B) A cooperative group or center of the National Institutes of Health.

''(C) Either of the following if the conditions described in paragraph (2) are met:

''(i) The Department of Veterans Affairs.

''(ii) The Department of Defense.

''(2) 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—

''(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's coverage with respect to clinical trials.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(1) IN GENERAL.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer.

''(2) CONSTRUCTION.—Nothing in this section shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(g) STUDY AND REPORT.—

''(1) STUDY.—The Secretary shall study the impact on group health plans for covering routine patient care costs for individuals who are entitled to benefits under this section and who are enrolled in an approved cancer clinical trial program.

''(2) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains an assessment of—

''(A) any incremental cost to group health plans resulting from the provisions of this section;

''(B) a projection of expenditures to such plans resulting from this section; and

''(C) any impact on premiums resulting from this section.

''SEC. 9830A. PROHIBITING DISCRIMINATION AGAINST PROVIDERS.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This subsection shall not be construed as requiring the coverage under a plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants and beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

''(b) NO REQUIREMENT FOR ANY WILLING PROVIDER.—Nothing in this section shall be construed as requiring a group health plan that offers network coverage to include for participation every willing provider or health professional who meets the terms and conditions of the plan.

''SEC. 9830B. GENERALLY APPLICABLE PROVISION.

''In the case of a group health plan that provides benefits under 2 or more coverage options, the requirements of this subchapter shall apply separately with respect to each coverage option.''.

(b) DEFINITION.—Section 9832(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(4) FULLY INSURED GROUP HEALTH PLAN.—The term 'fully insured group health plan' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.''.

(c) CONFORMING AMENDMENT.—Chapter 98 of the Internal Revenue Code of 1986 is amended in the table of subchapters in the item relating to subchapter C, by striking ''Subchapter C'' and inserting ''Subchapter D''.

SEC. 103. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle B—Right to Information About Plans and Providers

SEC. 111. INFORMATION ABOUT PLANS.

(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

''SEC. 714. HEALTH PLAN COMPARATIVE INFORMATION.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides coverage in connection with group health insurance coverage, shall, not later than 12 months after the date of enactment of this

section, and at least annually thereafter, provide for the disclosure, in a clear and accurate form to each participant and each beneficiary who does not reside at the same address as the participant, or upon request to an individual eligible for coverage under the plan, of the information described in subsection (b).

''(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a plan or issuer from entering into any agreement under which the issuer agrees to assume responsibility for compliance with the requirements of this section and the plan is released from liability for such compliance.

''(3) PROVISION OF INFORMATION.—Information shall be provided to participants and beneficiaries under this section at the address maintained by the plan or issuer with respect to such participants or beneficiaries.

''(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each package option available under a group health plan the following:

''(1) A description of the covered items and services under each such plan and any in- and out-of-network features of each such plan, including a summary description of the specific exclusions from coverage under the plan.

''(2) A description of any cost-sharing, including premiums, deductibles, coinsurance, and copayment amounts, for which the participant or beneficiary will be responsible, including any annual or lifetime limits on benefits, for each such plan.

''(3) A description of any optional supplemental benefits offered by each such plan and the terms and conditions (including premiums or cost-sharing) for such supplemental coverage.

''(4) A description of any restrictions on payments for services furnished to a participant or beneficiary by a health care professional that is not a participating professional and the liability of the participant or beneficiary for additional payments for these services.

''(5) A description of the service area of each such plan, including the provision of any out-of-area coverage.

''(6) A description of the extent to which participants and beneficiaries may select the primary care provider of their choice, including providers both within the network and outside the network of each such plan (if the plan permits out-of-network services).

''(7) A description of the procedures for advance directives and organ donation decisions if the plan maintains such procedures.

''(8) A description of the requirements and procedures to be used to obtain preauthorization for health services (including telephone numbers and mailing addresses), including referrals for specialty care.

''(9) A description of the definition of medical necessity used in making coverage determinations by each such plan.

''(10) A summary of the rules and methods for appealing coverage decisions and filing grievances (including telephone numbers and mailing addresses), as well as other available remedies.

''(11) A summary description of any provisions for obtaining off-formulary medications if the plan utilizes a defined formulary for providing specific prescription medications.

''(12) A summary of the rules for access to emergency room care. Also, any available educational material regarding proper use of emergency services.

''(13) A description of whether or not coverage is provided for experimental treatments, investigational treatments, or clinical trials and the circumstances under which access to such treatments or trials is made available.

''(14) A description of the specific preventative services covered under the plan if such services are covered.

''(15) A statement regarding—

''(A) the manner in which a participant or beneficiary may access an obstetrician, gynecologist, or pediatrician in accordance with section 723 or 724; and

''(B) the manner in which a participant or beneficiary obtains continuity of care as provided for in section 726.

''(16) A statement that the following information, and instructions on obtaining such information (including telephone numbers and, if available, Internet websites), shall be made available upon request:

''(A) The names, addresses, telephone numbers, and State licensure status of the plan's participating health care professionals and participating health care facilities, and, if available, the education, training, specialty qualifications or certifications of such professionals.

''(B) A summary description of the methods used for compensating participating health care professionals, such as capitation, fee-for-service, salary, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(C) A summary description of the methods used for compensating health care facilities, including per diem, fee-for-service, capitation, bundled payments, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(D) A summary description of the procedures used for utilization review.

''(E) The list of the specific prescription medications included in the formulary of the plan, if the plan uses a defined formulary.

''(F) A description of the specific exclusions from coverage under the plan.

''(G) Any available information related to the availability of translation or interpretation services for non-English speakers and people with communication disabilities, including the availability of audio tapes or information in Braille.

''(H) Any information that is made public by accrediting organizations in the process of accreditation if the plan is accredited, or any additional quality indicators that the plan makes available.

''(c) MANNER OF DISTRIBUTION.—The information described in this section shall be distributed in an accessible format that is understandable to an average plan participant or beneficiary.

''(d) RULE OF CONSTRUCTION.—Nothing in this section may be construed to prohibit a group health plan, or health insurance issuer in connection with group health insurance coverage, from distributing any other additional information determined by the plan or issuer to be important or necessary in assisting participants and beneficiaries or upon request potential participants and beneficiaries in the selection of a health plan or from providing information under subsection (b)(15) as part of the required information.

''(e) CONFORMING REGULATIONS.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under part 1, to reduce duplication with respect to any information that is required to be provided under any such requirements.

''(f) HEALTH CARE PROFESSIONAL.—In this section, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the health plan involved for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711, and inserting ''sections 711 and 714''.

(B) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) is amended by inserting after the item relating to section 713, the following:

''Sec. 714. Health plan comparative information.''.

(b) INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Health plan comparative information.'';

and

(2) by inserting after section 9812 the following:

''SEC. 9813. HEALTH PLAN COMPARATIVE INFORMATION.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—A group health plan shall, not later than 12 months after the date of enactment of this section, and at least annually thereafter, provide for the disclosure, in a clear and accurate form to each participant and each beneficiary who does not reside at the same address as the participant, or upon request to an individual eligible for coverage under the plan, of the information described in subsection (b).

''(2) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a plan from entering into any agreement under which a health insurance issuer agrees to assume responsibility for compliance with the requirements of this section and the plan is released from liability for such compliance.

''(3) PROVISION OF INFORMATION.—Information shall be provided to participants and beneficiaries under this section at the address maintained by the plan with respect to such participants or beneficiaries.

''(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each package option available under a group health plan the following:

''(1) A description of the covered items and services under each such plan and any in- and out-of-network features of each such plan, including a summary description of the specific exclusions from coverage under the plan.

''(2) A description of any cost-sharing, including premiums, deductibles, coinsurance, and copayment amounts, for which the participant or beneficiary will be responsible, including any annual or lifetime limits on benefits, for each such plan.

''(3) A description of any optional supplemental benefits offered by each such plan and the terms and conditions (including premiums or cost-sharing) for such supplemental coverage.

''(4) A description of any restrictions on payments for services furnished to a participant or beneficiary by a health care professional that is not a participating professional and the liability of the participant or beneficiary for additional payments for these services.

''(5) A description of the service area of each such plan, including the provision of any out-of-area coverage.

''(6) A description of the extent to which participants and beneficiaries may select the primary care provider of their choice, including providers both within the network and outside the network of each such plan (if the plan permits out-of-network services).

''(7) A description of the procedures for advance directives and organ donation decisions if the plan maintains such procedures.

''(8) A description of the requirements and procedures to be used to obtain preauthorization for health services (including telephone numbers and mailing addresses), including referrals for specialty care.

''(9) A description of the definition of medical necessity used in making coverage determinations by each such plan.

''(10) A summary of the rules and methods for appealing coverage decisions and filing grievances (including telephone numbers and mailing addresses), as well as other available remedies.

''(11) A summary description of any provisions for obtaining off-formulary medications if the plan utilizes a defined formulary for providing specific prescription medications.

''(12) A summary of the rules for access to emergency room care. Also, any available educational material regarding proper use of emergency services.

''(13) A description of whether or not coverage is provided for experimental treatments, investigational treatments, or clinical trials and the circumstances under which access to such treatments or trials is made available.

''(14) A description of the specific preventative services covered under the plan if such services are covered.

''(15) A statement regarding—

''(A) the manner in which a participant or beneficiary may access an obstetrician, gynecologist, or pediatrician in accordance with section 723 or 724; and

''(B) the manner in which a participant or beneficiary obtains continuity of care as provided for in section 726.

''(16) A statement that the following information, and instructions on obtaining such information (including telephone numbers and, if available, Internet websites), shall be made available upon request:

''(A) The names, addresses, telephone numbers, and State licensure status of the plan's participating health care professionals and participating health care facilities, and, if available, the education, training, specialty qualifications or certifications of such professionals.

''(B) A summary description of the methods used for compensating participating health care professionals, such as capitation, fee-for-service, salary, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(C) A summary description of the methods used for compensating health care facilities, including per diem, fee-for-service, capitation, bundled payments, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(D) A summary description of the procedures used for utilization review.

''(E) The list of the specific prescription medications included in the formulary of the plan, if the plan uses a defined formulary.

''(F) A description of the specific exclusions from coverage under the plan.

''(G) Any available information related to the availability of translation or interpretation services for non-English speakers and people with communication disabilities, including the availability of audio tapes or information in Braille.

''(H) Any information that is made public by accrediting organizations in the process of accreditation if the plan is accredited, or any additional quality indicators that the plan makes available.

''(c) MANNER OF DISTRIBUTION.—The information described in this section shall be distributed in an accessible format that is understandable to an average plan participant or beneficiary.

''(d) RULE OF CONSTRUCTION.—Nothing in this section may be construed to prohibit a group health plan from distributing any other additional information determined by the plan to be important or necessary in assisting participants and beneficiaries or upon request potential participants and beneficiaries in the selection of a health plan or from providing information under subsection (b)(15) as part of the required information.

''(e) HEALTH CARE PROFESSIONAL.—In this section, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the health plan involved for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.''.

SEC. 112. INFORMATION ABOUT PROVIDERS.

(a) STUDY.—The Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine for the conduct of a study, and the submission to the Secretary of a report, that includes—

(1) an analysis of information concerning health care professionals that is currently available to patients, consumers, States, and professional societies, nationally and on a State-by-State basis, including patient preferences with respect to information about such professionals and their competencies;

(2) an evaluation of the legal and other barriers to the sharing of information concerning health care professionals; and

(3) recommendations for the disclosure of information on health care professionals, including the competencies and professional qualifications of such practitioners, to better facilitate patient choice, quality improvement, and market competition.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall forward to the appropriate committees of Congress a copy of the report and study conducted under subsection (a).

Subtitle C—Right to Hold Health Plans Accountable

SEC. 121. AMENDMENT TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended to read as follows:

''SEC. 503. CLAIMS PROCEDURE, COVERAGE DETERMINATION, GRIEVANCES AND APPEALS.

''(a) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every employee benefit plan shall—

''(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant; and

''(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

''(b) COVERAGE DETERMINATIONS UNDER GROUP HEALTH PLANS.—

''(1) PROCEDURES.—

''(A) IN GENERAL.—A group health plan or health insurance issuer conducting utilization review shall ensure that procedures are in place for—

''(i) making determinations regarding whether a participant or beneficiary is eligible to receive a payment or coverage for health services under the plan or coverage involved and any cost-sharing amount that the participant or beneficiary is required to pay with respect to such service;

''(ii) notifying a covered participant or beneficiary (or the authorized representative of such participant or beneficiary) and the treating health care professionals involved regarding determinations made under the plan or issuer and any additional payments that the participant or beneficiary may be required to make with respect to such service; and

''(iii) responding to requests, either written or oral, for coverage determinations or for internal appeals from a participant or beneficiary (or the authorized representative of such participant or beneficiary) or the treating health care professional with the consent of the participant or beneficiary.

''(B) ORAL REQUESTS.—With respect to an oral request described in subparagraph (A)(iii), a group health plan or health insurance issuer may require that the requesting individual provide written evidence of such request.

''(2) TIMELINE FOR MAKING DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—A group health plan or a health insurance issuer shall maintain procedures to ensure that prior authorization determinations concerning the provision of non-emergency items or services are made within 30 days from the date on which the request for a determination is submitted, except that such period may be extended where certain circumstances exist that are determined by the Secretary to be beyond control of the plan or issuer.

''(B) EXPEDITED DETERMINATION.—

''(i) IN GENERAL.—A prior authorization determination under this subsection shall be made within 72 hours, in accordance with the medical exigencies of the case, after a request is received by the plan or issuer under clause (ii) or (iii).

''(ii) REQUEST BY PARTICIPANT OR BENEFICIARY.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of a participant or beneficiary if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the participant or beneficiary.

''(iii) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if

the request involved indicates that the treating health care professional has reasonably documented, based on the medical exigencies, that a determination under the procedures described in subparagraph (A) could seriously jeopardize the life or health of the participant or beneficiary.

''(C) CONCURRENT DETERMINATIONS.—A plan or issuer shall maintain procedures to certify or deny coverage of an extended stay or additional services.

''(D) RETROSPECTIVE DETERMINATION.—A plan or issuer shall maintain procedures to ensure that, with respect to the retrospective review of a determination made under paragraph (1), the determination shall be made within 30 working days of the date on which the plan or issuer receives necessary information.

''(3) NOTICE OF DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(A), the plan or issuer shall issue notice of such determination to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and, consistent with the medical exigencies of the case, to the treating health care professional involved not later than 2 working days after the date on which the determination is made.

''(B) EXPEDITED DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(B), the plan or issuer shall issue notice of such determination to the participant or beneficiary (or the authorized representative of the participant or beneficiary), and consistent with the medical exigencies of the case, to the treating health care professional involved within the 72 hour period described in paragraph (2)(B).

''(C) CONCURRENT REVIEWS.—With respect to the determination under a plan or issuer under paragraph (2)(C) to certify or deny coverage of an extended stay or additional services, the plan or issuer shall issue notice of such determination to the treating health care professional and to the participant or beneficiary involved (or the authorized representative of the participant or beneficiary) within 1 working day of the determination.

''(D) RETROSPECTIVE REVIEWS.—With respect to the retrospective review under a plan or issuer of a determination made under paragraph (2)(D), the plan or issuer shall issue written notice of an approval or disapproval of a determination under this subparagraph to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and health care provider involved within 5 working days of the date on which such determination is made.

''(E) REQUIREMENTS OF NOTICE OF ADVERSE COVERAGE DETERMINATIONS.—A written notice of an adverse coverage determination under this subsection, or of an expedited adverse coverage determination under paragraph (2)(B), shall be provided to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and treating health care professional (if any) involved and shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average participant or beneficiary;

''(ii) the procedures for obtaining additional information concerning the determination; and

''(iii) notification of the right to appeal the determination and instructions on how to initiate an appeal in accordance with subsection (d).

''(c) GRIEVANCES.—A group health plan or a health insurance issuer shall have written procedures for addressing grievances between the plan or issuer offering health insurance coverage in connection with a group health plan and a participant or beneficiary. Determinations under such procedures shall be non-appealable.

''(d) INTERNAL APPEAL OF COVERAGE DETERMINATIONS.—

''(1) RIGHT TO APPEAL.—

''(A) IN GENERAL.—A participant or beneficiary (or the authorized representative of the participant or beneficiary) or the treating health care professional with the consent of the participant or beneficiary (or the authorized representative of the participant or beneficiary), may appeal any adverse coverage determination under subsection (b) under the procedures described in this subsection.

''(B) TIME FOR APPEAL.—A plan or issuer shall ensure that a participant or beneficiary has a period of not less than 180 days beginning on the date of an adverse coverage determination under subsection (b) in which to appeal such determination under this subsection.

''(C) FAILURE TO ACT.—The failure of a plan or issuer to issue a determination under subsection (b) within the applicable timeline established for such a determination under such subsection shall be treated as an adverse coverage determination for purposes of proceeding to internal review under this subsection.

''(2) RECORDS.—A group health plan and a health insurance issuer shall maintain written records, for at least 6 years, with respect to any appeal under this subsection for purposes of internal quality assurance and improvement. Nothing in the preceding sentence shall be construed as preventing a plan and issuer from entering into an agreement under which the issuer agrees to assume responsibility for compliance with the requirements of this section and the plan is released from liability for such compliance.

''(3) ROUTINE DETERMINATIONS.—A group health plan or a health insurance issuer shall complete the consideration of an appeal of an adverse routine determination under this subsection not later than 30 working days after the date on which a request for such appeal is received.

''(4) EXPEDITED DETERMINATION.—

''(A) IN GENERAL.—An expedited determination with respect to an appeal under this subsection shall be made in accordance with the medical exigencies of the case, but in no case more than 72 hours after the request for such appeal is received by the plan or issuer under subparagraph (B) or (C).

''(B) REQUEST BY PARTICIPANT OR BENEFICIARY.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of a participant or beneficiary if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the participant or beneficiary.

''(C) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if the request involved indicates that the treating health care professional has reasonably documented, based on the medical exigencies of the case that a determination under the procedures described in paragraph (2) could seriously jeopardize the life or health of the participant or beneficiary.

''(5) CONDUCT OF REVIEW.—A review of an adverse coverage determination under this subsection shall be conducted by an individual with appropriate expertise who was not directly involved in the initial determination.

''(6) LACK OF MEDICAL NECESSITY.—A review of an appeal under this subsection relating to a determination to deny coverage based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, shall be made only by a physician with appropriate expertise, including age-appropriate expertise, who was not involved in the initial determination.

''(7) NOTICE.—

''(A) IN GENERAL.—Written notice of a determination made under an internal review process shall be issued to the participant or beneficiary (or the authorized representative of the participant or beneficiary) and the treating health care professional not later than 2 working days after the completion of the review (or within the 72-hour period referred to in paragraph (4) if applicable).

''(B) ADVERSE COVERAGE DETERMINATIONS.—With respect to an adverse coverage determination made under this subsection, the notice described in subparagraph (A) shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average participant or beneficiary;

''(ii) the procedures for obtaining additional information concerning the determination; and

''(iii) notification of the right to an independent external review under subsection (e) and instructions on how to initiate such a review.

''(e) INDEPENDENT EXTERNAL REVIEW.—

''(1) ACCESS TO REVIEW.—

''(A) IN GENERAL.—A group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan shall have written procedures to permit a participant or beneficiary (or the authorized representative of the participant or beneficiary) access to an independent external review with respect to an adverse coverage determination concerning a particular item or service (including a circumstance treated as an adverse coverage determination under subparagraph (B)) where—

''(i) the particular item or service involved—

''(I)(aa) would be a covered benefit, when medically necessary and appropriate under the terms and conditions of the plan, and the item or service has been determined not to be medically necessary and appropriate under the internal appeals process required under subsection (d) or there has been a failure to issue a coverage determination as described in subparagraph (B); and

''(bb)(AA) the amount of such item or service involved exceeds a significant financial threshold; or

''(BB) there is a significant risk of placing the life or health of the participant or beneficiary in jeopardy; or

''(II) would be a covered benefit, when not considered experimental or investigational under the terms and conditions of the plan, and the item or service has been determined to be experimental or investigational under the internal appeals process required under subsection (d) or there has been a failure to issue a coverage determination as described in subparagraph (B); and

''(ii) the participant or beneficiary has completed the internal appeals process under subsection (d) with respect to such determination.

''(B) FAILURE TO ACT.—The failure of a plan or issuer to issue a coverage determination under subsection (d)(6) within the applicable timeline established for such a determination under such subsection shall be treated as an adverse coverage determination for

purposes of proceeding to independent external review under this subsection.

''(2) INITIATION OF THE INDEPENDENT EXTERNAL REVIEW PROCESS.—

''(A) FILING OF REQUEST.—A participant or beneficiary (or the authorized representative of the participant or beneficiary) who desires to have an independent external review conducted under this subsection shall file a written request for such a review with the plan or issuer involved not later than 30 working days after the receipt of a final denial of a claim under subsection (d). Any such request shall include the consent of the participant or beneficiary (or the authorized representative of the participant or beneficiary) for the release of medical information and records to independent external reviewers regarding the participant or beneficiary.

''(B) TIMEFRAME FOR SELECTION OF APPEALS ENTITY.—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—

''(i) select an external appeals entity under paragraph (3)(A) that shall be responsible for designating an independent external reviewer under paragraph (3)(B); and

''(ii) provide notice of such selection to the participant or beneficiary (which shall include the name and address of the entity).

''(C) PROVISION OF INFORMATION.—Not later than 5 working days after the plan or issuer provides the notice required under subparagraph (B)(ii), or earlier in accordance with the medical exigencies of the case, the plan, issuer, participant, beneficiary or physician (of the participant or beneficiary) involved shall forward necessary information (including, only in the case of a plan or issuer, 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 qualified external appeals entity designated under paragraph (3)(A).

''(D) FOLLOW-UP WRITTEN NOTIFICATION.—The plan or issuer involved shall send a follow-up written notification, in a timely manner, 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 be a physician of the same specialty, when reasonably available, 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 including both generally accepted medical practice and recognized best practice; medical literature as defined in section 556(5) of the Federal Food, Drug, and Cosmetic Act; the following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information; and findings, studies, or research conducted by or under the auspices of Federal Government agencies and nationally recognized Federal research institutes including the Agency for Healthcare Research and Quality, National Institutes of Health, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purposes of evaluating the medical value of health services.

''(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) EXPEDITED REVIEW.—Notwithstanding subparagraph (A), a review described in such subparagraph shall be completed not later than 72 hours 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; if the completion of such review in a period of time in excess of 72 hours would seriously jeopardize the life or health of the participant or beneficiary.

''(C) LIMITATION.—Notwithstanding subparagraph (A), and except as provided in subparagraph (B), a review described in subparagraph (A) 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 AND ACCESS TO CARE.—

''(A) IN GENERAL.—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.

''(B) TIMETABLE FOR COMMENCEMENT OF CARE.—Where an independent external reviewer determines that the participant or beneficiary is entitled to coverage of the items or services that were the subject of the review, the reviewer shall establish a timeframe, in accordance with the medical exigencies of the case, during which the plan or issuer shall comply with the decision of the reviewer with respect to the coverage of such items or services under the terms and conditions of the plan.

''(C) FAILURE TO COMPLY.—If a plan or issuer fails to comply with the timeframe established under subparagraph (B) with respect to a participant or beneficiary, where such failure to comply is caused by the plan or issuer, the participant or beneficiary may obtain the items or services involved (in a manner consistent with the determination of the independent external reviewer) from any provider regardless of whether such provider is a participating provider under the plan or coverage.

''(D) REIMBURSEMENT.—

''(i) IN GENERAL.—Where a participant or beneficiary obtains items or services in accordance with subparagraph (C), the plan or issuer involved shall provide for reimbursement of the costs of such items of services. Such reimbursement shall be made to the treating provider or to the participant or beneficiary (in the case of a participant or beneficiary who pays for the costs of such items or services).

''(ii) AMOUNT.—The plan or issuer shall fully reimburse a provider, participant or beneficiary under clause (i) for the total costs of the items or services provided (regardless of any plan limitations that may apply to the coverage of such items of services) so long as—

''(I) the items or services would have been covered under the terms of the plan or coverage if provided by the plan or issuer; and

''(II) the items or services were provided in a manner consistent with the determination of the independent external reviewer.

''(E) FAILURE TO REIMBURSE.—Where a plan or issuer fails to provide reimbursement to a provider, participant or beneficiary in accordance with this paragraph, the provider, participant or beneficiary may commence a

civil action (or utilize other remedies available under law) to recover only the amount of any such reimbursement that is unpaid and any necessary legal costs or expenses (including attorneys' fees) incurred in recovering such reimbursement.

''(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) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) is amended by adding at the end the following:

''(8) The Secretary may assess a civil penalty against any plan of up to $10,000 for the plan's failure or refusal to comply with any timeline applicable under section 503(e) or any determination under such section, except that in any case in which treatment was not commenced by the plan in accordance with the determination of an independent external reviewer, the Secretary shall assess a civil penalty of $10,000 against the plan and the plan shall pay such penalty to the participant or beneficiary involved.''.

(c) CONFORMING AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the item relating to section 503 and inserting the following new item:

''Sec. 503. Claims procedures, coverage determination, grievances and appeals.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after 1 year after the date of enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

TITLE II—WOMEN'S HEALTH AND CANCER RIGHTS

SEC. 201. WOMEN'S HEALTH AND CANCER RIGHTS.

(a) SHORT TITLE.—This section may be cited as the ''Women's Health and Cancer Rights Act of 1999''.

(b) FINDINGS.—Congress finds that—

(1) the offering and operation of health plans affect commerce among the States;

(2) health care providers located in a State serve patients who reside in the State and patients who reside in other States; and

(3) in order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in 1 State as well as health plans operating among the several States.

(c) AMENDMENTS TO ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 111(a), is further amended by adding at the end the following:

''SEC. 715. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, 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 consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000;

whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides 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 (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be

covered by the plan or coverage involved under subsection (d).''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.''.

(d) AMENDMENTS TO PHSA RELATING TO THE GROUP MARKET.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.) is amended by adding at the end the following new section:

''SEC. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, 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 consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000;

whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan that provides 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 (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d).''.

(e) AMENDMENTS TO PHSA RELATING TO THE INDIVIDUAL MARKET.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–51 et seq.) (relating to other requirements) (42 U.S.C. 300gg-51 et seq.) is amended—

(1) by redesignating such subpart as subpart 2; and

(2) by adding at the end the following:

''SEC. 2753. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND SECONDARY CONSULTATIONS.

''The provisions of section 2707 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(f) AMENDMENTS TO THE IRC.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 111(b), is further amended by inserting after section 9813 the following:

''SEC. 9814. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan 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 consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan and shall be transmitted—

''(1) in the next mailing made by the plan to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000;

whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan that provides 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 (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES.—A group health plan may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the

physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan involved under subsection (d).''.

(2) CLERICAL AMENDMENT.—The table of contents for chapter 100 of such Code is amended by inserting after the item relating to section 9813 the following new item:

''Sec. 9814. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.''.

TITLE III—GENETIC INFORMATION AND SERVICES

SEC. 301. SHORT TITLE.

This title may be cited as the ''Genetic Information Nondiscrimination in Health Insurance Act of 1999''.

SEC. 302. AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 702(a)(1)(F) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(a)(1)(F)) is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by sections 111(a) and 201, is further amended by adding at the end the following:

''SEC. 716. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''A group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).''.

(3) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 702(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)) is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 716.''.

(B) TABLE OF CONTENTS.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974, as amended by sections 111(a) and 201, is further amended by inserting after the item relating to section 715 the following new item:

''Sec. 716. Prohibiting premium discrimination against groups on the basis of predictive genetic information.''.

(b) LIMITATION ON COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Section 702 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182) is amended by adding at the end the following:

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan or issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan or issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan or issuer.''.

(c) DEFINITIONS.—Section 733(d) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(d)) is amended by adding at the end the following:

''(5) FAMILY MEMBER.—The term 'family member' means with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(6) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(7) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(8) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(9) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(d) EFFECTIVE DATE.—Except as provided in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning 1 year after the date of the enactment of this Act.

SEC. 303. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

(a) AMENDMENTS RELATING TO THE GROUP MARKET.—

(1) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION IN THE GROUP MARKET.—

(A) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 2702(a)(1)(F) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(1)(F)) is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(B) NO DISCRIMINATION IN PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by section 201, is further amended by adding at the end the following new section:

''SEC. 2708. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION IN THE GROUP MARKET.

''A group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or family

member of the individual (including information about a request for or receipt of genetic services).''.

(C) CONFORMING AMENDMENT.—Section 2702(b) of the Public Health Service Act (42 U.S.C. 300gg–1(b)) is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 2708.''.

(D) LIMITATION ON COLLECTION AND DISCLOSURE OF PREDICTIVE GENETIC INFORMATION.—Section 2702 of the Public Health Service Act (42 U.S.C. 300gg–1) is amended by adding at the end the following:

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan or issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan or issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan or issuer.''.

(2) DEFINITIONS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg–91(d)) is amended by adding at the end the following:

''(15) FAMILY MEMBER.—The term 'family member' means, with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(16) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(17) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(18) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(19) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(b) AMENDMENT RELATING TO THE INDIVIDUAL MARKET.—Subpart 2 of part B of title XXVII of the Public Health Service Act, as amended by section 201, is further amended by adding at the end the following new section:

''SEC. 2754. PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''(a) PROHIBITION ON PREDICTIVE GENETIC INFORMATION AS A CONDITION OF ELIGIBILITY.—A health insurance issuer offering health insurance coverage in the individual market may not use predictive genetic information as a condition of eligibility of an individual to enroll in individual health insurance coverage (including information about a request for or receipt of genetic services).

''(b) PROHIBITION ON PREDICTIVE GENETIC INFORMATION IN SETTING PREMIUM RATES.—A health insurance issuer offering health insurance coverage in the individual market shall not adjust premium rates for individuals on the basis of predictive genetic information concerning such an individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a health insurance issuer offering health insurance coverage in the individual market shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a health insurance issuer offering health insurance coverage in the individual market that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the health insurance issuer offering health insurance coverage in the individual market shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A health insurance issuer offering health insurance coverage in the individual market shall post or provide, in writing and in a clear and conspicuous manner, notice of the issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A health insurance issuer offering health insurance coverage in the individual market shall establish and maintain appropriate administrative, technical, and physical safeguards to

protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such issuer.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to—

(1) group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after 1 year after the date of enactment of this Act; and

(2) health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after 1 year after the date of enactment of this Act.

SEC. 304. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

(a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 9802(a)(1)(F) of the Internal Revenue Code of 1986 is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by sections 111(b) and 201, is further amended by adding at the end the following:

''SEC. 9815. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''A group health plan shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).''.

(B) CONFORMING AMENDMENT.—Section 9802(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or the receipt of genetic services), see section 9815.''.

(C) AMENDMENT TO TABLE OF SECTIONS.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by sections 111(b) and 201, is further amended by adding at the end the following:

''Sec. 9816. Prohibiting premium discrimination against groups on the basis of predictive genetic information.''.

(b) LIMITATION ON COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Section 9802 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(d) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES; DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (e), of such predictive genetic information.

''(e) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan.''.

(c) DEFINITIONS.—Section 9832(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(6) FAMILY MEMBER.—The term 'family member' means, with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(7) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(8) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(9) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(10) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(d) EFFECTIVE DATE.—Except as provided in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning after 1 year after the date of the enactment of this Act.

TITLE IV—HEALTHCARE RESEARCH AND QUALITY

SEC. 401. SHORT TITLE.

This title may be cited as the ''Healthcare Research and Quality Act of 1999''.

SEC. 402. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended to read as follows:

''TITLE IX—AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

''PART A—ESTABLISHMENT AND GENERAL DUTIES

''SEC. 901. MISSION AND DUTIES.

''(a) IN GENERAL.—There is established within the Public Health Service an agency to be known as the Agency for Healthcare Research and Quality. In carrying out this subsection, the Secretary shall redesignate the Agency for Health Care Policy and Research as the Agency for Healthcare Research and Quality.

''(b) MISSION.—The purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of healthcare services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions. The Agency shall promote healthcare quality improvement by—

''(1) conducting and supporting research that develops and presents scientific evidence regarding all aspects of healthcare, including—

''(A) the development and assessment of methods for enhancing patient participation in their own care and for facilitating shared patient-physician decision-making;

''(B) the outcomes, effectiveness, and cost-effectiveness of healthcare practices, including preventive measures and long-term care;

''(C) existing and innovative technologies;

''(D) the costs and utilization of, and access to healthcare;

''(E) the ways in which healthcare services are organized, delivered, and financed and the interaction and impact of these factors on the quality of patient care;

''(F) methods for measuring quality and strategies for improving quality; and

''(G) ways in which patients, consumers, purchasers, and practitioners acquire new information about best practices and health

benefits, the determinants and impact of their use of this information;

''(2) synthesizing and disseminating available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and

''(3) advancing private and public efforts to improve healthcare quality.

''(c) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND PRIORITY POPULATIONS.—In carrying out subsection (b), the Director shall undertake and support research, demonstration projects, and evaluations with respect to the delivery of health services—

''(1) in rural areas (including frontier areas);

''(2) for low-income groups, and minority groups;

''(3) for children;

''(4) for elderly; and

''(5) for people with special healthcare needs, including disabilities, chronic care and end-of-life healthcare.

''(d) APPOINTMENT OF DIRECTOR.—There shall be at the head of the Agency an official to be known as the Director for Healthcare Research and Quality. The Director shall be appointed by the Secretary. The Secretary, acting through the Director, shall carry out the authorities and duties established in this title.

''SEC. 902. GENERAL AUTHORITIES.

''(a) IN GENERAL.—In carrying out section 901(b), the Director shall support demonstration projects, conduct and support research, evaluations, training, research networks, multi-disciplinary centers, technical assistance, and the dissemination of information, on healthcare, and on systems for the delivery of such care, including activities with respect to—

''(1) the quality, effectiveness, efficiency, appropriateness and value of healthcare services;

''(2) quality measurement and improvement;

''(3) the outcomes, cost, cost-effectiveness, and use of healthcare services and access to such services;

''(4) clinical practice, including primary care and practice-oriented research;

''(5) healthcare technologies, facilities, and equipment;

''(6) healthcare costs, productivity, organization, and market forces;

''(7) health promotion and disease prevention, including clinical preventive services;

''(8) health statistics, surveys, database development, and epidemiology; and

''(9) medical liability.

''(b) HEALTH SERVICES TRAINING GRANTS.—

''(1) IN GENERAL.—The Director may provide training grants in the field of health services research related to activities authorized under subsection (a), to include pre- and post-doctoral fellowships and training programs, young investigator awards, and other programs and activities as appropriate. In carrying out this subsection, the Director shall make use of funds made available under section 487 as well as other appropriated funds.

''(2) REQUIREMENTS.—In developing priorities for the allocation of training funds under this subsection, the Director shall take into consideration shortages in the number of trained researchers addressing the priority populations.

''(c) MULTIDISCIPLINARY CENTERS.—The Director may provide financial assistance to assist in meeting the costs of planning and establishing new centers, and operating existing and new centers, for multidisciplinary health services research, demonstration projects, evaluations, training, and policy analysis with respect to the matters referred to in subsection (a).

''(d) RELATION TO CERTAIN AUTHORITIES REGARDING SOCIAL SECURITY.—Activities authorized in this section shall be appropriately coordinated with experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Amendments of 1967. Activities under subsection (a)(2) of this section that affect the programs under titles XVIII, XIX and XXI of the Social Security Act shall be carried out consistent with section 1142 of such Act.

''(e) DISCLAIMER.—The Agency shall not mandate national standards of clinical practice or quality healthcare standards. Recommendations resulting from projects funded and published by the Agency shall include a corresponding disclaimer.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to imply that the Agency's role is to mandate a national standard or specific approach to quality measurement and reporting. In research and quality improvement activities, the Agency shall consider a wide range of choices, providers, healthcare delivery systems, and individual preferences.

''PART B—HEALTHCARE IMPROVEMENT RESEARCH

''SEC. 911. HEALTHCARE OUTCOME IMPROVEMENT RESEARCH.

''(a) EVIDENCE RATING SYSTEMS.—In collaboration with experts from the public and private sector, the Agency shall identify and disseminate methods or systems that it uses to assess healthcare research results, particularly methods or systems that it uses to rate the strength of the scientific evidence behind healthcare practice, recommendations in the research literature, and technology assessments. The Agency shall make methods and systems for evidence rating widely available. Agency publications containing healthcare recommendations shall indicate the level of substantiating evidence using such methods or systems.

''(b) HEALTHCARE IMPROVEMENT RESEARCH CENTERS AND PROVIDER-BASED RESEARCH NETWORKS.—In order to address the full continuum of care and outcomes research, to link research to practice improvement, and to speed the dissemination of research findings to community practice settings, the Agency shall employ research strategies and mechanisms that will link research directly with clinical practice in geographically diverse locations throughout the United States, including—

''(1) Healthcare Improvement Research Centers that combine demonstrated multidisciplinary expertise in outcomes or quality improvement research with linkages to relevant sites of care;

''(2) Provider-based Research Networks, including plan, facility, or delivery system sites of care (especially primary care), that can evaluate and promote quality improvement; and

''(3) other innovative mechanisms or strategies to link research with clinical practice.

''SEC. 912. PRIVATE-PUBLIC PARTNERSHIPS TO IMPROVE ORGANIZATION AND DELIVERY.

''(a) SUPPORT FOR EFFORTS TO DEVELOP INFORMATION ON QUALITY.—

''(1) SCIENTIFIC AND TECHNICAL SUPPORT.—In its role as the principal agency for healthcare research and quality, the Agency may provide scientific and technical support for private and public efforts to improve healthcare quality, including the activities of accrediting organizations.

''(2) ROLE OF THE AGENCY.—With respect to paragraph (1), the role of the Agency shall include—

''(A) the identification and assessment of methods for the evaluation of the health of—

''(i) enrollees in health plans by type of plan, provider, and provider arrangements; and

''(ii) other populations, including those receiving long-term care services;

''(B) the ongoing development, testing, and dissemination of quality measures, including measures of health and functional outcomes;

''(C) the compilation and dissemination of healthcare quality measures developed in the private and public sector;

''(D) assistance in the development of improved healthcare information systems;

''(E) the development of survey tools for the purpose of measuring participant and beneficiary assessments of their healthcare; and

''(F) identifying and disseminating information on mechanisms for the integration of information on quality into purchaser and consumer decision-making processes.

''(b) CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS.—

''(1) IN GENERAL.—The Secretary, acting through the Director and in consultation with the Commissioner of Food and Drugs, shall establish a program for the purpose of making one or more grants for the establishment and operation of one or more centers to carry out the activities specified in paragraph (2).

''(2) REQUIRED ACTIVITIES.—The activities referred to in this paragraph are the following:

''(A) The conduct of state-of-the-art clinical, laboratory, or health services research for the following purposes:

''(i) To increase awareness of—

''(I) new uses of drugs, biological products, and devices;

''(II) ways to improve the effective use of drugs, biological products, and devices; and

''(III) risks of new uses and risks of combinations of drugs and biological products.

''(ii) To provide objective clinical information to the following individuals and entities:

''(I) Healthcare practitioners and other providers of healthcare goods or services.

''(II) Pharmacists, pharmacy benefit managers and purchasers.

''(III) Health maintenance organizations and other managed healthcare organizations.

''(IV) Healthcare insurers and governmental agencies.

''(V) Patients and consumers.

''(iii) To improve the quality of healthcare while reducing the cost of Healthcare through—

''(I) an increase in the appropriate use of drugs, biological products, or devices; and

''(II) the prevention of adverse effects of drugs, biological products, and devices and the consequences of such effects, such as unnecessary hospitalizations.

''(B) The conduct of research on the comparative effectiveness, cost-effectiveness, and safety of drugs, biological products, and devices.

''(C) Such other activities as the Secretary determines to be appropriate, except that grant funds may not be used by the Secretary in conducting regulatory review of new drugs.

''(c) REDUCING ERRORS IN MEDICINE.—The Director shall conduct and support research and build private-public partnerships to—

''(1) identify the causes of preventable healthcare errors and patient injury in healthcare delivery;

''(2) develop, demonstrate, and evaluate strategies for reducing errors and improving patient safety; and

''(3) promote the implementation of effective strategies throughout the healthcare industry.

"SEC. 913. INFORMATION ON QUALITY AND COST OF CARE.

''(a) IN GENERAL.—In carrying out 902(a), the Director shall—

''(1) conduct a survey to collect data on a nationally representative sample of the population on the cost, use and, for fiscal year 2001 and subsequent fiscal years, quality of healthcare, including the types of healthcare services Americans use, their access to healthcare services, frequency of use, how much is paid for the services used, the source of those payments, the types and costs of private health insurance, access, satisfaction, and quality of care for the general population including rural residents and for the populations identified in section 901(c); and

''(2) develop databases and tools that provide information to States on the quality, access, and use of healthcare services provided to their residents.

''(b) QUALITY AND OUTCOMES INFORMATION.—

''(1) IN GENERAL.—Beginning in fiscal year 2001, the Director shall ensure that the survey conducted under subsection (a)(1) will—

''(A) identify determinants of health outcomes and functional status, and their relationships to healthcare access and use, determine the ways and extent to which the priority populations enumerated in section 901(c) differ from the general population with respect to such variables, measure changes over time with respect to such variable, and monitor the overall national impact of changes in Federal and State policy on healthcare;

''(B) provide information on the quality of care and patient outcomes for frequently occurring clinical conditions for a nationally representative sample of the population including rural residents; and

''(C) provide reliable national estimates for children and persons with special healthcare needs through the use of supplements or periodic expansions of the survey.

In expanding the Medical Expenditure Panel Survey, as in existence on the date of enactment of this title, in fiscal year 2001 to collect information on the quality of care, the Director shall take into account any outcomes measurements generally collected by private sector accreditation organizations.

''(2) ANNUAL REPORT.—Beginning in fiscal year 2003, the Secretary, acting through the Director, shall submit to Congress an annual report on national trends in the quality of healthcare provided to the American people.

"SEC. 914. INFORMATION SYSTEMS FOR HEALTHCARE IMPROVEMENT.

''(a) IN GENERAL.—In order to foster a range of innovative approaches to the management and communication of health information, the Agency shall support research, evaluations and initiatives to advance—

''(1) the use of information systems for the study of healthcare quality, including the generation of both individual provider and plan-level comparative performance data;

''(2) training for healthcare practitioners and researchers in the use of information systems;

''(3) the creation of effective linkages between various sources of health information, including the development of information networks;

''(4) the delivery and coordination of evidence-based healthcare services, including the use of real-time healthcare decision-support programs;

''(5) the utility and comparability of health information data and medical vocabularies by addressing issues related to the content, structure, definitions and coding of such information and data in consultation with appropriate Federal, State and private entities;

''(6) the use of computer-based health records in all settings for the development of personal health records for individual health assessment and maintenance, and for monitoring public health and outcomes of care within populations; and

''(7) the protection of individually identifiable information in health services research and healthcare quality improvement.

''(b) DEMONSTRATION.—The Agency shall support demonstrations into the use of new information tools aimed at improving shared decision-making between patients and their care-givers.

"SEC. 915. RESEARCH SUPPORTING PRIMARY CARE AND ACCESS IN UNDERSERVED AREAS.

''(a) PREVENTIVE SERVICES TASK FORCE.—

''(1) ESTABLISHMENT AND PURPOSE.—The Director may periodically convene a Preventive Services Task Force to be composed of individuals with appropriate expertise. Such a task force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the healthcare community, and updating previous clinical preventive recommendations.

''(2) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operations of the Preventive Services Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

''(3) OPERATION.—In carrying out its responsibilities under paragraph (1), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

''(b) PRIMARY CARE RESEARCH.—

''(1) IN GENERAL.—There is established within the Agency a Center for Primary Care Research (referred to in this subsection as the 'Center') that shall serve as the principal source of funding for primary care practice research in the Department of Health and Human Services. For purposes of this paragraph, primary care research focuses on the first contact when illness or health concerns arise, the diagnosis, treatment or referral to specialty care, preventive care, and the relationship between the clinician and the patient in the context of the family and community.

''(2) RESEARCH.—In carrying out this section, the Center shall conduct and support research concerning—

''(A) the nature and characteristics of primary care practice;

''(B) the management of commonly occurring clinical problems;

''(C) the management of undifferentiated clinical problems; and

''(D) the continuity and coordination of health services.

"SEC. 916. CLINICAL PRACTICE AND TECHNOLOGY INNOVATION.

''(a) IN GENERAL.—The Director shall promote innovation in evidence-based clinical practice and healthcare technologies by—

''(1) conducting and supporting research on the development, diffusion, and use of healthcare technology;

''(2) developing, evaluating, and disseminating methodologies for assessments of healthcare practices and healthcare technologies;

''(3) conducting intramural and supporting extramural assessments of existing and new healthcare practices and technologies;

''(4) promoting education, training, and providing technical assistance in the use of healthcare practice and healthcare technology assessment methodologies and results; and

''(5) working with the National Library of Medicine and the public and private sector to develop an electronic clearinghouse of currently available assessments and those in progress.

''(b) SPECIFICATION OF PROCESS.—

''(1) IN GENERAL.—Not later than December 31, 2000, the Director shall develop and publish a description of the methodology used by the Agency and its contractors in conducting practice and technology assessment.

''(2) CONSULTATIONS.—In carrying out this subsection, the Director shall cooperate and consult with the Assistant Secretary for Health, the Administrator of the Health Care Financing Administration, the Director of the National Institutes of Health, the Commissioner of Food and Drugs, and the heads of any other interested Federal department or agency, and shall seek input, where appropriate, from professional societies and other private and public entities.

''(3) METHODOLOGY.—The Director, in developing assessment methodology, shall consider—

''(A) safety, efficacy, and effectiveness;

''(B) legal, social, and ethical implications;

''(C) costs, benefits, and cost-effectiveness;

''(D) comparisons to alternate technologies and practices; and

''(E) requirements of Food and Drug Administration approval to avoid duplication.

''(c) SPECIFIC ASSESSMENTS.—

''(1) IN GENERAL.—The Director shall conduct or support specific assessments of healthcare technologies and practices.

''(2) REQUESTS FOR ASSESSMENTS.—The Director is authorized to conduct or support assessments, on a reimbursable basis, for the Health Care Financing Administration, the Department of Defense, the Department of Veterans Affairs, the Office of Personnel Management, and other public or private entities.

''(3) GRANTS AND CONTRACTS.—In addition to conducting assessments, the Director may make grants to, or enter into cooperative agreements or contracts with, entities described in paragraph (4) for the purpose of conducting assessments of experimental, emerging, existing, or potentially outmoded healthcare technologies, and for related activities.

''(4) ELIGIBLE ENTITIES.—An entity described in this paragraph is an entity that is determined to be appropriate by the Director, including academic medical centers, research institutions and organizations, professional organizations, third party payers, governmental agencies, and consortia of appropriate research entities established for the purpose of conducting technology assessments.

"SEC. 917. COORDINATION OF FEDERAL GOVERNMENT QUALITY IMPROVEMENT EFFORTS.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—To avoid duplication and ensure that Federal resources are used efficiently and effectively, the Secretary, acting through the Director, shall coordinate all research, evaluations, and demonstrations related to health services research, quality measurement and quality improvement activities undertaken and supported by the Federal Government.

''(2) SPECIFIC ACTIVITIES.—The Director, in collaboration with the appropriate Federal officials representing all concerned executive agencies and departments, shall develop and manage a process to—

''(A) improve interagency coordination, priority setting, and the use and sharing of research findings and data pertaining to Federal quality improvement programs, technology assessment, and health services research;

''(B) strengthen the research information infrastructure, including databases, pertaining to Federal health services research

and healthcare quality improvement initiatives;

''(C) set specific goals for participating agencies and departments to further health services research and healthcare quality improvement; and

''(D) strengthen the management of Federal healthcare quality improvement programs.

''(b) STUDY BY THE INSTITUTE OF MEDICINE.—

''(1) IN GENERAL.—To provide Congress, the Department of Health and Human Services, and other relevant departments with an independent, external review of their quality oversight, quality improvement and quality research programs, the Secretary shall enter into a contract with the Institute of Medicine—

''(A) to describe and evaluate current quality improvement, quality research and quality monitoring processes through—

''(i) an overview of pertinent health services research activities and quality improvement efforts conducted by all Federal programs, with particular attention paid to those under titles XVIII, XIX, and XXI of the Social Security Act; and

''(ii) a summary of the partnerships that the Department of Health and Human Services has pursued with private accreditation, quality measurement and improvement organizations; and

''(B) to identify options and make recommendations to improve the efficiency and effectiveness of quality improvement programs through—

''(i) the improved coordination of activities across the medicare, medicaid and child health insurance programs under titles XVIII, XIX and XXI of the Social Security Act and health services research programs;

''(ii) the strengthening of patient choice and participation by incorporating state-of-the-art quality monitoring tools and making information on quality available; and

''(iii) the enhancement of the most effective programs, consolidation as appropriate, and elimination of duplicative activities within various federal agencies.

''(2) REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall enter into a contract with the Institute of Medicine for the preparation—

''(i) not later than 12 months after the date of enactment of this title, of a report providing an overview of the quality improvement programs of the Department of Health and Human Services for the medicare, medicaid, and CHIP programs under titles XVIII, XIX, and XXI of the Social Security Act; and

''(ii) not later than 24 months after the date of enactment of this title, of a final report containing recommendations.

''(B) REPORTS.—The Secretary shall submit the reports described in subparagraph (A) to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Commerce of the House of Representatives.

''PART C—GENERAL PROVISIONS

''SEC. 921. ADVISORY COUNCIL FOR HEALTHCARE RESEARCH AND QUALITY.

''(a) ESTABLISHMENT.—There is established an advisory council to be known as the Advisory Council for Healthcare Research and Quality.

''(b) DUTIES.—

''(1) IN GENERAL.—The Advisory Council shall advise the Secretary and the Director with respect to activities proposed or undertaken to carry out the purpose of the Agency under section 901(b).

''(2) CERTAIN RECOMMENDATIONS.—Activities of the Advisory Council under paragraph (1) shall include making recommendations to the Director regarding—

''(A) priorities regarding healthcare research, especially studies related to quality, outcomes, cost and the utilization of, and access to, healthcare services;

''(B) the field of healthcare research and related disciplines, especially issues related to training needs, and dissemination of information pertaining to healthcare quality; and

''(C) the appropriate role of the Agency in each of these areas in light of private sector activity and identification of opportunities for public-private sector partnerships.

''(c) MEMBERSHIP.—

''(1) IN GENERAL.—The Advisory Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Advisory Council shall be voting members other than the individuals designated under paragraph (3)(B) as ex officio members.

''(2) APPOINTED MEMBERS.—The Secretary shall appoint to the Advisory Council 21 appropriately qualified individuals. At least 17 members of the Advisory Council shall be representatives of the public who are not officers or employees of the United States. The Secretary shall ensure that the appointed members of the Council, as a group, are representative of professions and entities concerned with, or affected by, activities under this title and under section 1142 of the Social Security Act. Of such members—

''(A) 4 shall be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to healthcare;

''(B) 4 shall be individuals distinguished in the practice of medicine of which at least 1 shall be a primary care practitioner;

''(C) 3 shall be individuals distinguished in the other health professions;

''(D) 4 shall be individuals either representing the private healthcare sector, including health plans, providers, and purchasers or individuals distinguished as administrators of healthcare delivery systems;

''(E) 4 shall be individuals distinguished in the fields of healthcare quality improvement, economics, information systems, law, ethics, business, or public policy, including at least 1 individual specializing in rural aspects in 1 or more of these fields; and

''(F) 2 shall be individuals representing the interests of patients and consumers of healthcare.

''(3) EX OFFICIO MEMBERS.—The Secretary shall designate as ex officio members of the Advisory Council—

''(A) the Assistant Secretary for Health, the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Care Financing Administration, the Assistant Secretary of Defense (Health Affairs), and the Under Secretary for Health of the Department of Veterans Affairs; and

''(B) such other Federal officials as the Secretary may consider appropriate.

''(d) TERMS.—Members of the Advisory Council appointed under subsection (c)(2) shall serve for a term of 3 years. A member of the Council appointed under such subsection may continue to serve after the expiration of the term of the members until a successor is appointed.

''(e) VACANCIES.—If a member of the Advisory Council appointed under subsection (c)(2) does not serve the full term applicable under subsection (d), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

''(f) CHAIR.—The Director shall, from among the members of the Advisory Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Advisory Council.

''(g) MEETINGS.—The Advisory Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the Director or the chair.

''(h) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—

''(1) APPOINTED MEMBERS.—Members of the Advisory Council appointed under subsection (c)(2) shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Advisory Council unless declined by the member. Such compensation may not be in an amount in excess of the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day during which such member is engaged in the performance of the duties of the Advisory Council.

''(2) EX OFFICIO MEMBERS.—Officials designated under subsection (c)(3) as ex officio members of the Advisory Council may not receive compensation for service on the Advisory Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

''(i) STAFF.—The Director shall provide to the Advisory Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

''SEC. 922. PEER REVIEW WITH RESPECT TO GRANTS AND CONTRACTS.

''(a) REQUIREMENT OF REVIEW.—

''(1) IN GENERAL.—Appropriate technical and scientific peer review shall be conducted with respect to each application for a grant, cooperative agreement, or contract under this title.

''(2) REPORTS TO DIRECTOR.—Each peer review group to which an application is submitted pursuant to paragraph (1) shall report its finding and recommendations respecting the application to the Director in such form and in such manner as the Director shall require.

''(b) APPROVAL AS PRECONDITION OF AWARDS.—The Director may not approve an application described in subsection (a)(1) unless the application is recommended for approval by a peer review group established under subsection (c).

''(c) ESTABLISHMENT OF PEER REVIEW GROUPS.—

''(1) IN GENERAL.—The Director shall establish such technical and scientific peer review groups as may be necessary to carry out this section. Such groups shall be established without regard to the provisions of title 5, United States Code, that govern appointments in the competitive service, and without regard to the provisions of chapter 51, and subchapter III of chapter 53, of such title that relate to classification and pay rates under the General Schedule.

''(2) MEMBERSHIP.—The members of any peer review group established under this section shall be appointed from among individuals who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group. Officers and employees of the United States may not constitute more than 25 percent of the membership of any such group. Such officers and employees may not receive compensation for service on such groups in addition to the compensation otherwise received for these duties carried out as such officers and employees.

''(3) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, peer review groups established under this section may continue in existence until otherwise provided by law.

''(4) QUALIFICATIONS.—Members of any peer-review group shall, at a minimum, meet the following requirements:

''(A) Such members shall agree in writing to treat information received, pursuant to their work for the group, as confidential information, except that this subparagraph shall not apply to public records and public information.

''(B) Such members shall agree in writing to recuse themselves from participation in the peer-review of specific applications which present a potential personal conflict of interest or appearance of such conflict, including employment in a directly affected organization, stock ownership, or any financial or other arrangement that might introduce bias in the process of peer-review.

''(d) AUTHORITY FOR PROCEDURAL ADJUSTMENTS IN CERTAIN CASES.—In the case of applications for financial assistance whose direct costs will not exceed $100,000, the Director may make appropriate adjustments in the procedures otherwise established by the Director for the conduct of peer review under this section. Such adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented or provider-based research, and for such other purposes as the Director may determine to be appropriate.

''(e) REGULATIONS.—The Director shall issue regulations for the conduct of peer review under this section.

''SEC. 923. CERTAIN PROVISIONS WITH RESPECT TO DEVELOPMENT, COLLECTION, AND DISSEMINATION OF DATA.

''(a) STANDARDS WITH RESPECT TO UTILITY OF DATA.—

''(1) IN GENERAL.—To ensure the utility, accuracy, and sufficiency of data collected by or for the Agency for the purpose described in section 901(b), the Director shall establish standard methods for developing and collecting such data, taking into consideration—

''(A) other Federal health data collection standards; and

''(B) the differences between types of healthcare plans, delivery systems, healthcare providers, and provider arrangements.

''(2) RELATIONSHIP WITH OTHER DEPARTMENT PROGRAMS.—In any case where standards under paragraph (1) may affect the administration of other programs carried out by the Department of Health and Human Services, including the programs under title XVIII, XIX or XXI of the Social Security Act, or may affect health information that is subject to a standard developed under part C of title XI of the Social Security Act, they shall be in the form of recommendations to the Secretary for such program.

''(b) STATISTICS AND ANALYSES.—The Director shall—

''(1) take appropriate action to ensure that statistics and analyses developed under this title are of high quality, timely, and duly comprehensive, and that the statistics are specific, standardized, and adequately analyzed and indexed; and

''(2) publish, make available, and disseminate such statistics and analyses on as wide a basis as is practicable.

''(c) AUTHORITY REGARDING CERTAIN REQUESTS.—Upon request of a public or private entity, the Director may conduct or support research or analyses otherwise authorized by this title pursuant to arrangements under which such entity will pay the cost of the services provided. Amounts received by the Director under such arrangements shall be available to the Director for obligation until expended.

''SEC. 924. DISSEMINATION OF INFORMATION.

''(a) IN GENERAL.—The Director shall—

''(1) without regard to section 501 of title 44, United States Code, promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title;

''(2) ensure that information disseminated by the Agency is science-based and objective and undertakes consultation as necessary to assess the appropriateness and usefulness of the presentation of information that is targeted to specific audiences;

''(3) promptly make available to the public data developed in such research, demonstration projects, and evaluations;

''(4) provide, in collaboration with the National Library of Medicine where appropriate, indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to healthcare to public and private entities and individuals engaged in the improvement of healthcare delivery and the general public, and undertake programs to develop new or improved methods for making such information available; and

''(5) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

''(b) PROHIBITION AGAINST RESTRICTIONS.—Except as provided in subsection (c), the Director may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

''(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Director) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Director) to its publication or release in other form.

''(d) PENALTY.—Any person who violates subsection (c) shall be subject to a civil monetary penalty of not more than $10,000 for each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act are imposed and collected.

''SEC. 925. ADDITIONAL PROVISIONS WITH RESPECT TO GRANTS AND CONTRACTS.

''(a) FINANCIAL CONFLICTS OF INTEREST.—With respect to projects for which awards of grants, cooperative agreements, or contracts are authorized to be made under this title, the Director shall by regulation define—

''(1) the specific circumstances that constitute financial interests in such projects that will, or may be reasonably expected to, create a bias in favor of obtaining results in the projects that are consistent with such interests; and

''(2) the actions that will be taken by the Director in response to any such interests identified by the Director.

''(b) REQUIREMENT OF APPLICATION.—The Director may not, with respect to any program under this title authorizing the provision of grants, cooperative agreements, or contracts, provide any such financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Director determines to be necessary to carry out the program in involved.

''(c) PROVISION OF SUPPLIES AND SERVICES IN LIEU OF FUNDS.—

''(1) IN GENERAL.—Upon the request of an entity receiving a grant, cooperative agreement, or contract under this title, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of the Department of Health and Human Services.

''(2) CORRESPONDING REDUCTION IN FUNDS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of the financial assistance involved by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Director. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

''(d) APPLICABILITY OF CERTAIN PROVISIONS WITH RESPECT TO CONTRACTS.—Contracts may be entered into under this part without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

''SEC. 926. CERTAIN ADMINISTRATIVE AUTHORITIES.

''(a) DEPUTY DIRECTOR AND OTHER OFFICERS AND EMPLOYEES.—

''(1) DEPUTY DIRECTOR.—The Director may appoint a deputy director for the Agency.

''(2) OTHER OFFICERS AND EMPLOYEES.—The Director may appoint and fix the compensation of such officers and employees as may be necessary to carry out this title. Except as otherwise provided by law, such officers and employees shall be appointed in accordance with the civil service laws and their compensation fixed in accordance with title 5, United States Code.

''(b) FACILITIES.—The Secretary, in carrying out this title—

''(1) may acquire, without regard to the Act of March 3, 1877 (40 U.S.C. 34), by lease or otherwise through the Director of General Services, buildings or portions of buildings in the District of Columbia or communities located adjacent to the District of Columbia for use for a period not to exceed 10 years; and

''(2) may acquire, construct, improve, repair, operate, and maintain laboratory, research, and other necessary facilities and equipment, and such other real or personal property (including patents) as the Secretary deems necessary.

''(c) PROVISION OF FINANCIAL ASSISTANCE.—The Director, in carrying out this title, may make grants to public and nonprofit entities and individuals, and may enter into cooperative agreements or contracts with public and private entities and individuals.

''(d) UTILIZATION OF CERTAIN PERSONNEL AND RESOURCES.—

''(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Director, in carrying out this title, may utilize personnel and equipment, facilities, and other physical resources of the Department of Health and Human Services, permit appropriate (as determined by the Secretary) entities and individuals to utilize the physical resources of such Department, and provide technical assistance and advice.

''(2) OTHER AGENCIES.—The Director, in carrying out this title, may use, with their consent, the services, equipment, personnel, information, and facilities of other Federal, State, or local public agencies, or of any foreign government, with or without reimbursement of such agencies.

''(e) CONSULTANTS.—The Secretary, in carrying out this title, may secure, from time

to time and for such periods as the Director deems advisable but in accordance with section 3109 of title 5, United States Code, the assistance and advice of consultants from the United States or abroad.

''(f) EXPERTS.—

''(1) IN GENERAL.—The Secretary may, in carrying out this title, obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Such experts or consultants shall be obtained in accordance with section 3109 of title 5, United States Code, except that the limitation in such section on the duration of service shall not apply.

''(2) TRAVEL EXPENSES.—

''(A) IN GENERAL.—Experts and consultants whose services are obtained under paragraph (1) shall be paid or reimbursed for their expenses associated with traveling to and from their assignment location in accordance with sections 5724, 5724a(a), 5724a(c), and 5726(C) of title 5, United States Code.

''(B) LIMITATION.—Expenses specified in subparagraph (A) may not be allowed in connection with the assignment of an expert or consultant whose services are obtained under paragraph (1) unless and until the expert agrees in writing to complete the entire period of assignment, or 1 year, whichever is shorter, unless separated or reassigned for reasons that are beyond the control of the expert or consultant and that are acceptable to the Secretary. If the expert or consultant violates the agreement, the money spent by the United States for the expenses specified in subparagraph (A) is recoverable from the expert or consultant as a statutory obligation owed to the United States. The Secretary may waive in whole or in part a right of recovery under this subparagraph.

''(g) VOLUNTARY AND UNCOMPENSATED SERVICES.—The Director, in carrying out this title, may accept voluntary and uncompensated services.

''SEC. 927. FUNDING.

''(a) INTENT.—To ensure that the United States's investment in biomedical research is rapidly translated into improvements in the quality of patient care, there must be a corresponding investment in research on the most effective clinical and organizational strategies for use of these findings in daily practice. The authorization levels in subsection (b) provide for a proportionate increase in healthcare research as the United States investment in biomedical research increases.

''(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this title, there are authorized to be appropriated $250,000,000 for fiscal year 2000, and such sums as may be necessary for each of the fiscal years 2001 through 2006.

''(c) EVALUATIONS.—In addition to amounts available pursuant to subsection (b) for carrying out this title, there shall be made available for such purpose, from the amounts made available pursuant to section 241 (relating to evaluations), an amount equal to 40 percent of the maximum amount authorized in such section 241 to be made available for a fiscal year.

''SEC. 928. DEFINITIONS.

''In this title:

''(1) ADVISORY COUNCIL.—The term 'Advisory Council' means the Advisory Council on Healthcare Research and Quality established under section 921.

''(2) AGENCY.—The term 'Agency' means the Agency for Healthcare Research and Quality.

''(3) DIRECTOR.—The term 'Director' means the Director for the Agency for Healthcare Research and Quality.''.

SEC. 403. REFERENCES.

Effective upon the date of enactment of this Act, any reference in law to the ''Agency for Health Care Policy and Research'' shall be deemed to be a reference to the ''Agency for Healthcare Research and Quality''.

TITLE V—ENHANCED ACCESS TO HEALTH INSURANCE COVERAGE

SEC. 501. FULL DEDUCTION OF HEALTH INSURANCE COSTS FOR SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Section 162(l)(1) of the Internal Revenue Code of 1986 (relating to allowance of deductions) is amended to read as follows:

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

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 502. FULL AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Section 220(c)(1)(A) of the Internal Revenue Code of 1986 (relating to eligible individual) is amended to read as follows:

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

''(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

''(I) which is not a high deductible health plan, and

''(II) which provides coverage for any benefit which is covered under the high deductible health plan.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 220(c)(1) of such Code is amended by striking subparagraphs (C) and (D).

(B) Section 220(c) of such Code is amended by striking paragraph (4) (defining small employer) and by redesignating paragraph (5) as paragraph (4).

(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(b) REMOVAL OF LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Section 220 of the Internal Revenue Code of 1986 (relating to medical savings accounts) is amended by striking subsections (i) and (j).

(2) MEDICARE+CHOICE.—Section 138 of such Code (relating to Medicare+Choice MSA) is amended by striking subsection (f).

(c) REDUCTION IN HIGH DEDUCTIBLE PLAN MINIMUM ANNUAL DEDUCTIBLE.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking ''$1,500'' and inserting ''$1,000'', and

(B) by striking ''$3,000'' in clause (ii) and inserting ''$2,000''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended—

(A) by striking ''1998'' and inserting ''1999''; and

(B) by striking ''1997'' and inserting ''1998''.

(d) INCREASE IN CONTRIBUTION LIMIT TO 100 PERCENT OF ANNUAL DEDUCTIBLE.—

(1) IN GENERAL.—Section 220(b)(2) of the Internal Revenue Code of 1986 (relating to monthly limitation) is amended to read as follows:

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible of the high deductible health plan of the individual.''.

(2) CONFORMING AMENDMENT.—Section 220(d)(1)(A) of such Code is amended by striking ''75 percent of''.

(e) LIMITATION ON ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Section 220(f)(4) of the Internal Revenue Code of 1986 (relating to additional tax on distributions not used for qualified medical expenses) is amended by adding at the end the following:

''(D) EXCEPTION IN CASE OF SUFFICIENT ACCOUNT BALANCE.—Subparagraph (A) shall not apply to any payment or distribution in any taxable year, but only to the extent such payment or distribution does not reduce the fair market value of the assets of the medical savings account to an amount less than the annual deductible for the high deductible health plan of the account holder (determined as of January 1 of the calendar year in which the taxable year begins).''.

(f) TREATMENT OF NETWORK-BASED MANAGED CARE PLANS.—Section 220(c)(2)(B) of the Internal Revenue Code of 1986 (relating to special rules for high deductible health plans) is amended by adding at the end the following:

''(iii) TREATMENT OF NETWORK-BASED MANAGED CARE PLANS.—A plan that provides health care services through a network of contracted or affiliated health care providers, if the benefits provided when services are obtained through network providers meet the requirements of subparagraph (A), shall not fail to be treated as a high deductible health plan by reason of providing benefits for services rendered by providers who are not members of the network, so long as the annual deductible and annual limit on out-of-pocket expenses applicable to services received from non-network providers are not lower than those applicable to services received from the network providers.''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 503. PERMITTING CONTRIBUTION TOWARDS MEDICAL SAVINGS ACCOUNT THROUGH FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP).

(a) AUTHORITY TO CONTRACT FOR CATASTROPHIC PLANS.—Section 8902 of title 5, United States Code, is amended by adding at the end the following:

''(p)(1) The Office shall contract under this chapter for a catastrophic plan with any qualified carrier that—

''(A) offers such a plan; and

''(B) as of the date of enactment of the Patients' Bill of Rights Plus Act, offers a health benefits plan under this chapter.

''(2) The Office may contract under this chapter for a catastrophic plan with any qualified carrier that—

''(A) offers such a plan; but

''(B) does not satisfy the requirement under paragraph (1)(B).''.

(b) GOVERNMENT CONTRIBUTION TO MEDICAL SAVINGS ACCOUNT.—

(1) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by adding at the end the following:

''(j)(1) In the case of an employee or annuitant who is enrolled in a catastrophic plan described by section 8903(5), there shall be a Government contribution under this subsection to a medical savings account established or maintained for the benefit of the individual. The contribution under this subsection shall be in addition to the Government contribution under subsection (b).

''(2) The amount of the Government contribution under this subsection with respect to an individual is equal to the amount by which—

''(A) the maximum contribution allowed under subsection (b)(1) with respect to any employee or annuitant, exceeds

''(B) the amount of the Government contribution actually made with respect to the individual under subsection (b) for coverage under the catastrophic plan.

''(3) The Government contributions under this subsection shall be paid into a medical savings account (designated by the individual involved) in a manner that is specified by the Office and consistent with the timing of contributions under subsection (b).

''(4) Subsections (f) and (g) shall apply to contributions under this section in the same manner as they apply to contributions under subsection (b).

''(5) For the purpose of this subsection, the term 'medical savings account' has the meaning given such term by section 220(d) of the Internal Revenue Code of 1986.''.

(2) ALLOWING PAYMENT OF FULL AMOUNT OF CHARGE FOR CATASTROPHIC PLAN.—Section 8906(b)(2) of such title is amended by inserting ''(or 100 percent of the subscription charge in the case of a catastrophic plan)'' after ''75 percent of the subscription charge''.

(c) OFFERING OF CATASTROPHIC PLANS.—

(1) IN GENERAL.—Section 8903 of title 5, United States Code, is amended by adding at the end the following:

''(5) CATASTROPHIC PLANS.—(A) One or more plans described in paragraph (1), (2), or (3), but which provide benefits of the types referred to by paragraph (5) of section 8904(a), instead of the types referred to in paragraphs (1), (2), and (3) of such section.

''(B) Nothing in this section shall be considered—

''(i) to prevent a carrier from simultaneously offering a plan described by subparagraph (A) and a plan described by paragraph (1) or (2);

''(ii) to require that a catastrophic plan offer two levels of benefits; or

''(iii) to allow, in any contract year, for—

''(I) more than one plan to be offered which satisfies both subparagraph (A) and paragraph (1) (subject to clause (ii)); and

''(II) more than one plan which satisfies both subparagraph (A) and paragraph (2) (subject to clause (ii)).''.

(2) TYPES OF BENEFITS.—Section 8904(a) of such title is amended by inserting after paragraph (4) the following new paragraph:

''(5) CATASTROPHIC PLANS.—Benefits of the types named under paragraph (1) or (2) of this subsection or both, except that the plan shall meet the annual deductible and annual out-of-pocket expenses requirements under section 220(c)(2) of the Internal Revenue Code of 1986.''.

(3) DETERMINING LEVEL OF GOVERNMENT CONTRIBUTIONS.—Section 8906(b) of such title is amended by adding at the end the following: ''Subscription charges for medical savings accounts shall be deemed to be the amount of Government contributions made under subsection (j)(2).''.

(d) CONFORMING AMENDMENTS.—

(1) ADDITIONAL HEALTH BENEFITS PLANS.—Section 8903a of title 5, United States Code, is amended by redesignating subsection (d) as subsection (e) and by inserting after subsection (c) the following:

''(d) The plans under this section may include one or more plans, otherwise allowable under this section, that satisfy the requirements of clauses (i) and (ii) of section 8903(5)(A).''.

(2) REFERENCE.—Section 8909(d) of title 5, United States Code, is amended by striking ''8903a(d)'' and inserting ''8903a(e)''.

(e) REFERENCES.—Section 8903 of title 5, United States Code, is amended by adding at the end (as a flush left sentence) the following:

''The Office shall prescribe regulations under which the requirements of section 8902(c), 8902(n), 8909(e), and any other provision of this chapter that applies with respect to a plan described by paragraph (1), (2), (3), or (4) of this section shall apply with respect to the corresponding plan under paragraph (5) of this section. Similar regulations shall be prescribed with respect to any plan under section 8903a(d).''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to contract terms beginning on or after January 1, 2000.

SEC. 504. CARRYOVER OF UNUSED BENEFITS FROM CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsections (h) and (i) as subsections (i) and (j) and by inserting after subsection (g) the following new subsection:

''(h) ALLOWANCE OF CARRYOVERS OF UNUSED BENEFITS TO LATER TAXABLE YEARS.—

''(1) IN GENERAL.—For purposes of this title—

''(A) notwithstanding subsection (d)(2), a plan or other arrangement shall not fail to be treated as a cafeteria plan or flexible spending or similar arrangement, and

''(B) no amount shall be required to be included in gross income by reason of this section or any other provision of this chapter,

solely because under such plan or other arrangement any nontaxable benefit which is unused as of the close of a taxable year may be carried forward to 1 or more succeeding taxable years.

''(2) LIMITATION.—Paragraph (1) shall not apply to amounts carried from a plan to the extent such amounts exceed $500 (applied on an annual basis). For purposes of this paragraph, all plans and arrangements maintained by an employer or any related person shall be treated as 1 plan.

''(3) ALLOWANCE OF ROLLOVER.—

''(A) IN GENERAL.—In the case of any unused benefit described in paragraph (1) which consists of amounts in a health flexible spending account or dependent care flexible spending account, the plan or arrangement shall provide that a participant may elect, in lieu of such carryover, to have such amounts distributed to the participant.

''(B) AMOUNTS NOT INCLUDED IN INCOME.—Any distribution under subparagraph (A) shall not be included in gross income to the extent that such amount is transferred in a trustee-to-trustee transfer, or is contributed within 60 days of the date of the distribution, to—

''(i) a qualified cash or deferred arrangement described in section 401(k),

''(ii) a plan under which amounts are contributed by an individual's employer for an annuity contract described in section 403(b),

''(iii) an eligible deferred compensation plan described in section 457, or

''(iv) a medical savings account (within the meaning of section 220).

Any amount rolled over under this subparagraph shall be treated as a rollover contribution for the taxable year from which the unused amount would otherwise be carried.

''(C) TREATMENT OF ROLLOVER.—Any amount rolled over under subparagraph (B) shall be treated as an eligible rollover under section 220, 401(k), 403(b), or 457, whichever is applicable, and shall be taken into account in applying any limitation (or participation requirement) on employer or employee contributions under such section or any other provision of this chapter for the taxable year of the rollover.

''(4) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 1999, the $500 amount under paragraph (2) shall be adjusted at the same time and in the same manner as under section 415(d)(2), except that the base period taken into account shall be the calendar quarter beginning October 1, 1998, and any increase which is not a multiple of $50 shall be rounded to the next lowest multiple of $50.

''(5) APPLICABILITY.—This subsection shall apply to taxable years beginning after December 31, 1999.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

TITLE VI—PROVISIONS RELATING TO LONG-TERM CARE INSURANCE

SEC. 601. INCLUSION OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS IN CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125(f) of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by striking the last sentence and inserting the following: ''Such term includes any qualified long-term care insurance contract.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 602. DEDUCTION FOR PREMIUMS FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 222 as section 223 and by inserting after section 221 the following:

''SEC. 222. PREMIUMS FOR LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a deduction an amount equal to 100 percent of the amount paid during the taxable year for any coverage for qualified long-term care services (as defined in section 7702B(c)) or any qualified long-term care insurance contract (as defined in section 7702B(b)) which constitutes medical care for the taxpayer, his spouse, and dependents.

''(b) LIMITATIONS.—

''(1) DEDUCTION NOT AVAILABLE TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), subsection (a) shall not apply to any taxpayer for any calendar month for which the taxpayer is eligible to participate in any plan which includes coverage for qualified long-term care services (as so defined) or is a qualified long-term care insurance contract (as so defined) maintained by any employer (or former employer) of the taxpayer or of the spouse of the taxpayer.

''(B) CONTINUATION COVERAGE.—Coverage shall not be treated as subsidized for purposes of this paragraph if—

''(i) such coverage is continuation coverage (within the meaning of section 4980B(f)) required to be provided by the employer, and

''(ii) the taxpayer or the taxpayer's spouse is required to pay a premium for such coverage in an amount not less than 100 percent of the applicable premium (within the meaning of section 4980B(f)(4)) for the period of such coverage.

''(2) LIMITATION ON LONG-TERM CARE PREMIUMS.—In the case of a qualified long-term care insurance contract (as so defined), only eligible long-term care premiums (as defined in section 213(d)(10)) shall be taken into account under subsection (a)(2).

''(c) SPECIAL RULES.—For purposes of this section—

''(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).

''(2) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this section shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.''.

(b) CONFORMING AMENDMENTS.—

(1) Subsection (a) of section 62 of the Internal Revenue Code of 1986 is amended by inserting after paragraph (17) the following:

''(18) LONG-TERM CARE INSURANCE COSTS OF CERTAIN INDIVIDUALS.—The deduction allowed by section 222.''.

(2) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

''Sec. 222. Premiums for long-term care insurance.

''Sec. 223. Cross reference.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 603. STUDY OF LONG-TERM CARE NEEDS IN THE 21ST CENTURY.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall provide, in accordance with this section, for a study in order to determine—

(1) future demand for long-term health care services (including institutional and home and community-based services) in the United States in order to meet the needs in the 21st century; and

(2) long-term options to finance the provision of such services.

(b) DETAILS.—The study conducted under subsection (a) shall include the following:

(1) An identification of the relevant demographic characteristics affecting demand for long-term health care services, at least through the year 2030.

(2) The viability and capacity of community-based and other long-term health care services under different federal programs, including through the medicare and medicaid programs, grants to States, housing services, and changes in tax policy.

(3) How to improve the quality of long-term health care services.

(4) The integration of long-term health care services for individuals between different classes of health care providers (such as hospitals, nursing facilities, and home care agencies) and different Federal programs (such as the medicare and medicaid programs).

(5) The possibility of expanding private sector initiatives, including long-term care insurance, to meet the need to finance such services.

(6) An examination of the effect of enactment of the Health Insurance Portability and Accountability Act of 1996 on the provision and financing of long-term health care services, including on portability and affordability of private long-term care insurance, the impact of insurance options on low-income older Americans, and the options for eligibility to improve access to such insurance.

(7) The financial impact of the provision of long-term health care services on caregivers and other family members.

(c) REPORT AND RECOMMENDATIONS.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall provide for a report on the study under this section.

(2) RECOMMENDATIONS.—The report under paragraph (1) shall include findings and recommendations regarding each of the following:

(A) The most effective and efficient manner that the Federal government may use its resources to educate the public on planning for needs for long-term health care services.

(B) The public, private, and joint public-private strategies for meeting identified needs for long-term health care services.

(C) The role of States and local communities in the financing of long-term health care services.

(3) INCLUSION OF COST ESTIMATES.—The report under paragraph (1) shall include cost estimates of the various options for which recommendations are made.

(d) CONDUCT OF STUDY.—

(1) USE OF INSTITUTE OF MEDICINE.—The Secretary of Health and Human Services shall seek to enter into an appropriate arrangement with the Institute of Medicine of the National Academy of Sciences to conduct the study under this section. If such an arrangement cannot be made, the Secretary may provide for the conduct of the study by any other qualified non-governmental entity.

(2) CONSULTATION.—The study should be conducted under this section in consultation with experts from a wide-range of groups from the public and private sectors.

TITLE VII—INDIVIDUAL RETIREMENT PLANS

SEC. 701. MODIFICATION OF INCOME LIMITS ON CONTRIBUTIONS AND ROLLOVERS TO ROTH IRAS.

(a) INCREASE IN AGI LIMIT FOR ROLLOVER CONTRIBUTIONS.—Clause (i) of section 408A(c)(3)(A) of the Internal Revenue Code of 1986 (relating to rollover from IRA), as redesignated by subsection (a), is amended by striking ''$100,000'' and inserting ''$1,000,000''.

(b) CONFORMING AMENDMENTS.—

(1)(A) Subparagraph (B) of section 408A(c)(3) of the Internal Revenue Code of 1986, as redesignated by subsection (a), is amended to read as follows:

''(B) DEFINITION OF ADJUSTED GROSS INCOME.—For purposes of subparagraph (A), adjusted gross income shall be determined—

''(i) after application of sections 86 and 469, and

''(ii) without regard to sections 135, 137, 221, and 911, the deduction allowable under section 219, or any amount included in gross income under subsection (d)(3).''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 1999.

(2)(A) Subparagraph (B) of section 408A(c)(3) of such Code, as amended by paragraph (1), is amended to read as follows:

''(B) DEFINITION OF ADJUSTED GROSS INCOME.—For purposes of subparagraph (A), adjusted gross income shall be determined—

''(i) after application of sections 86 and 469, and

''(ii) without regard to sections 135, 137, 221, and 911, the deduction allowable under section 219, or any amount included in gross income under subsection (d)(3) or by reason of a required distribution under a provision described in paragraph (5).''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 2004.

(c) EFFECTIVE DATE.—Except as otherwise provided in this section, the amendments made by this section shall apply to taxable years beginning after December 31, 1999.

TITLE VIII—REVENUE PROVISIONS

SEC. 801. MODIFICATION TO FOREIGN TAX CREDIT CARRYBACK AND CARRYOVER PERIODS.

(a) IN GENERAL.—Section 904(c) of the Internal Revenue Code of 1986 (relating to limitation on credit) is amended—

(1) by striking ''in the second preceding taxable year,'', and

(2) by striking ''or fifth'' and inserting ''fifth, sixth, or seventh''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to credits arising in taxable years beginning after December 31, 2001.

SEC. 802. LIMITATION ON USE OF NON-ACCRUAL EXPERIENCE METHOD OF ACCOUNTING.

(a) IN GENERAL.—Section 448(d)(5) of the Internal Revenue Code of 1986 (relating to special rule for services) is amended—

(1) by inserting ''in fields described in paragraph (2)(A)'' after ''services by such person'', and

(2) by inserting ''CERTAIN PERSONAL'' before ''SERVICES'' in the heading.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

(2) CHANGE IN METHOD OF ACCOUNTING.—In the case of any taxpayer required by the amendments made by this section to change its method of accounting for its first taxable year ending after the date of the enactment of this Act—

(A) such change shall be treated as initiated by the taxpayer,

(B) such change shall be treated as made with the consent of the Secretary of the Treasury, and

(C) the net amount of the adjustments required to be taken into account by the taxpayer under section 481 of the Internal Revenue Code of 1986 shall be taken into account over a period (not greater than 4 taxable years) beginning with such first taxable year.

SEC. 803. RETURNS RELATING TO CANCELLATIONS OF INDEBTEDNESS BY ORGANIZATIONS LENDING MONEY.

(a) IN GENERAL.—Paragraph (2) of section 6050P(c) of the Internal Revenue Code of 1986 (relating to definitions and special rules) is amended by striking ''and'' at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting '', and'', and by inserting after subparagraph (C) the following new subparagraph:

''(D) any organization a significant trade or business of which is the lending of money.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges of indebtedness after December 31, 1999.

SEC. 804. EXTENSION OF INTERNAL REVENUE SERVICE USER FEES.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following new section:

''SEC. 7527. INTERNAL REVENUE SERVICE USER FEES.

''(a) GENERAL RULE.—The Secretary shall establish a program requiring the payment of user fees for—

''(1) requests to the Internal Revenue Service for ruling letters, opinion letters, and determination letters, and

''(2) other similar requests.

''(b) PROGRAM CRITERIA.—

''(1) IN GENERAL.—The fees charged under the program required by subsection (a)—

''(A) shall vary according to categories (or subcategories) established by the Secretary,

''(B) shall be determined after taking into account the average time for (and difficulty of) complying with requests in each category (and subcategory), and

''(C) shall be payable in advance.

''(2) EXEMPTIONS, ETC.—The Secretary shall provide for such exemptions (and reduced fees) under such program as the Secretary determines to be appropriate.

''(3) AVERAGE FEE REQUIREMENT.—The average fee charged under the program required by subsection (a) shall not be less than the amount determined under the following table:

''Category	Average Fee
Employee plan ruling and opinion ..	$250
Exempt organization ruling	$350
Employee plan determination	$300
Exempt organization determination.	$275
Chief counsel ruling	$200.

''(c) TERMINATION.—No fee shall be imposed under this section with respect to requests made after September 30, 2009.''.

(b) CONFORMING AMENDMENTS.—

(1) The table of sections for chapter 77 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 7527. Internal Revenue Service user fees.''.

(2) Section 10511 of the Revenue Act of 1987 is repealed.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to requests made after the date of the enactment of this Act.

SEC. 805. PROPERTY SUBJECT TO A LIABILITY TREATED IN SAME MANNER AS ASSUMPTION OF LIABILITY.

(a) REPEAL OF PROPERTY SUBJECT TO A LIABILITY TEST.—

(1) SECTION 357.—Section 357(a)(2) of the Internal Revenue Code of 1986 (relating to assumption of liability) is amended by striking '', or acquires from the taxpayer property subject to a liability''.

(2) SECTION 358.—Section 358(d)(1) of such Code (relating to assumption of liability) is amended by striking ''or acquired from the taxpayer property subject to a liability''.

(3) SECTION 368.—

(A) Section 368(a)(1)(C) of such Code is amended by striking '', or the fact that property acquired is subject to a liability,''.

(B) The last sentence of section 368(a)(2)(B) of such Code is amended by striking '', and the amount of any liability to which any property acquired from the acquiring corporation is subject,''.

(b) CLARIFICATION OF ASSUMPTION OF LIABILITY.—

(1) IN GENERAL.—Section 357 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(d) DETERMINATION OF AMOUNT OF LIABILITY ASSUMED.—

''(1) IN GENERAL.—For purposes of this section, section 358(d), section 362(d), section 368(a)(1)(C), and section 368(a)(2)(B), except as provided in regulations—

''(A) a recourse liability (or portion thereof) shall be treated as having been assumed if, as determined on the basis of all facts and circumstances, the transferee has agreed to, and is expected to, satisfy such liability (or portion), whether or not the transferor has been relieved of such liability, and

''(B) except to the extent provided in paragraph (2), a nonrecourse liability shall be treated as having been assumed by the transferee of any asset subject to such liability.

''(2) EXCEPTION FOR NONRECOURSE LIABILITY.—The amount of the nonrecourse liability treated as described in paragraph (1)(B) shall be reduced by the lesser of—

''(A) the amount of such liability which an owner of other assets not transferred to the transferee and also subject to such liability has agreed with the transferee to, and is expected to, satisfy, or

''(B) the fair market value of such other assets (determined without regard to section 7701(g)).

''(3) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this subsection and section 362(d). The Secretary may also prescribe regulations which provide that the manner in which a liability is treated as assumed under this subsection is applied, where appropriate, elsewhere in this title.''.

(2) LIMITATION ON BASIS INCREASE ATTRIBUTABLE TO ASSUMPTION OF LIABILITY.—Section 362 of such Code is amended by adding at the end the following new subsection:

''(d) LIMITATION ON BASIS INCREASE ATTRIBUTABLE TO ASSUMPTION OF LIABILITY.—

''(1) IN GENERAL.—In no event shall the basis of any property be increased under subsection (a) or (b) above the fair market value of such property (determined without regard to section 7701(g)) by reason of any gain recognized to the transferor as a result of the assumption of a liability.

''(2) TREATMENT OF GAIN NOT SUBJECT TO TAX.—Except as provided in regulations, if—

''(A) gain is recognized to the transferor as a result of an assumption of a nonrecourse liability by a transferee which is also secured by assets not transferred to such transferee, and

''(B) no person is subject to tax under this title on such gain,

then, for purposes of determining basis under subsections (a) and (b), the amount of gain recognized by the transferor as a result of the assumption of the liability shall be determined as if the liability assumed by the transferee equaled such transferee's ratable portion of such liability determined on the basis of the relative fair market values (determined without regard to section 7701(g)) of all of the assets subject to such liability.''.

(c) APPLICATION TO PROVISIONS OTHER THAN SUBCHAPTER C.—

(1) SECTION 584.—Section 584(h)(3) of the Internal Revenue Code of 1986 is amended—

(A) by striking '', and the fact that any property transferred by the common trust fund is subject to a liability,'' in subparagraph (A), and

(B) by striking clause (ii) of subparagraph (B) and inserting:

''(ii) ASSUMED LIABILITIES.—For purposes of clause (i), the term 'assumed liabilities' means any liability of the common trust fund assumed by any regulated investment company in connection with the transfer referred to in paragraph (1)(A).

''(C) ASSUMPTION.—For purposes of this paragraph, in determining the amount of any liability assumed, the rules of section 357(d) shall apply.''.

(2) SECTION 1031.—The last sentence of section 1031(d) of such Code is amended—

(A) by striking ''assumed a liability of the taxpayer or acquired from the taxpayer property subject to a liability'' and inserting ''assumed (as determined under section 357(d)) a liability of the taxpayer'', and

(B) by striking ''or acquisition (in the amount of the liability)''.

(d) CONFORMING AMENDMENTS.—

(1) Section 351(h)(1) of the Internal Revenue Code of 1986 is amended by striking '', or acquires property subject to a liability,''.

(2) Section 357 of such Code is amended by striking ''or acquisition'' each place it appears in subsection (a) or (b).

(3) Section 357(b)(1) of such Code is amended by striking ''or acquired''.

(4) Section 357(c)(1) of such Code is amended by striking '', plus the amount of the liabilities to which the property is subject,''.

(5) Section 357(c)(3) of such Code is amended by striking ''or to which the property transferred is subject''.

(6) Section 358(d)(1) of such Code is amended by striking ''or acquisition (in the amount of the liability)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers after October 19, 1998.

SEC. 806. CHARITABLE SPLIT-DOLLAR LIFE INSURANCE, ANNUITY, AND ENDOWMENT CONTRACTS.

(a) IN GENERAL.—Subsection (f) of section 170 of the Internal Revenue Code of 1986 (relating to disallowance of deduction in certain cases and special rules) is amended by adding at the end the following new paragraph:

''(10) SPLIT-DOLLAR LIFE INSURANCE, ANNUITY, AND ENDOWMENT CONTRACTS.—

''(A) IN GENERAL.—Nothing in this section or in section 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522 shall be construed to allow a deduction, and no deduction shall be allowed, for any transfer to or for the use of an organization described in subsection (c) if in connection with such transfer—

''(i) the organization directly or indirectly pays, or has previously paid, any premium on any personal benefit contract with respect to the transferor, or

''(ii) there is an understanding or expectation that any person will directly or indirectly pay any premium on any personal benefit contract with respect to the transferor.

''(B) PERSONAL BENEFIT CONTRACT.—For purposes of subparagraph (A), the term 'personal benefit contract' means, with respect to the transferor, any life insurance, annuity, or endowment contract if any direct or indirect beneficiary under such contract is the transferor, any member of the transferor's family, or any other person (other than an organization described in subsection (c)) designated by the transferor.

''(C) APPLICATION TO CHARITABLE REMAINDER TRUSTS.—In the case of a transfer to a trust referred to in subparagraph (E), references in subparagraphs (A) and (F) to an organization described in subsection (c) shall be treated as a reference to such trust.

''(D) EXCEPTION FOR CERTAIN ANNUITY CONTRACTS.—If, in connection with a transfer to or for the use of an organization described in subsection (c), such organization incurs an obligation to pay a charitable gift annuity (as defined in section 501(m)) and such organization purchases any annuity contract to fund such obligation, persons receiving payments under the charitable gift annuity shall not be treated for purposes of subparagraph (B) as indirect beneficiaries under such contract if—

''(i) such organization possesses all of the incidents of ownership under such contract,

''(ii) such organization is entitled to all the payments under such contract, and

''(iii) the timing and amount of payments under such contract are substantially the same as the timing and amount of payments to each such person under such obligation (as such obligation is in effect at the time of such transfer).

''(E) EXCEPTION FOR CERTAIN CONTRACTS HELD BY CHARITABLE REMAINDER TRUSTS.—A person shall not be treated for purposes of subparagraph (B) as an indirect beneficiary under any life insurance, annuity, or endowment contract held by a charitable remainder annuity trust or a charitable remainder unitrust (as defined in section 664(d)) solely by reason of being entitled to any payment referred to in paragraph (1)(A) or (2)(A) of section 664(d) if—

''(i) such trust possesses all of the incidents of ownership under such contract, and

''(ii) such trust is entitled to all the payments under such contract.

''(F) EXCISE TAX ON PREMIUMS PAID.—

''(i) IN GENERAL.—There is hereby imposed on any organization described in subsection (c) an excise tax equal to the premiums paid by such organization on any life insurance, annuity, or endowment contract if the payment of premiums on such contract is in connection with a transfer for which a deduction is not allowable under subparagraph (A), determined without regard to when such transfer is made.

''(ii) PAYMENTS BY OTHER PERSONS.—For purposes of clause (i), payments made by any other person pursuant to an understanding or expectation referred to in subparagraph (A) shall be treated as made by the organization.

''(iii) REPORTING.—Any organization on which tax is imposed by clause (i) with respect to any premium shall file an annual return which includes—

''(I) the amount of such premiums paid during the year and the name and TIN of each beneficiary under the contract to which the premium relates, and

''(II) such other information as the Secretary may require.

The penalties applicable to returns required under section 6033 shall apply to returns required under this clause. Returns required under this clause shall be furnished at such time and in such manner as the Secretary shall by forms or regulations require.

''(iv) CERTAIN RULES TO APPLY.—The tax imposed by this subparagraph shall be treated as imposed by chapter 42 for purposes of this title other than subchapter B of chapter 42.

''(G) SPECIAL RULE WHERE STATE REQUIRES SPECIFICATION OF CHARITABLE GIFT ANNUITANT IN CONTRACT.—In the case of an obligation to pay a charitable gift annuity referred to in subparagraph (D) which is entered into under the laws of a State which requires, in order for the charitable gift annuity to be exempt from insurance regulation by such State, that each beneficiary under the charitable gift annuity be named as a beneficiary under an annuity contract issued by an insurance company authorized to transact business in such State, the requirements of clauses (i) and (ii) of subparagraph (D) shall be treated as met if—

''(i) such State law requirement was in effect on February 8, 1999,

''(ii) each such beneficiary under the charitable gift annuity is a bona fide resident of such State at the time the obligation to pay a charitable gift annuity is entered into, and

''(iii) the only persons entitled to payments under such contract are persons entitled to payments as beneficiaries under such obligation on the date such obligation is entered into.

''(H) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out the purposes of this paragraph, including regulations to prevent the avoidance of such purposes.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this section, the amendment made by this section shall apply to transfers made after February 8, 1999.

(2) EXCISE TAX.—Except as provided in paragraph (3) of this subsection, section 170(f)(10)(F) of the Internal Revenue Code of 1986 (as added by this section) shall apply to premiums paid after the date of the enactment of this Act.

(3) REPORTING.—Clause (iii) of such section 170(f)(10)(F) shall apply to premiums paid after February 8, 1999 (determined as if the tax imposed by such section applies to premiums paid after such date).

SEC. 807. TRANSFER OF EXCESS DEFINED BENEFIT PLAN ASSETS FOR RETIREE HEALTH BENEFITS.

(a) EXTENSION.—

(1) IN GENERAL.—Section 420(b)(5) of the Internal Revenue Code of 1986 (relating to expiration) is amended by striking ''in any taxable year beginning after December 31, 2000'' and inserting ''made after September 30, 2009''.

(2) CONFORMING AMENDMENTS.—

(A) Section 101(e)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(e)(3)) is amended by striking ''1995'' and inserting ''2001''.

(B) Section 403(c)(1) of such Act (29 U.S.C. 1103(c)(1)) is amended by striking ''1995'' and inserting ''2001''.

(C) Paragraph (13) of section 408(b) of such Act (29 U.S.C. 1108(b)(13)) is amended—

(i) by striking ''in a taxable year beginning before January 1, 2001'' and inserting ''made before October 1, 2009'', and

(ii) by striking ''1995'' and inserting ''2001''.

(b) APPLICATION OF MINIMUM COST REQUIREMENTS.—

(1) IN GENERAL.—Section 420(c)(3) of the Internal Revenue Code of 1986 is amended to read as follows:

''(3) MINIMUM COST REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met if each group health plan or arrangement under which applicable health benefits are provided provides that the applicable employer cost for each taxable year during the cost maintenance period shall not be less than the higher of the applicable employer costs for each of the 2 taxable years immediately preceding the taxable year of the qualified transfer.

''(B) APPLICABLE EMPLOYER COST.—For purposes of this paragraph, the term 'applicable employer cost' means, with respect to any taxable year, the amount determined by dividing—

''(i) the qualified current retiree health liabilities of the employer for such taxable year determined—

''(I) without regard to any reduction under subsection (e)(1)(B), and

''(II) in the case of a taxable year in which there was no qualified transfer, in the same manner as if there had been such a transfer at the end of the taxable year, by

''(ii) the number of individuals to whom coverage for applicable health benefits was provided during such taxable year.

''(C) ELECTION TO COMPUTE COST SEPARATELY.—An employer may elect to have this paragraph applied separately with respect to individuals eligible for benefits under title XVIII of the Social Security Act at any time during the taxable year and with respect to individuals not so eligible.

''(D) COST MAINTENANCE PERIOD.—For purposes of this paragraph, the term 'cost maintenance period' means the period of 5 taxable years beginning with the taxable year in which the qualified transfer occurs. If a taxable year is in 2 or more overlapping cost maintenance periods, this paragraph shall be applied by taking into account the highest applicable employer cost required to be provided under subparagraph (A) for such taxable year.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 420(b)(1)(C)(iii) of such Code is amended by striking ''benefits'' and inserting ''cost''.

(B) Section 420(e)(1)(D) of such Code is amended by striking ''and shall not be subject to the minimum benefit requirements of subsection (c)(3)'' and inserting ''or in calculating applicable employer cost under subsection (c)(3)(B)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to qualified transfers occurring after December 31, 2000, and before October 1, 2009.

SEC. 808. LIMITATIONS ON WELFARE BENEFIT FUNDS OF 10 OR MORE EMPLOYER PLANS.

(a) 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.''.

(b) LIMITATION ON USE OF AMOUNTS FOR OTHER PURPOSES.—Section 4976(b) of the Internal Revenue Code of 1986 (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.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

SEC. 809. MODIFICATION OF INSTALLMENT METHOD AND REPEAL OF INSTALLMENT METHOD FOR ACCRUAL METHOD TAXPAYERS.

(a) REPEAL OF INSTALLMENT METHOD FOR ACCRUAL BASIS TAXPAYERS.—

(1) IN GENERAL.—Subsection (a) of section 453 of the Internal Revenue Code of 1986 (relating to installment method) is amended to read as follows:

''(a) USE OF INSTALLMENT METHOD.—

''(1) IN GENERAL.—Except as otherwise provided in this section, income from an installment sale shall be taken into account for purposes of this title under the installment method.

''(2) ACCRUAL METHOD TAXPAYER.—The installment method shall not apply to income from an installment sale if such income would be reported under an accrual method of accounting without regard to this section.

The preceding sentence shall not apply to a disposition described in subparagraph (A) or (B) of subsection (l)(2).''.

(2) CONFORMING AMENDMENTS.—Sections 453(d)(1), 453(i)(1), and 453(k) of such Code are each amended by striking ''(a)'' each place it appears and inserting ''(a)(1)''.

(b) MODIFICATION OF PLEDGE RULES.—Paragraph (4) of section 453A(d) of the Internal Revenue Code of 1986 (relating to pledges, etc., of installment obligations) is amended by adding at the end the following: ''A payment shall be treated as directly secured by an interest in an installment obligation to

the extent an arrangement allows the taxpayer to satisfy all or a portion of the indebtedness with the installment obligation.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to sales or other dispositions occurring on or after the date of the enactment of this Act.

SEC. 810. INCLUSION OF CERTAIN VACCINES AGAINST STREPTOCOCCUS PNEUMONIAE TO LIST OF TAXABLE VACCINES.

(a) IN GENERAL.—Section 4132(a)(1) of the Internal Revenue Code of 1986 (defining taxable vaccine) is amended by adding at the end the following new subparagraph:

''(L) Any conjugate vaccine against streptococcus pneumoniae.''.

(b) EFFECTIVE DATE.—

(1) SALES.—The amendment made by this section shall apply to vaccine sales beginning on the day after the date on which the Centers for Disease Control makes a final recommendation for routine administration to children of any conjugate vaccine against streptococcus pneumoniae.

(2) DELIVERIES.—For purposes of paragraph (1), in the case of sales on or before the date described in such paragraph for which delivery is made after such date, the delivery date shall be considered the sale date.

TITLE IX—MISCELLANEOUS PROVISIONS

SEC. 901. MEDICARE COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) FINDING.—The Senate finds that implementing competitive pricing in the medicare program under title XVIII of the Social Security Act is an important goal.

(b) PROHIBITION ON IMPLEMENTATION OF PROJECT IN CERTAIN AREAS.—Notwithstanding subsection (b) of section 4011 of the Balanced Budget Act of 1997 (Public Law 105–33)), the Secretary of Health and Human Services may not implement the Medicare Competitive Pricing Demonstration Project (operated by the Secretary of Health and Human Services pursuant to such section) in Kansas City, Missouri or Kansas City, Kansas, or in any area in Arizona.

(c) MORATORIUM ON IMPLEMENTATION OF PROJECT IN ANY AREA UNTIL JANUARY, 1, 2001.—Notwithstanding any provision of section 4011 of the Balanced Budget Act of 1997 (Public Law 105–33)), the Secretary of Health and Human Services may not implement the Medicare Competitive Pricing Demonstration Project in any area before January 1, 2001.

(d) STUDY AND REPORT TO CONGRESS.—

(1) STUDY.—The Secretary of Health and Human Services, in conjunction with the Competitive Pricing Advisory Committee, shall conduct a study on the different approaches of implementing the Medicare Competitive Pricing Demonstration Project on a voluntary basis.

(2) REPORT.—Not later than June 30, 2000, the Secretary of Health and Human Services shall submit a report to Congress which shall contain a detailed description of the study conducted under paragraph (1), together with the recommendations of the Secretary and the Competitive Pricing Advisory Committee regarding the implementation of the Medicare Competitive Pricing Demonstration Project.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico, under a previous order, is recognized for up to 10 minutes.

AUTHORITY FOR COMMITTEES TO REPORT

Mr. DOMENICI. Mr. President, I ask unanimous consent that notwithstanding the adjournment of the Senate, the committees have until 3 p.m. today in order to file committee-reported legislation.

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

ORDERS FOR MONDAY, JULY 19, 1999

Mr. DOMENICI. This is on behalf of the leader, and it is already concurred in by the minority leader.

Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until the hour of 12 noon on Monday, July 19. I further ask unanimous consent that on Monday, immediately following the prayer, the Journal of proceedings be approved to date, the morning hour be deemed to have expired, the time for the two leaders be reserved for their use later in the day, and that the Senate then stand in a period of morning business until 1 p.m. with Senators speaking for up to 5 minutes each with the following exceptions: Senator VOINOVICH, 15 minutes; Senator BAUCUS, 15 minutes.

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

PROGRAM

Mr. DOMENICI. For the information of all Senators, the Senate will convene at 12 noon and immediately begin a period of morning business until 1 p.m. Following morning business, the Senate will begin debate on a motion to proceed to the intelligence authorization bill. As a reminder, a cloture motion on the motion to proceed to the intelligence authorization bill was filed on Friday. That vote has been scheduled to take place at 10:30 a.m. on Tuesday. The leader has announced there will be no votes during Monday's session of the Senate. Therefore, the first vote on next week will take place at 10:30 a.m. on Tuesday.

ORDER FOR ADJOURNMENT

Mr. DOMENICI. If there is no further business to come before the Senate, I now ask unanimous consent that the Senate stand in adjournment under the previous order, following the remarks of Senators DORGAN and KENNEDY.

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

Mr. DOMENICI. I thank the Chair, and I thank the minority for concurring.

THE NON-SOCIAL SECURITY SURPLUS

Mr. DOMENICI. Mr. President, I will take a little time to speak about the surplus that we have over and above Social Security, which we call the non-Social Security surplus. That is the amount by which the taxpayers of this country have paid more into the U.S. Treasury than we need to run Government.

I choose now to speak to a proposal that I made with the introduction of a tax bill yesterday. I introduced it and had it printed and reported to the appropriate committee because I thought that even though I am not on the Finance Committee, that some of my ideas and thoughts might be relevant. I wanted the Senate to have the benefit of what I thought should be a good way to fix the Tax Code while we are reducing taxes.

Let me address this matter in a text that I have prepared and worked very hard on, including the bill that was introduced. I thank my staff for the diligent work and the Joint Committee on Taxation for their willingness to help us with evaluations of how much these various proposals will cost.

T.S. Eliot wrote, ''April is the Cruelest Month.'' Millions of Americans agree, especially around April 15. The Congress is going to pass a tax bill to make April a little kinder. I say it is time to share the surplus. Since without tax relief it takes the average worker until May 11 to earn enough money to pay his or her taxes, our tax bill also lets people start working for their families' benefit earlier in the year.

American families are currently saddled with an unprecedented tax burden. Total Federal tax collections are at a post-World War II high of 20.7 percent of the gross domestic product. Individual income tax collections alone are 10 percent of the gross domestic product and are projected to stay there. We have never experienced a government based on that level of income taxation, speaking of the income tax component of our total American government tax table.

The 1990s are truly a decade when government taxed the total population of America at a very excessive rate. The President will have a choice to spend on government programs or resist the urge to splurge and instead return the overpayment to its rightful owners in the form of a tax cut or tax relief. It is estimated the average American household will pay nearly $7,000 more in taxes than the government needs to operate the non-Social Security portion of the government over the next decade. The tax-writing committees of Congress are working right now to fashion a 10-year tax cut, phasing it in, that will total around $778 billion over the next 10 years. In the Senate it seems that they are working on that exact number because that is what the budget resolution we adopted said they should do. The House seems to be moving in a direction of a little larger tax cut over the decade, but we are talking now about $770 billion to $800 billion plus.

The ideas that are encapsulated in the bill I introduced take into account that the economy is booming. Personal income tax, as measured against adjusted gross income, is up 8.25 percent

from 1997 over 1996. That is a current year IRS statistic. That is, personal income, as measured as adjusted gross income, is up 8.25 percent. Income tax revenues are up 10.2 percent. This is good news and bad news, and these statistics encapsulate both.

The good news is our salaries, capital gains, and interest income are growing. The bad news is that bracket creep is pushing more and more Americans into higher tax brackets, even though we do not have as many brackets as we had years ago when bracket creep was a major American problem because of high inflation.

It is still pushing them into higher brackets, and at the same time, the code is working to make more and more American taxpayers pay what is commonly called now AMT taxes; that is, alternative minimum taxes, which really were never intended to cover the vast number of Americans that are currently being pushed into the alternative minimum tax portions of our code because they are being pushed into higher brackets.

I share with the Senate the key components of the bill I introduced, and I want to recognize that this bill builds upon legislation introduced by Senators COVERDELL, TORRICELLI, and MACK.

The philosophy behind the various provisions is something important, as I view it. I have been a long-time advocate of fundamental tax reform. I believe it would be better for our economy and simpler and fairer if we could shift our tax base from income that is earned and instead tax income that is consumed. There are very few who disagree that that would be a very good approach to a philosophy of taxation in our country. I have often said our current code is hostile to savings and investing and that we, as a Nation, pay the price in the form of lower economic growth.

The philosophical underpinnings of this package corrects some deficiencies. Let me go through it.

First section. Broad-based tax relief for all taxpaying families. Purpose: To cut taxes for 120 million American taxpayers by lowering and widening the 15-percent Federal income tax bracket.

Second, marriage penalty mitigation and burden reduction. The purpose is to return 7 million taxpaying families to the 15-percent bracket and to cut taxes for another 35 million taxpaying families who will benefit from a tax cut of up to $1,300 per family. It eliminates or mitigates the marriage penalty for many middle-class taxpaying families. That happens by merely adjusting the brackets downward and upward in the 15-percent area. I repeat, you do not change the marriage penalty for middle-class taxpaying families, but by making the 15-percent bracket broader, adding $10,000 to the adjusted gross income people can earn and still be in that bracket, and lowering the bottom bracket 1.5 percent, much of the marriage penalty is mitigated for people in those brackets.

Third, dividend and interest tax relief. Adjusting the tax base to recognize that dividends and interest should not be taxed. Now, obviously, there is not room in a tax package to totally eliminate dividends and interest. But the purpose of our bill is to provide an incremental step toward taxing income that is consumed rather than income that is earned and saved. It simplifies the code by eliminating 67 million hours of spent time in tax preparation. It eliminates Federal income taxes on savings for more than 30 million Americans in the middle-class families and reduces Federal income taxes on savings for an additional 37 million Americans. It essentially allows about a $10,000 nest egg to grow, tax free, and will let Americans enjoy the miracle of compound interest.

Specifically, it excludes the first $500 in interest and dividend taxation. That permits you to grow this nest egg and not have to pay taxes on the interest and dividends for the first $500 in that kind of income. It sounds small, but it affects a huge number of Americans and starts us in the direction of saying we ought to save, and we ought to start taxing not earned income, but consumed income.

The next provision is a capital gains cut by recognizing that investment and investing should be encouraged, not penalized. A Tax Code for the new century should exclude modest capital gains from taxation. The purpose of the provision is to provide an incremental step toward shifting our Internal Revenue Code away from taxing savings and investment. A savings-friendly Tax Code would lower the cost of capital so that prosperity, better paying jobs, and innovation can continue in the United States.

The bill would eliminate capital gains for 10 million American families, 75 percent of whose income is $75,000 or less. This provision is also a 70 million man-hour timesaver. I can think of many activities to spend 70 million hours on rather than filling out tax forms. The specific of this provision is that it exempts the first $5,000 in long-term capital gains from taxation. It eliminates it totally from taxation.

Another important section deals with retirement savings incentives. The purpose of this is to say that the savings rate for all Americans will increase by reforming the system to favorably treat income that is invested for retirement. It provides targeted incentives to middle-class families to increase their retirement savings in a traditional IRA by $1,000 per working member of the family per year. Specifically, it raises the contribution limit for traditional deductible IRAs from $2,000 to $3,000 and indexes the limit for inflation, when we can fit that into the dollars in the code.

The bill includes a death tax phase-out. It recognizes that death should not be a taxable event in the 21st century. We do not have sufficient resources to do away with it in toto. Some will be proposing it. I think they will find that it is rather expensive, even with $782 billion to spend. So the purpose of ours is to begin phasing it out. Specifically, it reduces tax from the top rate of 55 percent to 40 percent.

Then we have innovation and competitiveness. We all know those are characteristics that, at this point in our economic history, are rampant in our American economy. Innovation and competitiveness are the things that turned the American economy around and made Japan ask: What is America doing right? It made France and Germany ask: What are they doing right? Fifteen years ago, everybody was asking the reverse. Some were wondering if we should do things like they did things. I am grateful we did not, for most of the difference was planning by Government. They continued to do it and we came out of it with innovation and competitiveness.

Now we ought to make sure we do what we can with this available surplus to make the research and investment credit turn out to be a permanent part of the Tax Code. This change recognizes that the single biggest factor in creating better jobs through productivity growth is innovation. Productivity growth is derived from research and development conducted in the private sector. Between 60 to 80 percent of the productivity growth since the Great Depression can be traced to innovation.

Specifics of the proposal. The provisions here are the same as those contained in Senate bill 951, which I introduced. It makes this tax credit permanent, but also expands it to cover businesses that were not heretofore covered, including many small businesses that are filled with innovation but can't avail themselves of the research and development tax credit.

Last, but not least, the bill includes a section on energy independence. All I will say is that America is, once again, looking at itself in the world and finding that we grow more and more dependent on oil from abroad. In fact, it has gotten so high that there is no question that America is now dependent for its very survival upon importing oil from foreign countries. We have probably reached the point where we cannot avoid that. We will always be dependent. But the question is, Should we let an American oil and gas industry—principally made up of independent producers and risk takers—wither and die on the vine? Or should we change the Tax Code so more capital will be made available by the way we change the Tax Code for that kind of industry, the oil patch of America, for those who supply the services, take the risks, and those who pump the oil and gas.

We have made some changes and many Senators are interested in some of these issues, such as oil and gas capitalization, through changing the Tax Code. I won't read them one by one. To be specific, with reference to my own

State, this overall proposal cuts taxes for 574,000 New Mexican families who have to file an income tax return.

First, the bill cuts taxes by 10 percent by lowering the 15-percent bracket to 13.5 with a 5-year phase-in. This lowers taxes for families with adjusted gross incomes up to $44,000 for joint filers and $28,000 for single filers. The tax change puts 424,000 New Mexicans who weren't up to that amount in a new lower bracket and cuts their taxes by 10 percent. This bill also raises the threshold on the 15-percent bracket—something that was included in the proposals made by the distinguished Senator from Georgia and Senator TORRICELLI from New Jersey. It raises that threshold by $10,000 so that middle-income Americans can earn up to $55,000 in a joint return and only pay 15 percent, instead of being dumped into the higher bracket once they are at $44,000. This is going to cut taxes for families with adjusted gross incomes between $44,000 and $55,000. You know the rest.

According to our own revenue and taxation department in my home State, approximately 151,000 New Mexicans would be returned to the 15 percent tax bracket from which they have been pushed out; 83,000 of the families would see their taxes cut by $1,300 a year. Because of the progressive rate change structure, New Mexicans in the 28, 31, 36 and 39.9 brackets would all see their taxes cut by a similar amount because of the marginal rate concept in our law.

This bill excludes $500 in interest and dividends from taxation. The exclusion essentially makes a $10,000 nest egg tax free; 504,000 New Mexicans will be helped by it and file more simple tax returns. The bill exempts $5,000 in capital gains from taxation, amounting to a $1.4 million tax cut for 118,000 New Mexicans.

I close with a quote from Milton Friedman.

Milton Friedman said, and I agree:

> The estate tax sends a bad message to savers, to wit: that it is O.K. to spend your money on wine, women and song, but don't try to save it for your kids. The moral absurdity of the tax is surpassed only by its economic irrationality.

The death tax is also one of the most unpopular taxes. While most Americans will never pay it, 70 percent believe it is one of the most unfair taxes. Its damage to the economy is worse than its unpopular reputation. The Tax Foundation found that today's estate tax rates (ranging from 18 to 55 percent) have the same disincentive effect on entrepreneurs as doubling the current income tax rates and NFIB called it the ''greatest burden on our nation's most successful small businesses.''

The would make R&E credit permanent and phase-in some modifications during last five years. This is essentially the text of a bill I introduced earlier this year.

The bill increases expensing to $250,000. This will simplify record keeping for 2.5 million small businesses and save them a whopping 107,000,000 hours in tax preparation.

It also phases out the AMT for both indivduals and corporations.

The tax plan also recognizes that there are certain areas of the country—oil patch in particular that are being devastated. At the same time, the oil and gas industry pays some of the highest taxes in the country. For this reason the bill also includes oil and gas tax relief.

While the Joint Committee on Taxation has not completed its revenue estimate, it is my intention that these tax provisions can be accommodated within the Budget Resolution.

The PRESIDING OFFICER. The Senator from North Dakota is recognized for up to 10 minutes.

Mr. DORGAN. I ask unanimous consent to be recognized for 20 minutes.

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

PRIVILEGE OF THE FLOOR

Mr. DORGAN. I ask unanimous consent Tony Blaylock, a fellow on my staff, be given floor privileges until the end of the year.

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

Mr. DORGAN. Mr. President, I ask unanimous consent Kristi Schlosser be given floor privileges today.

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

THE FAMILY FARMER

Mr. DORGAN. Mr. President, one only needs to open a newspaper or turn on a television set to a news program in this country, the United States, to understand we are experiencing a wonderful economy, a wonderful turn of events. This has lasted a long while. Most people are working. Inflation is down. Budget deficits have evaporated. The country is growing. The economy is doing better, and there is a lot of good news.

In addition to the general economic news, the stock market is in a kind of go-go mood reaching record highs. These breathtaking heights in the stock market are coupled with stories about young people involved in the Internet who are making millions before they are old enough to shave. That is wonderful.

There are a lot of people doing well in this country because of the economy. But there are some who are left behind and left out. We ought to pay attention to some of these storm clouds. I am speaking especially about family farmers. They are this country's economic all stars and have been for some long while. They are suffering silently, but they are suffering in a very significant way today. This Congress has a responsibility to do something about it.

Let me read a letter that I received from a farmer in North Dakota a day or two ago. He says:

> As a family farmer and rancher, it doesn't seem to me there are many people who care much about us anymore. It sometimes brings tears to my eyes that maybe in a year or two I won't be around in farming anymore. This won't be easy to explain to my three daughters. I wanted to bring them up in a rural setting. If it happens I can't farm, I hope they read in the history books some day that it wasn't because their dad was a dumb man. It was caused by policy and giant concentrations of companies who want world dominance.

This farmer, who worries about losing his farm and worries about how he will explain that to his three daughters, worries about not being able to raise his daughters on the family farm. He says it is not his fault. And it isn't.

I want to describe what this man is going through.

Another farmer wrote to me and said:

> I'm sitting at the kitchen table at 3:30 in the morning. It is spooky quiet out here these days, neighbors going broke, moving away, family farmers can't make it. My family is asleep and I don't know how long I will be able to hang on to this family farm.

Let me describe what these farmers face. While the stock market reaches record highs, here is what happens to the price of wheat. Those family farmers see their income declining in a very significant way. No one else is experiencing declining income. CEO salaries aren't going down; they are going up, up, up—way up. The stock market is going up to record highs. Yet if you are raising wheat and you are a family farmer, you have seen your income collapse.

What if you are raising corn? Exactly the same thing. Your income is collapsing.

What if you are raising soybeans on the family farm? The same thing. The income is collapsing.

What share are you getting as a family farmer of the retail food dollar? Collapsing.

In the spring, you borrow some money, you buy some seeds, you fix up the tractor, plant the seeds, and hope they grow. You worry about insects; you worry about crop disease; you worry it will hail; you worry that it won't rain enough, or maybe too much; and then at the end you may get a crop. If you get a crop, you worry when you will get it off the ground. After you have combined it and harvested the crop, you put it on the truck and drive to the elevator, only to be told the grain trade says that the crop produced has no value. We are going to pay you $1.50 or $2 a bushel less than it cost to produce.

You sit in the truck as a family farmer, knowing you took all of these risks, that your family is depending on you, and that the world is hungry. You hear the stories. You hear that in the Sudan a million people face the abyss of starvation and old women climb trees to forage for leaves because they have nothing to eat.

The grain trade says the food we produce has no value. Farmers scratch their heads and say: I guess it is because the public policies in this country say that family farmers don't count. Family farmers don't matter.

That is what angers family farmers the most. They produce something of enormous importance to the entire world and are told it has no value. They are told that the farm bill is fundamentally bankrupt. The Freedom to Farm Act passed by this Congress several years ago is totally bankrupt. It ought to be repealed immediately.

Trade agreements, negotiated by trade negotiators who have done a terrible job and were totally incompetent, sold our farmers down the river.

So family farmers have a right to ask the question: Why can't we expect from this Congress, this Administration, and this country, a decent opportunity to make a living, a decent price for the food we produce, and a decent deal from trade agreements that are negotiated with other countries? Why can't we expect this country to stand up for family farmers?

A group from some farm States met this morning. We talked about how we will mobilize efforts to try to begin to provide two things. One, we need some emergency help—an emergency disaster relief bill to offset the income collapse which family farmers are facing. Second, we need a change in the farm program. We decided to seek a meeting next week with President Clinton at the White House. We will try to make sure this Administration proposes a robust disaster program and joins in proposing to change the underlying farm program to provide decent income support for family farmers when prices collapse.

Next week we will try to do that, meet with the President, and develop an emergency bill to provide disaster relief. Senator HARKIN and I proposed such a bill in the appropriations subcommittee. Senator CONRAD has proposed a number of ideas on how to provide disaster relief. I expect we will have to propose disaster relief somewhere in the $10-billion-plus range.

This Congress has a responsibility to respond to this issue and to do it soon.

Second, to change the farm bill so family farmers have a safety net. Others in this country have a safety net. But somehow the suggestion was made that we can just pull the safety net out from under family farmers and that would be fine. Nobody will care. Families care. Farmers care. I do not want anybody standing up in this Chamber saying they are profamily and then turn a blind eye to the needs of family farmers. That is what has been happening.

If there were fires or floods or tornadoes that hit our part of the country and devastated all the buildings, the economy and the infrastructure, we would have folks rushing out there with help. We would have FEMA all set up in big buildings and tents, getting people in to give help. Everybody would be helping. In fact, you wouldn't even need a tornado. If some hogs got sick with a mysterious disease, we would have the entire Department of Agriculture trying to find out what was wrong with the hogs. Only farmers can see their incomes collapse.

In our State, the incomes collapsed 98 percent in 1 year. Ask yourself, could your family stand a 98 percent loss in income? Could any Members of the Senate stand a 98 percent loss in their paycheck? Can wage earners stand a 98 percent loss in their wage? I don't think so. That is what happened to farmers in my State.

The question is, who is going to respond, when are they going to respond, and when is this country going to care whether we have family farmers left in our future? The answer for me is soon. The answer for me is now. Next week, we must expect to make progress with the President; yes, with the majority party and the minority party working together to try to provide disaster relief, No. 1, and a long-term safety net, No. 2.

I want to tell you about a fellow named Tom Ross who did something that I thought was unique in Minot, ND. Tom Ross is a newscaster with KMOT television. He got 48 acres just north and east of Minot, ND. He got some partners, and he planted 48 acres of durum wheat. His partners were experts in this area, seed companies, chemical companies, the Research Extension Service and so on. In 1997, they determined exactly what it cost, exactly what they planted, and exactly what they harvested, and what the outcome was. They did this on television to try to demonstrate the plight that family farmers were facing. Let me demonstrate what it was.

In 1997, they planted 48 acres, and they lost $50 an acre. This is with all the experts weighing in with Mr. Ross, the newsman, saying here is how we do it. They did it, and they lost $50 an acre. Next year, they planted the same 48 acres and they lost $1,930 an acre. So in 2 years they have lost almost $2,000 an acre on 48 acres of land. If you farm 1,000 acres, which is about an average size farm, slightly smaller than an average size farm in the farm belt, you would have lost $50,000 just in that first year.

This year, Mr. Ross planted 48 acres of roundup ready canola. Last week, I stood out in that field just northeast of Minot, ND. We will see what happens this year. Given the price, given the circumstances, they expect they will lose some money this year.

The point is that on 48 acres with controlled circumstances and all of the experts to help, you have massive losses of income over three years. This is multiplied by every family farmer across the farm belt. Why? Because prices have collapsed, and family farmers have no safety net, at least not a safety net that is available to help them survive.

This is a unique experiment, and it shows in the clearest way possible that this is not about whether family farmers are good farmers. They are the economic All-Stars in our country. The project that KMOT did in Minot, ND, demonstrates that when prices collapse, family farmers do not have a chance to make a decent living and someone has a responsibility to help. That someone is this Congress, this Senate, this President. And the time is now; not later—now. If we want to save family farmers for this country's future, we must take action now.

On Monday, I am going to talk about a paper that was just released by the Economic Policy Institute written by Robb Scott, ''The Failure of Agriculture Deregulation,'' describing the failure of Freedom to Farm, the failure of our trade policies, and the selling down the river of family farm interests in this country by people who should have known better. I will describe that in more detail on Monday.

We do not have time to waste. We do not have time to wait. We must act and do so with great effect to try to help family farmers. The fellow who says I may not be able to farm anymore, at least is farming now. A whole lot of folks sold out long ago, and more are selling out every month and every week.

A woman called me recently and said her 17-year-old son would not come down to the auction sale when they were forced to sell. She says it is not because he is a bad kid. This young boy stayed up in his bedroom because he was brokenhearted. He wanted to farm that land so bad and take it over from his dad at some point. He knew when the auction sale was held that it was over for him. His dreams were gone. She said he was so brokenhearted he simply could not come down and participate in the auction sale of the family farm.

That is happening all across the northern plains, all cross the farm belt. At the same time, the stock market shows record highs, and we hear about this robust economy. The economic all-Stars in this country, who produce so much of what the world needs, are being told what they produce has no value and their existence does not matter. Shame on this country if it does not stand up now and decide that family farmers have value. What they produce has enormous value, and family farmers are important for this country's future.

I am betting the energy exists with this President and this Congress to finally turn the corner and say we need to make a change. We need trade agreements that stand up for the interests of farmers. We need a safety net that says when farmers' incomes drop 98 percent, we stand to help because we care about you and your future.

The PRESIDING OFFICER (Mr. GREGG). THE SENATOR FROM MASSACHUSETTS.

PRIVILEGE OF THE FLOOR

Mr. KENNEDY. Mr. President, I ask unanimous consent that Jennifer Duck, a Labor Department detailee with my office, be granted the privilege of the floor.

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

MINIMUM WAGE

Mr. KENNEDY. Mr. President, yesterday, the House of Representatives with very little discussion and debate voted themselves a $4,600 pay increase. The Senate passed a similar measure earlier this month. Fair is fair. If Members of Congress deserve a raise, then surely the hard-working, lowest paid workers across this country deserve an increase in the minimum wage as well. Shame on this Congress when we vote ourselves a $4,600 pay increase, yet do nothing for the lowest paid workers in America.

I intend to do all I can to see that Congress acts to raise the minimum wage as soon as possible. When President Clinton signs the law to raise the pay for the 535 Members of Congress, he should also have on his desk the bill to raise the pay for the 11 million Americans who work for the minimum wage.

The case for an increase in the minimum wage is overwhelming. Since 1991, congressional pay has increased $39,400. In the same amount of time, a minimum wage worker has seen a pay increase of only $1,870.

Legislation to raise the minimum wage—the Fair Minimum Wage Act—has been installed for many months by this Republican Congress. Our proposal will raise the federal minimum wage from its present level of $5.15 an hour to $5.65 on September 1, 1999 and to $6.15 an hour on September 1, 2000.

Speaker HASTERT said last March, ''I feel Members of Congress come here, they do their work. I know there are Members that have three or four kids in college at a time. I'm not crying crocodile tears, but they need to be able to have a life and provide for their family.''

I say minimum wage workers have a life, too. They need to provide for their families, too. They need to put their children through college, too.

Under our proposal, a minimum wage worker would earn an additional $2,000 a year. That amount will pay for 7 months of groceries to feed the average family. It will pay to house an average family for 5 months. It will pay for 10 months of utilities. It will cover a year and a half of tuition and fees at a 2-year college. It will provide greater opportunities for all those struggling at the minimum wage to obtain the skills they need for better jobs and better careers and better support for their families.

We know that under current law, minimum wage earners can barely make ends meet. Working 40 hours a week, 52 weeks a year, they earn $10,712 almost $3,200 below the poverty line for a family of three. A full day's work should mean a fair day's pay. But for millions of Americans who earn the minimum wage, the pay is unfair.

Opponents complain that increasing the minimum wage hurts small business and causes job losses. But these claims have been proven wrong. In fact, since the most recent increases in the federal minimum wage—a 50-cent increase in October 1996 and a 40-cent increase in September 1997—employment has risen in virtually all sectors of the economy. Over 8 million new jobs have been added to the workforce, including 1.1 million retail jobs, 350,000 restaurant jobs, and more than 4 million jobs in the service industry. The increases boosted the earnings of 9.9 million low-wage workers directly, and millions more indirectly, but far from enough.

As Business Week has stated:

> [H]igher minimum wages are supposed to lead to fewer jobs. Not today. In a fast-growth, low-inflation economy, minimum wages raise income, not unemployment. . . . A higher minimum wage can be an engine for upward mobility. When employees become more valuable, employers tend to boost training and install equipment to make them more productive. Higher wages at the bottom often lead to better education for both workers and their children.

Even Business Week agrees, ''It is time to set aside old assumptions about the minimum wage.''

The national economy is the strongest in a generation, with the lowest unemployment rate in almost three decades. Under the leadership of President Clinton, the country as a whole is enjoying a remarkable period of growth and prosperity. Enterprise and entrepreneurship are flourishing—generating an unprecedented expansion, with impressive efficiencies and significant job creation. The stock market has soared. Inflation is low, unemployment is low, and interest rates are low.

But despite this unprecedented economic growth, too many workers are not reaping the benefits of this prosperity. To have the purchasing power it had in 1968, the minimum wage should be at least $7.49 an hour today, not $5.15. This unconscionable gap shows how far we have fallen short over the past 30 years in granting low-income workers their fair share of the country's extraordinary prosperity.

Since 1968, the stock market, adjusted for inflation, has gone up by over 150 percent—while the purchasing power of the minimum wage has gone down by 30 percent. Shame on Congress for allowing that decline.

As the economy reaches new heights, so do CEO salaries, often reaching tens of millions of dollars a year. At that rate, it takes a CEO barely 2 hours to earn what a minimum wage worker earns in an entire year. The rise in income inequality between the country's top earners and those at the bottom makes our Nation weaker, not stronger.

In a strong economy, we can clearly afford to give low income workers a rise. Our national wage total is over $4.2 trillion. That is what American employers are paying in wages today. The increase of one dollar that we proposed would raise the national wage total by only one-fifth of 1 percent.

That is a drop in the bucket in the overall American economy, but a significant benefit for low-income workers.

According to the Department of Labor, 59 percent of minimum wage earners are women. Nearly three-fourths are adults. Forty percent are the sole breadwinners in their families. Almost half work full time. They are teachers' aides and child care providers, home health care assistants and clothing store workers. They care for the elderly in nursing homes. They stock the food shelves at the corner store. They clean office buildings in thousands of communities across the country.

The minimum wage is a women's issue. It is a children's issue. It is a civil rights issue. It is a labor issue. It is a family issue. Above all, it is a fairness issue and a dignity issue. It is time to raise the federal minimum wage again. No one who works for a living should have to live in poverty.

This chart over here indicates clearly what has happened to the unemployment rate with previous increases in the minimum wage. For years, we have often heard that an increase in the minimum wage would see an increase in unemployment. In 1996, we had an increase in the minimum wage to $4.75 an hour, and we have seen the gradual decline in unemployment. Then we raised it to $5.15 an hour in September 1997, and we continue to see the decline in unemployment.

This chart over here indicates how long an average CEO has to work in order to make what a minimum-wage worker earns over the year. By 10:06 a.m. on the first working day—say, for January 1st—the average CEO has made what will take a minimum-wage worker to earn by 5 p.m. on December 31. In just over 2 hours, the average CEO has made what a minimum-wage worker will make by the end of the year.

Finally, this chart over here shows what the poverty line is for a family of three. The lower line here shows what the annual minimum-wage earnings are. What we see in 1999 is the continuing decline in the value of the minimum wage as minimum wage earners fall further below the poverty level.

It is time those men and women who work hard—play by the rules, work 52 weeks of the year, 40 hours a week, 8 hours a day—are not going to have to live in poverty. We are going to insist this issue be before the Senate in these next very few days or weeks.

THE PEACE PROCESS IN NORTHERN IRELAND

Mr. KENNEDY. Mr. President, I rise to express my deep disappointment by the failure of the parties to move forward with the peace process in Northern Ireland. The Good Friday Peace Agreement was endorsed by the overwhelming majority of the people of Northern Ireland, and it offers the only

realistic hope for lasting peace for the two communities. We cannot let it fail.

It is hard to understand why this moment was not seized. The Good Friday Peace Agreement is the only way forward—the only way to bring the two communities closer together to build a better future for the people of Northern Ireland.

Decommissioning was not a precondition for the formation of the Executive, but it should take place along with other provisions of the agreement. The Way Forward proposal outlined a clear timetable for addressing the issue. It required clear progress on decommissioning in the coming weeks. General De Chastelain would review progress on decommissioning in September, in December, and again in May 2000. He would need to say publicly that everyone is cooperating. Without significant progress, the Executive would be disbanded.

It is tragic that the opportunity to form the Executive was missed.

The Agreement is the mandate of the people, and must be implemented. It offers the Unionists their key demands—their constitutional position, the principle of consent, an end to violence.

I would hope that once out of the marching season and after a period of reflection and the review by the governments and parties of the working of the agreement—not a review of the agreement itself—that wiser counsels will prevail in September.

I share the frustration expressed by President Clinton that a breakthrough of this potential is being stalled by a dispute on sequencing, which should weigh very little compared to the historic agreement on areas of substance reached in the negotiations.

I applaud the determination of the two Prime Ministers and President Clinton to persist in their efforts, with the support of Senator Mitchell, to overcome this last hurdle.

Despite this latest impasse, all who care about peace must redouble their efforts to find a solution. We must focus our energy on increasing the political dialogue and securing full implementation of the agreement.

A way must be found to build trust between the two communities of Northern Ireland. It is clearly the will of the people of Northern Ireland.

The Governments of Ireland and Great Britain and the United States must continue to work together to revitalize the peace process. We cannot let it fail.

Mr. President, I yield the floor.

ADJOURNMENT UNTIL MONDAY, JULY 19, 1999

The PRESIDING OFFICER. If there is no further business to come before the Senate, under the previous order, the Senate stands adjourned until the hour of 12 noon, on Monday, July 19, 1999.

Thereupon, the Senate, at 2:14 p.m., adjourned until Monday, July 19, 1999, at 12 noon.